Gadjah Mada Journal of Professional Psychology (GamaJPP)
Journal Homepage: https://jurnal.ugm.ac.id/gamajpp
Email : gamajpp.psikologi@ugm.ac.id
e-ISSN 2407-7801 (Online)

Gadjah Mada Journal of Professional Psychology (GamaJPP) Vol **11**, No 2 (2025), 127–133
doi:10.22146/gamajpp.99687

Brief Cognitive Behavioral Therapy for an Adult Woman with Depression Who Receives Antidepressant Medication

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(Received 3 September 2024; revised 30 January 2025; accepted 6 February 2025; published 25 September 2025)

Abstract

Depression profoundly disrupts interpersonal relationships and impairs daily functioning. It is primarily associated with dysregulation of key neurotransmitter systems, making pharmacological intervention essential. Evidence indicates that combining pharmacotherapy with cognitive behavioral therapy (CBT) produces superior outcomes compared to pharmacotherapy alone in managing depression. This case study examines the application of CBT alongside antidepressant medication in the treatment of a 26-year-old woman working in the financial sector who experienced chronic anxiety and pervasive feelings of inadequacy. Her cognitive distortions led her to interpret neutral stimuli as threatening. The administration of quetiapine improved her sleep quality and enhanced emotional resilience under stress. Subsequently, she completed four brief online CBT sessions, which resulted in significant cognitive restructuring and enabled her to critically evaluate and modify negative automatic thoughts in daily life. As a result, she demonstrated greater self-efficacy and developed a more positive self-concept. This case contributes to the growing body of evidence supporting the effectiveness of combined pharmacotherapy and CBT in reducing depressive symptoms among adult women.

Keywords: brief CBT; online therapy; depression; core belief; quetiapine; generalization

Depression is a common clinical condition in Indonesia, with approximately 6.1%—or about 706,689 individuals over 15 years old—reported to experience the disorder (Ministry of Health of the Republic of Indonesia, 2018). Several factors contribute to the onset of depression in adulthood, including socioeconomic changes such as increasing demands for financial and social independence (Purborini et al., 2021), as well as stressful life events (Kendler & Gardner, 2010; Purborini et al., 2021). Individuals with depression typically exhibit functional impairments in their daily lives and are vulnerable to additional stressors, such as job loss and disruptions in social relationships (Uliaszek et al., 2012).

From a biological perspective, depression is associated with imbalances in several key neurotransmitters in the brain, including serotonin, norepinephrine, dopamine, glutamate, and gamma-aminobutyric acid (GABA) (Cui et al., 2024). Serotonin regulates mood, sleep, appetite, and cognitive function. Norepinephrine plays a crucial role in stress responses, attention, and motivation, and also influences the autonomic system, energy, and alertness; low levels can lead to fatigue, loss of interest in daily activities, and impaired concentration. Similarly, reduced dopamine levels in regions such as the nucleus accumbens and prefrontal cortex are linked to anhedonia (the inability to feel pleasure) and decreased motivation. In some cases of depression, reduced GABA activity leads to uncontrolled neuronal excitability, contributing to anxiety and sleep disturbances, while disturbances in the glutamate system—such as excessive activity or NMDA receptor dysfunction—can impair neuroplasticity and memory, thereby worsening depressive symptoms and cognitive functioning (Nutt, 2008).

Because of these neurochemical imbalances, pharmacological treatment is often required to relieve symptoms and improve quality of life. The choice of medication should consider specific symptoms, mechanism of action, safety profile, medical history, and prior treatment response. Treatment typically begins with a low dose and is adjusted according to the patient's response and the appearance of side effects (Grover et al., 2017). Selective serotonin reuptake inhibitors (SSRIs) are generally recommended as first-line antidepressants due to their favorable safety and side-effect profile (Stahl, 2015). By inhibiting serotonin reuptake in the synapse, SSRIs increase serotonin levels in the synaptic cleft and enhance serotonergic transmission. Common examples include fluoxetine, sertraline, citalopram, escitalopram, and paroxetine.

Nevertheless, pharmacotherapy alone is often less effective than a combined approach. Meta-analyses have shown that integrating pharmacotherapy with cognitive behavioral therapy (CBT) yields superior outcomes for patients with depression (Cuijpers et al., 2023). Since its introduction over 50 years ago, CBT has consistently been proven effective in reducing depressive symptoms (Kambeitz-Ilankovic et al., 2022). CBT focuses on identifying core beliefs and distorted thought patterns that generate negative automatic responses and perpetuate emotional and behavioral difficulties. Interventions are aimed at restructuring these thought patterns, thereby improving emotional regulation and everyday functioning.

Historically, the implementation of CBT has faced

barriers such as limited time, geographic constraints, and financial costs. However, recent developments—such as the use of online sessions—have helped overcome these obstacles. A systematic review by Kambeitz-Ilankovic et al. (2022) found that online CBT is comparably effective to face-to-face therapy. From a financial perspective, limited state health insurance coverage remains a key barrier to access. Therefore, brief CBT, which condenses therapy into four to eight sessions with specific therapeutic goals, offers a more practical and affordable option for self-financing patients (Cully & Teten, 2008). Research by Sam et al. (2023) demonstrated that brief CBT, which combines psychotherapy, behavioral activation, and problem-solving, can effectively reduce depressive symptoms.

Given the high prevalence of depression in Indonesia, combining pharmacotherapy and CBT represents a more effective treatment strategy than either approach alone. To address barriers to traditional CBT, both online delivery and the brief format provide feasible solutions. This study aimed to evaluate the benefits of brief CBT administered alongside antidepressant pharmacological therapy.

1. Methods

This article is a case study report on the implementation of brief CBT on a client undergoing pharmacotherapy. Participant M, a 26-year-old woman at the time of the study, was initially seen by a psychiatrist. M reported pain on the left side of her body, fatigue even after a long night's sleep, difficulty concentrating, falling silent, forgetfulness, easily crying, and irritability. Further, she reported she said she felt exhausted about life, although there was no specific thought about ending life. M reported experiencing irritability since 2021, which marked three years since the onset of her symptoms. However, the irritability had intensified, particularly as she faced heavy workloads and tasks at her job that conflicted with her moral values. Her inability to resign, despite feeling these pressures, further exacerbated her symptoms and contributed to her overall distress. M worked in the financial sector and handled a high volume of work. There were instances when she was asked to perform tasks that she believed might be illegal, which contradicted her ethical beliefs. Although M expressed a desire to resign, her company director did not allow her to do so.

An examination of M's mental health status found that she experienced mood dysphoria, limited affect that aligned with mood, and preoccupation with desperate thoughts such as believing that she was a failure who constantly disappointed her parents and would never be able to escape her current situation. An assessment using the Montgomery-Asberg Depression Rating Scale (MADRS) showed M's depression score at 28 (medium). The instrument was administered in the Indonesian language, following a self-conducted translation by a professional before being provided to the patient. Based on the assessment, M was categorized as depressed by a psychiatrist. She received medication: antidepressant fluoxetine, at a dose of 20mg from April to early June, which reportedly did not improve her mood and sleep quality. In July, M had several panic attacks 2–3 a week, felt coldness in her hands and feet, experienced trembling and palpitations, and became more fearful. Additionally, M felt less motivated to socialize with others and, at times, thought she heard people's voices in the office. The psychiatrist replaced M's medication with quetiapine, starting from a low dose (50mg) and, upon biweekly monitoring, turning into the optimal dose (300mg). This adjustment was made because the previous antidepressant did not adequately improve her mood and sleep quality. At the same time, quetiapine was considered more suitable to address both depressive symptoms and her persistent anxiety-related sleep disturbances. After the second medication, M reported feeling less anxious and calmer under pressure, with symptoms like trembling and panic diminishing.

After her condition improved, she was advised to see a psychologist to receive therapy. Prior to this referral, she had been under the care of a psychiatrist for approximately three months to stabilize her symptoms through pharmacological treatment. To the psychologist, M said that she used to be cheerful, active, and joyful. However, she felt that everything was wrong at the moment. Her constant anxiety disrupted her daily life, especially when she needed to make decisions at work. It became difficult for her to concentrate and think, and she said she was afraid to make decisions. The thought that she was a failure was always present, causing her to feel guilt toward herself and her parents, who MI said always tried to instill religious values in her. The belief that she was a failure was an accumulation of unpleasant experiences, including being ostracized by peers, a lack of appreciation from parents, and exposure to a non-supportive environment. The result was that MI became an irritable person who could easily get angered. She hoped that seeing a psychologist could help her overcome the condition. She felt very disturbed by her own thoughts, which caused excessive anxiety.

Studies have shown that CBT is the most effective psychotherapy for depression (Cully & Teten, 2008), and therefore, the psychologist offered M a CBT treatment. After considering M's psychological and financial conditions, the psychologist and M agreed on four brief sessions of online-delivered CBT. The goal was to identify cognitive distortions and challenge them so that M could mitigate excessive anxiety. Later, M wanted to be able to see herself more positively than before the psychotherapy, no longer constantly thinking of herself as a failure. Four CBT sessions were conducted over a period of six weeks. As agreed, one session was held each week, lasting 60 to 75 minutes, via the Zoom application in the evening after work hours. However, due to job demands, M had to postpone sessions two and four, which extended the overall timeline. The sessions included CBT psychoeducation, the identification of negative automatic thoughts, the recognition of false self-beliefs, efforts to challenge these thoughts, problem-solving skill training, goal setting, and relaxation techniques. M was assigned tasks to complete before each session. Despite not consistently filling out the provided worksheets, M expressed a desire to engage in the assignments. Some worksheets were completed, while others were only partially filled out. Nevertheless, during the sessions, M came prepared with answers from the worksheets for discussion. Table 1 outlines the implementation of the brief CBT conducted with M.

Table 1
Brief CBT Intervention

Session	Targeted Aspect	Description	Implementation of Intervention Activities
Session 1	Increase positive activities and enhance emotional stability	CBT psychoeducation, behavioral activation techniques, and relaxation techniques (deep breathing)	The psychologist provided an explanation about CBT and identified therapy goals and their success indicators together with the client. In addition, the psychologist encouraged the client to list enjoyable activities they usually engaged in and to schedule those activities. The psychologist then trained the client in relaxation techniques to reduce anxiety and instructed her to practice relaxation regularly.
Session 2	Identify negative thoughts and the events that trigger them	Checking mood, reviewing the implemented action plan, discussing situations experienced by the client, identifying negative automatic thoughts, and challenging them. The questioning technique used was the thought question, such as "What makes you feel the way you do right now?"	The psychologist provided an emotion scale to assess the client's current condition. The psychologist also asked about M's recent activities. The client was then guided to explore the connection between her thoughts, feelings, and behaviors, and was assisted in identifying negative automatic thoughts. As part of the homework, the client was asked to record any emerging negative thoughts, along with the associated emotions and behaviors, and to look for evidence that challenged those thoughts.
Session 3	Strengthen the client's ability to challenge negative thoughts	Checking mood, reviewing the thought record table, asking questions using the thought question technique, identifying core beliefs, and applying cognitive restructuring techniques.	The psychologist provided an emotion scale to assess the client's current condition. The psychologist also inquired about the completed thought records, including any difficulties experienced when challenging those thoughts. The client was encouraged to reflect on past successes as a resource for challenging the negative automatic thoughts that arise.
Session 4	Improve the client's problem-solving skills	Reviewing previous sessions, psychoeducation on setting goals using the SMART principle, and psychoeducation on problem-solving strategies.	The psychologist reviewed the previous sessions together with the client, including discussing the difficulties encountered. Then, the psychologist guided the client to list the pros and cons of potential solutions to the problems she was facing.

2. Results

Before explaining the results of the brief CBT treatment, we would first discuss the pharmacotherapy undertaken by M. There was a change from fluoxetine, an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class, to quetiapine, an atypical antipsychotic. The change was carried out for clinical reasons, among others, after almost two months of treatment, since the first drug did not give an adequate response, and there was a clinical need to target the sleeping difficulty symptom that was not solved by the SSRI drug.

In addition, due to the M's limited government health insurance program (BPJS Kesehatan) coverage, the psychiatrist could not increase the fluoxetine dose or replace it with antidepressants that have a sedating effect to help improve the M's sleep quality. After discussing the side effect profile, benefits and risks, and limitations, M agreed to replace the drug with quetiapine (one of the drugs still covered by BPJS Kesehatan and available in hospitals). The mechanism of quetiapine in the context of depression involves action on several neurotransmitter systems in the brain, including serotonin, dopamine, and norepinephrine. Quetiapine, with its antagonistic profile to serotonin 5-HT2A and dopamine D2 receptors, is more effective in stabilizing mood than fluoxetine, which primarily targets serotonin reuptake. Quetiapine also has a strong sedative effect due to its antagonism to histamine H1 receptors and Alpha-1 adrenergic receptors.

As for the psychotherapy, M followed the entire brief CBT agenda that was prepared and actively participated in the discussion. There were several silent periods in each session, especially when the psychologist proposed a thought question. M's intention to achieve the therapy's goals was shown by her efforts to complete CBT tasks. Now and then, M asked questions when she could not understand something. There were four sessions conducted in the therapy. In the first session, M was able to understand the explanation of CBT and began to be able to see the link between her thoughts, feelings, and behavior. M realized that having positive thoughts about herself was one of the indicators of achieving the therapy's goals because constant thoughts about failure had disrupted her life. In addition, M compiled an action plan for Week 1, including fun activities she previously did, e.g., night walking while looking at the moon and stars, sholawatan, and buying lavender scented candles. M could also follow the psychologist's direction for deep breathing and said she could try the technique in the subsequent week. M said she wanted to do relaxation shortly after waking up in the morning and before going to bed at night.

This provided a resource for M to challenge the automatic negative thoughts that emerge in difficult situations in the future.

In the last session, the fourth session, M was able to list alternative solutions and identify each solution specific to certain situations, for example choosing to discuss work-related moral conflicts with her supervisor rather than silently complying, or setting clearer boundaries to decline tasks that might involve illegal transactions. She could also name goals for the solution that had been chosen, which showed that M already had the resources to deal with the next difficult situations, for example setting a clear goal to maintain her integrity by consistently refusing illegal transactions and planning regular relaxation

practices to help manage anxiety during high-pressure periods.

Based on the mood checks carried out in the second to fourth sessions, there was a decrease in sad emotions, 3 out of 10. This was also reinforced by M's statement that the intensity and frequency of sadness had decreased, but she still felt occasionally sad when recalling that she was not in optimal health at the moment. The difficulty in concentrating and decision-making was also reduced, shown by M's refusal to carry out illegal transactions instructed by her superior. M could also work again in a team without any complaints related to her work. About activities, M had begun to routinely follow religious studies or recitation that she had left since the onset of the depression. These changes were considered as indicators of the success of the brief CBT program, as they reflected not only a measurable reduction in depressive symptoms but also a growing ability to apply coping strategies independently. M's improved concentration, renewed participation in religious activities, and assertiveness in setting personal boundaries demonstrated lasting cognitive and behavioral shifts beyond the therapy sessions. See Table 1

3. Discussion

This article reported the implementation of brief CBT in M, who were undergoing antidepressant medication. The improvement in M after changing the medication to quetiapine is in line with the results shown by Stahl (2015) that quetiapine may be more beneficial in depressed clients who experience significant sleep problems or sleep disorders associated with anxiety. When the condition is more stable, an individual with depression is better at using internal resources to engage in the therapeutic process, such as developing intrinsic motivation that contributes to the success of therapy (Philips & Wennberg, 2014). In this context, "more stable" refers to the point when acute symptoms such as persistent sadness, anxiety, and sleep disturbances have been reduced—allowing the person to think more clearly, regulate emotions more effectively, and participate actively in therapeutic.

The online brief Cognitive Behavioral Therapy (CBT) program led to a reduction in depressive symptoms for MI, as observed during the clinical interview in the final session. Notable improvements included enhanced concentration and decision-making abilities. A key factor contributing to the therapy's success was MI's motivation to overcome her current challenges. In the first session, she was taught relaxation skills aimed at stabilizing her negative emotions. After practicing the relaxation technique, she reported experiencing a sense of calmness. This finding aligns with a meta-analysis by Hamdani et al. (2022), which confirmed the effectiveness of relaxation techniques in reducing symptoms of depression. The behavioral activation techniques employed by M, from planning to implementation, facilitated emotional and behavioral changes. According to Stein et al. (2020), there is a bidirectional relationship between behavioral activation and mood improvement; engaging in behavioral activation can enhance mood, and improved mood can, in turn, promote further activation.

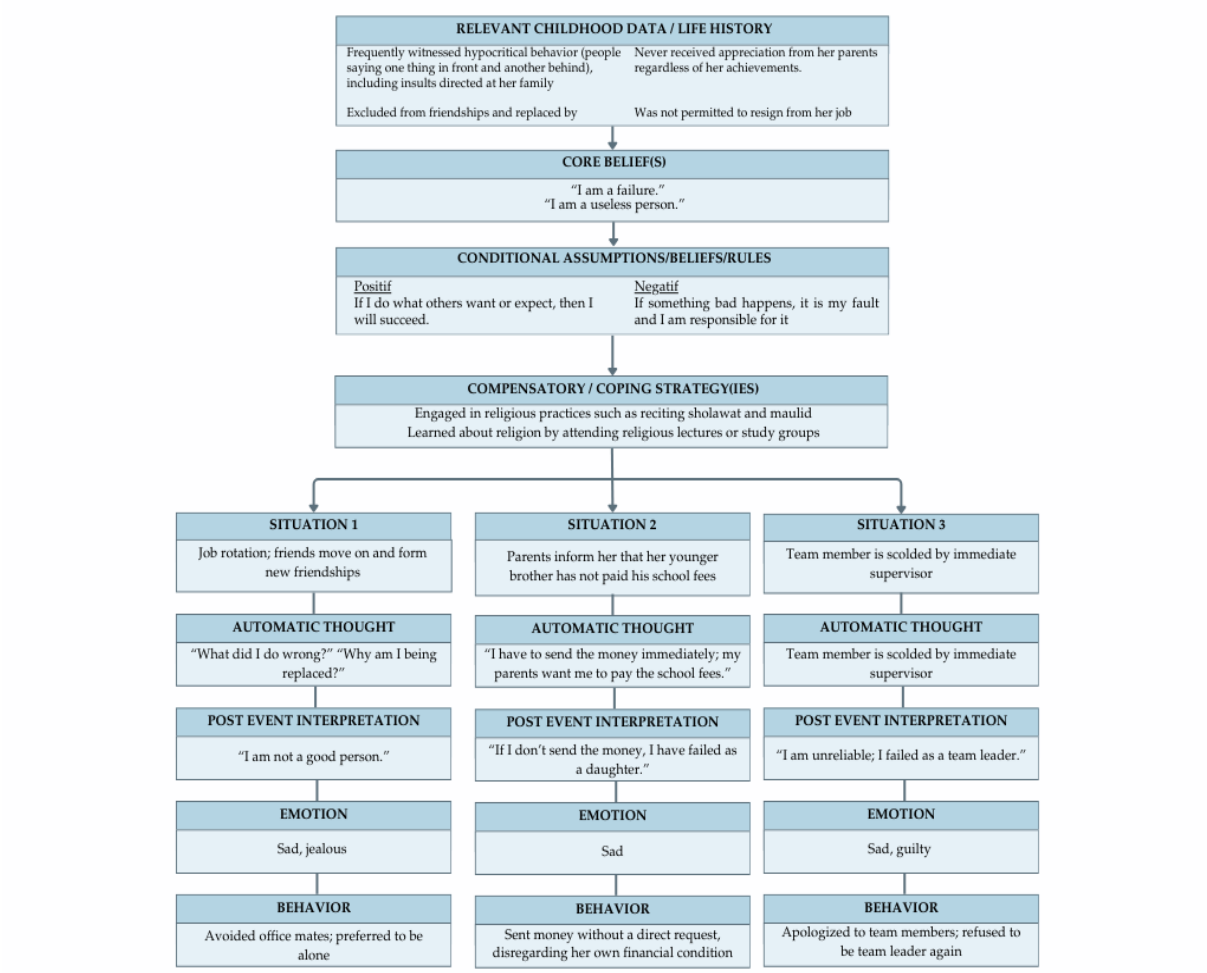
Furthermore, after behavioral activation, the therapy targeted M's negative automatic thoughts. These thoughts could be identified and challenged through a process called cognitive restructuring. After identifying the negative and unrealistic thinking of a situation, M was encouraged to replace the thought with a more realistic interpretation. Connections of information acquired during her developmental stage converged into the core beliefs underlying M's thought processes. These thoughts are interrelated with behavior and emotional experience across various situations. Cognitive restructuring techniques helped M transform negative automatic beliefs and thoughts into more appropriate forms that led to decreased symptoms of depression. This cognitive restructuring was shown to be effective in reducing depression symptoms in M. These results support the scoping review conducted by Santos et al. (2024) with regard to the effectiveness of cognitive restructuring in reducing depressive symptoms.

To prevent the relapse of depressive symptoms, M was equipped with additional skills, including problem-solving, to deal with difficult situations in the future. Adults with depression need more comprehensive psychotherapy beyond just equipping them with problem-solving skills (Krause et al., 2021). This shows equipping the client with problem-solving skills aligns with the result of the previous meta-analysis. M seemed to be able to formulate alternative solutions and choose solutions after weighing the pros and cons of each solution.

A combined treatment of pharmacotherapy and brief CBT was proven beneficial in reducing symptoms of depression. This integrative approach addresses both the biological and psychological dimensions of the disorder: pharmacotherapy helps to rebalance neurotransmitter activity, improving mood and regulating sleep, while CBT targets maladaptive thought patterns and strengthens coping skills. In M's case, the change to quetiapine stabilized her mood and reduced anxiety-related sleep disturbances, creating a more stable mental state that enabled her to fully participate in therapy. The brief CBT sessions then facilitated cognitive restructuring and the development of healthier behavioral responses, resulting in measurable improvements in concentration, decision-making, and emotional regulation. These combined effects illustrate how pharmacological treatment can lay the groundwork for psychological interventions to be more effective and sustainable.

Even so, in this case study, the CBT was delivered in the minimum number of sessions (four sessions). If the therapy was delivered in a longer period, such as an eight-session therapy, the therapist could further explore cognitive distortion and other core beliefs. However, this option was not pursued because both the client's financial considerations and her busy work schedule limited the feasibility of a longer treatment plan, making a brief four-session format the most practical and mutually agreed approach. In addition, it should be noted that one of the success ingredients of the therapy is the client's motivation or desire to change and the commitment to engage in discussions and work on tasks. In this study, the clinical interview was the only data collection method used by the psychologist. This was the limitation of the present study because there was no quantifiable baseline to be compared to in assessing changes in depressive symptoms

Figure 1
Case Conceptualization Diagram



after the therapy, even though the psychologist asked the client to rate her sadness in the second to fourth sessions.

4. Conclusion

Online brief CBT, conducted simultaneously with an antidepressant treatment, in a female adult diagnosed with depression, was shown to be beneficial in reducing depressive symptoms. The administration of quetiapine helped stabilize mood and improve sleep. The client, M, showed high motivation and commitment to change, demonstrated through active involvement in discussions as well as the execution of therapeutic tasks in each session. This participation made a significant contribution to how therapy was helpful to the client.

A change in mindset toward core beliefs, especially the feeling that she was constantly failing, allowed M to effectively challenge the negative automatic thoughts that arose in her daily life. She became better at giving appropriate responses, which had an impact on reducing symptoms of irritability and improved her emotion regulation. As the emotions became more positive, the behaviors displayed also improved, thus having a reverse impact on her own thought patterns and perceptions. In the end, M could recognize and appreciate the positive things she had.

4.1 Recommendation

Future studies could incorporate standardized questionnaires to obtain more comprehensive baseline data, rather than relying solely on clinical interviews when assessing the client's initial condition. In addition, subsequent research may explore the benefits of applying brief CBT alongside pharmacotherapy in other populations—such as depressed adult males or adolescent clients—to evaluate whether comparable improvements in mood regulation, cognitive restructuring, and overall functioning can be achieved across different demographic groups.

5. Declaration

5.1 Acknowledgements

The researchers expressed gratitude to the participant who allowed the publication of her case. Publication of this report was approved by the patient through a signed informed consent

5.2 Funding

The study did not receive any external funding and was fully funded by the researchers.

5.3 Author's Contribution

Author ATF and Author FK contributed equally to the research, from the conceptualization to the manuscript writing.

5.4 Conflict Of Interest

The authors are professionals who directly treated the patient in this case.

5.5 Declaration of Generative AI in Scientific Writing

The authors declare that Generative Artificial Intelligence (AI) tools (ChatGPT 4.0) were employed exclusively to assist with language refinement, including identifying precise wording to improve clarity and in checking English translations for accuracy and adherence to academic writing conventions. The author takes full responsibility for the accuracy, integrity, and originality of the content presented in this manuscript.

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