

Effectiveness of intervention based on quality of life therapy on the control of aggression girls from poor quality families

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Abstract: Background: This study aimed to investigate the effect of quality of life therapy on the control of aggression girls from poor quality families. **Materials and Methods:** In this study, the category applied research and design, a quasi-experimental research with pre-test and post-test and control group. The study population consisted of all adolescent and youth between the ages of 16 to 29 years, because of the irresponsible and derelict or being in 2012 in the city of Isfahan and Gaz Borkhar under welfare organization and the facilities have been under the care of the organization and affiliated centers. 32 women randomly selected from the population and randomly assigned to two groups of 16 (test and control) were placed. Gauges, Buss-Perry Aggression Questionnaire (1992) of data by software SPSS-v19 and analysis of covariance with the control pre-test were analyzed. **Findings:** There is significant difference between the mean scores for aggression, verbal aggression, anger and hostility based on group membership (two experimental and control groups) ($P < 0.01$). The findings also showed that the mean scores for physical aggression, there is no significant difference ($P < 0.05$). **Conclusion:** The findings of this study, evidence of the usefulness and effectiveness of the intervention of quality of life therapy on the control of aggression girls from poor quality families.

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1. Introduction

Nowadays, with the development of health psychology and positive psychology, attitude problems, the scope of medicine, pathology and removed one-factor model, the researchers believe that it is better to take into account the formation and development of mental disorders faulty lifestyles and quality of life was revealed (Donaldson, Dollwet & Rao, 2013; Shoshani & Steinmetz, 2014). Because of that matter which psychology is not only focus on diseases (Seligman, 2000; Kobau, Seligman, Peterson, Diener, Zack & Chapman, 2001; Wood & Tarrier, 2010; Hone, Jarden & Schofield, 2015), that's why positive psychology believe that rather than focusing solely on pathology, we must seek to understand the full range of human experience of loss, suffering, sickness, the prosperity, well-being and happiness (Biswas-Diener, 2010; Parks, 2015; Gable & Haidt, 2005; Joseph & Lindley, 2006). One of the approaches in the field of positive psychology, with the aim of increasing the quality of life, satisfaction with life and subjective well-being and reduce emotional, intervention based on quality of life therapy (Rodrigue, Mandelbrot & Pavlakis, 2011; Joachim, Deeg & Fairview Ave., 2015; Abedi & Vostanis, 2010; Clark, 2006; Magyar-Moe, 2009-2011).

Based on a combination of cognitive Therapeutic intervention quality of life of Aaron T. Beck in the clinical field, positive psychology, Seligman and Csikszent mihalyi for action theory, was designed in 2006 by Frisch (Frisch, 2006). This structured treatment with cognitive-behavioral task and exercise seek a change in 16 main areas of life which are as follows: 1. Health and physical health, 2. self-esteem, 3. Goals and values, 4. money, 5. work, 6. play, 7. learning, 8. Creativity, 9. help others, 10. Love, 11. Friends, 12 children, 13. Relatives, 14. Neighbors home, 15. Society, 16. spouse.

In this model, the change in quality of life, cognitive-behavioral therapy has done in five main themes. The five concepts in a nutshell CASIO (the first five letters of the word) called and include:

- Circumstance: The real objective conditions or with the characteristics of a field;
- Attitude: Perception, interpretation of a field in patterns of individual well-being;
- Standards of fulfillment;
- Importance: a person's happiness or well-being of value and importance to be attached to a domain;
- Overall satisfaction.

This theory, 5 method or model for quality of life and satisfaction with life as a blueprint for positive

psychology interventions oriented education and treatment based on the quality of life that is called and on the creation of satisfaction gap between what one wants and what that raise the quality of life (Frisch, 2006). Thus it can be stated that the quality of life for therapeutic intervention tries use the latest research and theories of happiness, positive psychology and management as well as knowledge of clinical work negative emotions and positive psychology to be effective and efficient and coherent (Frisch, 2012&2013; Toghyani, 2011; Rief, 2012; Godfrin, 2010; Allain, 2007; Hallböök, 2005). One of the areas of application of the intervention, especially in areas related to control emotions is controlled aggression. Aggression, behavior aimed at hurting himself or others. In this definition, the intention is important (Karimi, 2010). Aggression is one of the areas that behavior as a response to the perceived threat is considered (Niazi, S & Adil). Aggression may arise in many different forms that include:

1) Motor dimension: This dimension appears in the form of physical and verbal aggression and its main purpose is to harm others.

2) Affective dimension: This anger after the aggression that finds physiological arousal and emotional factors and internal conditions to prepare the organism.

3) Cognitive dimension: This factors that hostility name, creates a feeling of prejudice, hatred and malice towards others (Buss & Perry, 1992).

One of the most consistent gender differences are that boys are more aggressive than girls physically and girls show their indirect aggression (Archer, 2004). When it comes to verbal aggression, gender differences are removed and sometimes even its incidence is reported in girls (Egli & Stephen, 1986; quoted by Biyabangard, 2012). Various factors can be effective in aggressive behavior is but one of the most important factors causing aggression in people and family (Stover, Connell, Leve, Neiderhiser, Shaw, Scaramella & Reiss, 2012; Smith, 2012). Family, the smallest and the most important social institution, so if you are undergoing turmoil and economic and social problems, primarily on the mental health of members and traumatic and sometimes irreparable effects on society leaves (Dingwall, Eekelaar & Murray, 2014; Hetherington & Blechman, 2014). In fact, healthy, successful society actors have come out of the healthy families, and most unhealthy, unhealthy families have grown. As several studies, the role and influence of the family in shaping the concepts of health and disease, provide a model of normal and abnormal behavior have pointed out (Stuart & Jose, 2012; Fuller-Iglesias, Webster & Antonucci; 2015).

According to the subjects and backgrounds that stated, in this study believe that using therapeutic

models Frisch (Quality of Life Therapy) is an integrated combination of cognitive therapy and positive psychology, to intervene in the area of aggression daughters of poor pay and using this therapeutic model, changes in these areas together. Accordingly research hypotheses are:

1) Intervention based on the quality of life for children of poor physical therapy is effective in reducing aggression.

2) Therapeutic intervention based on the quality of life of poor children is effective in reducing verbal aggression.

3) Therapeutic intervention based on the quality of life of poor children is effective in reducing anger.

4) Therapeutic interventions to reduce hostility based on the quality of life of poor children are effective.

5) Intervention based on the quality of life of children of poor treatment is effective in reducing aggression.

Method:

Population and sample:

The study population consisted of all adolescent and youth between the ages of 16 to 29 years because of the irresponsible and derelict, in 2012 in Isfahan and Gaz Borkhar city under welfare organization and the facilities have been under the care of the organization and affiliated centers. A total of 32 people randomly selected from the population and randomly divided into two groups of 16 (test and control) were placed. In this study, the list of all child care centers and unsupervised adolescents or derelict city of the Welfare Organization was prepared. Also lists cases of the same families who work centers to August 2012, were referred through social work centers were prepared under the supervision of well-being. For every case was placed in a code and then the codes and using the table of random numbers, number 32 of the Code 32 (women) were randomly selected and randomly divided into control and experimental groups. In Table 1, demographic sample is provided.

As it's obvious in Table 1, the characteristics of the age, frequency percentile for age groups 21-25 and 26-30 year groups related to equal the six people who each 37.5% of the whole group membership form it, and least frequent in experimental and control groups regarding age is 16-20 years, 4 people, 25 Percentage of the experimental group and 3 percent of the control group make up about 18.75. The most frequent age category 25-20 years of age in the control group, which is equal to 7% of the total of control group make up 43.75 in male and female characteristics in the entire group, the participants them are women.

Table 1. Percentage demographic characteristics in terms of membership groups

Demographic characteristics		Test group		Control group	
		Frequency	Percentage	Frequency	Percentage
Age	16-20	4	25	3	18.75
	21-25	6	37.5	7	43.75
	26-30	6	37.5	6	37.5
Gender	Woman	16	100	16	100
	Total	16	100	16	100

Research Tools

Aggression Questionnaire:

The questionnaire was created in 1992 by Buss and Perry. The questionnaire has 29 questions, 4 verbal aggression factors (5 questions), physical aggression (9 questions), anger (7 questions) and hostility (8 questions) about the measure. In this questionnaire, the options are set in such a way that

the person in question, on a five-point scale from 1 (not perfectly describes me) to 5 (totally describes me). The internal reliability of the questionnaire 0.89 (high reliability) and subscales correlated with each other and with the 0.25 to 0.45 range of scale that indicates good internal validity is (Buss and Perry, 1992).

Table2. The Minutes of therapeutic treatment based on quality of life

Sessions	Comment on the quality of life therapy, speech rules in Group company, designs objective of the Group and expectations of participants, pre-test
Session 1	Over the previous session, introducing aspects of quality of life, assessed areas of life, use of metaphors, the strengths and skills (growth areas), determination
Session 2	Over the previous session, introduced five roots, the introduction of living conditions as a first strategy, design principles (inner richness, quality time, meaning construction, spread happiness, serve humbly), determination
Session 3	Over the previous session, introduced the strategy of "attitude", design principles, determination
Session 4	Over the previous session, the third strategy, "the objectives and criteria", stated principles, determination
Session 5	Over the previous session, introduced the fourth strategy "priorities", design principles, determination
Session 6	Over the previous session, the fifth strategy "to strengthen other areas of satisfaction" principles (basket of eggs), determination
Session 7	Over the previous session, layout, Homework
Session 8	Over the previous session, design principles, determination
Session 9	Over the previous session, design principles, determination
Session 10	Over the previous session, review the content posted in previous sessions, summarized and generalized five-roots training, implementation and post-test

Research method:

In this study, the list of all child care centers and unsupervised adolescents or derelict city of the Welfare Organization was prepared. Also lists cases of the same families who work centers to August 2012, were referred through social work centers were prepared under the supervision of well-being. The cases of adolescent and young girls between the ages of 16 to 29 years old were considered. Selected and discarded the rest. Of the young people who, for whatever reason, and living in care centers under the supervision of welfare organization were selected. Some of these reasons can be addicted parents, or has severe mental disorders (unsupervised) or death of one or both parents (orphans) or extreme poverty that led to the economic and drops her child and entrust the organization was well noted. Among the people who

were given the young age Welfare Organization and at the time of the study had reached adolescence and young adulthood. The selection of a minimum certification requirement for academic guidance is important. Other cases that did not have these conditions were excluded. For every case was placed in a code and then the codes and using the table of random numbers, 32 number or 32 codes, randomly selected. n two randomly assigned to experimental and control groups. Each group consisted of 16 people is daughter after an initial interview and explanation of the project team members present were asked to test Buss and Perry.

The independent variable of this research is to improve the quality of life based on the quality of life based therapy approach Frisch (2006). Dependent variables, including control anger and aggression that

Buss-Perry Aggression was measured by a questionnaire. Then health and quality of life projects for group therapy sessions, was applied for the experimental group. After repeated treatment sessions of both experimental and control groups were tested Buss-Perry Aggression. It should be noted that during this period the control group did not receive any treatment. In the end, similar meetings were also held

for the control group. Table 2 summarizes the topics offered in group sessions for test group is given.

Research and analysis of data

This study is part of the category applied research and design, the type of quasi-experimental pre-test and post-test with control group. The general aspect of the research is summarized in Table 3.

Table 3. Research projects

	Groups	First choice	Second choice	Pre-test	independent variable	Post test
General and specific hypotheses A and B	Test	S	R	T1	X	T2
	Control	S	R	T1	-	T2

As seen in Table 3, the project consisted of two groups.

Given that the present study is to evaluate the effect of treatment on quality of life is to control anger and aggression, in order to examine the hypothesis, the analysis of covariance with the control pre-test and SPSS-v19 software is used. For

analysis of variance normality and homogeneity of variance have two defaults to prove that to prove Kolmogorov-Smirnov test for normality of the data variance Levine test was used. Kolmogorov-Smirnov test for normality assumption was that operating results in Table 4.

Table 4. Results Kolmogorov-Smirnov test for normality assumption subscales

	k-s-z	Sig. level
Physical aggression	0.674	0.796
Verbal aggression	0.764	0.604
Anger Management	1.04	0.228
Hostility	0.725	0.670

According to the Kolmogorov-Smirnov statistic in $\alpha > 0.05$ is not significant, so assuming normal following scale will be accepted.

Levine test for equality of variances was assumed that the results in Table 5 below. If P Levine test is higher than 0.05, typically equal variances is

confirmed. As can be seen in Table Levine P value greater than 0.05, so the assumption of homogeneity of variances is confirmed.

After verifying the assumptions of normality and equal variances and control pre-test, analysis of covariance was performed.

Table 5. Levine's test results on the assumption of equal variances of the two groups in society

Research scales	F	df	First df (numerator)	Second df (denominator)
Physical aggression	0.052	1	30	0.821
Verbal aggression	0.010	1	30	0.923
Anger Management	1.816	1	30	0.285
Hostility	2.4	1	30	0.144

Findings:

The results were obtained in two levels of descriptive and inferential statistics are reported in

the table below. In Table 6, compare the average score to determine the effect of treatment on quality of life and physical aggression are the two groups.

Table 6. Effect of therapy on quality of life mean score of physical aggression between the two groups

	Pre test		Post test	
	Mean	S.D.	Mean	S.D.
Control	22.03	3.31	26.75	3.66
Experiment	27.31	2.86	27.56	3.74

As can be seen in Table 6, the average equal to 27.31 and the experimental group pretest posttest mean is equal to 27.56. While in the control group, the mean score of 22.3 in the pre-test and post-test, the average is about 26.75.

In Table 7, the mean score of verbal aggression to evaluate the effect of treatment on quality of life has been reported in both groups.

Table 7. Compare average score evaluate the effect of treatment on quality of life in both groups expressed verbal aggression

	Pre test		Post test	
	Mean	S.D.	Mean	S.D.
Control	23.06	3.53	23.31	4.14
Experiment	21.87	2.55	19.12	3.26

As can be seen in Table 7, the mean of the experimental group pre-test to post-test average is 19.12 and 21.87. While in the control group, the mean score of 23.06 in the pre-test and post-test, the average is about 23.31.

In the table 8, compare the average score to determine the effect of treatment on quality of life, reduce anger have been reported in both groups.

Table 8. Effect of therapy on quality of life mean score decreased in both groups anger

	Pre test		Post test	
	Mean	S.D.	Mean	S.D.
Control	27.50	6.58	27.31	6.68
Experiment	27.25	5.80	23.75	5.80

As can be seen in Table 8, the mean of the experimental group pre-test to post-test with 27.25 and the average is equal to 23.75. While in the control group, the mean score of 27.50 in the pre-test and post-test, the average is about 27.31.

In the table 9, compare the average score to determine the effects of treatment on quality of life are given the hostility between the two groups.

Table 9. Comparison of mean scores determine the effect of treatment on quality of life animosity between the two groups

	Pre test		Post test	
	Mean	S.D.	Mean	S.D.
Control	30.62	5.23	30.06	5.49
Experiment	30.93	4.66	24.75	3.90

As can be seen in Table 9, the mean of the experimental group pre-test to post-test with 30.93 and the average is equal to 24.75. While in the control group, the mean score of 30.56 in the pre-test and post-test, the mean is equivalent to 30.6.

In Table 10, analysis of the effects of group membership on the amount of physical aggression scores in the two groups is given.

Table 10. Analysis of the effects of group membership on the amount of physical aggression scores in the two groups

Variables	df	mean squares	F	Significant (P)	Impact	Statistical power
Pre-test	1	35.68	2.75	0.108	0.087	0.362
Group Memberships	1	4.19	0.324	0.574	0.011	0.085

Table 10 shows the mean scores for physical according to member groups (two experimental and control groups) there is no significant difference ($P < 0.05$). The first hypothesis was not confirmed.

In Table 11, analysis of the effects of group membership on the level of verbal aggression scores in the two groups has been reported.

Table 11. Results of analysis of covariance effects of group membership on the level of verbal aggression scores in the two groups

Variables	df	mean squares	F	Significant (P)	Impact	Statistical power
Pre-test	1	231.89	36.29	0.001	0.556	1
Group Memberships	1	74.70	11.69	0.002	0.287	0.911

As Table 11 shows, based on group membership, the scores of verbal subjects (two experimental and control groups) is significant difference ($P < 0.01$). The second hypothesis is confirmed. This effect is 28 percent rate. The quality of life therapy is effective on verbal aggression.

0.874 statistical power of this test showed high statistical accuracy and adequacy of the sample.

In Table 12, analysis of the effects of group membership on the scores of the two groups has been reported to reduce anger.

Table 12. Analysis of variance to reduce the effects of group membership on the scores of anger (anger) in two groups

Variables	df	mean squares	F	Significant (P)	Impact	Statistical power
Pre-test	1	4165.24	182.154	0.001	0.863	1
Group Memberships	1	1038.32	45.40	0.001	0.610	1

Table 12 shows, aggression scores between subjects in terms of membership groups (two experimental and control groups) is significant difference ($P < 0.01$). The third hypothesis is confirmed. This effect is 61 percent rate. The quality of life on reducing anger (anger) is effective.

Statistical power equal to 1 indicates high statistical accuracy and adequacy of the test sample.

In Table 13, analysis of the effects of group membership on the level of hostility scores were reported in both groups.

Table 13. Results of analysis of covariance effects of group membership on the level of hostility scores in the two groups

Variables	df	mean squares	F	Significant (P)	Impact	Statistical power
Pre-test	1	484.31	71.06	0.001	0.710	1
Group Memberships	1	247.54	26.32	0.001	0.556	1

Table 13 shows, hostility scores between subjects in terms of membership groups (two experimental and control groups) is significant difference ($P < 0.01$). The fourth hypothesis is confirmed. This effect is 55 percent rate. The hostility is effective on quality of life. With a high

statistical power of this test indicate statistical accuracy and adequacy of the sample.

In Table 14, analysis of the effects of group membership on the overall level of aggression scores in the two groups has been reported.

Table 14. Covariance analysis group membership impact on the overall level of aggression scores in the two groups

Variables	df	mean squares	F	Significant (P)	Impact	Statistical power
Pre-test	1	887.58	89.73	0.001	0.756	1
Group Memberships	1	89.38	9.036	0.001	0.238	0.828

Table 14 shows that anger scores between subjects in terms of membership groups (two experimental and control groups) is significant difference ($P < 0.01$). The fifth hypothesis is confirmed. This effect is 23 percent rate. The quality of life therapy is effective anger. Statistical power equal to 0.828 indicates a relatively high statistical accuracy and adequacy of the test sample.

Result and Discussion:

This study aimed to evaluate the effectiveness of quality of life based on the control of aggression in children of poor families was conducted. Quality of life therapy approach based on positive psychology and cognitive therapy was established, and so many techniques and methods that are used on this basis. So with that background, cognitive therapy approach to increase happiness and decrease negative emotions, it can be expected that quality of life is an effective

treatment in these cases. The result of the first hypothesis about the effect of therapy on quality of life for children of poor physical aggression was not confirmed and no significant differences were observed between the two groups. This means that in this study therapeutic intervention based on quality of life showed no significant role in reducing physical aggression. Since depression and a sedentary lifestyle often associated with bored Gay and numbness, as well as teenagers and young people who live in care centers and is under constant supervision and control and, in many cases allowed to show emotions (especially negative) do not usually have a learned helplessness. So when the mood goes up and a person are happier and more energetic, motivated and energized to express emotions and display it in them increases and probably becomes physical aggression.

A finding from the second hypothesis about the effect of treatment on quality of life in children of poor verbal aggression was approved. This means that the scores in post-test and there was significant difference in physical aggression. In general, it can be concluded that therapeutic intervention based on quality of life can play an effective role in reducing verbal aggression in adolescents and young people who have grown up in families have the disorder. It is obvious that people are happier when they have the ability to adapt and be more flexible (Biglaryan, 2012; Wrosch & Scheier, 2003; Carr, 2011). It will be easier for them to endure hardships (Inglehart, Borinskaya, Cotter, Harro, Ponarin & Welzel, 2013). When the hope of the future, the ability to delay his unreasonable demands, but also the rise. This is in the Koran, the Torah, the Gospel and other divine religions also strongly emphasized (to the believers to Paradise and eternal comfort given). As already mentioned therapeutic approach life quality of advice was great divine religions. And the hypothesis of the two views can be explained. First, flexibility increases and strength and happiness and second, that several recommendations in the divine religions that delay was unreasonable demands and control language, which in this hypothesis has been effective.

The results also show that the third hypothesis about the effect of therapy on quality of life, reduce anger of poor children also were approved. The results of research by Frisch (2005), Momeni and Shahbazi (2012), Ghasemi (2011), Toghyani (2011) was consistent. So it can be concluded that interventions for education about quality of life and cognitive change thoughts, behaviors and emotions and it offers targeted, effective in reducing anger has been troubled youth and adolescents.

The results of the fourth and fifth hypothesis that the role of therapeutic intervention based on the extent of hostility and aggression the quality of life of the

children of poor reviews, it was confirmed and the results of the research findings Momeni and Shahbazi (2012), Ghasemi (2011), Toghyani (2011) and Frisch (2005) was consistent. In general, and with regard to the fundamental role that cognitive theory and the thoughts change in therapeutic approach based on quality of life, it can be concluded that therapeutic intervention based on quality of life could possibly play an effective role in reducing hostility in adolescents and young people who have grown up in families have ravages.

In the first hypothesis that the quality of life therapy is effective in reducing physical aggression, was not confirmed. While on the surface it seems that this is not in line with previous research. But in fact it is not because the study subjects are often isolated, reclusive and distant from the community and participate in social relationships less are also usually bored and depressed mood. On the other hand, usually have experienced repeated failures in turn has caused a major offensive found and passive aggression because they usually benefit from physical aggression have especially when the subjects were female. People also make up more exchanges and communication more and more collisions also will follow naturally. The other assumptions that the role of therapy on quality of life and reduce hostility, anger and verbal aggression pays, were confirmed to be expected, as increased social interaction and verbal and physical aggression entail a reduction is, therefore, controlling anger. In general, though in this case there was no similar research but was consistent with the general principles and theories, and according to experts.

Among the limitations of this study is that the study population, both male and female clients living in Isfahan and its suburbs (Gaz Borkhar). But due to lack of cooperation boy subjects in generalizing the results to other sectors of society and patients were male and the rest should take precautions to be observed. The restrictions and regulations governing the maintenance centers sometimes possible to do some exercises do not fully accept that probably affected the results. Another limitation of the study tool, because the tool is a questionnaire, so we have to analyze the results of a questionnaire study limitations should be considered.

Since research on the welfare care centers and welfare offices of Isfahan and its suburbs is executed, it is recommended that it is similar in other cities and provinces in the country are examined. The study was conducted on adolescent and young girls, recommended that similar studies in the boys run. According to the results of research, treatment, intervention on quality of life and reduction in depressive symptoms, anger and effective coping styles patients' welfare organization knows, the

Welfare Organization and Imam Khomeini Relief Committee (RA) and other relevant agencies Ali particular work centers suggested that the recommendations have clients in this case. Finally, since the emphasis on prevention and quality of life therapy-based approach given the importance of preventive interventions, recommended to authorities in the prevention of mood disorders and mental health benefit most from the findings.

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