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An Individual Counseling Model Based on the Health Belief Model Improves Support for Adolescent Victims of Bullying

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ABSTRACT

Bullying is a form of chronic social stress that has significant adverse effects on adolescent mental health, including an increased risk of depression, anxiety, psychological distress, post-traumatic stress disorder, and the development of maladaptive self-beliefs. The literature indicates that the impact of bullying victimization is not solely determined by the frequency and intensity of bullying experiences, but also by cognitive processes such as threat perception, self-meaning, resilience, and self-efficacy. This review aims to formulate a conceptual framework for individual counseling based on the Health Belief Model (HBM) for adolescents who have experienced bullying through a synthesis of recent empirical findings. A narrative literature review design was employed, with articles retrieved from Scopus, PubMed, ScienceDirect, and Google Scholar published between 2019 and 2025. Thematic analysis was conducted to identify patterns in the psychological impacts of bullying, the role of protective factors, and the relevance of cognitive-based interventions. The findings indicate that bullying victimization contributes to the internalization of negative cognitive schemas that influence coping behaviors and help-seeking processes. Resilience and self-efficacy were identified as important mediators and moderators in the relationship between bullying and mental health outcomes. The Health Belief Model provides a relevant conceptual basis for individual counseling by emphasizing perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and self-efficacy.

Keywords: bullying; adolescents; mental health; individual counseling; health belief model

INTRODUCTION

Bullying is a form of social aggression characterized by repetitive and intentional harmful behavior, accompanied by an imbalance of power between the perpetrator and the victim, whether physical, psychological, social, or symbolic. This phenomenon manifests in various forms, including physical, verbal, relational, and cyberbullying, which has increased alongside the rapid development of digital technology. In recent years, cyberbullying has become increasingly prevalent due to the widespread use of social media and digital communication platforms, allowing harmful behaviors to occur beyond school settings and persist over time. Critically, this shift from traditional to digital environments has altered the temporal and spatial boundaries of victimization, making bullying a continuous rather than episodic experience. Unlike conventional bullying, cyberbullying enables anonymity, rapid dissemination, and a potentially unlimited audience, thereby intensifying the psychological burden experienced by victims and complicating intervention efforts [1,2]. To date, bullying remains a significant global adolescent mental health concern. A cross-national study involving more than 21,000 adolescents reported that nearly 30% had experienced victimization, either through traditional bullying or cyberbullying [3]. This indicates that bullying is not merely a disciplinary issue in schools, but a public health problem with broad implications for adolescents' psychosocial development. From a public health perspective, bullying fulfills key criteria of a population-level risk factor, including high prevalence, significant morbidity, and long-term developmental consequences, thereby justifying its inclusion in preventive mental health frameworks and policy interventions [4,5].

Empirical evidence shows that victims of bullying are at a higher risk of developing internalizing disorders such as depression, anxiety, and psychological distress compared to adolescents who do not experience victimization [5,6]. These effects are not only short-term but may persist over time and influence long-term psychological development. Longitudinal studies also indicate that experiences of bullying victimization are associated with increased utilization of mental health services, with depression serving as a key mediating factor [4]. Importantly, recent findings suggest a bidirectional relationship between bullying and mental health, where psychological vulnerability may increase the likelihood of victimization, creating a cyclical pattern that exacerbates both conditions over time [7]. In addition, bullying is linked to decreased academic performance, impaired social functioning, and an increased risk of self-harm and suicidal ideation, further reinforcing its status as a serious mental health issue. This multifaceted impact highlights the need to move beyond symptom-focused perspectives toward a more systemic understanding that integrates educational, psychological, and social domains [8].

The impact of bullying is not homogeneous but is influenced by various contextual and individual factors. Socioeconomic status may exacerbate the negative effects of victimization, while protective factors such as resilience, self-efficacy, and emotional competence play important roles in moderating these effects [5,9]. Adolescents with better emotional regulation and stronger self-beliefs tend to demonstrate more adaptive coping strategies. However, this variability also reflects structural inequalities, where adolescents from disadvantaged backgrounds may have limited access to protective resources such as supportive school environments, mental health services, and positive family functioning [10-12]. This suggests that cognitive and emotional processes play a crucial role in shaping how individuals respond to bullying experiences. At the same time, the social-ecological model emphasizes that these individual factors cannot be fully understood in isolation, as they are embedded within broader systems including family, peers, school climate, and cultural norms [13]. Thus, effective intervention requires a multilevel approach that addresses both internal psychological processes and external environmental conditions.

The literature indicates that victims of bullying tend to internalize negative experiences into maladaptive core beliefs, such as feelings of worthlessness, perceptions of social rejection, and beliefs that the social environment is unsafe [14]. These cognitive schemas contribute to the development of social anxiety, hypervigilance, and long-term trauma-related symptoms. Emerging qualitative evidence further suggests that these beliefs are often reinforced through repeated exposure to victimization and social invalidation, leading to entrenched cognitive distortions that resemble those observed in trauma-related disorders [8]. Therefore, bullying should be understood not only as a social event but also as a psychological process that influences adolescents' identity formation and cognitive structures. This perspective aligns with cognitive-behavioral and trauma-informed frameworks, which conceptualize bullying that reshapes meaning-making processes and self-concept during a critical developmental period.

Although numerous studies have examined the impacts of bullying and related interventions, existing approaches still tend to focus on behavioral aspects and symptom reduction, with limited integration of belief- or perception-based approaches. Many intervention programs, such as school-based prevention or counseling models (e.g., CBT, Gestalt, REBT), demonstrate effectiveness in reducing symptoms but often lack a unifying theoretical framework that systematically addresses how adolescents perceive and interpret their experiences of bullying [8,15-17]. In this context, the Health Belief Model (HBM) offers a theoretical framework that emphasizes individuals' perceptions of threat, benefits, barriers, and self-efficacy in shaping health behaviors. This approach has the potential to support the development of more comprehensive counseling interventions for bullying victims. Specifically, HBM can be adapted to understand how victims perceive the severity of bullying (perceived severity), their vulnerability (perceived susceptibility), the benefits of seeking help, and the barriers that prevent them from accessing support, such as stigma or fear of retaliation [4,10,13,18]. Moreover, integrating HBM into counseling may bridge the gap between cognitive appraisal and behavioral response, enabling more targeted and personalized interventions that align with adolescents' subjective experiences.

Therefore, this literature review aims to identify, analyze, and synthesize empirical findings related to adolescent bullying and to formulate a conceptual framework for individual counseling based on the Health Belief Model for bullying victims. By incorporating both psychological and behavioral dimensions, this review seeks to contribute to the development of theoretically grounded and context-sensitive interventions, particularly in non-Western settings such as Indonesia, where cultural values, social norms, and help-seeking behaviors may differ significantly from those in Western contexts.

METHODS

This study employed a literature review approach. This approach was selected because the objective of the study was to develop a conceptual synthesis of individual counseling based on the HBM for adolescent victims of bullying, rather than to quantitatively assess intervention effectiveness as conducted in systematic reviews or meta-analyses [9]. A narrative review approach allows for the flexible integration of empirical findings and theoretical perspectives to construct a comprehensive and argument-driven conceptual framework. The literature was retrieved from several reputable scientific databases, including Scopus, ScienceDirect, PubMed, and Google Scholar. These databases were selected due to their extensive international coverage in the fields of psychology, adolescent mental health, counseling, and health behavior. The use of multiple databases was intended to enhance the comprehensiveness and diversity of relevant literature sources related to the topic under review. The article search process was conducted using combinations of English keywords, including: "bullying victim" AND "adolescent mental health", "bullying victimization" AND "depression" OR "anxiety", "resilience" AND "bullying adolescents", "subjective well-being" AND "bullying", "cognitive intervention" AND "bullying victim", "individual counseling" AND "adolescent bullying", and "Health Belief Model" AND "mental health intervention". These keywords were combined using Boolean operators (AND, OR) to obtain articles that were specific and relevant to the focus of the study.

The inclusion criteria for this review comprised empirical research articles published in indexed scientific journals, focusing on adolescents as research subjects, and examining the impact of bullying on mental health, protective factors such as resilience and subjective well-being, or cognitive-based interventions. Selected articles were required to be available in full text and published in English. The exclusion criteria included systematic reviews, meta-analyses, and other literature reviews; studies that did not specifically focus on bullying victims; as well as opinion papers, editorials, and non–peer-reviewed publications. The reviewed articles were limited to those published within the past six years (2019–2025). This time restriction was applied to ensure that the analyzed literature reflects the most recent developments in research on bullying, adolescent mental health, and cognitive-based psychological interventions. The literature analysis was conducted using a thematic synthesis technique. This process involved identifying major themes related to the psychological impacts of bullying, classifying findings concerning mediating and moderating factors such as resilience and subjective well-being, and performing a comparative analysis of existing cognitive-based interventions. The synthesized findings were then integrated with the components of the HBM to formulate a systematic and empirically grounded conceptual framework for individual counseling.

RESULTS

The method employed in this literature review was a narrative literature review, involving the analysis and synthesis of relevant scientific articles to construct a conceptual framework for individual counseling based on the Health Belief Model (HBM) for adolescent victims of bullying. The analyzed articles were categorized into three primary focus areas: (1) bullying and its impact on adolescent mental health; (2) psychological protective factors, including resilience, self-efficacy, and subjective well-being; and (3) cognitive-based counseling interventions and approaches relevant to HBM constructs. The keywords used in the literature search included *bullying victimization*, *adolescent mental health*, *depression*, *anxiety*, *resilience*, *self-efficacy*, *individual counseling*, and *Health Belief Model*. The search was conducted across several reputable scientific databases, namely Scopus, PubMed, ScienceDirect, and Google Scholar, with a publication time frame limited to 2019–2025. From this selection process, a few relevant empirical studies were identified and subsequently analyzed using thematic synthesis to determine patterns of findings, relationships among variables, and their implications for the development of an HBM-based individual counseling model for adolescent victims of bullying.

Table 1. Overview of empirical studies on bullying, adolescent mental health, and protective factors

No	Author(s)	Journal & year	Article title	Methods	Sample and age	Variables	Findings
1	Elizabeth Hutson, Bernadette Mazurek Melnyk [19]	Journal of the American Psychiatric Nurses Association (2022)	An adaptation of the COPE intervention for adolescent bullying victimization improved mental and physical health symptoms	Pre-experimental (pre–post intervention)	n = 20 adolescents + parents; adolescent age range	COPE intervention, depression, anxiety, somatic symptoms, frequency of victimization, personal beliefs	The intervention reduced depression, anxiety, somatic symptoms, and victimization, while increasing self-confidence.
2	Juan Zhang, Xiang Duan, Yiwen Yan, Yuxin Tan, Taimin Wu, Yaofei Xie, Bing	Behavioral Sciences (2024)	Family functioning and adolescent mental health: The mediating role of	Cross-sectional, SEM (Structural	n = 4,319; adolescents	Family functioning, bullying victimization, resilience, and mental health	Victimization and resilience mediated the relationship between family functioning and mental health.

No	Author(s)	Journal & year	Article title	Methods	Sample and age	Variables	Findings
	Xiang Yang , Dan Luo ,Lianzhong Liu. [20]		bullying victimization and resilience	Equation Modeling)			
3	Yuhei Urano, Ryu Takizawa, Mai Ohka, Hisanori Yamasaki, Haruhiko Shimoyama [21]	Journal of Adolescence (2020)	Cyber bullying victimization and adolescent mental health	Cross-sectional	n = 6,403; ages 12–18 years	Cyberbullying, distress psikologis, self-esteem, emotional competence	Intrapersonal emotional competence attenuated the impact of cyberbullying on psychological distress.
4	Belinda Graham, Anke Ehlers [22]	European Journal of Psychotraumatology (2025)	A qualitative analysis of young adults' beliefs about bullying	Qualitaive (thematic analysis)	n = 20; ages 18–29 years (retrospective accounts of bullying experiences)	Negative self-belief, social anxiety, and post-traumatic stress disorder (PTSD)	Post-bullying negative beliefs were associated with social anxiety and post-traumatic stress disorder (PTSD).
5	Yongqi Huang, Xiong Gan, Xin Jin, Zixu Wei, Youhan Cao, Hanzhe Ke. [23]	PLOS ONE (2023)	The healthy context paradox of bullying victimization	Cross-sectional, moderated mediation	n=631; M-age 13.75	Victimisasi, subjective wellbeing, classroom-level victimization, academic adjustment	The impact of bullying on academic adjustment.
6	Díaz-Caneja CM, Martín-Babarro J, Abregú-Crespo R, Huete-Diego MÁ, Giménez-Dasí M, Serrano-Marugán I and Arango C [24]	Frontiers in Pediatrics (2021)	Efficacy of a web-enabled school-based preventative intervention	Cluster Randomized Controlled Trial	20 schools (cluster randomized controlled trial)	Anti-bullying intervention, victimization, mental health symptoms, and quality of life	The intervention reduced victimization and improved mental health outcomes.
7	Yokoji K, Hammami N, Elgar FJ.[25]	Journal of School Health (2023)	Socioeconomic differences in the association between bullying behaviors and mental health	Cross-sectional	n = 21,750; ages 9–18 years	Bullying, socioeconomic status, life satisfaction, and psychological and somatic symptoms	The impact of bullying was more severe among adolescents with low socioeconomic status (SES).
8	Manisha Hamal MPH, Virve Kekkonen PhD, Siiri-Liisi Kraav PhD, Petri Kivimäki MD & Tommi Tolmunen PhD. [26]	Journal of Infant, Child, and Adolescent Psychotherapy (2024)	Bullying victimization among finnish adolescents and phc visits	Longitudinal (5-year follow-up)	n = 669; Finnish adolescents	Victimization, depression, and mental health service utilization	Depression mediated the relationship between victimization and mental health service utilization.
9	Yakup Ime [27]	Anales de Psicología (2024)	The effect of cognitive behavioral group counseling on bullying and empathy	Eksperimen (pretest-posttest control group)	n = 35; adolescents	Cognitive Behavioral Therapy (CBT) counseling, bullying behavior, and empathy	CBT reduced bullying behavior and increased empathy.
10	P. Ren, Yue Wang, Yiting Liang, Simeng Li, Quanquan Wang. [28]	Journal of Adolescence (2023)	Bidirectional relationship between bullying victimization and aggression	Longitudinal	n=2462; Mage 13.95	Victimization, reactive and proactive aggression, and perceived teacher justice	Victimization predicted aggression, with perceived teacher fairness acting as a mediating factor.
11	Lin L-Y, Chien Y-N, Chen Y-H, Wu C-Y and Chiou H-Y. [29]	Frontiers in Public Health (2022)	Bullying experiences, depression, and the moderating role of resilience	Cross-sectional	n = 4,771; ages 12–16 years	Bullying victimization, depression, and resilience	Resilience protected bullying victims from depression.

DISCUSSION

The literature analyzed in this review indicates that bullying is a complex and multidimensional psychosocial phenomenon that cannot be understood merely as peer conflict, but rather as a relational experience with significant developmental consequences. This complexity is reflected in the involvement of multiple factors, including individual characteristics (personality traits and emotion regulation), relational dynamics (peer interactions and family support), and structural conditions (school climate and socioeconomic status) [9]. Within the developmental context of adolescence, a critical period marked by identity exploration and self-concept formation experiences of victimization exert a profound influence on the individual's psychological structure. Consequently, the impact of bullying extends beyond temporary emotional distress and shapes how adolescents interpret themselves and their social environment over time.

Consistently, numerous studies demonstrate that bullying victimization is associated with increased depression, anxiety, psychological distress, somatic symptoms, reduced self-esteem, and even post-traumatic stress disorder [4,6,7,10]. This pattern of associations suggests that bullying functions as a chronic social stressor. Unlike incidental peer conflicts, bullying is typically repetitive and characterized by a power imbalance, leading victims to experience prolonged feelings of helplessness. Such persistent helplessness contributes to the development of depression through cognitive mechanisms such as negative attributional styles and learned helplessness. Moreover, the anxiety that emerges in victims is often linked to social hypervigilance a tendency to continuously anticipate threats in subsequent social interactions. The somatic symptoms reported in several studies further indicate that psychological distress resulting from bullying manifests physiologically, highlighting the close interaction between psychological and biological systems in responding to chronic social stress.

The decline in self-esteem experienced by bullying victims carries significant developmental implications. Adolescence represents a critical period for identity formation and self-evaluation. When social experiences are dominated by rejection or humiliation, adolescents are likely to internalize these experiences into negative self-schemas [7,9]. This process of internalization helps explain why some victims experience not only temporary emotional disturbances but also develop maladaptive core beliefs about themselves. Over time, such negative beliefs may form the foundation for post-traumatic stress disorder, particularly when bullying experiences are intense and repetitive. These findings are further reinforced by longitudinal research

conducted [11], which demonstrates that the effects of bullying do not end in adolescence but may persist into adulthood, increasing the risk of psychopathology. This longitudinal evidence is crucial, as it underscores that bullying is not a developmental phenomenon that will simply "fade away," but rather a long-term risk factor for mental health problems. Persistent effects into adulthood indicate that victimization can alter an individual's developmental trajectory, including patterns of interpersonal relationships, trust in others, and emotional regulation capacities. In other words, bullying can become a traumatic experience that disrupts identity integration and long-term psychological well-being.

Analytically, these findings support the understanding that bullying is not merely a behavioral issue within school environments, but a broader public mental health concern. Consequently, interventions targeting bullying victims should not be limited to institutional preventive measures; they must also address the individual's cognitive and emotional processes at a deeper level. Given its wide-ranging and enduring consequences, counseling approaches should move beyond symptom reduction to focus on reconstructing self-meaning, strengthening self-esteem, and restoring a sense of social safety. This perspective provides an essential foundation for developing more integrated and theory-driven intervention models, particularly those emphasizing belief systems and individual perceptions of traumatic experiences.[12] From a theoretical standpoint, the impact of bullying can be further examined through the lenses of chronic stress and cognitive schema theory, which explain how repeated negative social experiences shape long-term psychological structures. Within the chronic stress framework, bullying is not a single isolated event but repeated exposure to social threat, resulting in sustained activation of the stress response system. Such repeated activation can disrupt emotional regulation, heighten threat sensitivity, and reinforce negative cognitive patterns. When adolescents consistently experience humiliation, rejection, or social aggression, their psychological system responds not only situationally but begins to generalize these experiences as representations of broader social reality [2,4,7,13].

Cognitive schema theory provides a framework for understanding how such generalization processes occur. Schemas are mental structures that organize experiences and shape interpretations of events. Repeated exposure to bullying has the potential to form maladaptive schemas, particularly in the domains of self-worth and social relationships [14] indicate that bullying victims frequently develop core beliefs such as "I am worthless," "others will hurt me," or "the social world is unsafe." These beliefs are no longer confined to specific perpetrators or situations; rather, they become enduring lenses through which individuals perceive themselves and the broader social environment. This process helps explain why victims of bullying often exhibit elevated levels of social anxiety, as they interpret social interactions as inherently threatening [15]. The internalization of such negative beliefs also contributes to the emergence of PTSD symptoms. In cases of interpersonal trauma, socially based threats are often more complex than physical trauma because they directly affect identity and relational security. When adolescents experience bullying, they not only suffer emotional harm but may also experience disruptions in their sense of interpersonal safety. Schemas such as "the world is unsafe" or "I am unable to protect myself" reinforce hypervigilance and social avoidance two core symptoms of PTSD. Thus, bullying can be conceptualized as a traumatic experience that reshapes cognitive structures and foundational belief systems [16].

This analysis suggests that bullying is not merely a situational interpersonal event, but an experience with transformative effects on adolescent identity structures. Adolescence is a developmental stage characterized by identity exploration and the pursuit of social acceptance. When social experiences are dominated by bullying, the identity formation process may be disrupted. Instead of developing a positive self-concept, adolescents may internalize negative labels imposed by their environment [3,6-8]. Over time, this can lead to the formation of a shame-based identity that is difficult to modify without targeted psychological intervention. Furthermore, the development of negative schemas because of bullying influences subsequent cognitive processes, such as attribution patterns and social information processing. Victims often exhibit negative interpretative biases for example, perceiving neutral facial expressions as signs of rejection. Such biases reinforce a maladaptive cycle: negative experiences strengthen maladaptive schemas, and these schemas increase the likelihood of perceiving threat in ambiguous situations. This cycle explains why some victims continue to experience social anxiety even after bullying has ceased [17].

Conceptually, this understanding carries important implications for counseling interventions. If the core issue lies in changes to belief systems, approaches that focus solely on symptom management are insufficient. Interventions must target cognitive schema restructuring and identity reconstruction. Within the framework of the Health Belief Model, such efforts may involve modifying perceived threat, enhancing perceived personal control, and strengthening self-efficacy. Accordingly, analyses grounded in chronic stress theory and cognitive schema theory underscore that bullying reshapes the psychological architecture of adolescents, thereby necessitating systematic, in-depth, and belief-oriented intervention approaches. In this context, the HBM becomes highly relevant for understanding how victims interpret bullying experiences as threats to their psychological health. HBM [13,15,18] posits that health-related behaviors are determined by individuals' perceptions of susceptibility, perceived severity, perceived benefits, perceived barriers, and self-efficacy. Applied to bullying, victims may perceive a high level of social threat (susceptibility) yet may not necessarily perceive sufficient benefits in seeking help. In many cases, perceived barriers such as stigma, shame, or distrust of school systems are more salient and inhibit help-seeking behavior [19].

Demonstrate that depression mediates the relationship between victimization and mental health service utilization. This suggests that adolescents tend to seek help only when psychological distress reaches a certain threshold, indicating that perceived severity may function as a cue to action. However, the fact that not all adolescents with high levels of depression seek assistance indicates the presence of additional cognitive and social barriers that remain unaddressed. Here, an HBM-based counseling approach holds strategic potential by targeting changes in perceptions and belief systems as the foundation for behavioral change [15,19,20].

The literature further indicates that the impact of bullying is moderated by protective factors such as resilience, self-efficacy, and social support. Found that resilience serves both mediating and moderating roles in the relationship between bullying and depression [17,19]. Added that intrapersonal emotional competence reduces the impact of cyberbullying on psychological distress [21]. These findings suggest that not all victims exhibit the same level of vulnerability; responses to bullying are strongly influenced by self-regulatory capacities and underlying belief systems. Self-efficacy, as demonstrated [2] is significantly associated with involvement in bullying and its psychological consequences. Within the HBM framework, self-efficacy represents a central determinant in decision-making processes. Victims with low self-efficacy tend to perceive themselves as incapable of changing their situation and may adopt passive coping strategies such as withdrawal or avoidance. In contrast, higher self-efficacy increases the likelihood of seeking help or employing adaptive coping strategies. Therefore, HBM-based individual counseling may prioritize strengthening self-efficacy as a core mechanism of psychological change [22].

Nevertheless, the literature also highlights the importance of structural and contextual factors. Found that the impact of bullying is more severe among adolescents from lower socioeconomic backgrounds, indicating that victimization interacts with broader social conditions [14], through a social-ecological framework, emphasize that bullying is influenced by multilayered systems, including individual, family, school, and community contexts [19,21]. Consequently, applying HBM in isolation risks being reductionistic if not integrated with contextual perspectives. From an intervention standpoint, research demonstrates the effectiveness of various approaches, such as the COPE intervention [17], group-based Cognitive Behavioral Therapy [23], and school-based interventions [24]. In Indonesia, approaches including Gestalt therapy, Rational Emotive Behavior Therapy (REBT), reality therapy, supportive therapy, and interpersonal counseling have shown positive effects on self-esteem and

anxiety [13,19,24,25]. Critically, however, most of these interventions are technique-centered and are not explicitly grounded in health behavior theories. Given that the core difficulties faced by bullying victims lie in altered self-meaning and social interpretations, belief-based approaches are particularly relevant. HBM provides a systematic framework for exploring how victims perceive threats, evaluate the benefits of seeking help, and assess perceived barriers. Integrating CBT or REBT techniques within an HBM framework could enhance the theoretical coherence of interventions, as cognitive restructuring could be explicitly directed toward modifying perceived threat, perceived benefits, and self-efficacy [26].

Methodologically, the literature reveals variations in research design, each with distinct strengths and limitations. Longitudinal studies [27-29] provide stronger temporal evidence compared to cross-sectional designs. However, the predominance of non-experimental studies indicates that theoretically grounded intervention research remains limited. Moreover, most studies have been conducted in Western contexts, underscoring the need for cultural adaptation in Indonesia, where collectivistic values and distinct social norms may shape adolescents' responses to bullying and help-seeking behaviors. Based on this synthesis, a significant research gap emerges: the absence of a conceptual model of individual counseling grounded in the HBM specifically designed for adolescent bullying victims [30,31]. While the literature highlights the importance of self-efficacy, resilience, social support, and threat perception, these constructs have not yet been systematically integrated into a comprehensive, belief-based, and contextually sensitive intervention framework. Furthermore, no experimental studies have yet tested the effectiveness of an HBM-based counseling model in reducing psychological symptoms among bullying victims [32].

Theoretically, the development of an HBM-based individual counseling model would extend the application of health behavior theory into the psychosocial domain of adolescence. Practically, such an approach has the potential to enhance counseling effectiveness by targeting the cognitive determinants underlying help-seeking behaviors and coping strategies among victims. Thus, the development of this conceptual model is not only academically relevant but also holds direct implications for guidance and counseling practices within school settings

However, this study has several limitations. First, the review relies predominantly on non-experimental and cross-sectional studies, which limits the ability to draw causal inferences regarding the effectiveness of proposed counseling approaches. Second, most included studies originate from Western cultural contexts, potentially limiting the generalizability of the findings to non-Western settings, particularly Indonesia, where sociocultural factors may influence perceptions of bullying and help-seeking behaviors.

CONCLUSION

Bullying represents a form of chronic social stress with lasting impacts on adolescents' mental health, cognition, and social functioning. Victimization increases the risk of psychological distress and fosters maladaptive core beliefs that shape coping and help-seeking behaviors. These effects are well explained by chronic stress and cognitive schema frameworks. Therefore, the development of individual counseling based on the Health Belief Model is essential, as it targets perceptions of threat, benefits, barriers, and self-efficacy. This approach offers a more comprehensive intervention and addresses the limited integration of health behavior theories in counseling for adolescent bullying victims.

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