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Techniques for Mitigating Bullying Behavior in Children:(Mechanisms for Prevention and Combating Bullying)

KhetibZoulikha[1], Larid Hasni[2]
[1]Department of Educational Faculty of Social Sciences University of Oran 2, Algeria.
[2]Department of Educational Faculty of Social Sciences University of Mostaghanem, Algeria.
Email : khetib.zoulikha@univ-oran2.dz[1], hasni.larid@univ-mosta.dz[2]

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Abstract:
The current study aims to shed light on cognitive-behavioral therapy as one of the most significant therapeutic programs proposed to address and mitigate bullying problems within the school environment. It is based on a tri-dimensional perspective that integrates behavior, thoughts, and emotions. The study reviews several definitions of this therapy while highlighting the most modern techniques used to reduce bullying behavior in children according to this approach. These techniques include assertiveness training, problem-solving, relaxation, role-playing, reinforcement, and self-regulation in children.
The importance of this study lies in its theoretical foundation, providing a wealth of scientific material to researchers in the field of cognitive-behavioral therapy. Mastery of these techniques facilitates their practical application and implementation by specialists in the field.
Keywords: Cognitive-behavioral therapy, bullying behavior in children, therapeutic techniques.

Introduction

Bullying is an age-old phenomenon present in all societies across human history in various forms and to varying degrees, emerging when favorable conditions are met. However, research on this topic is relatively recent. A behavior is considered bullying when it involves unprovoked psychological, verbal, or physical aggression toward a victim. This behavior typically begins in early childhood, around the age of two, as children start forming an initial understanding of bullying. This understanding gradually develops, peaking during the final three grades of elementary school, continuing through middle school, and then gradually declining by the end of adolescence.

Addressing bullying problems has become a priority for schools in several countries, which have proposed numerous methods to tackle such issues. Among these is cognitive-behavioral therapy, considered a relatively modern therapeutic approach that integrates cognitive therapy, with its diverse techniques, and behavioral therapy, with its methodologies. This approach addresses various disorders through a tri-dimensional perspective, dealing with them cognitively, behaviorally, and emotionally. It emphasizes establishing a collaborative therapeutic relationship between the therapist and the client, whereby the client takes personal responsibility for distorted thoughts and irrational beliefs that are considered the root causes of their disorders and subsequent distress and suffering.

Bullying behavior is among the most prevalent psychological disorders in children, manifesting significantly through its psychological, social, educational, and economic impacts on individuals and society. Furthermore, bullying in children may vary in form depending on their age, gender, culture, upbringing, and socialization, and it can appear in various shapes and manifestations.

1. Study Problem

The phenomenon of bullying behavior has increased significantly in recent times, becoming a widespread issue among children. It often develops at an early age and persists into later stages, affecting their future interactions and leading to clear emotional and behavioral disturbances during childhood. A child may act as a bully toward peers or may become a victim of bullying by others.

Bullying behavior is considered an acquired behavior influenced by the environment in which the individual lives. It yields dire consequences for all parties involved. The stronger party (the bully) inflicts psychological, physical, verbal, and social harm on another individual with weaker physical capabilities (the victim). Hala Ismail (2010) emphasized that school bullying, characterized by aggression toward others—whether physical, verbal, social, or electronic—has negative impacts on the bully, the victim, and the overall school environment. Adams (2006) also noted that aggressive behavior could lead to bullying behavior among students.

Schools have become the setting for daily bullying incidents, and the prevalence of bullying in these environments has been confirmed by numerous global studies. For instance, Coy's (2001) study, titled *"Bullying in Schools,"* revealed that approximately 160,000 students skip school daily due to bullying by their peers. Bullying is defined as a form of violence, abuse, and harm inflicted by an individual or group of individuals on another individual or group. The aggressor is typically more powerful than the victim and may use physical assault, harassment, or other violent methods,

employing intimidation, threats, and fear tactics. Bullying is generally classified into four main types: verbal bullying, physical bullying, emotional bullying, and cyberbullying. The study recommended adopting Dan Olweus' Bullying Prevention Program and implementing it in schools across Saudi Arabia.

Additionally, Ismail (2010) conducted two studies. The first investigated the psychological variables among bullying victims in primary school, revealing a significant positive correlation at the 0.01 level between bullying victims and study variables, including state and trait anxiety, self-esteem, psychological security, and loneliness. A correlation at the 0.05 level was also found between school bullying victims and low psychological security. The second study examined the effectiveness of bibliotherapy in reducing school bullying among children, highlighting the efficacy of bibliotherapy in mitigating bullying in school settings.

This paper focuses intensively on school bullying and its important dimensions, relying on recent scientific studies to describe its reality within the school environment. It employs illustrations and diagrams to present findings and concludes with a discussion of the latest global intervention programs for preventing bullying in schools, as well as local practices in the field.

Cross et al. (2011) conducted a study on the effectiveness of the "Friendly Schools" program in reducing bullying behavior. The study involved a sample of 29 schools, using a self-assessment bullying questionnaire and a counseling program implemented across several schools. The program aimed to provide support to teachers, bullying students, and their victims, as well as to monitor bullying behavior among students in the schools where the program was applied. The findings revealed a positive correlation between low social contexts, parental mistreatment, and school abuse with the prevalence of bullying.

Farmer et al. (2010) evaluated the impact of an early education program in rural areas aimed at increasing teachers' and students' awareness of peer groups to reduce bullying behaviors. The study included 39 teachers and 466 students, where teachers delivered lessons on social dynamics and peer group processes. Social cognitive mapping techniques were used to assess and balance students' perceptions.

Through our research and review of previous studies, it is evident—based on the researcher's knowledge—that few studies have specifically addressed cognitive-behavioral therapeutic techniques for mitigating bullying behavior.

Thus, the study's main problem centers on the following question:

- What are the most important cognitive-behavioral therapeutic techniques that can mitigate bullying behavior in school-aged children?

2. Study Objectives

- To identify the most effective cognitive-behavioral therapeutic techniques that may reduce bullying behavior among school-aged children.
- To determine the most common manifestations of bullying behavior within a group of school-aged children.
- To contribute to the utilization of cognitive-behavioral therapy principles and techniques in designing therapeutic programs aimed at mitigating bullying behavior among school-aged children.

3. Study Significance

This study holds particular importance by drawing the attention of specialists and stakeholders to the value of cognitive-behavioral therapy and introducing its key principles and techniques. It emphasizes the importance of addressing a specific segment of society—school-aged children, who represent a vital component of the educational process. The study seeks to understand the phenomenon of bullying and provides an in-depth understanding of the most effective cognitive-behavioral therapeutic techniques that can be employed to develop treatment programs.

4. Definition of Study Concepts

- **Bullying Behavior:** A form of intentional, deliberate, and repeated verbal, physical, or psychological abuse aimed at causing harm and damage to others.
- **Therapeutic Techniques:** Techniques developed within therapeutic programs to test their effectiveness with clients.

To answer the study's main question, we reviewed the relevant literature, including books, articles, and previous studies. Our review identified six (6) core techniques that have proven effective in reducing bullying behavior. These techniques will be explained and clarified in detail.

To fully understand these techniques, it is essential first to examine cognitive-behavioral therapy.

Therapeutic Techniques in Cognitive-Behavioral Therapy

A program that integrates cognitive and behavioral techniques.

1. Definition of Cognitive-Behavioral Therapy

- Cognitive-behavioral therapies are integrated approaches that combine various treatments within a shared theoretical framework. This framework encompasses learning theories, cognitive theories, and emotional theories, all subjected to scientific scrutiny (Bouffet, 2019, p. 43).
- According to Palazzolo (2005), cognitive-behavioral therapy focuses on altering maladaptive behavior in a person's daily life while also addressing the cognitive aspects, or knowledge, associated with maladaptive behavior (Bolquérat, 2018, p. 71).

- Cognitive-behavioral therapies represent a dominant trend in the field of psychotherapy, especially in many Anglo-Saxon countries. These therapies are often referred to as Cognitive-Behavioral Therapy (CBT) in English or ThérapiesCognitivo-Comportementales (TCC) in French (Farhat, 2019, p. 10).

2. Principles of Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is based on the principle that cognitive processes are causally linked to emotional distress and behavioral problems. This approach also targets emotional experiences, physical symptoms, and behaviors (Hofmann, 2012, p. 33). Notably, several principles form the foundation of the cognitive-behavioral approach, involving the therapist, the client, and the therapeutic experience, along with their related aspects. These principles include:

a. The client and therapist work collaboratively to assess problems and develop solutions.
b. Cognition plays a fundamental role in most human learning.
c. Cognition, emotion, and behavior are causally interconnected.
d. Attitudes, expectations, attributions, and other cognitive activities are crucial in understanding and producing behavior, as well as in predicting and evaluating the effects of therapy.
e. Cognitive processes are integrated within behavioral models.

3. Cognitive-Behavioral Psychotherapist

3.1. Definition of a Psychotherapist:

Cognitive-behavioral therapists are practitioners who have chosen the profession of psychotherapy. They possess a desire to assist individuals suffering from psychological difficulties and aim for a deeper understanding of psychological life in general. They undergo specialized education, such as studying medicine with a specialization in psychiatry or pursuing clinical psychology or psychopathology at the university level.

After completing their higher education, they undertake training in cognitive-behavioral therapies, which typically lasts two to three years. Initially, they practice under the supervision of an expert therapist. They also participate in additional training sessions, seminars, and workshops to exchange experiences, develop their skills, and stay updated on new therapeutic techniques. They can practice therapy in various settings, including private clinics, hospital departments, and nursing homes. (Bouffet, 2019, p. 73).

3.2. Role of the Cognitive-Behavioral Psychotherapist:

The role of the psychotherapist involves working with the patient to develop adaptive solutions for solvable problems. They encourage the patient to ask questions to ensure they understand the therapeutic approach and agree with it.

The primary role of the psychotherapist in cognitive-behavioral therapy is highly active. The therapist must teach patients the fundamental principles of this therapeutic approach. Additionally, therapists often find that patients require significant guidance during the early stages of therapy to help them accurately identify or recognize misconceptions and automatic thoughts.

As therapy progresses, the patient is expected to take a more active role in the treatment process. A skilled therapist in this approach promotes the patient's independence (Hofmann, 2012, p. 49).

4. The Cognitive-Behavioral Approach to Explaining Psychological Disorders

Beck distinguishes between cognitive, experiential, and behavioral approaches, based on the nature of the treatment strategy. These are all significant aspects of cognitive-behavioral therapy. Proponents of the cognitive-behavioral approach suggest that maladaptive beliefs (schemas) can lead to adaptive cognitions (often automatic) when attention is directed toward specific stimuli, such as situations, events, sensations, or even other thoughts. These attentional processes frequently exhibit a high degree of automatism and can occur at a level intrinsic to consciousness.

When this process reaches the level of awareness, stimuli are interpreted and evaluated, leading to personal experience, physical symptoms, and behavioral responses (Hofmann, 2012, p. 39).

Positive interactions between the therapist and the patient establish a collaborative relationship. In general, the therapist's behavior should be honest and warm, and the patient should not be perceived as passive but rather as an expert on their own personal problems. Patients actively and effectively participate in the therapeutic process. For example, therapists encourage patients to formulate and test specific hypotheses to gain a better understanding of the real world and their own problems (Hofmann, 2012, p. 49).

5. Mechanism of Bullying According to the Cognitive-Behavioral Approach

Dan Olweus, a Norwegian researcher regarded as the founding father of studies on school bullying, defines bullying as intentional negative actions by one or more students aimed at harming another student. These actions are repeated over time and can manifest in various forms.

Negative actions may involve verbal expressions such as threats, reprimands, teasing, and insults. They can also include physical contact like hitting, pushing, or kicking. Furthermore, bullying can occur without words or physical contact, such as through facial grimaces, inappropriate gestures, deliberate social exclusion, or refusal to fulfill a peer's request.

According to Olweus, bullying can only be identified when there is an imbalance of power or strength (an unequal power relationship), where the victim finds it difficult to defend themselves. In cases where a conflict arises between two students who are roughly equal in physical strength and psychological energy, it is not considered bullying. Similarly, friendly teasing or joking among peers does not qualify as bullying. However, persistent, ill-intentioned teasing that continues despite clear signs of distress and objection from the targeted student falls within the scope of bullying.

6.Global Anti-Bullying Programs

First: The Olweus Bullying Prevention Program (OBPP)

The Olweus Program is one of the most comprehensive frameworks for addressing bullying. It provides a clear structure for administrators, teachers, and parents, enabling its application both nationally and globally across different educational levels. The program operates at the school, classroom, and student levels and emphasizes the collaborative efforts of school administrators, teachers, parents, students, and external specialists to ensure commitment to stopping bullying.

The program is implemented over the course of a year or more, with periodic evaluations to measure its effectiveness in reducing the prevalence of bullying and mitigating its impact. The program has resulted in numerous positive outcomes, including:

- Promoting discussions and exchange of opinions among teachers and administrators.
- Strengthening cooperation and information sharing between teachers and parents.
- Improving relationships between teachers and students, fostering greater understanding, transparency, and clarity.
- Positive changes in organizational structures, including adjustments to break-time rules and the redesign of playground areas.
- A significant reduction in cases involving bully/victim problems in classrooms where key components of the intervention were implemented, compared to classrooms that applied only a few program elements.
- A decrease in students' engagement in antisocial behaviors and an improvement in the social climate of classrooms.

The program encompasses interventions at the school, classroom, and individual levels.

Second: Other Programs and Strategies

Other programs and scattered strategies have been used worldwide to address different aspects of bullying at the school, classroom, and individual levels.

7. Addressing Bullying According to the Cognitive-Behavioral Approach

Researchers have identified several strategies used by victims to cope with bullying. The strategy most commonly mentioned by students was **seeking social support**, such as asking for advice or encouragement from parents, teachers, and friends. Additional strategies for dealing with bullying included:**Problem-solving**, such as developing a plan and reducing stress.**Distancing**, such as ignoring and walking away from the source of anxiety and tension.**Cognitive restructuring**, such as focusing on positive aspects.**External behaviors**, such as self-blame.(El-Dessouky, 2016, p. 26).

Positive interactions between the psychotherapist and the patient create a collaborative relationship. Generally, the therapist's behavior should be honest and warm, and the patient should not be seen as passive but rather as an expert in their personal problems. Patients actively participate in the therapeutic process. For instance, the psychotherapist encourages patients to formulate and test specific hypotheses to gain a better understanding of the real world (Hofmann, 2012, p. 49).

After establishing the therapeutic relationship, the therapist follows these steps during the treatment process:

a. Encouraging the child to accept their condition.
b. Assessing current difficulties.
c. Agreeing on a list of problems.
d. Setting goals.
e. Evaluating the severity of the child's bullying behavior.
f. Asking questions and gathering information to monitor the child's mood.
g. Explaining the cognitive model.
h. Training the child to fill out pleasant activity schedules, achievement logs, and to value each activity.
i. Training the child in therapeutic strategies (problem-solving, relaxation, and cognitive restructuring).

Ensuring the effectiveness of therapy to reduce relapses. (Burney et al., 2008, p. 217)

Cognitive-behavioral therapies encompass a wide range of therapeutic techniques (behavioral, cognitive, and emotional), which serve as tools for intervention in cognitive-behavioral therapy. Therapists must master these techniques to apply them effectively according to each disorder and with each patient. These techniques have a dual purpose: improving the patient's condition and helping the patient develop self-regulation skills.

We will present and explain the most significant therapeutic techniques used, based on our review of previous studies and the literature on this topic, as follows:

7.1 Relaxation

According to Abdul Sattar Ibrahim (1993), relaxation is the complete cessation of all muscle contractions and tensions. It differs from mere outward calmness or even sleep (Belhassini, 2014, p. 106). Relaxation is a physical technique within the behavioral approach that allows individuals to achieve a state of relaxation. Various relaxation methods exist (Bouffet, 2019, p. 22).

Relaxation was integrated into cognitive-behavioral therapies as a set of techniques taught to patients in therapy sessions with a therapist, followed by independent regular practice by the patient. Relaxation sessions typically last a few minutes, often between 10 and 30 minutes. This technique is based on two primary methods:

- **Schultz's method** (*Training autogène*), which focuses on sensations of warmth and heaviness in the body.
- **Jacobson's method**, known as progressive muscle relaxation, which relies on the physiological response of muscle tension and relaxation.(Farhat, 2019, p. 125).

Training in structured relaxation is usually conducted over six therapy sessions in psychological clinics, with each session dedicating at least 20 minutes to relaxation exercises. Simultaneously, patients are instructed to practice relaxation exercises independently for 15 minutes daily, following therapeutic guidelines (Abdul Sattar, 1994, p. 160).

The Fundamentals of Relaxation

- ✓ The therapist explains to the patient that they are about to learn a new skill, similar to any other skill they may have learned in their life. In other words, the therapist clarifies that the patient, like many people, has learned to be tense and stressed but can also learn the oppositeto relax and be calm. The therapist's role is to guide them toward achieving this.
- ✓ The therapist also explains that as a result of relaxation, the patient may experience unusual sensations such as tingling in their fingers or a sensation akin to falling. The patient is reassured that these are normal and indicate that the body's muscles are starting to loosen.
- ✓ The therapist advises the patient to focus entirely on the present momentspecifically, on the relaxation process. This focus helps deepen the sensation of relaxation. To assist in this, the therapist may ask the patient to recall moments in their life when they felt calm and at ease.
- ✓ Some patients may fear losing control over themselves during relaxation. In such cases, it is preferable for the therapist to intervene occasionally to reassure the patient. The therapist's optimal role during these moments is that of a guide or teacher—not to control the body, but to teach the patient a new skill.(Abdul Sattar, 1994, pp. 161–164)

7.2 Assertiveness

The concept of assertiveness is defined as the ability to appropriately express any emotion regarding situations and individuals (Abdul Sattar, 1994, p. 203). This technique is used with children experiencing depression to develop relational skills that allow them to assert themselves in social interactions in general, and especially in relationships that cause them stress (Bouffet, 2019, p. 106).

Assertiveness is considered a trait of a positive personality, a skill that can be trained, mastered, and developed in individuals. It involves expressing oneself and defending one's personal rights. The goal of therapy is to train patients to enhance their ability to express themselves assertively and to increase their self-confidence in situations where they previously struggled. This means not fearing the disclosure of emotions to others, rather than keeping them hidden. Such openness fosters warm relationships, positive interaction, and mutual reassurance. This type of positive relationship is one of the important aspects of overcoming depression (Mahmoud, 2009, p. 201).

7.3 Cognitive Restructuring

The original model of bullying behavior in cognitive-behavioral therapy assumes that individuals who engage in bullying have a negative view of themselves, the future, and the world. These schemas trigger automatic, maladaptive cognitions in certain situations. Through cognitive-behavioral therapy, maladaptive cognitions are identified, explored, and corrected, targeting these dysfunctional beliefs and schemas (Hofmann, 2012, p. 169).

The aim of the cognitive restructuring technique is to enable school-aged children to identify their thoughts, evaluate their validity (i.e., question them, as they are by definition distorted), and replace them with more adaptive thoughts. Cognitive work focuses on irrational thoughts. The therapist must examine the depressive-inducing thoughts to determine whether they are adaptive (rational) or maladaptive (irrational). If the thoughts causing depression are rational, attempting to restructure them would be a mistake. Therefore, the therapist must accurately identify the irrational aspects of the thoughts before deciding to apply cognitive restructuring (Bouffet, 2019, p. 110).

7.4 Thought Correction (Modifying False Beliefs)

The principle of cognitive-behavioral therapy is that thoughts guide behavior and trigger emotions, and distorted thinking leads to various psychological problems. Cognitive therapists focus on restructuring patients' negative automatic thoughts, encouraging them to explore the core reasons behind their negative and illogical thinking (Belhassini, 2014, p. 115).

Psychotherapists have developed concepts emphasizing the value of cognitive and intellectual factors in psychological disorders. They agree that psychological or mental disorders cannot be separated from how patients think about themselves, the world, or their attitudes toward themselves and others. Psychotherapy should focus directly on altering these mental processes before expecting any significant change in the patient's personality or the symptoms that prompted them to seek treatment (Abdul Sattar, 1994, p. 273).
During therapy sessions, the psychotherapist seeks to adjust and correct these cognitive distortions. Three specific questions (known as Socratic questions) are posed to the client to help them reassess their negative thoughts. These questions are:

1. What evidence supports your beliefs?
2. How else could you interpret the situation?
3. If that were true, what would it mean to you?

Each question provides a way to delve deeper into negative beliefs and elicit more objective thoughts (Belhassini, 2014, p. 116).

7.5 Positive Reinforcement

The concept of reinforcement refers to any action that increases the likelihood or frequency of a particular response, such as words of praise, encouragement, or material or moral rewards for certain behaviors or patterns of responses exhibited by an individual. Reinforcement can be either positive or negative (Abdul Sattar, 1994, p. 160).
Cognitive-behavioral therapies focus on the theory of reinforcement to help individuals modify problematic behaviors, with positive reinforcement being the most frequently used in these therapies (Bouffet, 2019, p. 26).
Positive reinforcement refers to any action or event that, when provided to an individual, increases the occurrence of a desired behavior (Abdul Sattar, 1994, p. 230).
This technique is used in cases where patients suffer from significant behavioral disruptions. Introducing positive reinforcements during therapy can support desirable behaviors. For instance, the therapist encourages the child when they apply therapeutic techniques or gradually overcome their difficulties, saying phrases like, “That’s wonderful! Bravo! Congratulations, you did a great job!” These are examples of positive reinforcements commonly used in cognitive-behavioral therapy to enhance treatment and support patient progress.
When patients observe their improvement, it serves as a form of self-reinforcement, motivating them to continue making efforts in therapy.

Primary or secondary positive reinforcements may also be employed (Bouffet, 2019, p. 25).

7.6 Behavioral Activation (Homework Assignments)

Bullying behavior is often associated with aggression, which leads to a lack of reinforcements, satisfaction, and happiness in the lives of bullies. Therefore, behavioral activation is essential at the beginning of therapy to increase the patient's energy levels. This involves using a program to gradually resume activities while considering the typically low motivation of the child.

The therapist and the client create a list of activities that the child should have been engaging in but has stopped. A realistic and feasible activity is then selected, broken down into manageable steps, and a plan is devised to implement each step.

When the child successfully completes the first step, it often enhances their sense of personal competence and self-esteem, acting as positive reinforcement to support subsequent steps and the resumption of activities. This dynamic has an effective impact on reducing bullying behavior (Bouffet, 2019, p. 107).

Conclusion

Based on the theoretical framework presented regarding cognitive-behavioral therapy and its approach to addressing school bullying, we conclude that cognitive-behavioral therapy is a relatively recent therapeutic approach that integrates cognitive therapy with its various techniques and behavioral therapy with its own methodologies. It aims to treat different disorders from a three-dimensional perspective, addressing them cognitively, emotionally, and behaviorally. The approach also emphasizes the establishment of a collaborative therapeutic relationship between the therapist and the child, based on full understanding, a non-judgmental stance, adopting the patient's perspective, and the ability to comprehend their motivations.

Additionally, we have identified the most effective cognitive-behavioral techniques in reducing bullying behavior among school-aged children, including relaxation, assertiveness training, cognitive restructuring, correcting false beliefs, positive reinforcement, behavioral activation, and modeling. Cognitive-behavioral therapy plays a significant role in reducing bullying problems among school students when the efforts of all involved parties are combined. By guiding, advising, and raising awareness among students about the concept of bullying, its forms, manifestations, and causes, we can help prevent behaviors that cause harm to others. This includes training students to develop creative thinking and avoiding excessive punishment or verbal attacks, as these behaviors create an aggressive model that makes it difficult to overcome bullying issues.

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