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Taming the tiger within

managing aggression in young adults (18 – 25 years) through group therapy: a grounded theory study

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Taming the Tiger Within:

Managing Aggression in Young Adults (18 – 25 years) through Group Therapy – A Grounded Theory Study

by

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<u>DEDICATION</u>

This work is dedicated to my husband (Dr. Chuma Osuchukwu), my daughters

(Shekinah, Shalom, Shiloni) and my sons (Shemaiah and Shenazar).

I am forever grateful

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<u>ABSTRACT</u>

Though perspectives on meaning and management may vary, aggressive behaviours have been acknowledged by researchers, victims, perpetrators and the society at large as problems requiring urgent attention. The recent increase in aggressive behaviours among young adults and the subsequent social impact seemed to have drawn renewed attention to this social problem. This study, therefore, explored young adults' pre-and-post therapy perspectives on the meaning of aggression as well as the helpful and unhelpful factors in managing their aggressive behaviours after group therapy. Twelve participants (aged 18 - 25 years) were interviewed using semi-structured questions. The interviews were audio-recorded, transcribed and data analysed using Strauss and Corbin's (1990) version of grounded theory.

The study found that prior to group therapy, participants viewed aggression as an uncontrollable rage which can be useful in communicating unspoken thoughts and feelings. Post-therapy, however, their perspective became more flexible as they believed that aggression is as much an internal emotional struggle as it is a social and interpersonal problem. They asserted that aggressive behaviours can be controlled with appropriate skills and resources. 'Powerlessness', arising from ineffective self-regulation and developmental maladaptation, was identified as core category that underpins aggressive behaviours in young adults. The three inter-linked conditions suggested for effective management of their aggressive behaviours were: functional mixed-age group therapy, personal commiment to change and social norm flexibility.

The study, therefore, proposed Relational Integrative Model of Therapy (RIMOT) using S.K.I.P.S framework for managing aggression in young adults. The S.K.I.P.S framework stands for: **S**kills, **K**nowledge, **I**mproving personal quality, unconditional **P**ositive regards, and **S**ocial awareness campaign. The framework would enable counselling psychologists and therapists to assist clients deal with the underlying maladaptive intra- and inter- personal issues as well as provide them skills for managing the resultant aggressive behaviours.

CHAPTER 1: INTRODUCTION

1.1. <u>BACKGROUND INFORMATION</u>

Aggression is a concept that has been well-studied in fields of study such as education, psychology, counselling, sociology, and psychiatry (Anderson and Bushman, 2002; Coie and Dodge, 1998). Though many of these disciplines tend to tailor their study of aggression to perspectives that specifically relate to their discipline, the overall reported knowledge regarding the nature and functions of aggression seems to be consistent across all disciplines (Geen, 2001). With regards to the impact of aggressive behaviours, they are viewed to have devastating social, economic, relational and health impacts on families, relationships, schools, and workplaces (Anderson, et al, 2003; Dodge et al., 1997; Vitaro et al., 2006/1998). On a global scale, studies noted a progressive increase in the rate of aggression in many countries since the Second World War (Anderson and Bushman, 2002; Armitage and Conner, 2001; Barker et al, 2006). The UK is not exempted from this continued rise in aggressive behaviours which are evident across all ages but especially among young adults between the ages of 18 – 25 years (Farrington, 1996/2003).

1.1.1. General Concept of Aggression

Generally, people tend to view 'aggression' as a generic concept which describes a variety of interpersonal problems ranging from difficulty with emotional regulation to severe conduct behaviours (Schaeffer et al., 2003). Consequently, the term 'aggression' is often used synonymously with terms such as 'anger problems', 'conduct disorders', 'emotional control disorder', and 'violence' (Anderson et al.,

2003). From a scholarly standpoint, 'aggression' is mostly described as behaviours directed at others with the intention to cause harm (Geen, 2001). The intention to cause harm to others is the defining characteristic of aggression; hence the unintentional harm to others was not considered as aggression.

Some scholars have, however, queried the centrality of the concept of 'intention' or 'intended' in the definition of aggression (Dollard et al., 1939; Geen, 2001). They argued that it is difficult to measure 'intentions', hence, their suggestion that rather than emphasising 'intentions', attention should be on the observable and measurable behaviours associated with aggression. It has been reasoned that the lack of concrete definition and delineated boundaries of aggression makes it a socially challenging phenomenon (Anderson and Bushman, 2002). Without minimizing the other forms of aggression (e.g. cyber bullying), physical and verbal aggression have continued to draw scholarly attention. It may possibly be because these forms of aggression seem to typify the boundariless nature of aggression which unchecked can easily escalate into violence. Many young people have lost their lives because of aggressive/violent behaviours.

In relation to aggressive behaviours, the following three components have been identified: 1) purposeful/goal-oriented process; 2) the antisocial motivation; and 3) negative affects (Anderson and Bushman, 2002; Berkowitz, 2001). The goal/purpose-oriented process of aggression indicates that aggression is not a random accidental action; it is rather a calculated action with the specific aim to cause harm to the targeted object (Dodge et al., 1997). The antisocial motivation component of aggression denotes patterns of action which run contrary to the

generally accepted norms and values for interactions and relationships within a given society (Anderson and Bushman, 2002). Aggressive behaviours are also viewed to exhibit some negative affect of sadistic and narcissistic desires whereby the aggressor derives satisfaction in hurting or causing pain to another person (Bushman and Baumeister, 1998).

While these components can be identified across many aggressive behaviours, some scholars have argued that social norms and values vary from society to society, consequently, what is viewed as negative and unacceptable in one social setting or developmental stage may be viewed as normal and acceptable in another (Anderson and Bushman, 2002; Bobadilla, Wampler and Taylor, 2012). They have, therefore, suggested that to have deeper understanding of the impacts of aggression on people and society as well as account for the multifaceted and interdisciplinary processes involved in the phenomenon, the concept of aggression needs to be placed within developmental and sociocultural contexts (Anderson and Huesmann, 2003; Coie and Dodge, 1998).

1.1.2   Prevalence of Aggression

Aggressive behaviours are viewed as a worldwide social problem which has plagued societies cutting across cultures, ages, gender and social status (Chon, 2000; Crick, Ostrov and Werner, 2006). In our modern societies, aggressive behaviours are considered as antisocial behaviours ranking second to violence in terms of their prevalence and cost to social order (Anderson and Huesmann, 2003; Card and Little, 2006; Kumpulainen and Rasanen, 2000). World Health Organization's (2002) latest

report showed that extreme physical aggression is one of the major causes of death for people between the ages of 15 and 44 years. This accounts for 14% of deaths among males and 7% among females. Mahuire and Pastore (1999) noted that rates of physical aggression increase about twofold in early adolescent years (ages 14–17) but the rate increases almost threefold for young adults aged 18–24 years.

In America, Leonard et al. (2002) found that within a community sample, 44% of young adult men aged 18 to 30 years have experienced direct aggression either as the victim or perpetrator while 28% of women within similar age and sample had experienced some form of direct aggression in earlier years. Within the educational system, approximately 75% of adolescents are reported to have been victims of some form of aggressive behaviours during their schooling with almost 30% of these youths experiencing a more intense and consistent aggression from their peers (Raskauskas and Stoltz, 2004). Perkins (1997) offered that people within the age group of 18 – 25 years have a greater risk of aggression than any other age group. By 1994, studies estimated the cost of medical treatment for aggression-related injuries in the USA at about 2.3 billion dollars (Cook et al., 1999). Lochman (2002) also recorded that within the prison systems in America, over 60% of the prison inmates were in their early twenties when they were jailed and their offences were aggression-related. The study estimated the prison cost for inmates per year to be above 1.4 million dollars.

In the United Kingdom, there has been a recorded exponential increase in the rate of aggressive behaviours especially among young people in the last decades (Cook et al., 2006; Jackson and Brownstein, 2004; McGuire, 2008). Interestingly, few studies

showed that the rate of aggressive behaviours and violent crimes (except for homicide in the UK) is comparable to those in America (Farrington, 1996/2003; Mcguire, 2005/2008). Farrington's (1996/2003) longitudinal studies showed that aggressive behaviours are highest within the age range of 16 to 25 years. Statistically, there are over 7 million young adults aged 18 to 25 years in the UK, 83% of which live in England (Population Trends 106, winter, 2001). This means that at least, 7 million people within the UK population are at a high risk of experiencing one form of aggressive behaviour or the other.

The impact of these aggressive behaviours is felt in all works of life in the UK. The UK's Department of Education in 2009/2010 noted that 980 (17%) of permanent and 64,030 (19%) of fixed period exclusions of young people are because of aggressive behaviours, especially physical assault against other pupils. With the high percentage of permanent or fixed period exclusion from schools, these young adults run further risk of being influenced by other deviant peer groups to engage in other antisocial and criminal behaviours e.g. substance abuse, stealing, and vandalism (Farrington, 2003/2007; Farrington and Coid, 3003; McGuire, 2008).

Within the social context, relational aggression is gradually gaining momentum among young people with 60% of girls and 70% of boys being affected either as victims or perpetrators (Cavell et all., 1998). One of the implications of the rise in relational aggression is that many of these youths end up with varieties of psychological problems (such as depression, anxiety, social phobias, and suicidal ideation) as well as social problems (such as hate, knife and gun crimes)

(Raskauskas and Stoltz, 2004; McGuire, 2005/2008). Studies have shown that relational aggression is often difficult to identify and may go on for a long time without being detected or dealt with, hence, substantial financial and psychological costs are often incurred by the individuals as well as the society (Little et al, 2003; Meysamie et al, 2013; Raskauskas and Stoltz, 2004; Young et al, 2006).

Medical records also showed a similarly high rate of aggressive behaviour presentations. The National Institute for Health and Care Excellence (NICE) (2013) showed that there are estimated 5% to 8% of young people in Britain with serious behavioural problems and 5% to 6% of them are clinically diagnosed with significant conduct disorders. The report also revealed that aggression and antisocial behaviour account for 30% of a typical GP's consultations and 45% of community health referrals of children and young adults in the UK (NICE, 2013). This means that a large amount of the taxpayers' money is required for managing these problems.

1.2. <u>STATEMENT OF THE PROBLEM</u>

This section of the current study highlighted the following three main issues: 1) current social attitude towards young people, 2) current sources of information used in therapy, and 3) current therapeutic models for managing aggressive behaviours.

1.2.1. Problem 1: Current Social Attitudes Towards Young Adults

In the UK, young adults are often portrayed as a troubled group in the media and among policymakers in political, educational, and medical settings (Farrington, 2003; Fergusson, Horwood, and Ridder, 2005). Often, young adults are the focus of

attention and discussion when it comes to social decadence, yet, very little seemed to have been done to provide appropriate resources within the health, social, and financial services to cater for this group of people in the society (Arnett, 2000). Within the National Health System in the UK, for instance, there are two main established services: CAMHS and AMHS. While the CAMHS has a model of care that is tailored to age group under-18-year-olds, the AMHS has a one-for-all model across all ages ranging from 18 years and above (Singh et al., 2008). Despite the established knowledge on transitory and volatile nature of developmental stage of 18 – 25 years, significant efforts are yet to be made in the UK to put in place healthcare systems that specifically target the needs and well-being of individuals within this developmental stage (Kennedy and Sawyer, 2008; Singh et al., 2008).

Individuals aged 18 – 25 years with psychosocial and developmental challenges tend to fall between the stalls of CAMHS and AMHS. Currently, Early Intervention Psychosis (EIP) is reported to be one of the few statutory mental health services that are age-specific for the young adult clients (18 – 25 years) (YoungMinds, 2006). For many other mental health and/or psychosocial challenge, young-adult clients aged 18 – 25 years would have to settle for the undifferentiated adult model that AMHS offers even when it may not be addressing their specific needs (Howarth and Street, 2000; Singh et al., 2010). Currently, there are limited number of NHS Trusts that run the programme for managing aggressive behaviours, yet medical records showed that aggression and antisocial behaviours account for 30% of GP's consultations and 45% of community health referrals of children and young adults in UK (NICE, 2013).

Among researchers, there seems also to be a repeat pattern of anonymizing this age group especially those with aggressive behaviours. Most of the studies carried out on aggression were focused either on young people within the age range of 7-17 years or on adults as an undifferentiated group (Baumeister et al., 1996; Daly and Wilson, 1988; Kumpulainen and Rasanen, 2000). Though many studies have acknowledged that ages 18 – 25 years are transitory and that there is high rate of aggression among youths within this age range (Geen, 2001; Heilbron and Prinstein, 2008; Ruble and Seidman, 1996), there has been little in-depth study on the value of resources available for these young adults with aggressive behaviours. It is important to emphasize that the current study is not concerned with all aggressive behaviours, but those which are viewed as problematic and potentially dangerous to individuals and society. The current study is also interested in the role of counselling psychologists and their skills in managing aggressive behaviours in young adults.

The disengaged view towards young adults is not any different on the socio-political front. George Osborne, former UK Exchequer, in his 2015 budget announcement repeated the pattern of marginalisation of young adults aged 18 – 25 years. Financial provisions were made for people under the age of 18 years as well as those above the age of 25 years. Young adults between 18 and 25 years were, however, left to fend for themselves. Similarly, in the recent UK vote to 'REMAIN' or 'LEAVE' the European Union (EU), statistics showed that most young adults voted to REMAIN in the EU but were outvoted by the older voters who have much less time, on average, than younger people to live with the Brexit decision (Guardian, 2016). This is also an example of how societies can marginalize the voices of young people in social

matters which also affect them. Young people are inadvertently made to feel less important in the social agenda, hence, worsening their already dented social identity and unstable behaviours.

1.2.2. Problem 2: Current Sources of Data for Research/Therapy

Golmaryami and Barry (2010) suggested that it is vital to pay attention to the source of the data used to gain deeper understanding on the concept of aggression. They noted that there are three possible sources of data in relation to aggression: 1) observers/third parties (e.g. teachers, researcher, parents, therapists etc.), 2) recipients (aggressed/victim), and 3) perpetrators (aggressors). According to Golmaryami and Barry (2010), majority of the studies on aggression seemed to draw their inferences from self-reports gathered from either the observers or victims of aggression. The perpetrators are often left out of the whole process of acquiring knowledge about aggression and its management. Consequently, important source of data for conceptualization, and management of aggressive behaviours is consistently omitted. The current study attempts to highlight the aggressors' voice and perspective on the meaning of aggression as well as the factors and strategies that were helpful or unhelpful in the management of their aggressive behaviours.

1.2.3. Problem 3: Current Therapeutic Models

In relation to the management of aggressive behaviours, several models, techniques and strategies have, over the years, been proposed and implemented (Bushman, 2005). Many of these models are generally classified into individual or group

therapeutic models. Individual therapeutic models have been the primary method of intervention in many settings and across many presenting problems (Barry and Lochman, 2004). In recent times, however, studies showed that group therapeutic intervention can be time and cost efficient and as effective as individual therapy in managing aggression among the youths (Barry and Lochman, 2004). Anderson and Bushman (2005) suggested that since aggressive behaviours are usually viewed as social (interpersonal) issues, group therapy is an appropriate therapeutic model for managing aggressive behaviours because it offers clients both skills and social environment to practice conflict resolution, problem solving and interpersonal relationship building. Although group therapy has been proposed, implemented and reported as effective, many of the reported positive therapeutic outcomes are based on the therapists' account or restricted self-report questionnaire responses from the clients and observers.

1.3.   **UNIQUENESS OF STUDY**

The uniqueness of this study lies in its focus on the aggressors' perspectives of the meaning and management of aggressive behaviours. Though studies acknowledged that the co-existence of aggressive behaviours and transitory developmental stage of 18 – 25 years are crisis prone combination (Arnett, 2000), the challenges faced by this age-group, the associated aggressive behaviours and their management seemed to be under researched (Anderson and Huesmann, 2003; Mahuire and Pastore, 1999). The extensive search carried out during the preparatory stage of this current study revealed that many available studies on the management of aggressive behaviours in young adults were based on the therapist's account or on

participants' (aggressors') questionnaires that typically contained items consisting of forced- choice questions. Though the questionnaires enable larger quantity of data to be gathered, it limits what participants could offer (Blaikie, 2007). Considering the continuous rise in the level of aggressive behaviours in the UK, scholars have suggested for therapists, researchers, other professionals and the society at large to facilitate effective and lasting change, the multi-perspectives on aggression (including aggressors and victims) would need to be explored (Cook et al, 2006; Green and Price, 2016; McGuire, 2008). This current study employed semi-structured interview to capture aggressor's (young adults aged 18 – 25 years) perspective of meaning, helpful/unhelpful factors in managing aggressive behaviours. The findings were used to generate a therapeutic model that counselling psychologists, psychotherapists, educators, and school counsellors can use in facilitating change in young adults' aggressive behaviours and the accompanying emotional instability. This may, consequently, aid in reducing prison sentences, with court charges, broken relationships or jobs loses associated with such antisocial behaviours.

1.4. THE OBJECTIVES OF THE STUDY

The objectives of this study were:

1. to explore and describe the common themes in the ways young adults manage their aggressive behaviours.

2. to investigate and describe young adults' identified helpful and unhelpful strategies in managing their aggressive behaviours.

3   to identify and describe young adults' perspectives on the role(s) of group therapy and their experiences of age-specific group therapy for managing their aggression.

4   to examine and describe young adults' perspectives on the meaning of aggression and any changes in their understanding and management of it after group therapy.

1.5. <u>RESEARCH QUESTIONS</u>

The following research questions were addressed in this study:

1. What do participants (aged 18 – 25 years) identify as helpful and unhelpful factors in managing aggression following a group therapy?

2. What is the experience, in terms of common themes of the meaning of aggression and any changes in their understanding of it, for participants who have had age-sensitive group therapy for managing their aggressive behaviours?

1.6.   <u>SCOPE OF STUDY</u>

This study focused on the generic, undifferentiated phenomenon of aggression. The decision to focus on the generic concept of aggression was based on the following premises. The first premise was that recent studies showed that there are often overlaps of the subgroups of aggression and that the subgroups can co-exist in the same person though they may be exhibited at different times of their life (Anderson and Huesmann, 2003; Barker, Oliver and Maughan, 2010; Bushman and Anderson, 2001; Card and Little, 2006). These studies explained that someone may exhibit one

type of aggression in one context and another type in a different context. The reactive aggressor in one context can be a proactive aggressor in another context. Little et al. (2003) reported that there is about 69% reliance overlap of the subtypes of aggression, especially among young adults. The study offered that in an attempt to achieve their desired goal, 'aggressive adolescent will resort to whatever means of aggression [that] are available and effective' (Little et al., 2003, p. 130).

The second premise is that, within the therapeutic context, it is a common practice for clients to be referred to group therapy because of their aggressive behaviours and not according to the subgroup (Barry and Lochman, 2004). Barry and Lochman (2004) however warned that the main challenge in having generic group therapy is adapting effective interventions to address each group member's unique causal problems. The study suggested that a rigid adherence to a prescribed manual may not work for everyone. Though the scope of this study is limited to aggression as a generic concept, theoretical sampling enables me to gather data on the differences in the ways participants with the subtypes of aggression managed their behaviours.

The socio-demographic data of the participants were also considered in the scope of the study. The study consisted of mixed gender and was opened to young adults from any demographic background. The mixed gender was chosen based on the premise that males and females can be aggressive; their mode and intensity of aggressing may, however, differ (Archer and Coyne, 2005; Crick and Grotpeter, 1995; Moffitt et al., 2001). This is discussed in detail in chapter 2. Based on the definition of aggression used in this study, unintentional or accidental behaviours that

caused harm to another person were not considered in this study. Self-harm, which may be intentional, was also not considered because it is not seen as an interpersonal behaviour. The final product of this study is, therefore, a grounded theory model that could help counselling psychologists, psychotherapists, and policymakers gain a deeper understanding of strategies for managing of aggressive behaviours among young adults in future. The RIMOT has both preventive and therapeutic benefits, hence can be useful to therapists working with clients from other age groups.

CHAPTER 2: LITERATURE REVIEW

2.1. <u>CONCEPTUALIZING AGGRESSION: ORIGIN AND NATURE</u>

As mentioned earlier, aggression is often described as behaviours directed towards another person with the intention of causing harm to life (or ego) (Anderson & Bushman, 2002; Geen, 2001). Huesmann et al (2002) suggested that whether the harm is to life or damage to ego, the phenomenon of aggression is often regarded by many scholars as a real and important part of human condition and narrative. The study, however, explained that the divergence of opinions among scholars are usually linked to how aggressive behaviours and their management are interpreted and presented by researchers and policymakers. Some studies, for instance, were highly critical of the mainstream empirical literatures that tend to conceptualise aggressive behaviours from a psychopathological perspective, subsequently, pathologizing (e.g. DSM-5 [APA, 2013]) and criminalising normal human behaviours (Chon, 2000; Hawley et al., 2007; Heilbron and Prinstein, 2008).

Many critics of the mainstream (i.e. psychopathological) perspective tend to acknowledge the existence of aggressive behaviours but described these behaviours as existential, innate and adaptive interactions that are used to address real and/or imaged threats (Bobadilla, Wampler and Taylor, 2012; Brendgen et al., 2006). They argued that everybody has the propensity to exhibit aggressive behaviours irrespective of age, family background, gender, socioeconomic class, and educational status (Heilbron and Prinstein, 2008; Huesmann et al., 2002). Hawley et al. (2007) reasoned that since aggressive behaviours are strategies for survival

which everybody utilises when threatened or vulnerable, selected few should not be punished for exercising their survival instincts.

On the other end of the scholarly debate are also studies that acknowledged the existence of the phenomenon of aggression but seemed to have a negative view of aggressive behaviours. They argued that aggressive behaviours are primitive and punitive behaviours with far-reaching devastating impacts on the people involved and the society at large (Dodge, Coie, and Lynam, 2006; Loeber et al., 2005; McAdams and Schmidt, 2007). These scholars believed that the primitive nature of aggression is rooted in the individuals' limited ability and resources in managing the apparent challenging situations. Looking at the phenomenon from developmental and social perspectives, Dodge, Coie, and Lynam (2006) offered that the negative impacts of aggression outweigh any supposed survival benefits. The negative impacts that were identified ranged from losses (financial, relationship, identity etc.) to serious bodily injuries and death (Dodge et al., 1997; Domitrovich and Greenberg, 2003; Vitaro et al., 2006/1998).

Expounding on the negative impact of aggression, Anderson and Carnagey (2004) pointed out that aggressive behaviours are one of today's most substantial social problems that cut across ages, cultures and nations. In young adults, these behaviours, are shown to have high correlation with increased delinquency (e.g. street violence, gun and knife crime), substance abuse, poor social adjustment, and academic difficulties (e.g. poor academic performance, exclusion, and dropping out of school) (Barry and Lochman, 2004; Dodge, Coie, and Lynam, 2006). It was also

noted that whilst recipients (victims) of aggressive behaviours suffer tremendously, the aggressors are also affected in many ways such as social exclusion, reduced psychological well-being, self-hate (Herschler, 2006).

Despite many years of investigation and vast number of studies on the concept of aggression, there are continued debates and varied scholarly views on the origin, nature, classifications and management of aggression (Heilbron and Prinstein, 2008; Longa, 2011). The views on the sources of aggression seemed to be spread across a continuum with most of them falling into three main categories: external, internal and interaction of internal-external sources. On one end of the categories are scholars who believe that aggression is an external concept. While some of the 'external' proponents view aggression as a concrete external phenomenon acting on the individual, others believe that aggression is not an existing 'thing' which can be deconstructed into its elements; it is rather people's attempt to concretize a 'fuzzy' concept in order to gain control over other people (Russell and Fehr, 1994).

At the other extreme of the scholarly positions regarding aggression are scholars who view it as an internal phenomenon which is inherent, fundamental and universal part of the human function (Chon, 2000). This perspective holds that the presence of hormones and brain chemicals in everyone meant that we are all prone to exhibit aggressive behaviours at certain situations of our life especially when we feel threatened. At the middle of this scholarly continuum are the interactionists who view aggression as an interaction between external and internal factors (Anderson and Huesmann, 2003). They opined that these two sources of aggression need to be

factored in if we are to gain a good understanding of the concept. These three main

scholarly positions are explored below in details.

2.1.1. Aggression as an External Phenomenon

There is a range of social theories that view aggression as an external phenomenon.

Many of the commonly used theories in this range are often grouped into the

following categories: the frustration – aggression theory, the social learning theory,

the adult attachment theory – Mentalisation, and the social constructionist views.

2.1.1.1. The frustration – Aggression Theory

According to the two-factor theory, aggression is activated by situational clues which

follow the frustration – aggression phenomenon using the cause-and-effect process

(Berkowitz, 1989/1990). The theory offered that without a cause (action), there will

possibly be no effect (reaction). Aggressive behaviours are, therefore, explained as a

response to external real/perceived threat (Berkowitz, 1989; Dollard et al., 1939;

Miller et al., 1941). Recent study showed that the frustration – aggression

phenomenon is linked to sense of powerlessness (Øien and Lillevik, 2013).

Powerlessness in this context was described as a lack of predictability, control,

influence/authority, voice-ability, and alternatives (Øien and Lillevik, 2013). In a

situation of threat, the individuals with aggressive behaviours seemed to feel unable

to resolve the situation amicably and as a result resort to aggression.

The proponents of this perspective reasoned that since powerlessness underpins the

frustration – aggression phenomenon, managing powerlessness is a vital strategy for

dealing with aggressive behaviours in young people (McAdams and Lambie, 2003; Øien and Lillevik, 2013). Though the frustration – aggression hypothesis may be viewed as plausible, some scholars argued that this perspective to aggression seems to clearly explain the reactive but not proactive aggression (Dodge and Crick, 1990; Marsee and Frick, 2007).

2.1.1.2. The Learnt Behaviour Theory on Aggression

From the social learning theory perspective, aggression is essentially a learned behaviour which is propagated either because of its perceived direct rewards (positive reinforcement) (Skinner, 1553/1974) or because it is observed as a standard (role-modelling) (Bandura, 1977; Bandura, Ross and Ross, 1961). In relation to reward theories, studies showed that young adults often utilize aggressive behaviours as a way of achieving their desired goals which include attracting attention within social group (Patterson, 1990), establishing authority, power and dominance (Wolfgang and Ferracuti, 1967), maintaining social hierarchy and popularity (Gest et al., 2003). Cohen and Nisbett (1994) noted that aggressive behaviours can also be a means of gaining status (and defending honour) within peer-group, in their family, or in relation to other groups. If there are perceived/real threats to personal or group reputation and honour, young people often use aggressive behaviours to defend their honour.

Aggressive behaviours, therefore, become their way of establishing and maintain their desired social identity (Archer, 1989; Gest et al., 2003). The behavioural theories summed that without the associated rewards, aggressive behaviours would

in time be reduced or extinct (Skinner, 1974). In response to the reward theories, some scholars argued that this perspective on aggression may account for the proactive type of aggression which is premeditated and purposeful in nature but not the reactive aggression which tends to be instinctive (Bandura and Walter, 1966; Hubbard et al., 2001; Wood and Gross, 2002). With regards to the role-model theories, aggressive behaviours studies suggested that these can be learnt by observing others such as parents, family members and/or significant others (Bandura, 1973; Bandura, Ross, and Ross, 1961; McAdams and Foster, 2009). The role-model theories focused on the social, environmental and family dynamics and their corresponding influences on the young adults' aggressive behaviours (Bryan, 2005; Epstein, 2001). Aggressive behaviours are thought to develop during childhood when family dysfunctions (such as marital discord, divorce, domestic violence, financial difficulties) have significant influence on the young people's life (Paylo, 2005).

Studies suggested that families of the young adults with aggressive behaviours are often characterised by harsh and inconsistent discipline, little positive parental involvement, and poor monitoring and supervision of the young person's activities (Patterson, Debaryshe, and Ramsey, 1989). These disorganized relational patterns are, therefore, learnt by the young person as a way of interaction with others. The apparent influence of family dynamics and environmental influences on aggressive behaviours were, therefore, thought to explain why it has been extremely difficult to describe, predict, and address youth aggression based on personality or character traits alone (Quinsey et al., 2006). Studies also showed that aggressive behaviours

can be socio-culturally influenced, hence in a society where aggression is generally seen as acceptable norm, people tend to be desensitised to the impact of aggressive behaviours (Gentile et al., 2011; Gest et al., 2003; Persson, 2005; Saleem and Anderson, 2013).

In support of the effect of socio-cultural influence, the Script Theories supposed that young adults who are involved in violent gaming or live in a violent environment tend to have long-term effects in their 1) perceptual and cognitive, 2) cognitive-emotional, and 3) emotional constructs (Anderson and Dill, 2000; Gentile et al., 2013; Greitemayer and Muge, 2014). The changes in their perceptual and cognitive constructs include developing normative views about aggression and having aggressive fantasies (Anderson and Dill, 2000). Their cognitive-emotional constructs are also changed as they tend to portray aggressive behaviours as acceptable and develop a stereotypical negative attitude towards selected group of people (Saleem and Anderson, 2013). The emotional construct's changes include affective habituation (e.g. desensitisation to aggression) and affective traits (e.g., trait anger) (Greitemayer and Muge, 2014).

In accordance with the script theories, scripts are well-rehearsed, highly associated concepts in people's memory and often involved causal links, goals, and action plans (Abelson, 1981; Marsh et al., 1998). These scripts (conceptualised experiences) often define situations and guide behaviours. People initially selects a script that represents an aggressive situation and then assumes a role in the script. Once the role is learnt and rehearsed, it could be retrieved and used as a guide for behaviour

in future social interactions, consequently, become a self-fulfilling prophecy (Anderson 1983; Anderson and Godfrey, 1987).

2.1.1.3. Attachment and Mentalisation Theories

Attachment Theory and Aggressive Behaviours: Attachment Theories focus the degree to which a child's relationship with the care-giver provides emotional protection and stability to the child (O'Connor and Scott, 2007; Hardy, 2007). Attachment was described as a 'lasting psychological connectedness between human beings' (Bowlby, 1969, p.194). Expounding on the processes involved in this psychological connectedness between people, attachment theories offered that attachment relationships are internalized cues and styles of relating which are established in childhood and carried forward into other important relationships (Ainsworth at el., 1978; Bowlby, 1988; Bretherton and Munholland, 2008).

These internalized cues or abstract representation of attachment style are organised into patterns of function referred to as the 'Internal Working Model' (IWM) (Cowie, 2012; Taubner and Curth, 2013). In a secure child-caregiver attachment relationship, the IWM enables people to self- regulate, control and react to threatening or unfavourable situation effectively (Bowlby, 2002; Elliott and Place, 2004). It, therefore, encompasses strategies for emotional regulation and attachment-need satisfaction which in turn creates a sense of security (Grossmann and Grossmann, 2004; Hardy, 2007). While the secure IWM enables the individual to autonomously develop a sense of safety and flexibility in varied social context, the insecure IWM is viewed as rigid, inflexible and less adaptive (Taubner and Curth, 2013).

Studies suggested that when the child – caregiver interactions are insufficient or irregular, the 'internal working model' will be defectively developed resulting in dissatisfaction of needs and inability to regulate emotions (Hardy, 2007; Mikulincer and Shaver, 2007; Taubner and Curth, 2013). It has been shown that developmental transition stage of adolescence tends to emphasize the need for attachment related safety as there are significant changes in the physical, cognitive and social domains (Taubner and Curth, 2013). During this stage, young adults are required to redefine their existing relationship with care-giver and build new ones as well as maintain the between their sense of autonomy and that of connectedness. Studies showed that the established childhood IWM are applied to the new important relationships and strangers (Allen et al., 2007; Feeney, Cassidy and Ramos-Marcuse, 2008).

In attachment – related challenges such interpersonal conflicts, the dysfunctional IWM in childhood was shown to be linked to people's inability to self-soothe and resolve situational dissonance (Feeney, Cassidy and Ramos-Marcuse, 2008). This leads to a sense of vulnerability or helplessness and the consequent recur to maladaptive behaviours such as aggression to cope with the negative feelings later in adulthood (Briere, 1992/2002; Davey, Day and Howells, 2005). Poor or absent early childhood attachment relationship (insecure IWM) was also identified as instrumental to the lack of societal values for authority, conformity and relationships found in many young people (Elliott, Huizinga and Ageton, 1985; Patterson, 1996).

Exploring the relationship between specific attachment style and aggressive behaviours, some studies opined that insecure disorganized attachment style is

strongly related to varied psychopathological presentations such as aggressive

behaviours (Deklyen & Greenberg, 2008; Greenberg, 1999; Taubner and Juen,

2010). George and West (2008) noted that two third of their sample aggressive

group had an unresolved trauma, disorganized attachment pattern and showed

failed affect regulation during distress. Other studies emphasized that aggressive

behaviours in childhood and adolescents highly associated with the avoidant

insecure attachment pattern (Allen et al., 2002; Allen et al., 2007; Becker-Stoll, 2002;

Seiffge-Krenke and Beyers, 2005; Zimmermann et al., 2001). These studies

suggested that young adults with avoidant attachment style tend to show disruptive

conflict resolution strategies and are less able to draw from available social

resources. From attachment theory perspective, therefore, aggressive behaviours

are internalized, maladaptive and insecure relational ways of regulating and

managing unpleasant feelings or overwhelming negative experiences (Allen et al.,

2007; Hardy, 2007).

Mentalisation Theory and Aggressive Behaviours: The focus of Mentalization theory

is mainly on people's capacity to 1) infer the inner psychological state of another,

and 2) affectively respond to the emotional expression of another (emotional

empathy) (Blair, 2005/2008). It is, thus, interested in the concept of intersubjectivity

and empathy/responsiveness in the child–caregiver attachment bond and their

impact in other relationships. Taubner and Curth (2013) presented Fonagy, Gergely

and Target's (2007) view of mentalisation as one's capacity to view self and other

selves as 'intentional agents whose behavior is based on mental states' (p.180).

Mentalisation is, therefore, understood as a dynamic process which requires self-

reflective and interpersonal stance thereby allowing people to feel their pain as well as the pains of others and as a result modify their actions (Bateman and Fonagy, 2004). Studies showed that people's mentalisation skills can vary in intensity and in different social contexts (Fonagy, Bateman, and Luyten, 2012; Humfress et al., 2002; Lane and Garfield, 2005; Jurist, 2005) and these variations are often shaped by the stresses in people's earlier attachment relationships (Allen, Fonagy, and Bateman, 2008; Taubner et al., 2012).

According to Fonagy et al. (2002), many psychopathological problems in adolescents and young adults are linked to mentalisation difficulties. The study argued that psychological problems in young people are not due to the 'usual' internal conflict experienced in this developmental stage, rather, they are as a result of dysfunctions in the mentalization process. It offered that the deficiency in people's ability to mentalise can be traced to traumas and disruptions in early years attachment relationships. In such situation, the lack of the mentalizing ability becomes desirable protection that enables the individual to cope and depend on the perpetrators without thinking about their motives (Fonagy et al., 2002; Taubner et al., 2012). Over time, this defective pattern of relating becomes consolidated, subsequently, actions from self and others would not be considered or interpreted in terms of motives, wishes, and emotions. Social situations would also not be considered from intentional but physical stance; hence, 'an angry voice can be perceived as being loud only and a threatening gesticulation is seen as a raised arm only' (Taubner and Curth, 2013, p. 181). They would, therefore, speak about their behaviours or actions but would not acknowledge the psychological pains and stress

their victims may be going through (Taubner et al., 2012).

Adding to the discourse, Taubner and Curth (2013) suggested that often aggressors with average reflective functions tend to be conflicted about their aggressive behaviours, hence, they acknowledge the suffering of their victims but maintain that their victims deserved what they got. On the other hand, the aggressors with low reflective functions tend to engage in behavioural change without acknowledging their victims' psychological pain and suffering. Wiswede et al. (2011) also opined that the lack or reduced activation of the frontal lobe (the area of brain responsible for reflection in or of actions) could explain the aggressive behaviours in young adults. The study questioned the possibility of neuro-biological dysfunction as a crucial variable in the mentalization difficulties in young adults.

Other studies argued that many young adults with aggressive behaviours have the capacity to infer the inner psychological state of another (cognitive empathy) but seem to be impaired in their emotional empathy (the ability to affectively respond to the emotional expression and needs of another) (Griffin and Gross, 2004; Stevens, Charman, and Blair, 2001; Sutton, Reeves, and Keogh, 2000). These studies, therefore, suggested that the aggressors often understand the emotions (pains and suffering) of their victims but these emotions do not resonate with them (i.e. lacked empathy). The lack of emotional empathy, therefore, meant that the aggressors' intent to harm others would not be moderated or inhibited (Llorca-Mestre et al., 2017). Expounding on the lack of mentalisation in aggressive behaviours, Bateman and Fonagy (2012) concluded that 'the absence of interpersonal understanding is

what makes the perpetration of violent acts' (p. 298).

2.1.1.4. The Labelling (Social Constructivist) Theory on Aggression

From the labelling theorist (social constructivist) perspective, aggression is a socially constructed script that people in authority use to moderate social behaviours and enforce the desired behaviours on members of the society (Bernburg, Krohn and Rivera, 2006; Foucault, 1977/1980; Gergen, 2009). This perspective suggested that language and power (in the form of 'labelling') are tools people in authority use to isolate and punish individuals who fail to conform to the mainstream set rules and norms (Bernburg, 2009; Chiricos et al., 2007; Foucault, 1977). Other studies also noted that labelling has the propensity to shape people's thoughts and behaviours into the shared perceptions and judgments that the label represents (Bernburg, Krohn and Rivera, 2006; Persson, 2005; Teraguchi and Kugihara, 2015). This means that when people are labelled aggressive, over time, they tend to accept aggression as part of their way of functioning, consequently continuing the behaviours and may become desensitized to the indicators for change (Bernburg, 2009; Bernburg and Krohn, 2003; Winnick and Bodkin, 2008).

Expounding on the issue of labelling, Persson (2005) opined that 'labelling' people aggressive could be either disabling or enabling dependent on whether the perpetrators interpreted the outcome of such behaviour as positive (beneficial) or negative (detrimental). The interpretation of such a label as negative was believed to be associated with guilt feelings, sense of isolation and low self-esteem which have been shown to be common presentations among some individuals with behaviours

that are viewed as aggressive (Teraguchi and Kugihara, 2015). When, however, such labels are viewed as positive or beneficial, the perpetrators tend to become more confident in using such behaviours to achieve their desired goals (Persson, 2005). People's behaviours are, therefore, modulated by attributing positive or negative meaning to them. Studies also suggested that these attributions can have significant impacts on how others relate to people with such behaviours (Teraguchi and Kugihara, 2015; Kaufman and Johnson, 2004).

In a society where such behaviours are generally seen as a sign of bravery and strength, people with aggressive behaviours seem to be respected and the behaviours desired but where they are viewed as destructive and non-conformist, the people are ostracised (Teraguchi and Kugihara, 2015). Foucault (1977) reasoned that such social divide and misuse of power could be a recipe for more aggressive behaviours, revolts and disruption of social order by the members of the society. The recent surge of social unrest among young people could, therefore, be explained to be because of the widening gap between the constructed/established social norms and the actual people's desired way of behaving (Kaufman and Johnson, 2004). Critiquing the external perspectives on aggression, some scholars argued that the idea of blaming others for people's aggressive behaviours underplays aggressors' personal responsibility, power of choice, and behavioural change (Bandura, 1999; Dattilio and Freeman, 2007; Deci and Ryan, 1985b).

2.1.2. Aggression as Internal Phenomenon

On the other end of the spectrum on the concept of aggression, are scholars who view aggression as an internal phenomenon. While some of them explained the internal phenomenon as concrete <u>biological process</u> controlled by hormones and neurotransmitters (Carrillo et al., 2009; Crockett et al., 2008; Decety et al., 2009; Kalat, 1998; Montoya et al., 2012), others suggested that the internal phenomenon is moderated by the individual's <u>cognitive self-regulatory systems </u>(Barkley, 2001; Dewall, Bushman, Anderson, 2011; Kochanska et al., 2000; Seguin and Zelazo, 2005). These variations of the internal phenomenon discourse are explained below.

2.1.2.1. Biological Theories on Aggression: Hormonal, and Neuro-transmitter Effects

Aggressive behaviours are described by the biological theorists as one of the innate, necessary and adaptive behaviours which are genetically coded and hormonally controlled for survival (Tremblay and Nagin (2005). People, therefore, do not need to see or learn aggressive behaviours to act aggressively. From this perspective, aggression is humans' natural survival of the fittest mechanism often exhibited in the form of demand for respect, dominance in a group and/or deal with threats (Archer and Webb, 2006; Dabbs et al., 1991; Mehta et al., 2010). Many recent studies noted that hormones (e.g. testosterone) are found to be linked to the human expression of aggressive behaviours (Crockett et al., 2009; Montoya et al., 2012; Seo et al., 2008). Kalat (1998) reported that men aged 15 to 25 years, who had the highest levels of testosterone, showed the highest levels of aggression and violence and they had higher criminal records than their counterparts in the population.

Studies also documented that in non-human animal cases, castrated male animals fought least. The high level and presence of testosterone in males were, therefore, thought to account for the gender differences in aggression, consequently, such behaviours are believed to be the prerogative of males (O'Connor et al., 2002). When compared to male aggression, studies showed that female aggression is poorly understood from a behavioural neuroendocrine basis but suggested that steroids other than testosterone (e.g., progesterone, estrogen) seem to respond to aggressive challenges in females as much as testosterone does in males (Davis and Marler, 2003). Many studies were inconclusive on whether testosterone or its metabolite, estradiol (estrogen) is directly responsible for female aggression (Elekonich and Wingfield, 2000; Rubenstein, and Wikelski, 2005). They, therefore, concluded that aggressive behaviours in females are least partly mediated by steroid hormones.

In exploring the pre-menstrual syndrome, Floody (1968) noted that during pre-menstrual period when there is hormonal fluctuation with an increase in progesterone, women had increased irritability and aggression and are more likely to commit crime during such period. Hu, Zhang, Shen and Azhar (2010), therefore, argued that since progesterone (a precursor for both testosterone - predominately male hormone; and estrogen - predominately female hormone), is increased in aggression, aggressive behaviours may not be a sole characteristic of males; rather, it is a human phenomenon. Proponents of the biological route for aggression also hypothesised that imbalance between testosterone and other body chemicals such as cortisol is a significant predictor for aggressive behaviours (Terburg et al., 2009).

They suggested that high testosterone to cortisol ratio is associative of social aggression. With a high level of testosterone and low level of cortisol, people tend to exhibit aggressive behaviours. This is because cortisol is shown to be a moderating factor between testosterone and aggressive behaviours (Dabbs et al., 1991). Within the clinical population involving children and adult with conduct disorders, studies suggested similar relationship among testosterone, cortisol and aggression (Glenn et al., 2011; Mehta and Josephs, 2010; Popma et al., 2007). To distinguish between the subtypes of aggression, scholars noted that low levels of serotonin (5-HT) in the presence of high testosterone, low cortisol levels is associated with the impulsive (reactive) subtype of aggression (Dabbs et al., 1991; Hawes, 2009; Kuepper, 2010; Terburg et al., 2010).

The hormonal and neurotransmitter perspective on aggression discourse seemed to provide the basis for the medical practitioners' use of medication in the management of aggressive behaviours often diagnosed as conduct disorder (Decety, 2009). Geen (2001), however, noted that the general trend of studies was to interpret the correlations between hormones - neurotransmitters and aggression as indicating that hormone level is the precursor while aggression is the outcome but this relationship could be a case of cause and effect which could also work in the opposite direction. Consequently, the cascade of systems involved in aggressive behaviour may be responsible for the increase in the hormone level. The biological perspective seems to assume a determinist position which holds the behaviours such as aggression are cause by factors outside the individual's direct control (Gross, 2009). This perspective was viewed as contrary to the freewill perspective which supposed that

humans are agencies with freewill and self-regulatory abilities, hence, should be responsible for their actions (Bandura, 1999).

With regards to gender differences, Anderson and Bushman (2005) opined that gender differences in aggressive behaviour may be more of the intensity and patterns of aggressive expression rather than a phenomenon of aggression. This is line with Björkqvist, Lagerspetz, and Kaukiainen (1992) which offered that, boys may fight and girls manipulate/slander but the baseline purpose of both forms of aggressive behaviours is to discomfort another for a personal goal. Many recent studies showed that although the gender differences in aggression appear fairly reliably, they are not large (Ramirez, 2003). The overall research findings indicated that gender differences explain only about 5% of aggressive behaviours, consequently, 95% are not accounted for by gender differences (Hyde, 1984). This indicates that factors other than gender account for the 95% of the variance in aggression. Ramirez (2003) argued that gender differences in aggression is obviously smaller and the impact of testosterone subtle. The study explained that testosterone has only an indirect effect of increasing dominant and competitive behaviours. Hence, aggressive behaviours may be more directly influenced by other factors than testosterone.

Other scholars argued that gender roles, cultural norms, and social identity play more significant roles in the gender differences in aggression (Berkowitz, 1989; Lightdale and Prentice, 1994). According to the social role theory, males but not females often learn early in their development that aggressive responses are

allowable and influential behaviours that present them better for the masculine role (Eagly et al., 2000; Wood and Eagly, 2002). The social expectancies associated with the female roles, however, prohibit aggression as part of an expressive set of responses (Wood and Eagly, 2002).

2.1.2.2. Cognitive Theories on Aggression on Aggression

Among the proponents of aggression as an internalized phenomenon are the Cognitive theorists. They suggested that aggressive behaviours are influenced by cognitive processes especially personal schema (thinking codes) which are informal rules and beliefs on social interactions and responses to situations (Dodge and Newman, 1981). These theorists explained that biological and other factors can predispose people to aggression but such factors influence aggressive behaviours through the emergence of specific cognitive patterns that make aggression possible (Anderson and Bushman, 2002; Dryden, 2015; Hofmann, 2011).

Humans are believed to be free-willed, autonomous and self-regulating agents capable of planning, evaluating, executing actions, self-organizing, and self-reflecting, consequently, they are capable for effecting change in their behaviours (Bandura, 1991a; Dattilio and Freeman, 2007; Deci and Ryan, 1985b). Pfander (1967) opined that acts of will (purposeful behaviours) are solely experienced ''not as an occurrence caused by a different agent but as an initial act of the ego-center itself'' (p. 20). Other studies explained that external other or inner drives may supply the reasons or incentive for self-determined act, but for such acts to happen, self or ego-center must permit the external promptings (Deci and Ryan, 2000; Ryan and

Deci, 2006). The cognitive theorists, therefore, suggested that rather than blaming the environment or biology for the aggressive behaviours, scholarly attention needs to be focused more on human's cognitive processes involved in decision-making (Barkley, 2001; Bushman and Anderson, 2001). Guerra and Huesmann (2004) concluded that aggressive behaviours can be managed through the development of the compensatory cognitive mechanisms, such as cognitive self-regulation systems which control impulsivity.

As Guerra and Huesman (2004) observed, recent studies on aggression seem to have heeded to the cognitive theorists' suggestions by increasingly making more reference to the idea of cognitive involvement in the development of aggressive behaviours. This shift of perspective seemed to have culminated to the emergence of several integrative social cognitive models of aggression (e.g. Anderson and Bushman, 2002; Crick and Dodge, 1994; Huesmann, 1998). Though the focus of these models is slightly varied, they commonly emphasised the need to include information-processing skills (thought process) and social knowledge (thought content) in conceptualizing and managing aggression (Guerra and Huesmann, 2004). The two main theories often used to support the cognitive view on aggression are 'The Self-Regulation Theory' and 'Social Information Processing Theory'.

The self-regulation theories suggested that impairment of the cognitive process of self-regulation (self-control) is significantly associated with aggression (Vohs and Baumeister, 2004). Self-regulation was described as people's capacity to deliberately control and modify their intended action by overruling their previously

reinforced responses or desires (Bandura, 1999; Barkley, 2001). Studies suggested that effective self-regulation often depends on efficient cognitive executive functions (Seguin and Zelazo, 2005), a cascade of cognitive processes that underpin purposeful behaviours (Stuss and Benson 1987), effective problem solving, and goal attainment (Welsh and Pennington 1988). The executive functions such as behavioural inhibitions (self-control) regulate negative affect and when these inhibitions are lacking, people tend to exhibit aggressive behaviours (Baumeister et al., 1994; Gottfredson and Hirschi, 1990; Richards and Gross, 2000).

Relating to the above trend of thought, few studies suggested that there is significant association between poor self-control and criminal behaviours including aggression (Cochran et al., 1998; Dewall et al., 2007; Krueger et al., 1996; Longshore and Turner, 1998). Other research also showed that young children who exhibited reduced capacity for exerting self-control were less able to control their anger, hence more prone to using aggression as a strategy for resolving conflicts or managing uncomfortableness (Dewall, Bushman, and Anderson, 2011; Kochanska, Murray, and Harlan, 2000). Tangney, Baumeister, and Boone (2004) suggested that individuals with poor self-control tend to respond to anger-provoking situations with aggressive behaviours than people with high self-control.

In line with previous studies, Caspi (2000) opined that individual differences in young adults' self-control could predict the variation in the degrees of behavioural problems and criminality over long periods of time. People with well-developed cognitive system of self-control are shown to be better able to make decision between

aggressive and non-aggressive responses in any given situation than those with less self-control (Guerra and Huesmann, 2004). With the application of several performance-based measures of executive functions, recent studies documented that reactive and proactive aggressive behaviours are linked to different aspects of self-control. The reactive aggression is associated with people's inability to override their impulsive desire to cause harm (willpower aspect of self-regulation) (Deater-Deckard et al., 2010; Ellis et al., 2009; Rathert et al., 2011; Rothbart and Bates, 2006). The proactive aggression, on the other hand, is linked to people's premeditated behaviour which is often driven by purposeful goals (motivation aspect of self-regulation) (DeWall et al., 2011; Ryan and Deci, 2006; Zhou et al., 2011).

In their Social Information Processing Theory, Dodge and Crick (1990) reiterated the view that reactive and proactive aggressive behaviours are merely different aspects of the same continuum of antisocial behaviour. They hypothesized that people's behavioural responses are a function of six cognitive processing steps: (1) encoding of external and internal cues, (2) interpretation and mental representation of these cues, (3) clarification or selection of a goal, (4) response construction, (5) response decision, and (6) behavioral enactment (Dodge and Crick, 1990). Though this theory offered a cascade of sequential steps in social information processing, it acknowledged that multiple social information-processing activities can concurrently occur in a nonlinear interactional pattern at different stages of the process thereby making the clear divide of aggression subtype difficult (Crick and Dodge, 1994). The effective execution of these information processes is, therefore, assumed to result in the socially competent way of responding, while deficit or ineptitude in these

processes often leads to an aggressive or incompetent way of responding to social interactions (Crick and Dodge, 1994; Dodge and Crick, 1990). The stage at which the deficit occurs is, therefore, the determinant of the variant of aggression. While reactive aggression is associated with deficits in the earlier steps of the process (step 1 and 2), proactive aggression, is linked to deficits in the later steps.

Schippell et al. (2003) suggested that as well as heightened attention to threat cues due to a deficit of the inhibitory system, reactive aggression may be associated with suppressed attention to social cues such as rejection, ridicule, or failure. Thought many scholars acknowledged the contributions of cognitive theories to our understanding of internal processes involved in aggression, some critics argued that the explanation of aggression solely from cognitive perspective was reductionist in nature (Archer and Coyne, 2005; Gest et al., 2003; Tanti et al., 2011). They reasoned that this perspective tends to ignore or minimized the impact of external and contextual factors (e.g. social, culture, family background) in behaviour formation and expression. Aggressors are, therefore, punished for problems that are not entirely within their control (Archer and Coyne, 2005; Persson, 2005).

2.1.3. Aggression as an Internal – External Interaction Phenomenon

At the middle of the continuum in aggression discourse are the person – situation interactionists. These scholars held the view that aggression is a concrete and complex concept which is often triggered and maintained by interaction between internal (person) and external (situation) factors (Bushman and Anderson, 2001; Heilbron and Prinstein, 2008; Mischel and Shoda, 1995). They suggested that for better understanding and management of aggression, these sources of influence would have to be factored in and adequately accounted for. The two common theories that supports the interactionism perspective to aggression are the 'General Aggression Model', and 'Developmental Adaptation (Psychosocial).

2.1.3.1. The General Aggression Model

The General Aggression Model (GAM) is one of the current theories on aggression which suggest that aggressive behaviours are influenced by both personal (internal) and situational (external) factors (Anderson and Bushman, 2002). Laucht, Brandeis, and Zohsel (2014) explained that GAM proponents believed that the present difficulties in unifying the available knowledge on the concept of aggression despite the many years of studying this phenomenon may be due to scholarly focus on the 'either/or' perspective rather than the 'both/interactional' perspective on influencing factors. Some studies explained that, though for ease of study, it may be useful to categorize aggressive behaviours in terms of sources (internal or external), forms (e.g. indirect, physical, or verbal) or types of aggression (e.g., proactive/reactive, hostile/instrumental, or impulsive/premeditated), but in reality, these categories often

overlap and interact with each other to produce complex phenomenon (Bushman and Anderson, 2001; Barker, Oliver and Maughan, 2010). Route

Other current studies also showed that contextual factors such as developmental, cultural, and socio-economical contribute significantly to the current diverse subtypes of aggressive behaviours but these factors do not often follow the scholarly dichotomy of forms and types of aggression (Archer and Coyne, 2005; Longa, 2011; Underwood, Galen and Paquette, 2001). In support of the interactionist views on aggression, Brendgen et al. (2006) reported that while genetic effect accounted for 39% of reactive and 41% of proactive aggression, unique environmental effect accounted for the remaining 20%. The study, therefore, showed that though genetic effect had a significant correlation of 0.87, the environmental effect also has a significant correlation of 0.34. According to this study, aggressive behaviours are influenced by both genetic and environmental factors though genetic factors may play a more significant part.

2.1.3.2. Developmental Adaptation (Psychosocial) Theory on Aggression

According to developmental adaptation theories, most of the changes and challenges (e.g. physical, psychological and social) experienced during the young adulthood are contributory to the development of their self-identity (Erikson, 1963/1968; Marcia, 1987; Tanti et al., 2011). Building on Erikson's (1963) eight stages in the life-long development of human identity, Tanti et al., (2011) offered that human identity development can be grouped into two main components: personal (psycho) and social. These are summed up in the questions: "Who am I?" and

"where do I belong". Earlier studies found that the continued 'identity and role confusion' experienced by young adults is often linked to their inability to cope with the marked changes and instability in their personal identity (individual attributes) (Harter, 1998; Rosenberg, 1986; Smollar and Youniss, 1985) and social identity (e.g. lack of group memberships and attributes) (Kegan, 1982; Newman & Newman, 1976). Kroger (2000) added that the confusion in personal and social identity in young adults often result in 'affiliation versus alienation'. Group identity was also seen to be a dominant theme for young adult as they strive to achieve sense of belonging within a valued social group (Kroger, 2000). Other studies found that the strive for belonging or social identity was a precursor for proper development of personal identity and intimacy in adolescents and young adults (Erikson, 1968; Newman and Newman; 2001).

From this perspective, developmental progression/adaptation involved effective management of the identity crisis and role confusion during the adolescent stage which would lead to integrated understanding of self and identity (Ruble et al., 2004; Tanti et al., 2008). In such situation, the individual may be said to have become well-adapted to their developmental challenges. Marcia (1989) identified two forms of adaptation: connectedness (sense of "fitting-in-ness") and individuation (sense of 'autonomy'). While 'connectedness' indicates that one can exist comfortably within one's given environment, 'individuation' shows that one can make choices and decisions which may or may not fit in but are based on personal values and evaluations. Well-adapted young people are, therefore, those that can balance and function between their sense of connectedness and individuation (Hawley, 2007;

Heilbron and Prinstein, 2008). Aggressive behaviours, from this perspective, were explained as the outcome of people's mal-adaptability to the demands of the stage they are in (Erickson, 1968; Kroger, 2000; Newman and Newman, 2001).

2.2. CONTINUITY OF AGGRESSIVE BEHAVIOURS IN YOUNG ADULTS

With regards to the existence of aggression, scholars seemed to agree that aggressive behaviours are observable in all ages and developmental stages (Anderson and Huesmann, 2003; Dodge, Coie, and Lynam, 2006; Huesmann, 1988). There were, however, debates on the continuity (stability) of aggressive behaviours across developmental stages from childhood to adulthood. Some studies queried the unitary idea of continuity of aggression (Blumstein and Cohen, 1987; Loeber, 1982; Moffitt, 1990; Moffitt, 1993; Pulkkinen and Pitkänen, 1993). Burt et al. (2011) also noted that many studies showed that life-course persistent antisocial behaviours (also referred to as Childhood-onset) only represented 5 – 10% of aggressive and violent behaviours which starts at childhood and ends up in negative adult outcome. By contrast, the adolescence-limited (also termed adolescence-onset) was shown to represent the normative and transient aggressive behaviours which emerge in adolescence and dissipate by young adulthood.

Loeber (1982) and Barker et al. (2007) reported that often the trajectory pattern of aggressive behaviours tend to change during the adolescent developmental period with a decline in the number of young people who were involved in direct aggressive behaviours (such as fighting) between the ages of 6 – 16 years. Other studies also

showed that the plot of age versus rate of aggressive behaviours showed that prevalence and incidence peaked at the age of 17 years and then dropped sharply in young adulthood (Caspi and Moffitt, 1991; Moffitt, 1993). Moffitt (1993) reasoned that since the majority of aggressive behaviours are self-limiting and often diminish as the children get into their adolescent age, it is crucial for scholars to make a distinction between the two types of aggressive people: Life-course-persistent (i.e. those with persistent and stable aggressive or antisocial behaviours) and the Adolescent-Limited (i.e. temporary and situational aggressive behaviours).

Moffitt (1993) suggested that theories need to 1) account for the discontinuity of the aggressive behaviours and the proximity of the causal factors for those whose behaviours are limited to the adolescent developmental stage. 2) They also need to account for the few people with life-course persistent aggression, the causal factors must be located in their childhood and must explain the continuity of the behaviours in later years (Moffitt, 1993). Millon (1991) pointed out that one vital limitation in previous classifications of antisocial behaviours was that they were not rooted in theories which ought to provide 'the glue that holds a classification together and gives it both its scientific and its clinical relevance' (p. 257).

Roisman et al. (2010) explained that though Moffitt's (1993) dual taxonomy of aggressive behaviours have been supported by many earlier studies, current findings suggested that those earlier studies may have 'under-pathologized' the adolescence-limited sub-group of aggressive behaviours. Similar to this assertion, Burt (2011) reported that, contrary to Moffitt's (1993) suggestion, some of the

adolescence – limited aggressors continued the behaviours into the early adulthood, though less than the life-course-persistent ones. Considering Blumstein and Cohen's (1987) findings which showed that majority of the aggressive behaviours and criminal activities are committed by teenagers and that by the early 20s, the rate reduced to 50%, and at 28 years, 85% of them have stopped the behaviours, it may be reasoned that the reported aggressive and criminal behaviours were well into the young adulthood. These findings are inconsistent with Moffitt's (1993) original theory.

In line with the current continuity trend of thought and contrary to the earlier supposition, Moffitt et al. (2002) reported that adolescence – limited aggressive behaviours were found not discontinued even in early adulthood, rather the people continued to engage in low level aggressive behaviours. Many proponents of continuity of aggressive behaviours offered that there are consistent overwhelming evidences from many recent longitudinal studies indicating that aggressive behaviours are relatively stable and self-perpetuating behaviours (Cowie, 2012; Dodge, Coie, and Lynam, 2006; Farrington, 2003; Fergusson, Horwood, and Ridder, 2005; Huesmann et al., 1984/2002; Huesmann, Dubow and Boxer, 2009; Juon et al., 2006; Moffitt et al., 2001; Tremblay, 2000; Tremblay, 2010).

Farrington (2003) and Dodge, Coie, and Lynam (2006), for instance, found that significant numbers of UK children who were aggressive at 8 years old remained aggressive at the age of 30. Other studies also found that people with aggressive behaviours in their early years tend to have a high likelihood of criminal conviction by the age of 30 years (Baldry and Farrington, 2000; Huesmann, Eron and Dubow,

2002; Huesmann et al., 2009). It has also been documented that about 67% of children who were diagnosed with conduct disorder at two were still conduct disordered at 6 years old and a third of aggressive 5-year-olds were still aggressive at 14 years (Shaw, Gilliom and Giovanelli, 2000; Bor et al., 2001). And up to 50% of these children maintain these behaviours into adolescence (Campbell 1995).

The Columbia County Longitudinal study found that both males and females showed moderate level of continuity of aggressive behaviours from age of 8 to 48 years (Huesmann et al., 2009). The study reported that the life-course-persistent aggressive behaviours can be high or low level. The high level aggressive participants were found to have consistently poor outcomes across domains of life success, criminal behaviours and psychosocial functioning (such as arrests, incarceration, aggression towards spouse; poor educational and occupational attainment) by the age of 48 (Huesmann et al., 2009). Temcheff et al. (2008) also reported that the high-level life-course persistent aggressive behaviours have indirect risk paths to violence towards spouse and children (child abuse) through lowered educational attainment and parental absence.

In other studies, the low level aggressive participants were shown to avoid severe negative outcomes but continued to engage in low level crime such as damage to property and often have addiction and mental health problems (Burt et al., 2011; Burt and Hopwood, 2010; Moffitt, 2002/2003). While Juon et al. (2006) offered that continuity and antisocial behaviours are 'the few knowns in aggression and criminology research' (p.194), Other studies asserted that individual stability of

aggression have been alluded as strong as that of intelligence – assuming a trait-like character (Olweus, 1979; Persson, 2005). The overwhelming evidences in favour of the notion of continuity of aggressive behaviours could, therefore, indicate that if childhood aggressive behaviours are not adequately managed, they have the propensity to persist into adulthood as well as have devastating impact on self, others and the society (Burt et al., 2011; Farrington, 2003; Temcheff et al., 2008).

2.3. DIMENSIONS OF AGGRESSION IN YOUNG ADULTS

In the quest to gain better understanding on the phenomenon of aggression, scholars have provided information the methods of delivery (i.e. the 'what' or 'forms') and the purpose (i.e. the 'why' of 'functions') of the aggressive behaviours (Marsee, 2011). Unlike the earlier studies on aggressive behaviours which seemed to focus on either the forms or the functions of aggression, current studies highlighted the need to consider these dimensions of aggressive behaviours together to inform long-lasting therapeutic interventions (Little et al., 2003; Marsee and Frick, 2007; Ostrov and Crick, 2007; Ostrov and Houston, 2008; Prinstein and Cillessen, 2003). This section explored the forms and functions of aggression in young adults.

2.3.1. The 'What Dimension': Forms of aggression

The aggressive behaviours exhibited by young adults are generally grouped into two main forms: direct (overt) and indirect (covert) aggressions (Card, Stucky, Sawalani and Little, 2008; Marsee et al., 2011). These two forms of aggressive behaviours are shown to be associated with variety of social, psychological and developmental problems (Marsee and Frick, 2010). These are discussed below.

2.3.1.1. Indirect (Covert) Aggression

The indirect aggression (also called relational or social aggression) is described as behaviours which harm others by damaging their relationships, friendships, or feelings of inclusion and acceptance in the peer group (Crick et al., 2007; Lagerspetz, Björkqvist, and Peltonen, 1988). Relational aggression, as an indirect aggression, consists of behaviours such as deformation of character, gossiping and rumouring about others, or excluding and encouraging others to exclude target person from a group (Crick and Grotpeter, 1995; Raskauskas and Stoltz, 2004). Recent studies suggested that relational aggression is often the dominant form of aggression during young adulthood (18 and 25 years) and it often involves damaging the other person's (i.e. victim's) social status and relationships (Ryan, 2001; Steinberg, Reyome, and Bjornsen, 2001).

Other studies also showed that due to the transitory, rapid developmental and social changes during the adolescence – young adulthood, the aggressive behaviours reported among this age-group tend to be linked to issues such as: lack of belonging to a peer group (Tanti et al., 2008); intimacy problems (Erikson, 1968); in-group favoritism (Kroger, 2000). Sociometric or popularity status has also been shown to be pivotal to young adults' personal and social identity formation, hence, the need for in-group membership, loyalty, respect and order can be a source or trigger for aggressive behaviours (Dodge et al., 1990; Ryan, 2001). Ojala and Nesdale (2004) suggested that relational aggression can be either proactive or reactive depending on the purpose it is serving. While proactive aggression is often used to maintain the popularity status, power and order within or between peer groups, the reactive

aggression is linked to the aggressors' hostile attribution bias whereby they assume that other people's intentions are hostile (Ojala and Nesdale, 2010).

In relation to gender effects, there were varied views among scholars. Some studies noted that females' aggressive behaviours are often more relational because they tend to easily experience fear in potentially harm-inducing situations and are more able to avoid direct aggressive confrontation (Archer, 2004; Campbell, 1999; Simmons, 2002). Males, on the other hand, are believed to be more prone to direct than relational aggression because they are more willing to take risks and they often place lesser value on long-term consequences of their actions (O'Connor et al., 2002; Cherek et al., 1997; Daly and Wilson, 1990). Males were shown to have greater tendency than women to harbour revengeful thoughts (Sukhodolsky, Golub, and Cromwell, 2001) and have more frequent and long-lasting homicidal fantasies than women (Crabb, 2000; Loeber et al., 2005).

The combination of males' high tendency to risk-taking, low consideration for consequence, and revengeful thoughts could contribute to their use of direct aggression. Contrary to the gender divide, the interactionists maintained that the forms of aggression exhibited by males and females often depend on the purpose underpinning the actions (Bushman and Anderson, 2001; Moffitt, 2001). They believe that the aggressive behaviours of males and females can be relational or direct as well as proactive or reactive because these forms and functions of aggressive behaviours are moderated by many interacting factors other than gender (Archer and Coyne, 2005).

2.3.1.2. Direct (Overt) Aggression

The direct (overt) aggression is described as behaviours that harm others by damaging their well-being through physical contact (fighting, pushing, kicking, and hitting) and/or verbal confrontation (name calling, threatening and insulting another person) (Coie and Dodge, 1998; Moffitt, 1993). Many studies have noted that in situations of perceived threat or vulnerability, young adults tend to employ direct (physical and/or verbal) aggression to protect themselves and possibly deal with the situation (Prinstein and Cillessen, 2003; Ostrov and Houston, 2008). Tanti et al. (2011) found that direct aggression is linked to people's cognitive executive functions, hence, those with the high cognitive executive ability for managing interpersonal conflicts were less prone to aggression than their counterpart.

Other studies found that the reverse was also true; those with low internal resources such as the cognitive executive ability for solving the personal problem and resolving interpersonal conflicts, tend to be more prone to direct aggressive behaviours (Ellis, Weiss and Lochman, 2009; Séguin and Zelazo, 2005). Physical and verbal aggression were found to be part of childhood developmental trajectory which can lead to adolescent delinquency and conduct disorder and if not managed could become the individual's way of dealing with issues in adulthood (Barry and Lochman, 2004; Farrington, 2003; Fergusson, Horwood, and Ridder, 2005). Beaver et al (2009) concluded that childhood issues such as maternal rejection, interparental violence, parental neglects, severe or inconsistent discipline, sexual/physical abuses are associated with the development of violent behaviours in children which, in turn, can be predictive of aggressive behaviours and other antisocial behaviours in adulthood.

2.3.2. The 'Why Dimension': Function of aggression

Based on the functions of aggression, aggressive behaviours are categorised into: proactive (also called instrumental) and reactive (also referred to as hostile/affective) aggression (Anderson and Bushman, 2002; Dodge et al., 1997). These two forms of aggression are often distinguished one from another based-on presence or absence of provocation (Raine et al., 2006).

2.3.2.1 Proactive Aggression

Anderson and Huesman (2003) described proactive aggression as an organized, predatory and premeditated attack on someone with the aim to achieve some desired goals. Proactive aggression is, thus, viewed as a goal-oriented and offensive behaviour which requires neither provocation nor anger to be exhibited on vulnerable targets (Marsee and Frick, 2007; McAdams and Lambie, 2003). Studies suggested that people (including young adults) use proactive aggression when they anticipate personal rewards (dominance/control over another person, status from peers, self-confirmation, gratification, etc.) (Dodge et al., 1990; Ryan, 2001; Vitaro et al., 1998; Vitaro and Brendgen, 2005). This perspective agreed with the reward theories on aggression that the benefits/rewards are motivators for the proactive aggressions.

Hubbard et al. (2001) explained that due to the predatory nature of proactive, it can be executed strategically, methodically, subtly, and often with increasing intensity until the desired goal is achieved. Other studies also noted that aggressors who are strong and have large physical built tend to achieve dominance through threats, intimidation or fighting (Larke and Beran, 2006; Salmivalli and Nieminen, 2002).

These studies also suggested that proactive aggressors who lacked physical edge over their target, tend to use deception, coercion, and manipulation to gain the control they desired. Proactive aggressors were found to frequently utilise rationality and logic, verbal proficiency, emotional control, cunning, and patronization to achieve the goals (Halberstadt et al., 2001; Sutton and Keogh, 2001). They may, therefore, possess highly developed cognitive executive functions that enabled to execute the complex processes that may be involved to achieve their goal.

Young adults with proactive aggression were found to show little or no remorse for their behaviours, rather they tend to offer coherent reasons why their aggressive behaviours were justified and unavoidable (Sanders, 2004) and the strategies used by the authorities to deal with their aggressive behaviours were unjust (Brendgen et al., 2001; McAdams and Schmidt, 2007). They, therefore, do not take responsibility for their action and tend to blame their victims for the aggressive incidence and the authority for being against them (Sutton, Reeves and Keogh, 2000). Other studies also found that many of these proactive aggressors have delinquency and callous-unemotional traits and so derive pleasure in harming others (Card and Little, 2006; Marsee and Frick, 2007). Though proactive aggressive behaviours are often presented in a negative light, Hawley et al. (2007) offered that these are inherent characteristics for dominance and survival which enable us to mark and protect our valued territories, hence, not limited to some selected few.

2.3.2.2 Reactive Aggression

Reactive aggression, on the other hand, is described as a spontaneous or impulsive response to real/perceived threat to one's sense of safety (Bushman & Anderson, 2001; Geen, 2001). This form of aggression is viewed as defensive, retaliatory, emotional, and reactionary to an antecedent situation and are usually targeted at the source of the provocation/threat (Berkowitz, 1969; Dogde and Coie, 2001). Reactive aggression is thought to be perpetuated by the angry – frustration phenomenon (Berkowitz, 1969). Reactive aggressors are often said to be 'hot-blooded', 'short fused' and automatic in response to immediate and often misperceived threat (Hubbard et al., 2001; Wood and Gross, 2002). Studies suggested that young adults exhibiting reactive aggressive behaviours need to learn how to effectively attend to, understand, and consider others' intentions (Dodge, 1991).

McAdams and Schmidt (2007) opined that history of rejections (real/perceived) or lack of close relationship with caregivers are linked to the development of reactive aggression. This is because such individuals tend to develop and maintain high levels of internalised anger and insecurity which make them susceptible to excessively emotional and forceful responses to personal threats (McAdams and Schmidt, 2007; Vitaro, Brendgen, and Tremblay, 2002). The young adults who frequently exhibit reactive aggression were, therefore, shown to have some form of psychosocial maladjustment (e.g. internalizing problems) and self-regulation difficulties (e.g. deficits in executive functioning, attention-deficit/hyperactivity disorder symptoms, emotion dysregulation) (Barkley, 2001; Bobadilla et al., 2012). Within the community and college sample, however, studies have found that the

proactive – reactive aggression classification was not dichotomously clear-cut because people were found to have attributes of both proactive and reactive aggression (Barker et al., 2006; Bushman and Anderson, 2001; Dodge, Coie, and Lynam, 2006; Fite et al., 2008; Leonard, Quigley and Collins, 2002; Little et al., 2003). These studies, therefore, suggested that in the management of aggressive behaviours, it would be worth-the-while to plan intervention strategies that cater for the two forms of aggression.

2.4. COUNSELLING PSYCHOLOGICAL MODES AND MODELS FOR MANAGING AGGRESSIVE BEHAVIOURS

Commenting on the aggressive behaviours among young adults aged 18 to 25 years, Arnett (2000) asserted that the co-existence of aggressive behaviours and the transitory developmental challenges of young adulthood is a crisis combination that requires urgent and efficient intervention. Within the counselling psychological field, many therapeutic interventions for managing behavioural issues (including aggression) have been proposed and implemented. In relation to therapeutic practices, the following are usually the two key aspects to consider: Mode of Therapy and Model of Therapy.

2.4.1. The Modes of Therapy for Aggressive Behaviours

The most commonly used mode of therapeutic interventions for managing aggressive behaviours are individual (1-to-1) Therapy and Group (Interpersonal) Therapy (Cartwright and Zander, 1970; Fung, 2008). Historically, studies showed that psychotherapy started as one-to-one type of therapy but with the shift from

individuation to the social system psychology in the 1930s, psychotherapy expanded to include the group-type of therapy (Cowger, 1979; Hood and Johnson, 1997). Filstead (1979) described a paradigm as a "set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organised study of that world" (p. 34). The paradigm shift in the mode of therapy meant that rather than focusing solely on clients as unique, complex entity that required therapeutic support tailored to their peculiar needs, group therapy focused on understanding clients and their presenting problems in the context of their social or group environment (Fuhriman and Burlingame, 1990; Fung and Wong, 2007).

Earlier studies noted that meta-analyses which compared the outcomes of group and individual therapy found no differential effectiveness or advantage between these modalities (Bednar and Kaul, 1994; Fuhriman and Burlingame, 1990/1994b; Lambert and Bergin, 1994; Shaw, 1932). These studies indicated that while group-therapy may offer a beneficial and cost-effective treatment format, both individual and group therapies were effective in the treatment for the problems they managed (McRoberts, Burlingame and Hoag, 1998). The meta-analysis also showed that when studies were organized in accordance to the treatment focus and clients with defined problems, group therapy were found to have superior outcomes than individual therapy (Kivlighan, Coleman, and Anderson, 2000; Nietzel et al., 1987; Shapiro and Shapiro, 1982). Included in such problems are substance abuse, aggression, stress-related problems, job-related problems, and V-code diagnoses that do not meet strict criteria for mental health diagnosis (Burlingame et al., 1995).

In their studies, Holmes and Kivlighan (2000) and Kivlighan and Holmes (2004) also found that the positive outcome ratings of relationship – climate and other – versus – self focus impacts were higher in the group therapy, while the ratings of emotional awareness – insight and problem definition – change were higher in the individual therapy. This means that 'other/social – related' problems like aggression and social anxiety could be better managed using group-type of therapy (Fung and Wong, 2007; Taft et al., 2003; Taube-Schiff et al., 2007), while self-critical problems like depression may be better managed with individual therapy (Nietzel et al.,1987). Based on the numerous well-documented research findings, scholars concluded that group-therapy could be used as an efficacious, cost-effective alternative to individual therapy under many different conditions (Fung, 2008; Scheinfeld, Rochlen, and Buser, 2011).

2.4.1.1. Managing Aggressive Behaviours in Group-Therapy

The principles underpinning group therapy were said to be rooted in the social systems theories which offered that certain phenomena are often embedded in social relationship systems rather than in individuals and that the management of such phenomena need to be situated within a social context (Ryum et al., 2009; Tasca et al., 2007). Current studies showed that in group therapy, clients tend to take part in varieties of roles and relationships and often learn how the group roles and relationships can mimic the complex interactions in their external world (Sandahl, Lindgren, and Herlitz, 2000; Scheinfeld, Rochlen, and Buser, 2011; Tasca et al., 2007). This meant that group members could practice their newly learnt skills for managing interpersonal conflicts in a controlled social environment of group

therapy before exercising the skills in their natural environments. Scholars, however, warmed that since the natural environment is too complicated to be predicted and controlled in experimental environment, clients would need to be equipped with skills and confidence that would enable them to adjust their learning to suit their peculiar needs and social environments (DeWall, Anderson and Bushman, 2011; Gilbert, Fiske, and Lindzey, 1998).

2.4.1.1.1. Group-therapy Contribution to Change

Helpful Factors in group therapy

In a quest to improve group-therapy experience, Yalom (1995) identified the following eleven therapeutic factors as essential elements of group-promoted change: instillation of hope, universality, imparting information, altruism, family recapitulation, developing of socialising techniques, interpersonal learning, cohesiveness, catharsis, existential factors, and imitative behaviour. Studies such as Fuhriman et al. (1999) and Shechtman, Bar-El, and Hadar (1997) suggested that out of the eleven factors identified by Yalom (1995), only the follow three factors were clients' perspectives of most helpful: group cohesiveness, catharsis, and interpersonal learning (social skills). Shechtman, Bar-El and Hadar (1997) noted that while the first two factors (group cohesiveness, and catharsis) were consistent with the literature on adult groups, the third one (interpersonal learning) is typical of adolescents and young adults, for whom the establishment of social relationships is often a crucial developmental task. With regards to interpersonal learning, recent studies suggested that the use of feedback could be a helpful source of learning both

for the recipient and the rest of the young adult group members (Lambert et al., 2001; Lambert et al., 2002).

Some studies also reported that clients found group support, catharsis, and self-disclosure most helpful experiences that enabled them to achieve their desired outcomes (Cheung and Sun, 2000; Lieberman and Golant, 2002). Other studies suggested that alliance (individual and group), therapy environment, cohesion, commitment and empathy had significant effects on the members' positive therapeutic experience and desired outcome (Hornsey et al., 2009; Johnson et al., 2005). Kivlighan, Coleman, and Anderson (2000) noted that though there could be an overlap of the list of helping factors, a meta-analysis showed that the following four categories tend to be consistent: emotional awareness–insight, relationship–climate, other-versus-self focus, and problem identification–change. The emotional awareness–insight refers to the strong feelings that people experience when they gain some insight on or become aware of something. Relationship–climate relates to the development and maintenance of relationships within a group. Other-versus-self-focus refers to learning from others and the problem identification–change focused on solving problems and changing behaviours.

Unhelpful Factors in group therapy

While there are wealth of up-to-date literature on helpful factors for positive outcomes in group-therapy, there seemed to be a dearth of scientific studies information on the hindering factors to client's process in group therapy (Bowman and Fine, 2000; Roback, 2000). Some studies suggested that the unhelpful factors

may be grouped into: 'therapist's factors', 'group-process factors', and 'client factors' (Roback, 2000; Roback and Smith, 1987).

In relation to therapist's factors, studies noted that clients are often reluctant to comment on the therapist's negative influence on their therapeutic process because they believe that such venture may be understood as disloyalty and ungratefulness to the professional help they received (Farber, Berano, and Capobianco, 2004; Roback, 2000). Few therapist's hindering factors were nevertheless documented. Corey (1990) and Harpaz (1994) emphasise that therapist's personality and skills can have influence on the dynamics of a group. Therapist's negative bias or countertransference toward a client has been found to affect the group's capacity to help that individual (Rutan and Stone, 1984; Shechtman, 2009). Roback (2000) noted that enigmatic therapists who overtly confront, and pressurise group members for immediate and highly personal self-disclosure, and who imposed their values and views on clients, often failed to recognise the breakdown defences in fragile members and hence can lead to increased rate of dropouts in the group.

Therapist's "laissez-faire" approach with negligence in providing adequate structure and protection for group members can also be unhelpful to clients' process (Kellish, 2014; Schofield and Roedel, 2012). Therapist's ambiguity about group goals and procedures was also shown to hinder group development and often feed clients' interpersonal distortions, fears, and subjective distress (Dies and Teleska, 1985; Mayer and Timms, 1970). Sonn (1977) reported that clients also found unhelpful therapist's lack of understanding and connectedness to their personal plights and

narratives. Though therapist's therapeutic orientation was shown not to predict the

effectiveness of therapy, Beutler et al., 2004; Skovholt and Jennings, 2004; Sandell

et al, 2007), therapist's strong allegiance to a theoretical orientation at the expense

of expressed wishes of group members was found to hinder the therapeutic process

and outcome (Lambert, 2013; Orlinsky, Grawe, and Parks, 1994; Quinn, 2015). The

therapist's lack of proper screening skills could question the appropriateness of

potential members for the group, hence issues like lack of readiness, and non-

commitment of such client could undermine the group process (Roback, 2000).

For group-process factors, studies showed that attack, rejection or highly critical

interpersonal feedback about a member's personal shortcomings by the group could

be an obstruction to cohesive group climate (Lieberman and Golant, 2002;

Lieberman et al., 1973). According to Roback (2000), feedback overload could also

have potential anti-therapeutic effects. Dies and Teleska (1985) also suggested that

scapegoats and deviant/resistant members are more likely to experience significant

negative effects if attacked at specific developmental stages of the group.

MacKenzie (1990) offered that clients bringing 'highly charged material might lead to

rejection because the group may find that information too overwhelming' (p. 219).

Miller and Manson (2013) offered that in an open-ended type of group therapy, the

stresses of not knowing from session-to-session who would be joining or leaving the

group, the re-visitation of the already covered topic and the resultant lack of sense of

progress for existing members could also be a potential hindrance.

With regards to the client factors, studies showed that the clients' varied stages in

the therapeutic change process and unrealistic therapy expectations could be

hindering factors (Lieberman and Golant, 2002; Lieberman et al., 1973). The following pre-group personal characteristics were identified as a possible hindrance to group experience and positive therapeutic outcome: 1) severe self-esteem problems; 2) the combination of poorly developed interpersonal skills and high interpersonal sensitivity; 3) a tendency to assume deviant group roles, and 4) being conflicted about self-disclosure and intimacy (Hartley, Roback, and Abramowitz, 1976; Lieberman, 1980). Clients' traumatic past relational (attachment) experiences (Briere, 2002; Feeney, Cassidy and Ramos – Marcuse, 2008; Davey, Day and Howells, 2005) and mentalization difficulties (Fonagy et al., 2002; Fonagy, Bateman, and Luyten, 2012; Taubner and Curth, 2013) could also hinder their interpersonal group experience and effective therapeutic outcome.

2.4.1.1.2. Personal (Resilient) Factors for Change

Studies suggested that as an agent of change, personal qualities can contribute to the change process (Bandura, 1991a). These qualities have been grouped into two main categories: motivation (self-determination/commitment) and confidence (self-efficacy/perceived competence). While <u>motivation</u> was described as the forces that compel people towards a specific goal (Sheldon et al., 2003), <u>confidence</u> was described as people's beliefs about their ability to perform a given action irrespective of circumstances or contexts (Bandura, 1997; Rollnick et al., 2000). Self-determination (motivation), and self-efficacy (confidence) were shown to be vital in achieving behaviour change (Armitage and Conner, 2002; Deci and Ryan, 2000; Rutter and Quine, 2002). This is of importance for young adults whose lack of these qualities may have been contributory to their aggressive behaviours (Armitage and

Conner, 2002). Deci and Ryan (2000) suggested that people are often motivated to pursue and maintain specific behaviours because such behaviours satisfy their personal need to be competent and in control. Studies suggested that 1) people's positive beliefs about the outcomes of the behaviour, 2) the healthy value they attach to these outcomes, and 3) their balanced subjective norms were crucial in behaviour change (Ajzen and Fishbein, 1975; Munro et al., 2007; Webb et al., 2010).

Client's readiness for and commitment to change were other factors identified as crucial in behaviour change process (Whipple et al., 2003). Earlier studies showed that poor therapeutic outcome may be because of the client going into therapy in a less-than-favorable stage of readiness to change (Prochaska, DiClemente, and Norcross, 1992). Prochaska and Prochaska (1999) suggested that combination of effective therapeutic techniques and client's readiness/commitment to change could improve therapy outcome. In relation to readiness for change, there are two types of beliefs that have been emphasised: the person's perceived vulnerability to threats and the expected consequences from such situation. People are constantly weighing the benefits associated with new behaviours against the perceived costs and negative consequences of not changing and that the benefit must outweigh the cost/negative consequence for it to be desirable. (Nisbet and Gick, 2008). Personal qualities such as higher intelligence, positive attitude, problem-solving skills; good communication skills; capacity to reflect and self-monitor were identified as vital contributory factors to behaviour change (Michie et al., 2011).

2.4.2. The Model of Therapeutic Intervention for Aggressive Behaviours

McAdams and Schmidt (2007) explained that to facilitate change in young adults with aggressive behaviours, they would need to be convinced that the proposed change is in their own best interest. The therapeutic intervention aimed at managing aggression must be able to convince the aggressors that the personal gains of behaviour change outweigh both the negative consequences and the potential benefit of not changing their aggressive behaviour (Pellegrini and Bartini, 2001). Often, therapeutic intervention models used for managing aggressive behaviours tend to reflect the theoretical positions or assumptions that inform and underpin the practice (Anderson and Bushman, 2002). The following three models are commonly used in managing aggressive behaviours: Behavioural Intervention Plan (BIP) model, Cognitive Behavioural Therapy (CBT) model, and Integrative Group Therapy (IGT) models.

2.4.2.1. Behavioural Intervention Plan (BIP) Model

The Theory of Planned Behaviour (TPB) is one of the extensively referenced behaviour theories and it is based on the theory of reasoned which supposed that intent to act is the primary predictor behaviours/actions (Fishbein and Ajzen, 1975). Behaviours can, therefore, be managed by modifying intentions and expectancy which are often underpinned by attitudes and beliefs (Ajzen, 1985/1991; Ajzen and Madden, 1986) The Behavioural Intervention Plan (BIP) model is a therapeutic model based largely on the theory of planned behaviours (Myers et al., 2007; Tremblay, 2000). The BIP Model is a specifically tailored behaviour modification

model used to manage each client's behaviours. The model's primary aim is to adjust the factors peculiar to each client that triggered their aggressive behaviours (Crone and Horner, 2003).

Though there has been recorded successes in the use of this model to help some clients with aggressive behaviours, critics suggested that the model is too complex, time-consuming and capital intensity (Blood and Neel, 2007; Couvillon, Bullock, and Gable, 2009). Scott, Anderson, and Spaulding (2008) argued that the model did not account for the human agency factor, hence, aggressors would have to rely on others to effect any required change. These critics seemed to be echoing the current position of the healthcare providers especially in the UK who are emphasising the Individual responsibility for health and self-care in recent health policy documents (Hardeman et al., 2002). In the face of the recent global financial constraint and budget cuts within the UK's National Health Services (NHS), this model seems to have lost some support in many quarters.

Currently, the UK government seemed to be more inclined to funding therapeutic models that can help a wider range of people within a shorter time and still be as effective in behaviour change as the capital-intensive approaches like BIP (HM Government, 2005; Hardeman et al., 2002). The Wanless' (2007) review of health care funding argued that public involvement in maintaining health could be a helpful strategy to reduce health care costs. For therapists, therefore, the challenge is to develop models that enable people to independently adopt healthier behaviours. The model generated in this current study is geared towards empowering young adults to

be actively involved in the management of their aggressive behaviours.

2.4.2.2. The Cognitive Behavioural Therapeutic (CBT) Model.

The Cognitive Behavioural Therapeutic (CBT) Model is underpinned by the cognitive theories which held that people are agents of action and have the capacity to modify their thinking and in turn change their behaviours and feelings (Beck, 1979; Butler, Fennell and Hackmann, 2008). Aggressive behaviours, from this perspective, are products of distortion of the cognitive executive function and perception of the client (Beck, 1979/1985; Kendall et al., 2000; Kendall et al., 2003). The CBT model, therefore, focuses on providing clients new techniques for challenging cognitive distortion, strengthening effective cognitive function, consequently, modifying their maladaptive behaviours (Dattilio and Freeman, 2003/2007; Hofmann, 2011). The skill-based model of CBT has been acknowledged as very essential in the management of aggressive behaviours especially in reactive aggression where the aggressors have been found to lack problem-solving skills (Fives et al., 2011; Lochman et al., 2010).

The CBT model, however, has been critiqued for focusing on the person in the situation and excluding the situational factors of aggression (e.g. social, economic, cultural, unconscious determinants) which have been considered as important as the emphasised personal cognitive factors (Del Vecchio and O'Leary, 2004; Larson and Lochman, 2002). These critics argued that the model's content and rules about intrapersonal and interpersonal relationships are not well defined. Bearing in mind that aggressive behaviours are generally viewed as social problems, the

management of such behaviours is expected to account for such contextual

component for it to be effective (Jackson, 2005).

2.4.2.3. Integrative Therapeutic Model

Most of the Integrative group therapy were shown to be underpinned by the

integrative theories such as: Theory of Interpersonal Behaviour (Triandis, 1977),

Value-Belief-Norm Theory (Stern et al., 1999/2000). From the integrative theoretical

perspective, aggression is a cascade of processes involving the: (1) person in the

situation (P), (2) situation (S), and (3) interaction between the person and the

situation (PS) (Anderson & Bushman, 2005; Guerra and Huesmann, 2004). Based

on this assumption, studies suggested that therapeutic intervention for aggression

would require a multidimensional framework which can effectively account for the

various facets of the phenomenon (e.g. forms and functions of aggression)

(Anderson and Bushman, 2005; Barry and Lochman, 2004).

Studies also showed that the integrative therapeutic models tend to incorporate the

humanistic, psychodynamic and CBT theoretical orientation in their practice (Guerra

and Huesmann, 2004; Hill and O'Brien, 1999; Prochaska, 1999). The humanistic

principles and skills are shown to be crucial for initiating and maintaining a

therapeutic relationship and alliance (Klein et al., 2013). This enables members to

establish rapport, create an environment of trust, and develop awareness of others.

The CBT skills are interventions that enable clients to work on the behavioural and

emotional components of aggression (i.e. frustration-aggression /expression of

repressed aggression) (Larson and Lochman, 2002). The focus of these

interventions was to enable people to effectively express their feelings and have some emotional relief in a socially and emotionally supportive environment (Eron and Huesman, 1984; Roback, 2000). The psychodynamic principles and skills provide insight and management resources for other aspects of clients' aggression such as 1) intrapsychic aspect (Transference displacement), 2) Interpersonal aspect (unconscious communication); 3) in-group/out-group social aspect (Reid, Patterson and Snyder, 2002; Rutan and Stone, 1984).

The main underlying integrative therapeutic assumption was that people make commitment to change and are willing to utilize their newly acquired skills when they can freely express their emotions knowing that they will be listened to, accepted and not judged (Scheinfeld, Rochlen, and Buser, 2011). In the General Integrative model, the primary aim is, therefore, to create a mid-point between real-life and experimental situation (DeWall, Anderson and Bushman, 2011; DeWall et al., 2007; Ryan, 2001). It allows the clients to develop the needed confidence (self-efficacy) and motivation (self-determination) by practising their new skills within an observable environment. This Model seems to be receiving increased attention from both the UK National Health Service (NHS) and community-based therapeutic organisations.

2.5.   <u>SUMMARY OF LITERATURE REVIEW</u>

The concept of aggression has continued to draw varied scholarly opinions and interests. The inconsistencies in the research findings regarding the meaning, expression and continuity of aggressive behaviours meant that its management and outcomes have continued to be diverse and often inconclusive (Anderson and

Bushman, 2001). From the literature reviewed, it was apparent that studies often concentrate on the enabling factors for an effective therapeutic outcome without paying much attention to the possible factors that could hinder the desired outcomes. Few studies also suggested that the dichotomous or factional approach to research and the single model to therapy may have contributed to ambiguity and sometimes ineffectiveness in managing aggressive behaviours (Bor et al., 2001; Burlingame et al., 1995).

The General integrative model used in a group setting was hoped to bridge the theoretical and therapeutic gap by providing a framework that reconciles many aspects of the aggression phenomenon and management (Bushman and Anderson, 2001; Chon, 2000; Shechtman et al., 2002). By so doing, several studies reported significant improvement in the clients' aggressive behaviours which enabled them to secure new jobs and established stable relationships at school/home (Anderson & Bushman, 2002; Ghanbari-Hashemabadi, Maddah-Shoorcheh, Maddah-Shoorcheh, 2014). As encouraging as these findings are, a closer look revealed that majority of the reports were based on third-party's (e.g. teachers, parents, other pupils) accounts. In addition to developing an integrative framework that could account for the heterogeneity of aggressive behaviours and reconcile the varied epistemological and theoretical presuppositions (Kozarić-Kovacić, 2008), there is also the need to balance data sources by including the views of the aggressors who have lived and managed these behaviours. Few studies such Anderson & Huesman (2003); and Fonagy et al. (2002) in America; Farrington (2003); Green & Price (2016); Mcguire (2008); and Tapson (2015) in UK have explored young people's perspective on

aggression and its management using qualitative method. With the continued increase in the rate of aggression and violence in the UK, there seem to be need for more of such studies to be carried out, especially in the UK. The current study, therefore, utilised grounded theory design to explore aggressors' perspectives of helpful and unhelpful factors in the management of their aggressive behaviours and generate a framework that accounts for these factors. Using grounded theory (qualitative methodology) allowed for 1) an in-depth examination of the interactions between the intrapersonal and interpersonal factors, 2) an exploration of the helpful and unhelpful interventions used in managing these interactions.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter discusses the research method and methodology used in this study and how they informed data collection, analysis, and development of theory. The chapter is divided into three main parts: 1) method and methodology consideration, 2) in-depth description of the research methodology used in this study and 3) the procedures (phases and process) involved in the data collection and analysis.

3.1. METHOD AND METHODOLOGICAL CONSIDERATIONS

3.1.1 Alternative Method and Methodology Considered

At the start of this project, few research designs were considered and assessed based on their suitability to the intended study. When the topic area was chosen, quantitative design was initially considered because this design was shown to be a useful avenue for measuring attitudes and occurrences across a large sample and consequently obtaining knowledge on population distribution of the understudied phenomenon (Blaikie, 2007). Quantitative method design was, however, discarded because it does not capture the main aim of this study which is to explore participants' perspectives on the meaning and management of aggressive behaviours.

With the initial search on the topic indicating the existence of wealth of research that used the quantitative method to study the concept of aggression but not as much research used qualitative design. It, therefore, seemed logical to employ qualitative design which would not only bring another angle to the discourse on aggression but also provide these participants (young adults) opportunity to share in depth their

views on meaning as well as contribute to management of the social issues like aggressive behaviours. The qualitative method is a widely-used method in many fields of study such as anthropology, sociology, and nursing but as Morrow et al. (2002) and Ponterotto (2002) noted, qualitative method is a relatively recent development in the field of psychology compared to other fields. Since its inception in the field of psychology, however, qualitative method has continued to gain favour and interest (Blaikie, 2007).

With regards to the current study, my preliminary search indicated that there is need for more qualitative studies in the UK to explore clients' perspectives on the meaning and management of their aggressive behaviours. Studies such as Farrington (1996/2003); Farrington and Coid (2003); Green and Price, 2016; McGuire (2008); Tapson, 2015; and Winter et al, (2017) have laid the platform for other studies like this current one to build on. Many other studies that used qualitative design focused on factors surrounding the phenomenon of aggression such as: gender differences in aggression (Bobadilla, Wampler, and Taylor, 2012), types of aggression (Anderson and Huesmann, 2003; Vitaro, Brendgen, and Barker, 2006), social and cultural constructs of aggression (Robrecht, 1995) etc. This, therefore, meant that findings from this current qualitative study design could add to the existing knowledge in the field counselling psychology by providing aggressors' perspectives on helpful and unhelpful factors in the management of aggressive behaviours. This will assist in improving services offered to these client groups.

Within the qualitative design, there are many possible methodologies that could possibly be used in this study but the only one that was a close match was the

Interpretative Phenomenological Analysis (IPA). This was because IPA also explores participants' phenomenology (meaning making) (Husserl, 1859–1938; Giorgi, 1997/2011). Smith et al. (2009) explained that IPA is underpinned by the assumption that human experience is evolving, process oriented and individualised, hence requires personal interpretations. This means that the primary purpose of the IPA methodology is to explore the participant's subjective view of what it means to be involved in a phenomenon like aggression. IPA, therefore, focuses on how people make-sense (meaning-making) of their personal lived experience (phenomenon).

The distinctive features of IPA are its commitment to detailed interpretative account of the data (hermeneutics) (Heidegger, 1962; Palmer, 1969) as well as its idiographic (individualised) view of participant's experience of the phenomenon (Smith et al.,1999/2003). The implication of these features is that the methodology is highly subjective and could not be used as a rule. Smith (2008) acknowledged that in IPA, 'one is sacrificing breadth for depth' (p. 56). IPA was, therefore, considered as inappropriate for the study because rather than the IPA idiographic experience of each participant, this current study is interested in the commonality or normative experiences of the participants.

3.1.2. Reasons for Choosing Grounded Theory Methodology

Grounded theory methodology (GTM) is described as a flexible yet rigorous methodology that develops a theory from the participants' data (Charmaz, 2006; Strauss and Corbin, 1998). It is shown to be appropriate for studying social processes, interpersonal relations and the interactions between people and society

with the goal of investigating <u>commonality</u> of actions and meanings of the phenomenon across the study population (Brocki and Wearden, 2006). This is in line with the purpose of this current study which focuses on the commonality of meaning and experiences of young adults in managing aggression following a group therapy. Focusing on the commonality may mean a slight compromise on the depth of individual experiences but gain on the breadth of such experiences. The materials that are used to develop the theory were, therefore, the best-fit for the epistemological stand of this study.

Grounded theory was also chosen based on <u>theoretical sensitivity</u>. This is described as 'the attribute of having insight, the ability to give meaning to data, the capacity to understand and capability to separate the pertinent from that which is not' (Guthery, 2010, p48). My knowledge and experience as a medical doctor of over twenty years and psychotherapist of ten years contributed to my faster understanding of the processes and actions described by participants as well as my ability to separate the pertinent from the not. I am, however, aware that this knowledge can, if not checked, be a hindrance and raise an importance concern on my bias. My biases were constantly monitored through memos and reflexivity as well as my supervisors' feedbacks. The next reason for choosing grounded theory is because of <u>its parsimony</u>. Studies showed that GTM provides a simplified explanation of complex multifaceted phenomena that occur in social interactions (Pope-Davis et al., 2002; Starks and Trinidad, 2007). Managing aggressive behaviours among young adult is a process that may involve a variety of factors. GTM was, therefore, used to provide a simple explanation of the inter-relationship of these factors.

Another reason for selecting GTM is because of its *ecological validity*. Ecological validity refers to as the extent to which research findings accurately represent real-world settings. GTM is to be close to reality because it is content-specific, detailed, rigorous, systematic and closely connected to data while permitting flexibility and freedom in interacting with the emerging knowledge (Jones and Alony, 2011). GTM enables this study to interact with the data and identify concise knowledge of commonality in participants' experiences in managing their aggressive behaviours without losing the dynamics and complexities involved in the reality of their experiences. GTM was also chosen for its *novelty*. Stern (1980) offered that 'the strongest case for the use of grounded theory is in investigations of relatively uncharted waters' (p. 20). There are very little studies done on young adults (18 – 25 years) managing aggressive behaviours. GTM, hence, provided opportunity for new insights to be gained on how to improve the therapeutic services counselling psychologists offer to these clients.

Grounded theory methodology (GTM) can involve both inductive and deductive analytic approaches. While the inductive approach allows the generation of theory from the data (Glaser and Strauss, 1967), the deductive approach occurs during the constant comparison of data. Though there are currently many versions of GTM with varied epistemological and ontological emphasis, they all seemed to agree that the emergent theory should be guided by the participants' data. In relation to the type of theory that is eventually generated, Strauss and Corbin (1998) noted that two types of theory that can be developed using GTM: substantive and formal theory. While substantive theories offer a theoretical explanation for the specific phenomenon in a

specific setting, formal theories offer a theoretical explanation to a *generic issue* which may apply to a wider range of fields of life. (Strauss and Corbin, 1998). Charmaz (2006) pointed out that most grounded theories are substantive theories as they focus on specific problems in a specific, substantive area but formal theories can be developed by combining findings from several substantive theories. Data gather from this study is, therefore, used to generate a substantive theory which focused specifically on meaning and management of aggression in young adults.

3.2 GROUNDED THEORY METHODOLOGY - AN OVERVIEW

Grounded Theory Methodology (GTM) is one of the main methodologies in a qualitative method that utilises data from observations or interviews to develop a theoretical explanation of the understudied phenomenon (O'Neill, 2002). Glaser (2001) offered that GTM is a detailed, rigorous, and systematic method of analysis which provides researchers the freedom to explore areas that are relatively unknown, consequently, allowing new ideas to emerge.

Building on Glaser's view, Walker (2006) asserted that GTM is a methodology that exhibits 'the depth and richness of qualitative interpretive traditions with the logic, rigour and systematic analysis inherent in quantitative survey research' (p. 548). In contrast to the quantitative method, which aims to achieve statistical generalizability through inferences and testing of existing theories, GTM aims to explain phenomena and develop a theory of interrelated concepts using the participants' own data (Strauss and Corbin, 1998).

3.2.1. Background of Grounded Theory Methodology

Historically, Glaser and Strauss (1967) developed grounded theory methodology (GTM) using data from their study of '*patients' awareness of dying'*. This version of GTM is currently referred to as the classical GTM and was built on the realist and positivist assumption which holds that 1) the world consists of detectable laws/systems and 2) reality can be inferred through observation (Bryant and Charmaz, 2007). Glaser and Strauss (1967) described grounded theory as 'the discovery of theory from data – systematically obtained and analysed in social research' (p.1). The classical GTM was viewed as an objective procedure used to explain social phenomena and accounts for patterns of behaviours that are relevant and often problematic to the people involved (Glaser, 1978). From the classical GTM perspective, researchers are to collect data without having a preconceived idea of the existing literature in the area of study (Glaser and Strauss, 1967). It is assumed that the emerging theory is already contained in the data awaiting to be *'discovered'.*

3.2.2. Main Ontological Traditions in GTM

 Since the inception of the classical GTM in the 1960s, it has evolved beyond its original text (O'Neill, 2002). Few years after the development of the classical GTM, Glaser and Strauss split up. Their subsequent separate works gave rise to the two initial versions of GTM: Glaser (1978/1992) and Strauss and Corbin (1990/1998). While Glaser (1992) maintained the traditional positivist, realist position which GTM started with, Strauss (1990) shifted slightly to assume a more post-positivist, critical realist stand. Bryant (2009) reasoned that Strauss' (1987) departure from the earlier GTM may have provided a springboard for other versions of GTM like constructionist

(Charmaz, 2000/2006) have emerged. In this section, the ontological stands of the following three main versions of GTM are discussed: 1) the realist/positivist (Glaser, 1978/1998); 2) the critical realist/post-positivist (Strauss and Corbin, 1990/1998); and 3) relativist/social constructionist (Charmaz, 2000/2006). Since this current study is situated within the critical realist/post-positivist (Strauss and Corbin, 1990/1998) ontological stand, the ontological stands of the first and third versions of GTM are discussed first. The critical realist version of GTM and its epistemological root is subsequently discussed in-depth.

3.2.2.1. Positivist (Realist) Position of GTM

The Glaser (1978/1998) version of GTM was based on the positivist, realist ontological stand which believed that reality, both natural and social, exists independent of human action and observation (Blaikie, 2007). According to this position, reality can be objectively measured by bracketing and methodologically limiting researchers' personal biases (Ramey and Grubb, 2009). Glaser (1998) viewed reality as objective and independent of the researcher's knowledge, hence data should be allowed to speak for itself. The whole emphasis was on the data and what data was doing. Glaser (2001) asserted that 'all is data… The researcher collects, codes and analyses exactly what he has whether baseline data, properline data, interpreted data or vague data' (para. 1). Grounded theory was said to be an objective methodology which transcends time, place and people and 'focus on concepts that fit and are relevant' (Glaser, 2001, para 3). Glaser (1998/2002) suggested that researchers are to assume a neutral position while generating the theory to avoid human distortions and biases which could arise when they attempt to

obtain an accurate description of the event or concept. Researchers are also to focus on conceptualising what is going on (what the data is doing) rather than attempting to produce an accurate description of the event.

This version of grounded theory has been hugely critiqued as reductionist (Charmaz, 2000). Bryant (2009) argued that Glaser's (1978) assertion of researcher's neutral role in grounded theory is non-committal, simplistic and an "epistemological fairytale" (p.13). The idea of 'knowledge with certainty' as espoused by positivists was viewed as a misconception that can render the conceptualization of social processes unattainable (Strauss and Corbin, 1998) and the concept of enlightenment unachievable (Giddens, 1990). Larrivee (2008) further argued that just as we cannot guarantee that the knowledge we have of a given situation is complete, we cannot also be certain that our actions will produce the outcomes we desire.

3.2.2.2. *Constructionist (Relativist) Tradition of GTM*

The constructionist version of GTM was propounded by Charmaz (2003, 2006). She explained that this version offers accessible methodology that could take qualitative research into the 21st century. Charmaz (2006) challenged the positivist idea of objective truth/reality. The constructionist version of GTM assumes the relativist ontological stand. This stand upholds that there are multiplicity of realities which are mutually created by the viewer and viewed and are aimed at gaining an interpretative understanding of their subjective meaning (Charmaz, 2003). From this perspective, meaning/reality does not inactively wait to be discovered as purported by the classical GTM, it is rather created as people constantly interact and interpret their

actions (Crotty, 1998). This GTM version, therefore, it holds that data or theory is not discovered; it is rather co-constructed between researcher and participants.

The constructionist GTM aims to explore how people construct their reality and make sense of their life experiences. Crotty (2003) offered that from the constructionist perspective, truth or meaning comes into existence as we engage with the realities of our world. Since people's worlds are often ideographic in nature, realities and meanings to any given concept especially social phenomenon would be expected to vary (Charmaz, 2003). Charmaz (2006) concluded that reality or truth is perceptual rather than objective and conclusions in social science studies ought to be derived from co-constructed interpretations rather that the preconceived theories of the researchers. The researcher's and participants' accounts of the social world are not definitive but evolved with experience and interaction (Charmaz, 2003). The researchers are, therefore, to assume a co-constructive and interpretative role wherein social phenomena and their meanings are continually constructed and revised through social interaction with the participants (Bryman, 2001). Charmaz (2003) suggested that constructionist version of GTM is a methodology that offer researchers and participants the flexibility to jointly construct understanding of their shared assumptions about a give phenomenon.

This version of GTM has, however, been critiqued as a step too far in the advancement of GTM (Glaser, 2002). Glaser (2002) described it as a 'misnomer' and a vital loss to GTM. The study explained that one major concern about the constructionist version is its stand on the personal predilections of interviewer and

interviewee. The idea that the interview data is a representation of the mutual (interactive) interpretation of the interviewer and of the interviewee is just 'an epistemological bias [used] to achieve a credible, accurate description of data collection' (Glaser, 2002, p. 10). Glaser (2002) further stated that this version 'is an effort to dignify the data and to avoid the work of confronting researcher biases' (p.10). The study argued that the implication of merging researcher's biases and participant's account is that, in sensitive-issue-oriented research which may be averse to implicit subversion, the voices of participants who do not share similar belief and passion with the researcher will either be distorted or not heard.

Adding to Glaser's views, Hammersley (1992) questioned the usefulness of the findings that are underpinned by a relativist ontology whereby there are multiple realities with each claiming legitimacy. Hammersley (1992) suggested that if these realities are all legitimate, there is then no reason for us to prefer one account over another. Research findings should, therefore, be viewed as just another account and as such cannot claim any form of uniqueness. Murphy et al. (1998) warned that the usefulness of research may be questioned if it is not contributing to knowledge in a uniquely meaningful way.

3.2.2.3. *Post-Positivist (Critical-Realist) Position of GTM*

Having moved away from the classical GTM, Strauss and Corbin (1990/1998) assumed an ontological position of post-positivism and critical-realism. Critical-realism is an ontological position rooted in the works Bhaskar (1975, 1978, 1989) and other people like Archer et al. (1998); Fleetwood (1999); Lawson (1997); Sayer

(1992, 2000). Zachariadis, Scott, and Barrett (2013) offered that critical realism is frequently described as a mid-way between realism (positivism) and relativism (interpretivism), hence both strict determinism of the positivism and non-determinism of relativism are rejected and a more nuanced version of realist ontology introduced. Being situated in critical realism, Strauss and Corbin's (1990/1998) version of GTM tend to constitute some aspects of realism and relativism (Archer et al., 1998). As is in realism, this version of GTM acknowledged the existence of external objective truth and universal laws (reality) independent of our knowledge and perception.

Unlike realist position, it queried the assertion that humans can know reality with certainty. It offered that all observations, measurements, and knowledge are fallible, have errors and are often shaped by contextual influences and biases. This implied that though there is objective truth, the articulation of knowledge about this truth is socially produced or influenced, consequently, yields to subjectivity (Archer et al., 1998; McEvoy and Richards, 2003). Strauss and Corbin (1998) suggested that the discovery of absolute truth is nearly impossible but hoped that research will provide better understanding of how our world works. Zachariadis et al. (2013) added that 'though there is one reality, it does not follow that we, as researchers, have immediate access to it or that we are able to observe and realize its every aspect' (p. 857).

Applying the critical-realism perspective to research, Corbin and Strauss (1990) suggested that 'since phenomena are not conceived of as static but as continually changing in response to evolving conditions, an important component of GTM is to

build change, through the process, into the method' (p.5). Flexibility and openness should be adopted in research to accommodate the change processes bearing in mind that people (actors) tend to respond to evolving conditions using the resources available to them. They make choices based on their perceptions about the options available. According to Corbin and Strauss (1990), the goals of GTM and role of researchers are, therefore, to 1) uncover relevant conditions, 2) determine how people (actors) respond to changing conditions and consequences of their actions.

3.2.3. <u>Epistemological Position of Strauss and Corbin's version GTM</u>

Ponterotto (2005) described epistemology as 'the study of knowledge, the acquisition of knowledge, and the relationship between the "knower" (research participant) and the "would-be knower" (researcher)' (p. 131). The epistemology underpinning Strauss & Corbin's (1990/1998) version of GTM is rooted in the philosophical tradition of pragmatism and symbolic interactionism (Birks and Mills, 2011; Bryant, 2009). While *Pragmatism* highlights people's role in the creation of objective reality (Chamberlain-Salaun, Mills, and Usher, 2013), *Symbolic Interactionism* emphasized the concept of shared meaning which is often generated through interactions between individuals and their social environment (Blumer, 1937). Strauss and Corbin's (1990) epistemological stand of symbolic interaction was influenced by sociologists like Mead (1934), Dewey (1938), Park (1952) and Blumer (1969). Clarifying social interactionism and its application in Strauss and Corbin's (1998) version of GTM, Chamberlain-Salaun, Mills, and Usher (2013) identified the following four key concepts: 1) *Meaning, 2) Action and interaction, 3) Self, and 4) Perspective.* These are discussed below.

Meaning

Chamberlain-Salaun, Mills, and Usher (2013) explained that realist would view meanings as inherent in the things that they are describing, hence, a hat is a hat. But from a symbolic interactionism perspective, things (e.g. hats) do not have a determined or inherent meaning; rather the meanings are derived from what the objects (e.g. hats) are doing or what is happening to the object (Mead, 1959). A hat can, therefore, be a fashion statement (ornamental) or a protective shield from the sun. From this perspective, meanings are generated from interactions and are adaptable to the context that they are being used (Blumer, 1969; Mead, 1934). In GTM, the process of attributing meanings to things corresponds to the processes involved in data analysis (i.e. Open, Axial and Selective coding). The change in meaning, due to the context and the function that the object, is also demonstrated in the process of constant comparison of within and between participant(s) data. The researchers continuously interact with data and reassign meaning to "what is really going on" in the data (Glaser, 1998, p. 12).

Action and interaction

Chamberlain-Salaun, Mills, and Usher (2013) asserted that actions are products of social interaction which can be non-symbolic and symbolic. *Non-symbolic interaction* is described as a "conversation of gestures" (Mead, 1934, p. 167) or people's response to others' gestures or behaviours (Blumer, 1969). *Symbolic interaction*, on the other hand*,* is an interpretative process that guides one's behaviours and conveys to the other selves how they are to respond or behave (Blumer, 1969). This

is a recurrent process wherein people continuously adjust or modify their behaviours in order to fit the existing or expected actions of others.

The concept of action and interaction is identified as key in grounded theory research. It is demonstrated in the simultaneous activities such as collecting, analysing and theoretical sampling of the data. This means that the researcher would have to analyse the first sets of data collected before proceeding to collect the next sets of data from other participants. The information gathered from the first would therefore direct the next course of action (i.e. where, what, and with who the researcher will theoretically include in the next phase of data collection). Chamberlain-Salaun, Mills, and Usher (2013) suggested that this process enables contingencies to be identified. Strauss (1993) offered the contingencies which could affect the direction of the studies can be grouped into external and internal contingencies. The external contingencies are shown to range from economic, political, organisational, to other socially situated factors. These contingencies are also expected to be considered so as to allow any pattern in the data that relates to external factors to be identified.

The internal contingencies, on the other hand, relate to the course of action itself. Chamberlain-Salaun, Mills, and Usher (2013) explained that people are often members of multiple social groups and sub-groups. In relation to research, therefore, researchers' affiliation to these social groups and sub-groups could be captured and bracketed through memo writing. Participants' membership to social groups and subgroups identified through demographic data and information gathered during interviews. The association between actions and emotions is also part of the internal

contingencies. The emotions and feelings associated in the participants' data can enable researchers to identify the meanings that these participants ascribed to conditions relating to the understudied phenomena (Corbin and Strauss, 2008).

Self

The symbolic interactionists would offer that while self is fundamental to all social actions, it is often shaped by social process (Blumer, 1969; Charon, 2007; Mead, 1934). According to Mead (1934), self is made up of two interlinked components: the subjective and objective components with the subjective represented as 'I' and the objective represented as 'Me'. People can experience the objective self when they take the role or perspectives of others and compare these perspectives with their own subjective meaning and attributions to the situation (Chamberlain-Salaun, Mills, and Usher, 2013; Murphy, 1959). Mead (1934) asserted that there is no personal thinking or sense of self that is independent of the social process because the I – Me self-experience takes place within the social nexus and these self-experiences are characterized through social learning. Other people's responses to our gestures enable us to develop the capacities for mental symbolization and meaning attached to the gestures. Hence organized 'language becomes possible when people share a common set of mental symbols' (Gergen, 2009, p. 89).

Mead (1934) offered that human ability to share symbols allows them to express their inherent capacity for role-taking through which they become conscious of self. Over time, they tend to 'develop a sense of a generalised other' (Gergen, 209, p. 89). The generalised sense of self enables people to become aware of self, consequently able to view themselves from the perspective of others and adjust their

behaviour to suit the situation they are in (Mead, 1934). The symbolic interactionist, therefore, supposes that meanings are social interactions that can be negotiated and modified over time through the reflexivity or interaction of the people involved (Goulding, 2005). While the interactionist dimension of self refers to the interaction between 'I' and 'Me', symbolic concept of self refers to self's reliance on the shared symbols with the other selves (Baert, 1998).

With regards to GTM research, Le Breton (2008) described self as "a corner stone of the conceptual edifice" (p.62). Chamberlain-Salaun, Mills, and Usher (2013) reasoned that though self is usually implicit in grounded theory methodology, memo writing enables self to be expressed and the dialogue between the 'I' and 'Me' of the researcher to be captured. Charon (2007) offered that memo writing is like an internal audit trail that captures 'the thinking that goes into decisions and actions' (p. 119). Mead's (1934, 1959) concept of the reflexive self has been linked to GTM's theoretical sensitivity (Birks et al., 2008; Chamberlain-Salaun, Mills, and Usher, 2013; Milliken and Schreiber, 2012). Theoretical sensitivity is also linked to self-expression because it demonstrates researcher's ability to recognise variations in the data and identify relevant aspects of the data for the emerging theory (Birks and Mills, 2011; Corbin and Strauss, 2008; Mills, Bonner, and Francis, 2006).

Perspective

Strauss and Corbin (1998) asserted that research 'analysis is an interplay between researchers and data' (p.13). The GTM research process involves researchers' conceptual ability to interpret participants' perspectives and meanings of the understudied phenomenon. The researcher is also responsible for negotiating the

difference and nuances in participants' perspectives in order to generate a robust and integrated theory. Studies showed that it is essential for researchers to be aware of possible multiple perspectives within and across participants' data and how these perspectives can influence participants' and their actions and interactions (Chamberlain-Salaun, Mills, and Usher, 2013; Corbin and Strauss, 2008). The researchers' insight on how and why different data categories are interrelated or associated would, therefore, produce a multi-dimensional theory that is grounded in the data (Chamberlain-Salaun, Mills, and Usher, 2013; Silverman, 2011).

It is, hence, assumed that researchers do have some influence on their studies but they also can be objective enough to maintain researcher – participants independent views (Strauss and Corbin, 1998). The researcher can, therefore, be both objective (science) and subjective (creativity). The objectivity lies in researcher's ability to maintain certain level of rigour and grounding analysis in data. The subjectivity (creativity), on the other hand, is demonstrated in researchers' ability to 'name categories, ask stimulating questions, make comparisons, and extract an innovative, integrated realistic scheme from masses of unorganized raw data' (Strauss and Corbin, 1998, p.13). The role of researchers is to strive to maintain a balance between objectivity and subjectivity. In their recent publication, Corbin and Strauss (2008) offered that GTM researchers have an interpretivist role whereby attention is on understanding people's perspectives in the context of the conditions and circumstances of their lives. This will enable researchers to maintain the balance between inductive and deductive approaches to the research process while analysing and developing interpretations of the data (Corbin and Strauss, 2008).

Strauss and Corbin (1998) rejected Glaser's (1998) assertion that researchers should be able to see the world (reality) just as it is and so can assume a totally objective and neutral role in data analysis. They argued that researchers have an active interpretative role in developing theory from the data, hence, cannot be completely objective in their stance. Researchers were viewed to be all biased and their observations often theory-laden. Strauss and Corbin (1998, 2008) suggested that researchers may, however, achieve some level of objectivity in social phenomenon through triangulation across multiple fallible perspectives as well as through reflexivity of the researchers.

The following six basic social processes (6C's) were identified as essential in the exploration of social phenomenon and the development of grounded theory*: causes, context, contingencies, consequences, co-variances, and conditions*. Strauss and Corbin (1998) asserted that theory can be developed by using a framework that 1) produces a model of causes, intervening conditions and consequences; and 2) explains the phenomenon, context, actions and interactions involved in the phenomenon. Researchers are expected to be flexible in exploring possible dimensions of the phenomenon and to establish relevant relationships among the identified categories without altering the meanings in the participants' original data. New ideas can, therefore, be discovered and knowledge increased by focusing on the interrelationships and interactions of the emerging categories within the data.

Responding to Strauss and Corbin's (1990/1998) version of GTM, Glaser (1992, p.123) argued that the version is a 'full conceptual description' which did not extend

understanding of empirically grounded theory; rather had departed significantly from the original ideas of GTM to develop the different method. He reckoned that this version of GTM is forcing preconceived theoretical frameworks on data and that is antithetical to the classic GTM. Critiquing Strauss and Corbin's (1998) views on the researchers' role, Partington (2002) pointed out that despite the frequency with which this version is cited by its proponents, it is practically an uphill task for researchers to achieve the proposed fine balance between procedural rigour and creativity.

3.2.4. GTM Version for Current Study: Ontology and Epistemology

This current work is situated in Strauss and Corbin's (1998) ontological position of critical realism and epistemological stands of symbolic interactionism – interpretivism. Based on the ontological position of critical realism, I believe that there is the objective truth (reality) which can be rigorously and systematically studied but I also believe that it is impossible to completely know the truth (reality) that may exist in the social phenomenon (Corbin and Strauss, 2008). I believe that for society to function as a unit, there will be shared symbols of thoughts, meanings, and actions. These symbols, which may be referred to as 'standards', are often representative of idiographic values as well as values of the 'generalised other' (normative base) (Mead, 1934; Ponterotto, 2005). In some conditions, however, there may arise discordance occurrences between the idiographic values and values of the 'generalised other' and if not adequately managed could result in personal and/or social crisis.

The current study takes a view that though researcher's epistemological stand may shift slightly depending on the peculiarities of study embarked on, it is generally within certain philosophical bounds (Glaser, 2005; Rennie, Watson, and Monteiro, 2002; Schwandt, 2000). This study is epistemologically positioned within the pragmatic – symbolic interactionist GTM tradition. It, therefore, strive to maintain a balance between objectivity and subjectivity (creativity). It is acknowledged in this study that the creative (interpretative) aspect of the study can be a source of bias, consequently, affecting it's level of objectivity and credibility. Bearing in mind that neutrality in research may never be fully attained, attempts were made to avoid obvious, conscious or systematic bias in the collection, interpretation, and presentation of data (Morgan, 2013). In line with this perspective, Crotty (1996), explained that researchers are usually the primary instrument for data collection and analysis in qualitative research and so it is virtually impossible for qualitative researchers to be totally objective. Parahoo (2006), therefore, encouraged researchers to beware of their own values, interests, perceptions, and be able to bracket off their biases to avoid adversely affecting research outcome.

To increase the credibility of this current study, address the issue of biases and account for human error and fallibility, strategies were put in place to identify and contain personal biases. For instance, a diary (memo) was used to write down thoughts, feelings, and perceptions. It enabled position and views to be re-examined when issues that might interfere or influence the research process were raised. Through reflexivity, biases were acknowledged and contained. External audits (supervisors) also monitored the progress and were keen to identify conflicts and

biases. With the use of continuous comparison of data with other data, attempts were also made to stay close to participants' data.

3.2.5. Reason for Chosen Version

Strauss and Corbin's (1998) version of GTM was used in this study for several reasons. The first reason for choosing this version was that it offered me a midpoint between the positivist and relativist stands, hence, provided me some flexibility while investigating social problems like aggression within a medical setting. Though the traditional Glaserian version would have offered the study high objective stand, its positivist view would have limited the rich creative role of the researcher in moving data to a conceptual/abstract level of analysis (Strauss and Corbin, 1998). Charmaz's (2006) version would also limited the study as it leans far into the creativity and less of objectivity. Its view of co-construction of meaning between researcher and the participants would have undermined my primary purpose of emphasizing participants' voices/perspective on the meaning and management of aggressive behaviours. The objectiveness of participants' data may, as such, be compromised.

Due to the peculiarity of the participants involved in the study, the Strauss and Corbin version of GTM seemed most appropriate for the study because it offered me the best of the other two worlds (aspects of realism/positivism and relativism / constructionism). This version of GTM offered me, the researcher, the flexibility to conceptualise and interact with participants' data without imposing my views on the participants or modifying their perspectives. This is essential because many

available studies in aggression were often focused on the perspectives of the victims or third parties (e.g. researchers, teachers, and parents) while the aggressors are left out of such studies. The study aims to capture as closely as possible the perspectives of young adults (participants' data) who are often marginalised in the society and excluded from many research studies. Strauss and Corbin's (1998) epistemological stand of symbolic interactionism was another reason for choosing this version of GTM. The stand acknowledged the interrelatedness and interactions of the different aspects of people's lives and suggested that psychological, social, historical and cultural factors play important part in shaping people's understanding of their world (Holton, 2008; Levers, 2013). This is crucial in gaining insight in the interacting factors that may be helpful and/or unhelpful to participants in managing their aggressive behaviours and as a result it helped me in generating a more holistic data for this study. Finally, this version provides me 1) clear systematic protocols and techniques for data analysis, 2) a step by step format for developing a substantive theory from the data (Strauss and Corbin, 1998). It, therefore, allows for ingenuity and creativity.

3.3. RESEARCH PROCEDURES

3.3.1. Design Method and Recruitment Procedures

3.3.1.1. Study Design

During the planning stage of this study, databases such as PsycInfo, PsychNet, PsycArticle, SCOPUS, EBSCO, ProQuest and Google Scholar were used to access and retrieve relevant and comprehensive information from articles, journals, and E-books. Books and subscribed E-books were also sourced from University of

Roehampton's Library. When these sources were selected, other articles/journals were often cited in them. These became the secondary reference sources which were also accessed and explored. For background reading on aggression, keywords such as 'aggression', aggressive behaviours', 'anger',' anger management', conduct disorder, anti-social behaviours were computed into the selected databases and the materials which were most relevant to the keywords were accessed and explored. Terms such as 'AND', 'NOT' and 'OR' were also used to widen the scope of search.

In line with current views on review of literature (Corbin and Strauss, 2008; Urguhart, 2007), this study utilised existing theories to plan and design the study, develop sample approach and generate semi-structured questions for fieldwork. During the fieldwork and early analysis of data, however, the focus was on gaining understanding of participants' perspectives and experiences, consequently, attention was moved from literature review to solely on participants' data. After data collection, an in-depth literature review was conducted on the various aspects of the study. At the end of the analysis, the research findings were then positioned within the context of other theories and contrasted with existing knowledge. While interpretation of data moved beyond the participants' descriptive account, much emphasis was placed on ensuring that the abstract interpretations were as closely related to the participants' data as possible.

3.3.1.2. Sample Design

This study adopted the purposive sampling design. Purposive sampling is described as the selection of research participants (sample) based on the researcher's

knowledge of the population, its elements, and the research aims (Babbie, 1997). It is, therefore, a sample that is not randomly selected but is based on some specific characteristics (Frey et al., 2000). Strauss and Corbin (1998) offered that purposive sampling is used to "maximise opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions" (p.201). In this study, purposive sampling was, thus, used to increase efficiency and the possibility of attaining theoretical saturation in time with the target group. The process involved selecting specific participants (young adults) who will provide personal perspective on managing aggressive behaviours. Data were regarded as theoretically significant or relevance to the evolving theory when they are repeatedly present or notably absent when comparing data with data (Strauss and Corbin, 1990). In accordance to Glaser's (1998) description, this current study collected data in groups of four participants, transcribed and initially coded. The process was repeated and in each cycle, new enquiry-leads were explored.

With regards to the composition of the sample group, there is often polarity of opinions as to whether samples should be homogenous or heterogeneous (Heath and Cowley, 2004). While some scholars supported homogeneous sampling (Patton, 1990; Guest et al., 2006), others were in favour of heterogeneous sampling (Blodgett, 2008). Patton (2002) highlighted that purposive homogeneous sampling tends to be less time consuming than other sampling methods because only suitable candidates are targeted. In the same line, Guest et al. (2006) and Becker (1993) offered that purposive homogeneous sampling makes saturation easier to be reached, consequently the time spent in the process reduced. Due to the time

constraint in the PsychD programme, it was crucial that theoretical saturation is reached as quickly as possible. The homogeneity of the targeted sample in this study lies in the participants' age group (18 -25 years); therapy type (completed group therapy) and concept understudied (management of aggression). Artinian, Giske, and Cone (2009) emphasised that at the initial stage of study, 'it is important to ensure homogeneity of the sample [to] control extraneous variables' (p. 9).

The Heterogeneity of sample (diversity) is also an important concept that has been strongly suggested in grounded theory. Blodgett (2008) highlighted that heterogeneous sampling allows differences across data to be identified thereby creating room for the role and significance of such differences to be explored and accounted for. While the homogeneity was captured in the participants' similar experience of managing aggression, the heterogeneity laid in the differences in the conditions wherein this management takes place. Consequently, heterogeneity was captured in the participants' varied demographic data such as culture, religion, socio-economic, gender, race, ethnicity, family and educational background, employment status etc. These diversities and uncategorized demographics provided rich data with regards to the nuances involved in managing aggression by young adults from and with varied demographic status. The heterogeneity also highlighted the latent and hidden themes in the data (Stark and Trinidad, 2007).

3.3.1.3. Recruitment Procedures

Opt – in format

The recruitment of participants followed an 'opt – in' format, hence, participants had a choice to take part or not. As shown in figure 3.1, 55 potential participants were

approached and provided with the participant information sheet which contained general information about the study. They were also given a letter of invitation which contained information such as confidentiality, the anonymity of their response, right to withdraw at any time, and contact numbers in case of distress during the study. These participants were also given a period of one week to think about it and were asked to contact the programme coordinator to indicate their interest. While 10 people declined and 30 did not respond to the invitation, 15 of them indicated interest and their contact details were forwarded to me. When participants that indicated interest were contacted, 12 of them honoured the invitation, 3 participants did not take part due to different reasons. While one of the interested clients moved home, and was not able to attend the interview, the other two clients were in individual therapy, hence, did not meet the incision criteria. To maintain participants' sense of safety and familiarity, the interviews took place in the same centre where participants had their group-therapy.
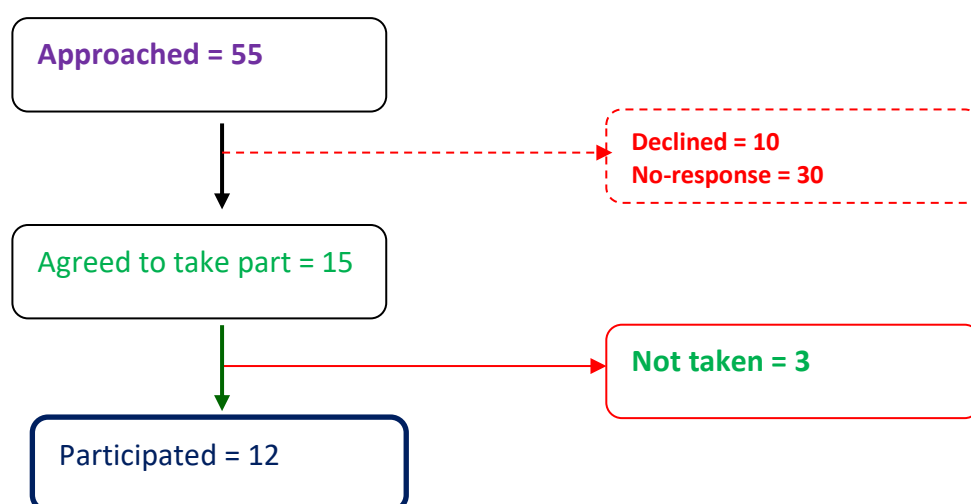
Fig. 3.1: Recruitment trail – Managing aggression in young adults

Inclusion Criteria

The following were the inclusion criteria for the potential participants:

- are aged 18 – 25 years old

- have identified with their aggressive behaviours

- have completed the group therapy programme for managing aggression

- are not currently in any other therapy (individual or group)

Exclusion Criteria

Not included in the study were those that

- are still undergoing therapy/interventions (e.g. individual/group)

- have diagnosed psychiatric conditions

- have an intellectual disability caused by other factors

3.3.1.4. Development of Interview Questions

The interview questions were developed with the research questions and objectives of this study in mind. Sets of open-ended questions were used to gather: (a) demographic information on the participants, (b) participants' perceptions on the meaning and management of aggression, and participants' perception on age-specific therapy. The open-ended questions were used to encourage participants to respond as freely and openly as they can (Bogdan and Biklen, 2003; Esterberg, 2002). Some follow-up questions were often used to encourage participants to clarify or provide detailed information on their response (Denzin and Lincoln, 2003). The open-ended questions were grouped into five sections to accommodate the major

areas of the study.

The first sets of questions focused on the *Descriptive data* (socio-demographic) which included: Personal data (e.g. race, age, gender, disability); Transitional data (e.g. education, family formation/living status, employment etc.). These questions were aimed to explore and possibly gather data on the contextual and casual conditions that may be linked to their aggressive behaviours (Strauss and Corbin, 1996). The second sets of questions focused on *participants' personal meaning of Aggression.* E.g. 1) Before attending the group therapy, what did 'aggression' mean to you? 2) What does it mean to you now (if your view has changed)? The questions on meaning of aggression were aimed to capture young adults' perspective on aggression as well as gather data on their awareness of the impacts of their behaviours on others (Persson, 2005). The third sets of questions focused on *the characteristics of group therapy and its contribution to the participants' management of aggressive behaviours.* E.g. What was group therapy like for you? These questions were aimed to explore participants' views on what the group provided and what participants needed/expected. The data collected and the existing resources will enable me to make recommendations on what should be provided.

The fourth sets of questions focused *on the concept of change and the factors that aid or hinder the change process.* E.g. 1) Were there changes you noticed in yourself since you started and completed the group therapy? Explain. 2) In general, what do you think made (could make) these changes possible? The 'change interview questions' were generated as proposed by Elliott, Slatick and Urman (2001) and they

were aimed at obtaining participants' awareness or understandings of what has changed and what contributed to or interfered with the change. These questions are also crucial to the current study because they provide participants' view on helpful and unhelpful factors in change processes. The fifth sets of interview questions focused on *participants' view on the idea of age-specific therapy*. E.g. 1) Are there potential benefits in having group therapy that is age-specific (e.g. 18 – 25-year-old)? After the semi-structured interviews, the audio materials are transcribed. To ensure transcript accuracy and reliability, the transcripts were read through while listening to the audiotapes. The transcripts were sent to each participant for their appraisal and they were contacted by phone for confirmation of the accuracy of the transcripts.

3.3.1.5. Interview Procedures

3.3.1.5.1. Pilot Interviews

Polit et al (2001) described pilot study as a 'small scale version, or trial run, done in preparation for the major study' (p. 467). Pilot study is viewed as an essential part of a good study design because it enables the researcher to assess the feasibility of the study before it is embarked on (Locke et al., 2000; Perry, 2001; Teijlingen van et al, 2001). Based on the research evidence of the benefits of pilot studies and the suggestions of my supervisors, pilot interviews were conducted using two young adults (male aged 18 years and female aged 21 years) as pilot participants. The selection of the pilot participants was not primarily focused on aggressive behaviours but on their ages which were within the age range for my study group. The main goals of the pilot interviews were: first, to ascertain the consistency (reliability) and

appropriateness (validity) of my interview questions (Leung, 2015). They aimed to assess if any of the questions was unclear, ambiguous or difficult and would require my further explanation for it to be understood. Such questions were either modified or removed. For instance, question 3 was modified from: '*Do you think people do not understand you or are your behaviours really a problem?*' to *'Did you think that people were just making a fuss about your behaviours or were you bothered that your behaviours were causing some discomfort to others?'* The pilot participants noted that though the earlier question was good, the language was not age appropriate.

The second reason for carrying out the pilot was to ensure that the questions are open and non-confrontational to enable participants to provide adequate range of responses. The pilot interviews gave me the chance to establish that the participants' responses can be interpreted in line with the research questions and objectives (Peat et al, 2002). I am aware that conducting a successful pilot study does not guarantee that the main study will be successful but it gave me the opportunity to be better equipped and make necessary adjustments or revisions for the main study. Some studies suggested that researchers can use pilot study to evaluate their readiness, capacity and commitment to qualitative study (Beebe, 2007; Lancaster et al, 2004). In addition to researchers' self-evaluation, pilot study can be useful in uncovering ethical and practical issues, hence, offering the opportunity to resolve the such issues which may have hindered the main study (Kelly, 2007; Sampson, 2004).

3.3.1.5.2. Participants' Interviews

Having completed the pilot interviews and adjusted few questions to suit the age group, the study participants were interviewed. This study followed McNamara's (2009) eight principles of interview preparation: (1) choosing a room in the Centre with little distraction; (2) explaining the purpose of the interview to each participant; (3) addressing terms of confidentiality; (4) explaining the format of the interview; (5) indicating the possible duration of the interview; (6) informing participants how to get in touch with me later if they want to; (7) asking them if they have any questions before we start the interview; and (8) informing them about the audio recording of the interview before starting. Participant were requested to sign a coded consent form and a copy of it given to them for future references.

At the beginning of each interview, the confidentiality clauses and the right to withdraw at any time without offering reasons were reiterated to the participants. They were informed that they do not have to answer any question which they felt uncomfortable about. Participants were given the opportunity to ask questions before and after the interview. They were individually debriefed after the interview with the debrief form. Participants were informed that both recordings and transcripts may be held up for ten years, after which they would be destroyed. All identifiable data were removed from the transcription and the participants were offered access to the transcript to confirm the exclusion of their identifiable data and the accuracy of the transcript. The time spent during data collection was an average of one hour and thirty minutes. This involved 60 minutes of semi-structured interview and 30 minutes for the personal data collection, consent signing, and debriefing. The duration of 60

minutes for the semi-structured interview was selected as a guide and it was based on the usually stipulated duration of therapy and was intended to replicate the therapeutic time frame that clients are familiar with. This is expected to help in reducing stress and anxiety that may be associated with interviews. Moreover, Glaser and Strauss (2009) stated that 'there is no specified length of time for a semi-structure interview for grounded theory....' (p.76). Fox (2009), on the other hand, noted that the average duration of the semi-structured interview within the healthcare setting is 30 – 90 minutes. The interview duration for this study was therefore within the suggested time frame in the healthcare setting where the study was carried out.

3.3.2. Data Collection

3.3.2.1. Setting

The participants were recruited within clinical setting. All the participants attended Anger Management and Emotional Control group therapy which held for 2.5 hours every week for 16 weeks. The group was made up of 2 or 3 therapists (facilitators) and the client group members of varied number. The group therapy session was structured as follows: first thirty minutes of checking in, one hour of skills training, and thirty minutes to one hour of group work, reflection of learning and peer discussion.

3.3.2.2. Participants' Demography

The study involved 12 participants aged 18 – 25 years. Many of the participants were from varied therapy groups but some were from same therapy group, hence, their experiences of the groups, therapeutic environments and therapists were varied. The

sample size of this study is similar to those used in other grounded theory studies (e.g., Chassman, Kottler, and Madison, 2010; Guest et al., 2006; Henretty, Levitt, and Mathews, 2008). All the participants completed group therapy for managing aggressive behaviours and the period post-group-therapy was one week. All participants are currently not in any therapy. Participant's gender: female (n = 6), male (n = 6), and 'other' (n = 0). The participants self-identified as White or Caucasian (*n* = 4), Black (n = 4), and mixed (n = 4). Participants' work status: employed (*n* = 5), unemployed (*n* = 2), and students (*n* = 5). Highest educational attainment included Degree (*n* = 2), A – Level (n = 4), GCSE (*n* = 3), and Secondary uncertificated (*n* = 3). Marital status was: in a relationship (n =7), single (n = 5).

3.3.3. Data Analysis Process

3.3.3.1. Coding Process

Data analysis was described as a process of fracturing, conceptualising, and integrating data to develop an in-depth understanding of the understudied phenomena (Strauss and Corbin, 1998). In accordance to Strauss and Corbin' (1990) protocol, the following coding processes were implemented in the current study: Open, Axial, and Selective coding. Open coding was the initial analytic process which involved line by line coding of participants' responses (Starks and Trinidad, 2007). The aim of this process was to identify indicators (i.e. phenomena, actions, and processes) in each participant's transcribed responses and to ascribe conceptual labels (code) to them. The codes were made to correspond very closely to the interview context and often taken from the participants' own words and statements (in vivo code). To identify these indicators, this study applied Strauss and

Corbin's (1998) suggestion of 'sensitizing questions' such as "Who are the actors involved?", "What are the actors' definitions and meaning of these phenomena or situations?" (p. 77).

Axial coding is the second coding process. It is aimed at "relating categories to subcategories along the lines of their properties and dimensions" (Strauss and Corbin, 1998, p. 123). The goal of axial coding is to add depth and structure to existing categories. According to Strauss and Corbin (1990), the axial coding is used to investigate the six Cs of social process and interactions (causes, contexts, contingencies, consequences, co-variances, and conditions). Hence the following questions are explored: (1) What process is the issue here? (2) Under what conditions does this process develop? (3) How does the participant think, feel, and act while involved with this process? (4) When, why, and how does the process change? and (5) What are the consequences of the process? (Strauss and Corbin,1990).

Selective coding is the third process in Strauss and Corbin's (1990/1998) version of GTM. The main aims of this process of coding were to develop an overarching theoretical structure that explains how each of the categories relates to another and to identify a core category (or the story line) which explained the experiences of participants (Strauss and Corbin 1998). This process was carried out by exploring which codes were relevant to the present study and should be retained in the final analysis. The resulting codes were then categorised by themes into a core category that ties the various aspects of the data into a coherent, explainable whole. (Starks and Trinidad, 2007). As Denzin (2004) indicated, the codes in selective process were

based on 'the range, density, linkages between and systematic relatedness of its

theoretical concepts, as well as by the theory's specificity and generality' (p. 329).

This process was therefore used to develop a model that waved together the

categories identified in the previous coding processes. The three coding processes

were used to capture the relatedness and dimensions in the content of participants'

data. They enabled the study to gain access to participants' common pattern of

making sense of and interacting with their aggressive behaviours and the influencing

variables. The coding processes enable data to be moved from participants' own

statements to a more abstract and conceptual level of analysis (Strauss and Corbin,

1998). Though the three processes of coding were distinct in their analytical focus,

the mechanism of coding involves moving continuous back-and-forth from one

process to the other (see Fig. 3.2). The coding process, therefore, followed a cyclical

rather than linear stepwise pattern (LaRossa, 2005).
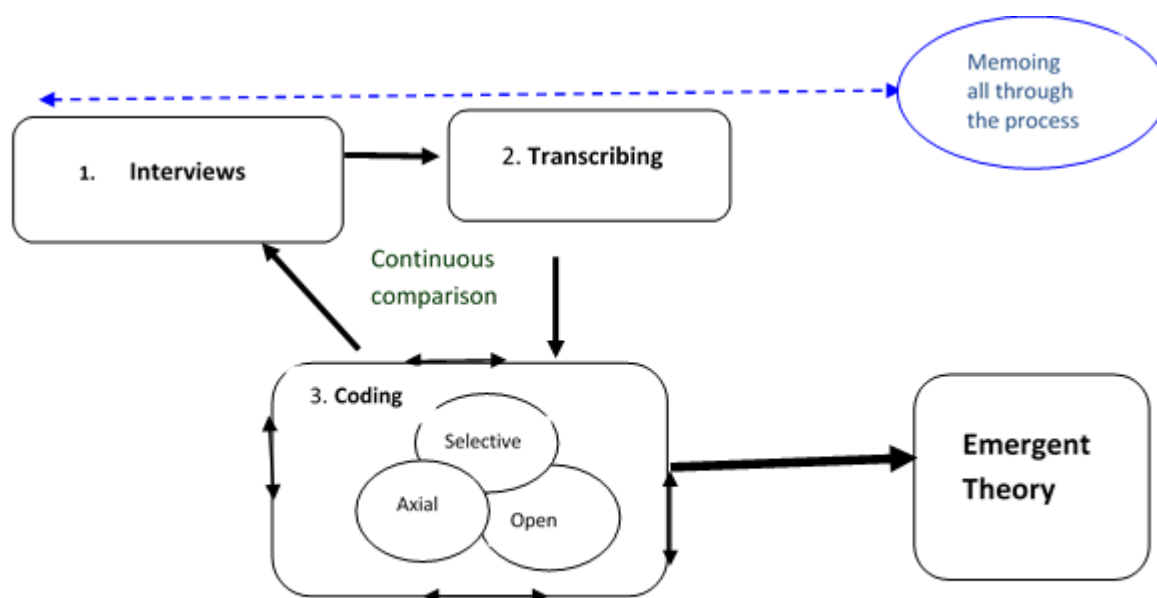
Fig 3.2: Phases of Developing a Grounded Theory.

3.3.3.2. Constant Comparative Analysis

Unlike observation and interview which were shown to be common to most qualitative methodologies, constant comparative analysis was suggested to be specific to grounded theory methodology (Glaser and Strauss, 1967). As noted in figure 3.2 above, continuous comparison of data was employed all through the data collection and coding process of this study. It was used within and between participants' data, consequently, enabled common patterns or similarities of data to be identified and categories generated. The continuous comparison, therefore, engendered the reliability of the emerging themes which are eventually used to develop a theoretical model (Richardson, Allen, and Vine, 2011).

3.3.3.3. Theoretical Memos

Grounded theorists suggested that memos assist researchers to stay in tune with the unfolding process involved in data collection, data analysis and the development of categories for the emergent theory (Charmaz, 2006; Strauss and Corbin, 1998). All through this study, memos (sets of notes) were kept and used to capture my thoughts, questions, interpretations, ideas and internal dialogues during the data collection and analysis. The memos helped me explore new ideas/leads, generate questions and hypothesis about potential meaning of each participants' statements. I was able to contain and later reflect on my views and biases, consequently, I was able to focus on useful thoughts/ideas. The memos also enabled me to compare concepts across in participants' transcripts and identify common themes.

3.3.4. Establishing Rigour

The following criteria were used to ensure rigour, quality and ecological validity of the data that were included: 1) best *fit and relevance* (how well do the categories relate to the data and derives from constant comparison and conceptualization of the data). 2) *Workability (*the ability to integrate categories into the core category that emerges). 3) *Modifiability* (the flexibility of the theory to be altered when new relevant data emerges) (Glaser 1998; Glaser & Strauss, 1967; Melia,1987).

3.3.4.1. Ethical Considerations

Ethical approval was received from the University of Roehampton's Ethics Committee board (see Appendix 1). The study involved interviewing participants from clinical settings, hence further ethical approval was sought and received from the organization. As part of the clinical organisation's requirements, the project was also reviewed by an independent reviewer (see Appendix 2). A participant information form and consent form were given to the participants to read and complete prior to the interview. These documents contain information on the purpose of the study, the interview process and participants' Id number for future correspondences. The study was conducted in line BPS Code of Ethics and Conduct (2006b) regulations for protecting research participants. The participants agreed that if they feel distressed at any point in the interview or by any of the questions, they will request for the interview to be stopped. In such situation, they agreed to contact their clinical lead for follow-up counselling. They also consented that if they disclosed information indicating a risk of harm to myself or others, I can notify appropriate person(s).

3.3.4.2. Auditability

Lincoln and Guba (1985) suggested that the "audit may be the single most important trustworthiness technique available to the naturalist" (p. 283). The role of the audits is to ensure that appropriate processes involved in GTM were adequately followed and that the emergent theory is grounded in the data. Two supervisors audited the process and product of this study; they were provided with the participants' data, emerging versions of codes and the theory. The auditors and I regularly met during data analysis and interpretation to discuss concerns and progress as well as review audit trail materials. Portions of the transcribed interviews and coded information could be made available for further inspection by other researchers. But for confidentiality reasons, audio files and the whole transcribed interview responses used in this study will not be released to anyone without written permission obtained from the participants. The contact and identifiable information of the participants, therefore, remains my exclusive property and so will not be shared.

3.3.5. SUMMARY OF METHODOLOGY

Since the inception of the grounded theory methodology (GTM), many versions have emerged resulting in a methodological situation that may be viewed as a blessing and a curse. The diversification of the GTM may be viewed as a blessing because it provides flexibility that allows researchers to choose a version that best fit their research objectives. It may be viewed as a curse because it raises within group tensions which often pull attention away from the primary and common goal of the methodology and places it on the semantic differences. Having explored the epistemological and ontological bases of the main versions of grounded theory methodology, Strauss and Corbin's (1998) version of GTM was considered as most appropriate for this study, hence, its analytical procedure was explored in detail.

CHAPTER 4: RESEARCH FINDINGS

The purpose of the current study is to develop a substantive theory that explains young adults' perspective of the meaning and management of aggressive behaviours. This chapter explains the research findings of data collected and analysed from 12 young adults who exhibited aggressive behaviours and had undergone group therapy. The chapter is in two sections: 1) the process of analysis and 2) the analysis of findings. In the first section, the process of analytical coding is discussed focusing on the three processes of coding; open, axial and selective coding. In the second section (the analysis of finding), the main emergent categories, core category, and the substantive theory are discussed in detail. *In discussing each construct, direct quotations are included to support the emergent theory but as mentioned in chapter 3, participants were given pseudonym names and number, hence the quotes used in this project are coded under such pseudonym names.*

4. 1. THE PROCESS OF ANALYTICAL CODING

In accordance with Strauss and Corbin's (1990) protocol, each participant's transcribed data was analysed using the three coding processes: open, axial and selective coding.

4.1.1. Open Coding

The open coding (line-by-line, in-vivo) system was used to break down participants' data into meaning making units. Process and action phrases were captured from each line of the transcripts. I employed in-vivo coding (i.e. coding from the participants own words/sentences) to help me generate the initial codes. The reason

for choosing the in-vivo coding was to be as close to participants' voice as possible

at this stage of the coding (Strauss and Corbin, 1998). This allowed me the

opportunity to highlight participants' thought patterns. To demonstrate my line-by-line

coding, a portion of Patricia's (participant 7) transcript is shown in Table 4.1.

Table 4.1: Open Coding (Line by line/ in vivo Coding)

Transcript: P7 – P22 (F/M)	Open Coding
1. **Question 1: Aggression is a word that means different things** 2. **to different people. Before you started attending the group** 3. **therapy, what did aggression mean to you?** 4. Aggression to me was a way of expressing how I felt inside. 5. It was just a manifestation of my uncontrollable rage and 6. I felt like it was a way to let it out and let people know that 7. I'm in distress. Erm, it was obviously coupled with my anger 8. – I was very angry and when I felt angry or there was a 9. build-up of emotions, I would 'let it all out' by being aggressive 10. and just being very hostile towards people. That was what it 11. meant to me, you know- a way of getting it out 12. **Question 1b: When you were talking, you said something** 13. **about aggression being something different from anger?** 14. Mhmm, yes because I might not necessarily be angry to be 15. aggressive. I might just have a lot going on and I don't 16. know how it's all going to fit in my head, you know – how 17. things are going to pan out so I'll let my aggression out. It's 18. not necessarily linked to anger, it just means, for me, a way 19. to let things out. Like, it a medium of communication. 20. That's how I tell somebody else that I'm going through 21. something.	 4. "aggression – a way of expressing" 5. "uncontrollable rage" 6. "a way to let out", "let people know" 7. "coupled with anger" 8. "build-up of emotions" 9. "let out by aggressive" 10. "being hostile towards people" 11. "a way of getting it out" 14. "mightn't be angry to be aggressive" 15. "have a lot going on" 16. "don't know how" 17. "let aggression out" 18. "not linked to anger" 19. "a medium of communication" 20. "that's how I tell" 21. "going through something"

Every line in the transcript and the corresponding opening coding were numbered

and the identified action or process phrase shown in quotations. The paragraphs and

sentences were, hence, reduced to the key message in the sentence. This made it

easier for constant comparison of data with data in each participant's material as well

as across participants on meaning and management of aggressive behaviours.For instance, the line-by-line coding of Patricia's material makes it easier for me to notice that Patricia's anger – aggression divide in lines 7 and 18. She described anger as uncontrollable emotion while aggression was viewed as behaviours or actions which may not be linked to anger. Data can also be compared between participants to see how many shared similar views on specific idea.

4.1.2. Axial Coding

The first phase in the Axial coding stage is to move data from participant's words to researcher's conceptual/abstract analysis (Strauss and Corbin, 1998). Hence, I used words/phrases that have similar meaning as participants' but show more psychological processes. This conceptual level enables me to see the concepts that are frequently expressed in each participant's material and across other participants. For example, table 4.2 showed that Patricia frequently used aggression as a 'communication tool', 'helplessness', and 'uncontrollable emotions' to describe meaning of aggression.

Table 4.2: Within Participant's Emerging Concepts for Axial Coding

Open Coding P7 – P22 (F/M)	Emerging Concepts
1. *Question 1: Aggression is a word that means different* 2. *things to different people. Before you started attending* 3. *the group therapy, what did aggression mean to you?*	
4. "a way of expressing" 5. "uncontrollable emotions" 6. "a way to let out, let people know" 7. "coupled with anger" 8. "build-up of emotions" 9. "let out by aggressive" 10. "being hostile towards people"	Communicating distress (L4) Uncontrollable (Helplessness) (L6) Communication tool Aggression – Anger divide (L7) Aggression – emotional outburst (L8, 9) Proactive aggression (L10)

11. "a way of getting it out"	Communication tool (L11)
12. Question 1b: When you were talking, you said something **13. about aggression being something different from anger?**	
14. "mightn't be angry to be aggressive" **15.** "have a lot going on" **16.** "don't know how it's to fit/pan out" **17.** "so, let aggression out" **18.** "not linked to anger" **19.** "a medium of communication" 20. "that's how I tell" **21.** "going through something"	Aggression – anger divide clarified (L14) Compounding life challenges (L15) Helplessness (L16) Aggression – anger divide (18) Aggression as a communication tool: 'Voiceability'/authority

There was also comparison of data across participants. Data were regarded as

theoretically significant or relevance to the evolving theory when they are repeatedly

present or notably absent when comparing data with data (Strauss and Corbin,

1990). Having coded all the responses to the interview questions and constantly

comparing data within and between participants, the next phase of axial coding is to

cluster the emergent concepts into sub-categories either based on similarity or

differences. The subcategories that share some properties are thereafter grouped

under main categories. The number of participants that expressed such views are

also identified (see Table 4.3). These categories and sub-categories are discussed

in detail on 'Analysis of Findings section.

Table 4.3: At-a-glance' of Main Categories, Sub-Categories, and participants with similar views

Main Categories	Sub-Categories	Number of participants with similar views
LACKING IN RESOURCES	1. Developmental factors	
	a. Environmental Context	11
	b. Age of Onset and Stability	6
	c. Bio-psychological Modifier	1
	2. Personal Qualities	
	a. Self-Motivation – Attitude	7
	b. Decision making	6
	c. Reflectivity	3
CONFLICTING IDENTITY	1. Personal Identity Crisis	
	a. Belief in Self	4
	b. Belief in Capacity	3
	c. Value (self and others)	3
	d. Meaning of aggression	11
	2. Social Identity Crisis	
	a. Social Norms/Values	12
	b. Social Disconnect	12
	c. Psycho-Social conflicts	12
	3. Lack of Support System	6
CHANGING THROUGH THERAPY	1. Skills training,	12
	2. Therapeutic Conditions	
	a. therapeutic Relationship,	9
	b. Therapy environment,	9
	c. Therapist's experience	7
	3. Procedural issues	7

From the participants' data, therefore, eight sub-categories were identified and organised (clustered) into three axial (main) categories (see figure 4.1). These three axial codes are: 'Lacking in *Resources'*, 'Conflicting *Identity*' and '*Changing through Therapy*'. Revolving around the first axial code, 'Lacking in Resources', are two main categories: Personal Qualities, and Developmental Factors. The second axial code termed 'Conflicting Identity' consists of three major categories: Person Identity Crisis, Social Identity Crisis and Lack of Support System. The third axial code, 'Changing Through Therapy' is made up of three major categories: Skills Training, Therapeutic Conditions, and Procedural Factors.
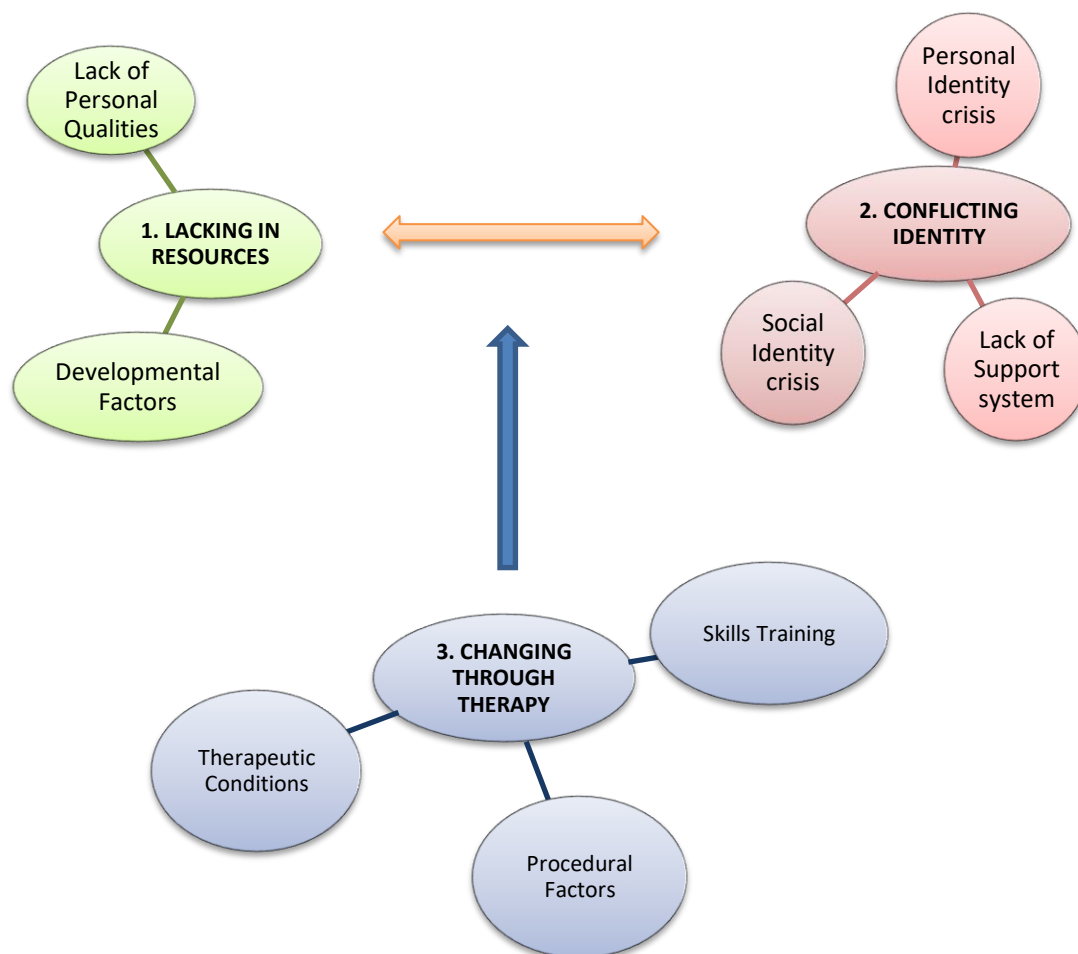
Figure 4.1: The axial codes with their related categories

4.1.3. Selective Coding

The selective coding is about finding the storyline that threads all the identified categories together and show the relationships or associations that exist among identified categories. In conceptualising the relationships among these emergent categories, many models/structures were explored to find the best fit for the data. Two models were particularly helpful: Strauss and Corbin's (1990) Basic Social Process format (see Appendix 3) and the Moderation – Mediation model (Aiken and West, 1991; Edwards and Lambert, 2007). While the Strauss and Corbin's (1990) format enabled me to identify the various conditions associated with aggression, the mediation – Moderation model helped me assess their relationships. The core category of this study is: 'Dealing with Powerlessness'. It is the storyline that threads together the major categories identified in the study and explains the relationships among the categories (see fig 4.2). This is discussed later in this chapter.

Figure 4.2. Core Category and its major categories: Moderation – Mediation Model
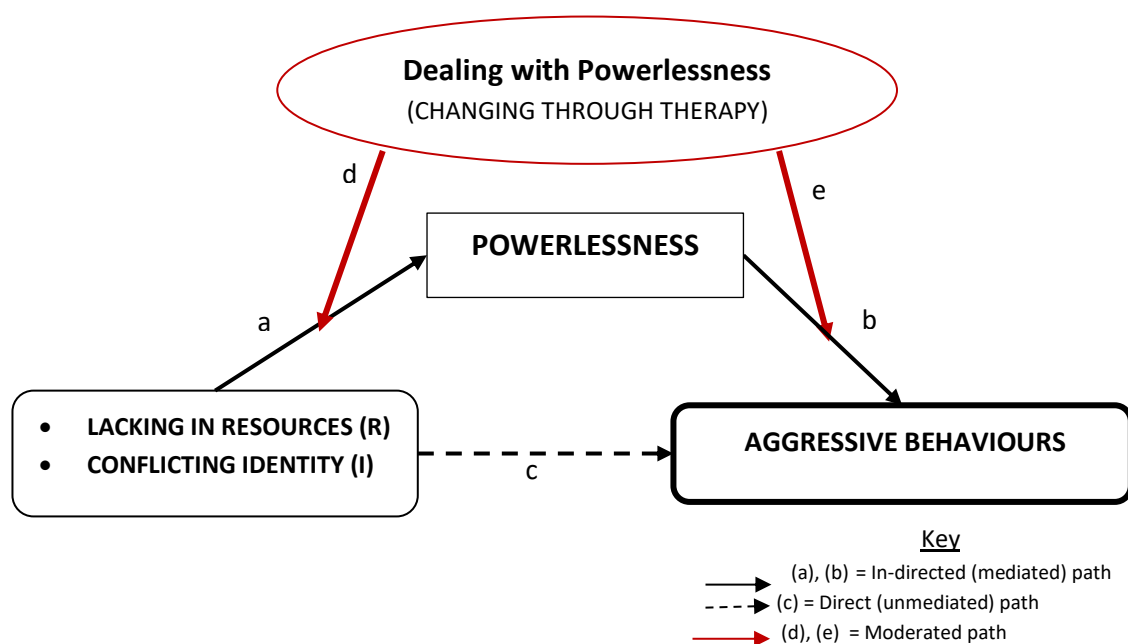
4.2. ANALYSIS OF FINDINGS

This section focuses on the analysis of the study's finding. For coherency purposes, this section is discussed in a funnel-shaped sequence. The first part of this section provides an in-depth description of the main categories and sub-categories that emerged from participants' data. The second part examines the overarching core category and how it relates to the underlying main categories. The third part discusses the emergent theory.

4.2.1. THE MAIN CATEGORIES

The study also found that there are patterned behaviours through which participants acted out their 'before – during – and – after' experiences. These are: **Recalling** the experiences of the perceived aggressive behaviours; **Realising** - becoming aware of the need for change 'things cannot continue this way'; **Deciding** to give therapy a chance; **Participating** in the group experience; **Exercising** learnt skills; **Desiring** better life experience (intra-personally and inter-personally). Pre-therapy experiences were also described as: "frustrating," "demanding," "challenging", "bottling". These behaviours were explained through the process of conflict and conflict management which pervaded the categories and formed the core of participants' experiences.

Following Richie et al (1997) format, the findings are discussed using some ranges to indicate the frequency of endorsement by the participants. For instance, terms such as "majority of," "many," and "most" are used to discuss codes that are expressed by 7 or more out of the 12 young adult participants. Words such as

"some," "several," and "a number of" indicate that 4 to 6 of the participants shared a similar view of the concept. "A few" is used to show concepts that are shared by 3 or fewer participants. As mentioned earlier, the following are the three main categories: '*Lacking in Resources*', '*Conflicting Identity*' and '*Changing through Therapy*'. These are discussed below.

4.2.1.1. LACKING IN RESOURCES

Most participants identified lack of adequate resources as a vital factor that perpetuated their aggressive behaviours. They explained that as they grew into young adulthood and were made to manage life challenges and demands by themselves, they realised that they did not have appropriate resources. This realisation often triggered in them the sense of vulnerability and helplessness. They acknowledged that they resorted to aggressive behaviours because they did not know how else to deal with the situation/issues neither did they know where to get appropriate help. They explained 'lack of resources' from the context of: 'Developmental Factors' and 'Personal Qualities'. These are discussed below.

4.2.1.1.1. The Developmental Factors

Developmental factors refer to the factors that are associated with the formation of people's personality and growth through their lifespan. These factors often involve internal and/or external factors that affect people's sense of self and self-function. In this study, the following clusters of codes were identified as developmental factors influencing participants' aggressive behaviours: 1) *Environmental Context, 2) Age of*

onset and stability of aggressive behaviours, and 3) Biological Modifier.

The Environmental context: Many of the participants mentioned that environmental factors (such as domestic violence, childhood neglect, relationship abuse, substance misuse, and broken/dysfunctional family dynamics) contributed to their current state of aggressiveness. They explained that what happened or is happening in their environment (location) has significant influence on how they viewed and related to themselves and others. Patricia said that she *'grew up in a very bad environment and aggression could have just started from there' (240-241).* Many participants identified relationship abuse and lack of problem-solving options as other sources of their aggressive behaviours. They said that they were often left with the option of either bottling it up or lashing out and often they resort to aggressive behaviours. Melisa said that it is '*mainly relationship abuse in the home because so many people just take it… so, then things pile up, one on top of the other and they keep piling up until they literally lash out. (581-590). Larrisa* said *'within my age group it's abuse in relationships… little comments and the knot would just build up and build up until you just finally let it go and then people see you as aggressive or that was really aggressive of you without knowing the things behind your reaction in the first place'* (298 – 314).

Increased pressure to perform in places like school, home and work without commensurate skills and resources were also identified as contributory to their emotional hypersensitivity and increased vulnerability. They believed that there is a general expectation for young adults to conduct themselves maturely, yet, nobody

has shown them 'the how to' of it. Participants explained that due to lack of life skills for dealing with challenging life situations, many young adults have taken to drinking and drugs as ways of escaping their helplessness and hopelessness. They suggested that in an environment (e.g. home) where there is easy access to alcohol and/or drugs, the aggressive behaviours of young adults tend to increase in frequency and intensity. Melisa explained: '*alcohol use environment… people are trying to drown certain things or certain emotions …they drown it with alcohol. Then because of the way they're feeling inside…, they are being steered by alcohol, but same time they become very aggressive and it could become physical*' (603-613).

The Age of Onset: is also a developmental contributor to aggressive behaviours that emerged from the data. The age of onset represents the age at which participants first start to engage in (or became aware of) their aggressive behaviours which have persisted for a relatively long period. Some participants mentioned that they became aware of their behaviours around 8 years while they were still in primary (early onset). Others noted that their behaviours were referred to as aggressive or unacceptable by others around the age of 14 years (later onset). Those that had early onset explained that they thought that aggression was part of their 'personality' and so did not see anything wrong with their behaviours. They, therefore, felt that people were just making a fuss. Fiona, for instance, reflects '*I thought it was just natural, that everyone had their different ways of behaving and this was just mine... So, I just felt that they must have been making a fuss (29-37).* The late onset group also thought that people were making a fuss because they saw aggression as a tool for communication and navigation through life. Participants in *b*oth groups of onsets

(early and later), however, acknowledged that the intensity of their aggressive behaviours increased with time because they were getting bolder and more successful at achieving their goals.

The Biopsychological Modifiers: Biological modifiers like hormones, neurotransmitters, and the brain executive function were also identified by one participant as a possible contributor to his aggressive behaviours. 'Roy' states '*I suspect that I may have ADHD, sometimes I just don't know what to say or how to react in public without being aggressive. I always feel that people could pick on me because I am vulnerable and so I live in the attack mode' (48-55).* Though he has not been certified as having ADHD, he observed that his social skills were poor and he is struggling to cope with basic life challenges, hence the perceived lack of control, vulnerability, and helplessness. The biological factors seemed to be particularly significant when other contributing factors are also present, consequently enhancing the vulnerability and lack of ability in performing age-expected functions.

The psychological modifiers referred to the participants' internal emotional self-state. Unstable internal environmental factors such as lack of calmness in self, lack of cognitive ability and knowledge were identified as contributors to aggressive behaviours. Some participants reported that the way they felt within themselves (i.e. their affects) did also influence their behaviours in many instances. They explained that because they do not feel happy and settled in themselves, they tend to appraise situations from a negative perspective and consequently expressed such feelings in their interactions and decision making.

4.2.1.1.2. Personal Qualities

The next emergent sub-category is the "*Personal Qualities*". Personal qualities are described as the character, strengths or virtue which enable people to function and cope with life challenges (Peterson and Seligman, 2004). Many participants in this study acknowledged that prior to therapy, they did not pay much attention to personal quality because they were constantly immersed in the negativity and the out-of-control situations that it became almost impossible to see anything good in themselves.

Motivation for Change

Many participants identified self-motivation as a prominent quality they possess although they were using it to serve only their aggressive purposes. They explained that being in a challenging environment stimulated in them the motivation to survive or overcome the hostile and threatening situations. They mentioned that qualities such as *willingness, self-determination, resilience, commitment, and readiness* for change enabled them to continue to go through the group therapy even when there was no obvious sign of change in their behaviours. They said that over time, they realised that without personal effort, no change would have happened. Larrisa said '*I was willing to go there and to share my thoughts. I was ready to accept the help… that really helped me get through the group therapy' (238-243).* Amada said *'I'm very determined and I think my passion is the main reason I over act…. now I'm using my passion and determination to work against my aggression' (331-339).*

Decision making

Most of the participants admitted that prior to therapy, many decisions they made regarding how they behaved were based on their emotional appraisal of the situation. They offered that due to their limited skills on how to regulate their emotions, they were frequently out of control with their emotions and consequently behaved excessively. According to Fiona '*when I get angry I cannot stop myself.... I didn't know when to stop in arguments and I didn't know how to speak without being angry/aggressive*' (58-60). Few participants said that their decisions were often not thought through, consequently, they tend to be irrational and self-gratifying.

Reflectiveness

Many participants noted that reflection – on – action was an acquired skill which they gained through therapy. They stated that the issue of consequences was not part of their thinking process because they were always either in situations where instant decisions were to be made, hence, there was no time to think about consequences or they were so focused on the target that they completely ignored the consequence aspect of the process. They mentioned that after the aggressive behaviours, they blocked any chance of reflection by quickly justifying the action as deserved. During group therapy, however, there was a turning point. Chris said that he has learnt to be more reflective, consequently *'I do think more about things before I do them'* (179)

4.2.1.2. CONFLICTING IDENTITY

Under the main category of 'Conflicting Identity' are three underpinning sub-categories: 'Personal Identity Crisis', 'Social Identity Crisis' and 'Lack of Support Network. These are discussed below:

4.2.1.2.1. Personal Identity Crisis

The desire to establish one's identity or self-definition is viewed as one of the core components for becoming a valuable individual in both love and work relationship (Archer, 1989; Erickson, 1968). In this study, most of the participants admitted that they were constantly in conflict with 'who they are'.

Belief in Self

They agreed that 'belief in self' was not their strong quality prior to therapy. Hence, self-acceptance, self-awareness, patient with self, and calmness were not at the participants' disposal at the time. Many participants mentioned that these qualities were gradually acquired while in therapy and as they practised the skills they were taught. They mentioned that they wished that more emphasis was placed on how to develop relationship with self because many of them reported having low sense of self. Their reluctance in accepting themselves made being patient with self a difficult task. 'Patient with self' is a concept many participants highlighted as crucial to their progress because it allowed them to become patient with others as well. Patricia explained '*I acquired some qualities since I started therapy. I had a very intolerable spirit before therapy but I now am more patient with self and others*' (351-353).

Belief in Capacity

Many participants offered that they had little or no belief in their capacity, consequently, were constantly feeling vulnerable and helpless. They, therefore, lacked confidence in their ability to adequately deal with challenging situations (*self-efficacy),* to manage self *(self-control*), and to *make decisions.* Few of them mentioned that they did not acknowledge their behaviours as a problem, frequently thought that people were just making a fuss and as a result did not seek help. The acknowledgement of their behaviours as problematic was, therefore, a significant turning point. Patricia, summed it by saying '*accepting that I had a problem was the first step to my change' (316-317).*

Values for Self and Other

Several participants acknowledged that they continued to have conflicts in their values and expectations. Though they often demand respect, understanding, and care from others, they had very little respect and care for themselves or anyone else. They wished people understood them but they often had reasons why they were not offering similar understanding to others. Few of them said that while fighting their opponents, they neither had value for their lives nor the life of the other person and that is why their fights ended up being very brutal. Patricia said: *I got into what could have been called the fight of the century. It was a very, very brutal fight that ended my education' (62-64).*

Meaning Attributions

All the participants said that prior to therapy, they were more concerned about their

unsettled internal (emotional) self-state than their aggressive behaviours. Some said

that aggression was just an externalisation (communication) of internal struggles or

helplessness which they were unable to resolve. Roy, for instance, explained that

'*When I'm stuck in a place or a thing and I don't know how to deal with it, that sets*

me off' (10 - 12). For Roy, aggression means '*attacking people without a reason and*

*getting easily upse*t (4 – 6). For Michael, aggression *is 'what you do when in a fix, or*

challenged' (4). Amanda said it is '*a way of making statement about what I was*

feeling inside without verbalizing anything' (4-6). Melisa said that it is *'my way of*

showing how I felt' (4). Most of the participants described their aggressive

behaviours as uncontrollable and overwhelming emotions. This indicated a sense of

helplessness (powerlessness), hence, not taking responsibility of the consequences

of their actions.

Patricia and Melisa described it as '*uncontrollable rage'*, Fiona said that '*it was*

difficult to control myself'. Shirida explained '*I wasn't really able to control how I was*

feeling like in a positive manner (5-6). Few other participants said that their

behaviours were merely their way of protecting self, establishing authority and

identity. Godswill for instance, asserts that he is '*just not letting any one walk over*

me'. Fiona (125, 131) and Melisa (174) suggested that aggression was a strategy for

gaining respect from mates and being heard. Aggressive behaviours for many

participants were, hence, tools for communication of internal discomfort, stuckness

as well as strategy for achieving personal and social/relational goals of protection,

identity and recognition. Though most participants acknowledged the existence of

aggression and their involvement in aggressive behaviours, few participants held a

different view on the issue of aggression. They described aggression as 'a label and a strategy of control' which people in authority use against others. Greg explained, *'It's just a name people give to people's behaviour. When… you just don't want to agree with people on what they're saying and you're trying to put your views across, they label you 'aggressive' (5-13).* He suggested that aggression is a label given to those who do not conform to the mainstream 'box' or norms. Sharing similar few as Greg, Amanda said, '*I felt like everybody judged me like why can't you be in this box'* (51-53).* For these participants, their everyday life often felt like an issue of 'struggle versus surrender'.

4.2.1.2.2. Social Identity Crisis

Three clusters were identified in relation to the social identity crisis.

Social norms/values

Most participants suggested that society's one – fit – for – all norms and values do not take into account the numerous challenges faced by young people. They reasoned that it often felt as though there is an implicit social belief that young people will not conform to social normal and values, hence, stringent punishment measures are already in place before any offense is committed. They offered that the social expectation and acceptability criteria are so high that young people did not bother to meet them. Many participants suggested that over time, they have taken on the socially predicted attitude. Goodswill said '*I have come to belief that rules are made to be broken, I don't care if anyone is hurt as long as I am happy'* (13-14).

Social disconnect: majority of the participants noted that the lack of consideration for the life challenges faced by young adults has led to the social disconnect between

them and the rest of the society. The disconnect is both in the literary sense of language barrier as well as believability/miss-understanding perspectives. They noted that there are general apathy and lack of empathy from policymakers and people in authority for young adults. Young adults are, therefore, pressured to conform to the norms and values without the adults and policy-makers taking any responsibility to offer guidance and listening ears to their needs.

Psycho – social conflicts

Many participants noted that due to inconsistencies in the social, political and cultural norms and values, they often experience identity and role confusion. The participants explained that rather than helping young adults integrate their social and personal identities, they are made to choose between them thereby giving rise to constant conflicts in their identities. They identified conflicts such as 'who I am' (individuation) versus 'where I belong' (connectedness), 'conforming versus defying', 'adult self-image versus child self-image'. This gave rise to the psycho-social conflicts of: 'us' (young adults) versus 'them' (society and people in authority). Patricia explained that the '*problems could be people feel they're not fitting in, so they rebel' (414 – 417).* Similarly, James said, *'nobody is listening when you say that the mould doesn't fit. It is really bad' (240-242).*

4.2.1.2.3 Lack of Support System:

All 12 participants suggested that lack of support network among their peer and/or from the society was a significant negative influence on their aggressive behaviours. Issues such as violation of personal values (disrespect), hierarchy struggles,

authority and identity issues, the quest for recognition, friendship, and popularity, in/out group alienation and discrimination were identified as common reasons for their aggressive behaviours among peers. For example, James explained that *another thing that can trigger aggression is 'people not believing you or they just disrespect you for no reason' (234-237).* Fiona said *'for me, being left out. I didn't like to be left out... When I was left out, I felt the need to show people I wasn't to be treated as such and not to be taken for granted' (333-338).* Most participants suggested that lack of readily-available and confidential social support meant that they could not access help without being labelled 'sick' by society or 'weak' by peers.

4.2.1.3. CHANGING THROUGH THERAPY

The next emergent construct is 'changing through therapy'. This explored the impact of group-therapy in participants' management of their aggressive behaviours. All the participants reflected that the group-therapy had some degree of impact in the way they currently manage their aggressive behaviours. The category of 'changing through therapy' is underpinned by the following three sub-categories: 'Skills Training', 'Therapeutic Conditions' and 'Procedural Issues'.

4.2.1.3.1. Skills Training

Skills training was identified by all the participants as the main intervening factors that brought a turning point in the way they manage their aggressive behaviours. They admitted that the various skills they acquired from the group-therapy provided them useful resources for in-therapy and outside-world application. Godswill said, '*I feel like the most helpful is the skills because, like I said, it's not something that stays*

in the room – you take that away with you (288-294). Many participants

acknowledged that the skills training taught them alternative ways of behaving,

dealing with life challenges, and making better decisions. Patricia said, *'therapy gave*

me skills to use and fight my own anger; that really did help me' (317-318). Fiona

said that 'not knowing how to solve my problem *was one of the reasons for my*

aggression… I learnt how to speak to people, how to refrain from being so

aggressive. I no longer need to force myself to make a point or be heard' (223-231).

Many participants acknowledged that skills training helped them identify positives in

themselves, consequently, able to gradually belief in self and their capacity. Their

view shifted from aggression being an uncontrollable emotion to emotions that can

be controlled with appropriate skills/techniques. The resultant effect was that they

became calmer in themselves, more accepting of self and others. Larissa reported

'I'm much calmer in myself, like I can contain myself now…I've learnt how to control

myself' (183-186). Shirida said *'I'm a lot calmer. I suppose I'm a lot more patient with*

people' (138-139). From most participants' response, it appears that the skills

training provided them skills for dealing with their intra- and inter-personal conflicts.

Few participants who viewed aggression as a label from people in authority also

acknowledge that some of the skills taught in the group-therapy were very useful in

some situations. 'Greg' said '*Erm, I think there were some skills like when you're*

upset, the things you're to do in order not to fight back. I took those ones and yeah,

that bit, I can say, they helped me a little' (201-206). With regards to communication,

only a few participants admitted having good communication skills prior to therapy.

They said that the communication skills facilitated their ability to demand what they

wanted, though forcefully most of the time. Majority of the participants, however, said that there was always communication barrier between them and others. They felt miss-understood, miss-judged and often were not listened to. Their opinions did not matter in any decision including the ones relating to them; they were seen but not heard. The participants offered that group-therapy taught them how to communicate their emotions and thoughts in non-aggressive ways.

4.2.1.3.2. Therapeutic Conditions

The therapeutic conditions refer to the factors that can influence the therapeutic process of group members as individuals and/or as a group. Below are few concepts that emerged from the participants' experiences of group-therapy.

Therapeutic Relationship: many participants reported that member-to-member relationship and members-to-therapist relationship were not as strong as they would have wished. Many participants noted that it appeared that emphasis of the group-therapy was more on skills training than on relationship building. Few participants mentioned that due to lack of strong relationship in the group, they found it difficult trusting others with their stories, hence, they were less involved in the group work/process.

Therapeutic Environment: Some of the participants suggested that due to weakened sense of trust in the group, the environment was not always welcoming. They reasoned that it may explain why many members had poor attendance and very little commitment to the programme. Few participants recalled feeling that atmosphere in the group, sometimes, felt like school where they had to compete for the teacher's

love and attention. The environment reminded them of what they experienced outside whereby they are to compete for recognition and conform to set views/rules or they will be subtly isolated/marginalised. Few participants suggested that there seemed to be the 'them' versus 'us' divide within the group; with 'them' representing the non-responsive, non-compliant, non-conformist while 'us' represents the members that conformed to the therapist's prescriptions and rules. Greg explained that *'There was this unspoken weird attitude in the group of 'us' (the teacher's pets) versus 'you' (the repel) (243-246).* He said that the therapists also *'tend to favour those that do as they say and I am made to feel that I can tag along if I care' (236-242).* The 'in-group' versus 'out group' dichotomy within the group was said to reenact the sense of rejection and outsider that they felted in their outside world.

Therapist's role in the group-therapy was also a concept shared by many participants. Few participants mentioned that they did not feel much warmth from the therapists because they often appeared as though they were just doing their job rather than helping the participants resolve their relational problems through modelling. Other participants offered that some therapists seemed to be more focused on skills training and meeting targets than connecting and building relationship with them. Fiona reflected *'It would have been better if the therapists shared some of their experiences to make it more real to the group. It will also close up the disconnection between them and us' (252-256).* Some participants also identified the apparent therapist's lack of expertise as hindering their therapeutic process. They suggested that some of the group-therapists seemed not to have special training or experience in working with young adults or dealing with

aggressive behaviours. Larissa said that members were *'just like a group of guinea pigs that they're trying to figure out what they're doing and how they react to different things'* (163-166). Fiona said she could *'see that they were talking from a textbook rather than experience and knowledge. They talk from ideal rather than reality. They needed to be more precise to our needs' (259-263).*

4.2.1.3.3. Procedural Issues

Emerging from the participants' data was also the concept of irregularities in the way group-therapy was conducted. Many participants commented that the 1.5 hours a week and the 16 weeks' format were inadequate considering the number of people in each group. They explained that the first four to five weeks of therapy were often lost because people were still settling into the routine of the group and getting to familiarize with the other group-members. They said that the programme seemed rushed towards the end and people who were slow at grasping things seemed short-changed because everyone leaves the group after the 16 weeks. Amanda said: '*if either the groups were a bit smaller or we extended the programme a little bit then it would definitely help deal with the problem a lot better (268-272).*

Many participants talked about the poor attendance and lack of commitment in the group which created some difficulties for regular attendees. They said that topics were constantly repeated, hence it often felt like not much progress was being made. The roll-on/roll-off (open group) system was also mentioned as hindering the progress of group members. Every week, one person left the group and another joined; making the group constantly changing and the bonding within group fragile

and unreliable. James summed '*People were coming and going all the time… it felt like we were going backwards and not forwards (115-120).* Shirida said '*I couldn't be bothered to connect with anyone because they will be there this week and gone the next like the others anyway*' *(122-126).* Michael said '*I have learnt to rely only on myself because that is the only constant; people are so unreliable including group members. They are there today and tomorrow they are gone, so sad'.* The lack of continuity of relationships seemed to be a common experience for many of the participants both in therapy and outside therapy environments.

Table 4.4 sums participants' identified helpful and unhelpful factors in managing their aggression.

Table 4.4. Summary of participants' Identified helpful and unhelpful factors

Helpful Factors	Unhelpful Factors

1. Therapy-related
    a. Skills training for behaviour management
    b. Knowledge acquisition on meaning and impact aggression
    c. Normalisation of experience
    d. Identification of personal strengths
2. Self-related
    a. Self-determination
    b. Willingness for change
    c. Resilience
    d. Commitment
    e. Readiness for change
	1. Therapy-related
	    a. Lack of explorative work
	    b. Poor therapeutic relationship
	    c. Therapeutic environment (competition rather than collaboration)
	    d. Therapist's attitude (emotionally distant)
	    e. Duration of therapy (too short for meaningful work)
	    f. Roll-on roll-off (open) system causing instability of the group
	    g. Poor commitment and attendance
	2. Self-related
	    a. Lack of self-acceptance
	    b. Lack of self-value and respect
	    c. Lack of belief in self and capacity
	    d. Not reflective and poor decision-making
	3. Social-related
	    a. Lack of support system
	    b. General Stereotyping and apathy
	    c. Communication barrier
	    d. Dysfunctional background
	    e. Pressure (peer, family, school, work)

4.2.2. THE CORE CATEGORY: DEALING WITH POWERLESSNESS

At the centre of the main influencing factors in the phenomenon of aggression in young adults, is the feeling of helplessness (powerlessness). All the participants identified helplessness (conceptualized during analysis as 'powerlessness') as the primary emotion that motivated their aggressive behaviours. **"Dealing with Powerlessness"** is, therefore, the core category that connects all the categories to produce a coherent explanation of participants' meaning and experience of managing aggressive behaviours through group therapy.

Participants indicated that the notion of dealing with helplessness (powerlessness) is a process that preceded the group therapy but was ineffective at the time. They indicated that prior to therapy, they dealt with their helplessness by either: 1) avoiding the situations that could trigger the overwhelming feelings or 2) dealing with the feelings through aggressive behaviours (see appendix 3). Participants admitted that aggressive behaviours were the primary/default strategy they used in dealing with the overwhelming sense of powerlessness because such behaviours often produced the desired result. The moderation – mediation model was used to explain the core category: dealing with powerlessness (see figure 4.3).

Figure 4.3. Relationship between Core Category and Aggressive Behaviours
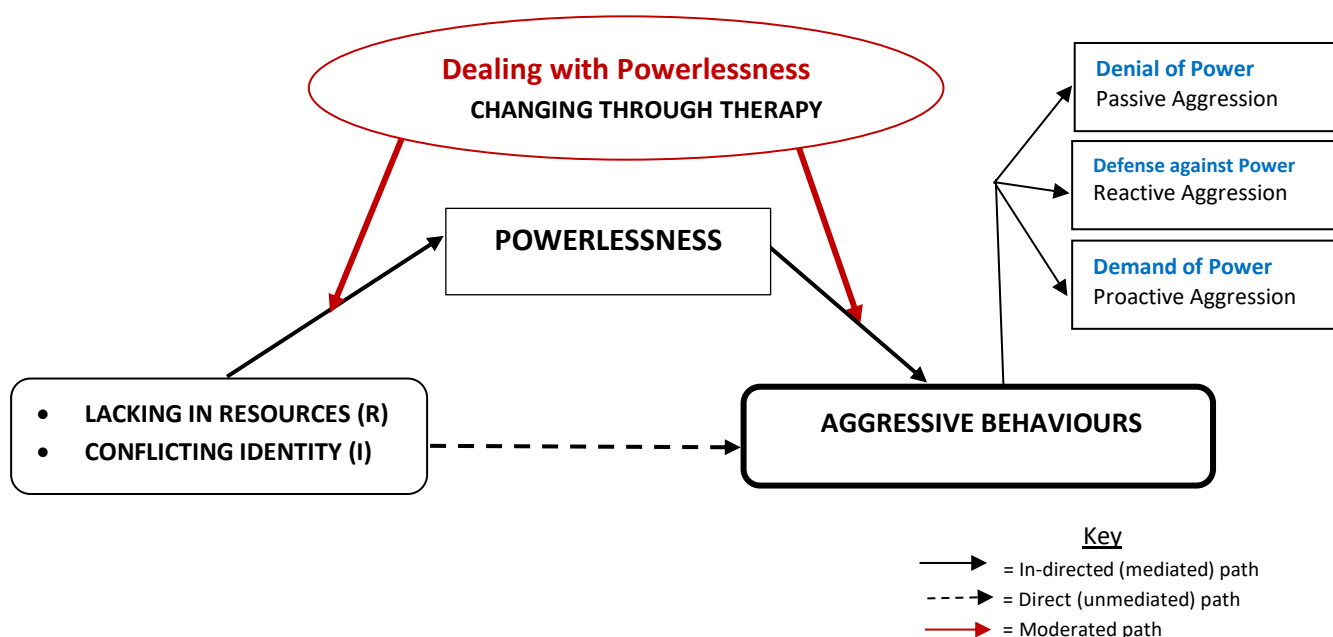
Powerlessness is identified as a vital *mediator* through which relationship between causal/contextual conditions ('Lacking in Resources' and 'Conflicting Identity') and outcome (aggressive behaviours) in young adults is transmitted. The feeling of powerlessness is usually underpinned by the continuing conflicts (crisis) in the personal and social identity: constant confusion regarding 'who am I?' and 'where I belong'. In addition to the identity crisis, the powerlessness is linked to or triggered by participants' lack of helpful resources for dealing with the challenges they encounter in their lives. Participants, therefore, indicated that the relationship between their identified conditions ('lacking in resources' / 'conflicting identity') and 'aggressive behaviours' is not entirely direct. The conditions tend to trigger sense of powerlessness which in turn motivated their aggressive behaviours. This implies that without the presence of the mediator (powerlessness), there would possibly be little or no influence of these causal/contextual conditions on their behaviours.

A change in the mediating factor (powerlessness) would, therefore, effect change on the outcome (aggressive behaviours). In relation to change, 'therapy' is identified as a *moderating* factor which influences the strength and/or direction of the mediated path. Changing through therapy (dealing with powerlessness therapeutically) involved providing young adults the necessary resources for managing their personal and inter-personal conflicts/challenges that underpinned their sense of powerlessness and in turn aggressive behaviours. The resources were in the form of information and support giving, knowledge and skills acquisition. The concept of 'change' was also important as the participants acknowledged that the turning point occurred when they contemplated changing their behaviours. Changing their perception was found helpful in moderating their feeling of powerlessness and their aggressive behaviours. Therapy, therefore, offered them effective strategies for managing their powerlessness and aggressive behaviours.

4.2.3. GROUNDED THEORY ON MEANING AND MANAGEMENT OF AGGRESSIVE BEHAVIOURS IN YOUNG-ADULTS

The emergent theory supposes that:

> *Aggressive behaviours in young adults are linked to causal and contextual conditions through a primary emotion of powerlessness. The effective management of aggressive behaviours and their underpinning powerlessness will involve: mixed-age relational group-therapy, personal commiment to change and social norm flexibility.*

Based on this theoretical presupposition and the participants' identified helpful and unhelpful factors in managing aggressive behaviours, this study proposes a Relational Integrative Model of Therapy (RIMOT') using a conceptual framework termed '**S.K.I.P.S.'** (*Skills, Knowledge, Improving Personal Qualities, Positive Regards, Social awareness campaign*) (see figure 4.4). Details of the model are discussed under 'implication of study' in chapter 5.
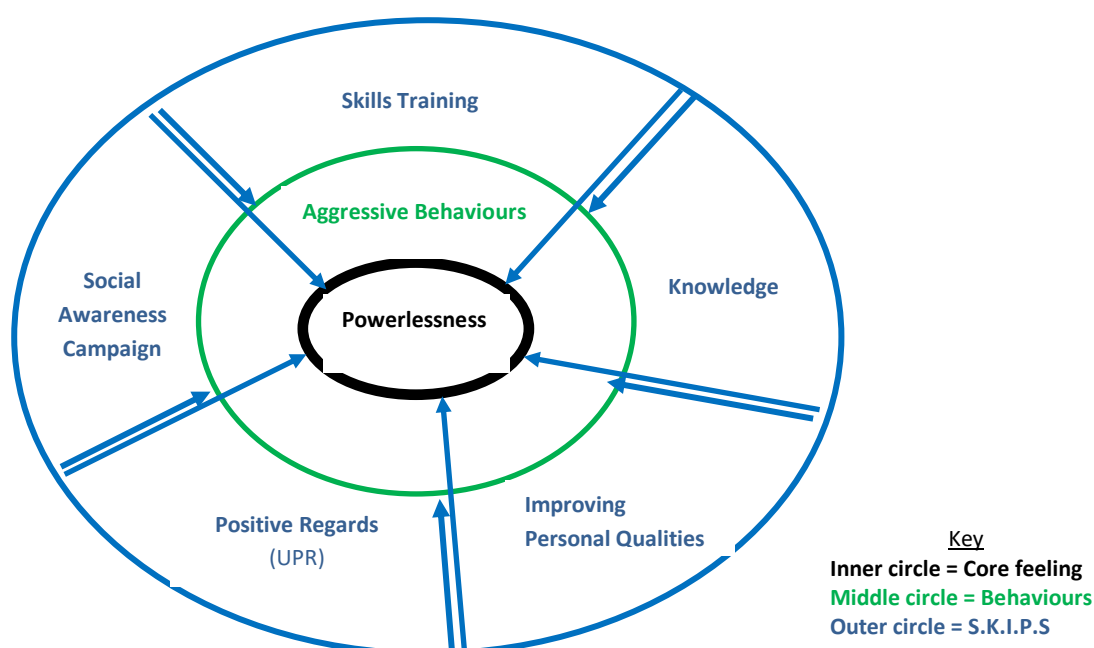
Figure 4.4. The Relational Integrative Model of Therapy (RIMOT): Managing Aggressive Behaviours in Young Adult using S.K.I.P.S. framework

4.3. SUMMARY OF RESEARCH FINDINGS:

Strauss and Corbin's (1998) three coding processes (open, axial, and selective coding) were used to analyse participants' data regarding their perspective of meaning and management of aggressive behaviours following group therapy. From the numerous processes identified during the open coding, eight clusters of emergent codes were generated. These sub-categories (clusters) were organised into three axial (main) categories: 'Lacking in *Resources'*, 'Conflicting *Identity'* and '*Changing through Therapy'*.

The moderation – mediation theory was used to explain the relationship among these categories. While 'lacking in resources' and conflicting identity' as casual/contextual conditions were shown to be linked to young adults' aggressive behaviours through powerlessness as a mediator, 'changing through therapy' was found to have a moderating impact on both the casual/contextual conditions and powerlessness. 'Dealing with powerlessness' was therefore found as the core category (storyline) in the selective coding. Dealing with powerlessness (and the accompanying aggressive behaviours) in young adults was found to involve: acquiring resources from socially situated professionals help, the individuals' resilience and commitment for change, and societal flexibility in the norms and values. Based on these findings, a substantive theory was generated and therapeutic model 'RIMOT using S.K.I.P.S. framework was proposed for managing aggressive behaviours in young adults.

CHAPTER 5: DISCUSSION

This chapter is made up of five sections. The first section explores the integrated theory of self-regulation and developmental adaptation in relation to powerlessness in young adults with aggressive behaviours. The second section provides an in-depth discussion of the findings in relation to the research questions that guided this project as well as their links to other studies. The third section is a discussion on the implication of the study: proposed relational integrative model of therapy. The fourth section is the limitations of the study and method. The final section is the conclusion and recommendations for further studies.

5.1. INTEGRATED THEORY OF SELF – REGULATION AND DEVELOPMENTAL – ADAPTATION: POWERLESSNESS IN YOUNG ADULTS EXPLAINED

Powerlessness is a conceptual term used in this study to describe participants' real and/or perceived experience of helplessness, non-participation, lack of control, and performance incapacitation in comparison to others. Based on the participants' data, the powerlessness they experienced could be explained using the 'Self-Regulation Theories' and 'Developmental – Adaptation Theories'. The link between young adults' powerlessness (aggressive behaviours) and dysfunctions in self-regulation and developmental maladaptation are explored below.

5.1.1. POWERLESSNESS AND SELF-REGULATION IN YOUNG ADULTS

Self-regulation is described as a process of controlling and modifying one's intended action by overruling their previously reinforced responses or desires (Bandura, 1999; Barkley, 2001). Studies showed that the processes involved in self-regulation can be

accessed intentionally as well as automatically when dealing with irregularities, disharmonies, and imbalances in people's internal and external self-state (Barkley, 2001; Dewall, Bushman, Anderson, 2011; Kochanska et al., 2000). In their work, Baumeister et al. (1994/2007) suggested that self-regulatory processes are made up of the following four main parts: 1) <u>standards</u> of the desired behaviours, 2) <u>motivation</u> to meet these standards, 3) <u>monitoring</u> the environment (internal and external) that may precede breaking the standards (i.e. evaluative mechanism that ensures effective assessment of actions and consequences in relation to the standards/norms), and 4) <u>willpower</u> – the internal strength/energy for controling impulsivity, undesirable behaviours, negative emotions and urges.

In this study, participants seemed to exhibit some level of dysfunctions in at least two out of the four aspects of self-regulation. Many participants seemed to be aware of the social standards and norms for human interaction and at some point, became aware that their behaviours were at variance to the set social norms. The inability to resolve the variance between the actual and expected behaviours resulted in their feeling of helplessness (powerlessness). Many of the participants indicated that they were motivated to deal with this sense of powerlessness by engaging in some of the premediated aggressive behaviours such as deformation of character, engagement in unprovoked fights. This finding correlates with the previous studies which showed that proactive aggressors are often driven by purposeful goals (DeWall et al., 2011; Ryan and Deci, 2006; Zhou et al., 2011). With regards to the monitoring of actions and willpower, most participants in the study reported 1) inability to intentionally monitor their actions and the outcome of their behaviours (i.e. lack of reflectivity and

sense of consequence) and 2) lack of willpower to control and modify self in order to act in a socially acceptable way. They explained that prior to therapy, they found their behaviours uncontroable once in-action and were hardly able to give much thoughts to or reflect on the consequences of their actions. They acknowledged that their lack of necessary skills for controlling their aggressive behaviours may have contributed to their often insuffient and abortive willpower to change. These findings are in line with previous studies which showed links between lack of self-control and aggressive behaviours (Baumeister et al., 1994; Gottfredson and Hirschi, 1990; Richards and Gross, 2000). The findings also correspond to other studies which suggested that young people's inability to mentalise (i.e. cognitive and emotional empathy) has strong association with their aggressive behaviours (Bateman and Fonagy, 2004; Fonagy et al., 2002; Taubner et al., 2010). The findings, however, seemed to slightly differ from other studies which suggested that the inability to override impulsive desire to cause harm is specifically associated with reactive aggressive behaviours (Deater-Deckard et al., 2010; Ellis et al., 2009; Rathert et al., 2011; Rothbart and Bates, 2006).

The concept of "Dealing with" is a regulatory process aimed at managing perceived or real inconsistencies or conflicts in function and bringing them within acceptable functioning range. In the study, dealing with powerlessness is the overarching core category that indicates young adults' application of efforts and strategies to regulate the imbalance of power/capabilities within self (intrapersonal) and between self and other selves (interpersonal interactions). All the participants in the study indicated that prior to therapy, they had tried to deal with (i.e. self-regulate) their sense of

powerlessness using variety of strategies from their limited resources. They, however, acknowledged that those strategies were often ineffective, hence, the need for therapy. The factors that participants identified as contributory to their ineffective self-regulation were grouped into the following categories: limited personal qualities, restrictive and unsupportive social environments, and limited or depleted resources.

The above findings seemed to support the mentalisation theories which supposed that lack or limited mentalisation skills and ability would result in the individual's inability to self-soothe, self-regulate, and control aggressive behaviours (Briere, 2002; Davey, Day and Howells, 2005; Sutton, Reeves and Keogh, 2000; Taubner and curth, 2013). The current study also found that irrespective of the dimensions of form or function of aggression, all the participants acknowledged that overwhelming lack of control, helplessness, or vulnerability (i.e. powerlessness) was often the driving force for their aggressive behaviours. These findings are in line with other existing studies that linked depletion of self-regulation to aggressive behaviours (DeWall et al, 2007; Dewall, Bushman and Anderson, 2011; Sayette, 2004; Tangney, Baumeister, and Boone, 2004) as well as those that linked lack of empathy and mentalization difficulties to aggressive behaviours (Allen et al., 2007; Feeney, Cassidy, and Ramos-Marcuse, 2008).

As also concluded by studies like Øien and Lillevik (2013), Ostrov and Houston (2008) and Prinstein and Cillessen (2003), this study found that though the presentations and intensity of aggressive behaviours in young adults may differ depending on the purpose they are serving, the underlying phenomenon of power-

relation (power imbalance) in aggression appears to be present in both proactive and reactive aggression as well in both males and females. The experience of powerlessness and its accompanying aggressive behaviours in young adults may, therefore, be linked to real/perceived dysfunctional, depleted or failed self-regulation.

5.1.2. POWERLESSNESS AND DEVELOPMENTAL ADAPTATION IN YOUNG ADULTS

Developmental adaptation refers to the process of settling, adjusting and dealing with conflicts and challenges associated with a given developmental stage of life cycle (Xie, Swift, Cairns and Cairns, 2002). As noted in a previous study (Marcia, 1989), participants in this study identified two constant conflicts of needs: the need for connectedness ('fitting-in-ness') and the need for individuation ('autonomy'). Many scholars reasoned that people's inability reconcile/balance their need for 'connectedness' with their need for 'individuation' is often associated with developmental maladaptation (Dattilio and Freeman, 2007; Hawley, 2007; Heilbron and Prinstein, 2008; Marcia, 1989; Tarrant, 2001). These studies emphasized that well-adapted people (including young adults) are able to reconcile these developmental needs and conflicts, consequently able to deal with challenges associated with that stage of development. It may, therefore, be deduced that participants in this study were struggling with the adaptation process. The developmental conflicts/crisis identified by many participants were similar to what earlier studies referred to as relationship conflicts (intimacy versus isolation) or idenity crisis (connectedness versus individuation) (Erikson, 1959). Most participants mentioned that they felt constantly under pressure to choose between belonging

('connectedness') and being alone ('individuation'). Erikson (1959) suggested that this psycho-social crisis is often emphasized between the ages of 18 and 40 years and that effective management of the previous stage crisis is crucial for the individual's ability to deal with the current stage crisis. With regards to the participants in this study, their lack of knowledge and skills on how to integrate the personal (who am I?) and social (where do I belong?) aspects of self, seemed to perpetuate the psycho-social conflict they experienced.

Participants also identified roles confusion as a significant factor that perpetuated their powerlessness and in turn aggressive behaviours. They felt that the society expects them to act as adults but often were not accepted or treated as adults by older adults and people in authority. It may, therefore, be deduced that the more the participants internalised those percieved unachievable role obligations (expectations), the more powerless they felt and as a result more likely to rebel against the social rules and norms. Interestingly, 'identity versus role confusion' is a crisis presentation that is said to occurs in early adolescent stage (9 – 18 years) (Erikson, 1968). It may be inferred, therefore, that maladjustment in the earlier developmental stage, possibly due to traumatic child-caregiver relationship, could be a precursor for the maladaptation that participants experienced during their adolescence and young adulthood (Briere, 2002; Davey, Day and Howells, 2005).

Many participants acknowledged that their aggressive behaviours started as early as 8 years and by their late teens and 20s, they were still exhibiting the aggressive behaviours. The early start of developmental maladaptation has two possible

implications. The first implication is that the participants will not be able to develop

appropriately the earlier virtues lsuch as <u>Trust</u> (inner calmness and grounding),

<u>Autonomy</u> (willpower and self-control), <u>Initiative</u> (sense of purpose and decision

making), <u>Industry</u> (competence in skills application), and <u>Identity</u> (confidence in self)

(Erikson, 1963/1968). These are personal qualities that young adults should have

acquired before they reached their adolescence and young adulthood where they

are meant to embrace intimacy (connectedness with others), consequently, able to

deal with relational life challenges (Erikson, 1968). In the study, most of the

participants identified with lack of these early virtue/personal qualities, hence their

current feeling of powerlessness.

The second implication of the early onset of participants' aggressive behaviours was

that there seemed to be some level of stability or continuity of the aggressive

behaviours into their adulthood. These findings reflect what has been reported by

many studies which opined that without appropriate interventions, aggressive

behaviours are stable and self-propagating and as a result have tendency to span

across developmental stages (Dodge, Coie, and Lynam, 2006; Farrington, 2003;

Fergusson, Horwood, and Ridder, 2005; Huesmann et al., 1984/2002; Huesmann,

Dubow and Boxer, 2009; Juon et al., 2006; Moffitt et al., 2001; Temcheff et al., 2008;

Tremblay, 2000/2010). These findings seemed to be contrary to Moffitt's (1993)

assertion that aggressive behaviours are self-limiting and only small percentage of

aggressive children exhibit in their adulthood. Many participants noted that the

sudden transition from dependency on caregivers to solely dependent on self was

overwhelming. They were suddenly faced with numerous unwritten social norms and

performance expectations which they were expected to effectively attend to. For example, they had to make decisions within a short time regarding their school, work, relationships, family contributions etc. In addition to the external pressures and challenges, they experienced some personal changes (e.g. physical, psychological, and biological) that constantly made them question their identity and abilities. This finding relates to previous studies which suggested that the transitory nature of adolescent developmental stage could complicate the already fragile self-state of many young people, thereby increasing the likelihood of their behaving in socially unacceptable ways (Arnett, 2006; Barry and Lochman, 2004; Bor et al., 2001).

For the participants in the study, the combination of the constant evolving situational pressures and the difficulty in coping with their developmental changes put them in a vulnerable rather than motivational mindset. Some of the participants who experienced aggressive behaviours early in their childhood could not develop a positive and successful life trajectory in their young adulthood. The findings in the current study tend to resonate with existing attachment theories which suggested that in attachment-related challenges, people with dysfunctional Internal Working Model (IWM) are unable to self-soothe and resolve any dissonance (Feeney, Cassidy and Ramos-Marcuse, 2008). The unresolved conflict in self tend to arouse in them a sense of vulnerability or helplessness and a need to recur to maladaptive behaviours such as aggression to cope with the negative feelings (Briere, 1992/2002; Davey, Day and Howells, 2005; Hardy, 2007).

According to the developmental adaption theories, life challenges are opportunities aimed at to creating new contexts across variety of domains (e.g. school, relationships, work) wherein developmental trajectories of life course can be changed or redirected (Masten et al., 2004; Schoen, Landale, and Daniels, 2007). As a result of the life encounter, the individuals develop basic virtues (personal qualities) which help them live an integrated self-identity and meaningful life across the lifespan (Newman and Newman, 2001; Tanti et al, 2011). The identity versus role confusion is, therefore, meant to serve as a precursor for a successful adulthood wherein young people can explore and identify 1) their strengths (personal qualities), 2) who they are (personal identity) and 3) how they fit in the bigger human framework (social identity) (Arnett, 2006; Tremblay, 2010). The aggressive behaviours exhibited by the participants during their developmental age of 18 – 25 years could, therefore, be interpreted as a function of depleted/defective adaptive strength (powerlessness) for managing challenges associated with that stage of life (Hawley, 2007; Tremblay and Nagin, 2005; Ostrov and Houston, 2008).

When discussing their sense of powerlessness and their effort to manage it, many participants suggested that the triggers of their feeling of powerlessness are multidimensional and the factors they mention seemed to fall within the frames of internal, external and internal – external mixed factors. Many of the participants explained that lack of personal qualities for adaptation (internal factor) and the negative social attitude towards them (external factor) created a social disconnect and made them feel like outsiders in the society. This often resulted in the self conflict of "us" (participants) versus "them" (other members of society) which in turn

maintained their aggressive disposition. The multi-source perspective seemed to be contradictory to some scholarship which supposed aggression as a unitary phenomenon involving either internal (Tremblay and Nagin, 2005) or external (Barkley, 2001) factors. It was, however, in line with the interactionist position which suggested that aggression is rather a multifaceted phenomenon requiring multi-dimensional intervention (Anderson and Bushman, 2001).

5.1.3. PRESENTATIONS OF POWERLESSNESS IN YOUNG ADULTS

Powerlessness (power imbalance) is a concept commonly discussed in relation to victims whereby they found it difficult to defend themselves effectively from the aggressors (Cowie and Jennifer, 2008; Olweus 1991/2004). But as noted in some studies (Øien and Lillevik, 2013; Ostrov and Houston, 2008), this current study found that a sense of powerlessness is also a core concept among participants (aggressors). The participants suggested that their aggressive behaviours were a product of real/perceived sense of powerlessness during interaction with peers or from society's inflexible norms. In line with the power-relation discourse on aggression, the powerlessness felt by aggressors can be explained from self-regulation (DeWall et al, 2007; Dewall, Bushman and Anderson, 2011) and developmental adaptation perspective (Dattilio and Freeman, 2007; Hawley, 2007).

The emotional expression of powerlessness which arises from the defective self-regulation may be described as an externalisation of internal conflict (intra-personal crisis), while the powerlessness from developmental maladaptation may be described as an internalisation of external conflicts (interpersonal / mentalisation

crisis) (Fonagy et al., 2002; Taubner and Curth, 2013). The conflicts that participants mentioned in this study may, therefore, be summed as a two-faced characterization of powerlessness involving defective self-regulation and developmental maladaptation. The depletion of the adaptive strength and self-regulatory systems could then be a precursor for a compensatory disposition of aggressiveness (Griffin and Gross, 2004; Sutton, Reeves, and Keogh, 2000).

Participants (aggressors) identified the following three ways of dealing with their sense of powerlessness (power imbalance): "*Denial"* of Power imbalance (Passive aggression)*, "Defense"* against Power imbalance (reactive aggression)*, or "Demand"* of Power that creates imbalance (proactive aggression) (see chapter 4, figure 4.3). In relation to 'Denial of Power" presentation, some of the participants noted that though they had a personal conflict of powerlessness, their aggressive behaviours are not usually prototypical and do no attract public attention because they are often law-abiding (socially conforming). They deal with their feeling of powerlessness by repressing the overwhelming feeling: '*Amanda'* described it as *'bottling things up' (6)*. They detach from their feelings and spend substantive energy keeping away from being overwhelmed by the threatening feeling of powerlessness. Many of these participants noted that they often project these feelings subtly into unrelated situations and possibly unsuspecting people. This is in line with the study which suggested that while all the three presentations of aggression have the potential to produce pain, proactive and reactive aggression have prototypical presentation but passive aggression is less prototypical (Xie et al., 2002).

The expression of powerlessness by young adults with passive aggressive behaviours can, therefore, existed under the radar of authorities, researchers, therapists, and other professionals, though their close relations can still feel the impact of such passive aggression. This category of young adults may be viewed as having over-regulated self and highly adaptive to the social norms and expectations, hence, no evidence of their passive aggression. Langer (1975), however, warned showed that the over-regulated self and highly adaptive disposition may be a 'control illusion' because individuals with such aggressive behaviours often develop a conflict of 'personal-need' versus 'personal-void' after a while. This conflict would eventually cause them to tilt towards either reactive aggression (defense of power) or proactive aggression (demand of power) depending on the situation and environment. '*Larissa (P5)'* summed it by saying that *'the knot would just build up and build up until you just finally let it go and then people see you as aggressive'.*

Participants who had presented with defense of power (reactive aggression) and demand of Power (proactive aggression) acknowledged that their behaviours often attracted negative and controversial attention and are often viewed as unacceptable by people in authorities and members of society at large. This finding corresponded to the existing studies which showed that individuals with either proactive and reactive aggression are more likely to be met with negative response from the society because they usually use antisocial strategies to resolve social conflicts or manage uncomfortableness ((Baumeister et al., 1994; Gottfredson and Hirschi, 1990; Kochanska, Murray, & Harlan, 2000; Dewall, Bushman, Anderson, 2011). Most of the participants in the study acknowledged that the form of aggressive

behaviours (e.g. reactive or proactive aggression) they exhibited often depended on

the situation and the form that they assessed as the best strategy for dealing with

their feeling of powerlessness. This finding seems to be in line with existing studies

which suggested that in real life situations, the aggression classification may not be

dichotomously clear-cut as people tend to have attributes of the various forms of

aggression and exhibit a specific form according to the situation they are in (Barker

et al., 2006; Bushman and Anderson, 2001; Dodge, Coie, and Lynam, 2006; Fite et

al., 2008; Little et al., 2003).

5.2. DISCUSSION OF THE RESEARCH QUESTIONS AND FINDINGS

This section provides a detailed discussion of the findings on the two research

questions that underpinned this study. The research questions were explored

through the four objectives of the study. While the first three objectives of this study

are linked to the research question 1, the fourth objective is linked to the research

question 2.

5.2.1. Research Question 1: What Do Participants (Aged 18 – 25 Years) Identify as Helpful and Unhelpful Factors in Managing Aggression Following a Group Therapy?

The research question 1 focused on what participants identified as helpful and

unhelpful factors in managing aggression following a group therapy. Contained in

this research question are the following first three objectives:

1) to explore and describe the common themes in the ways that they

managed their aggressive behaviours.

2) To investigate and describe young adults' identified helpful and unhelpful

strategies in managing their aggressive behaviours, and

3) to identify and describe young adults' perspectives on the role(s) of group therapy and their experiences of age-specific group therapy for managing their aggression.

These three objectives are discussed below.

5.2.1.1 Common ways young adults viewed and managed aggressive behaviours

In relation to participants' perspectives on their aggressive behaviours, most of them indicated that prior to therapy much of their attention and energy were on dealing with their helplessness (powperlessness) rather than their aggressive behaviours. They commonly thought that other people were making a fuss about their behaviours because they have justifications for their actions. To the participants with frequent proactive aggression, the victims of their aggressive behaviours deserved what they got because the victims were disrespectful and they (the aggressors) needed to establish respect, authority, dominance, and/or make their voice heard. They seemed to have a common believe of *'if you do not attack, you will be attacked; attack is the best defence'* (Larrisa, 44 – 46). This finding is in line with the existing studies which showed that aggressive behaviours can be perpetuated by people's need for dominance/control over another person and status from peers (Dodge et al, 1990; Ryan, 2001), self-confirmation and gratification (Vitaro, Brendgen, and Tremblay, 2002).

For the participants who often exhibit reactive aggressive behaviours, their behaviours were also justifiable; they believe that they were only defending themselves, notwithstanding the intensity of the force used. Many of them were of the view that they were the 'outsider', 'victim', and 'vulnerable' and that one will use whatever that is available to difuse threat and protect him/herself. These findings relate to earlier studies which suggested that the reactive aggression is linked to the aggressors' hostile attribution bias whereby they assume that other people's intentions are hostile (Ojala and Nesdale, 2004/2010). It is interesting to note that none of the participants (both the proactive nor reactive aggressors) took responsibility for their actions; they rather blamed others for their behaviours. The cognitive behavourists would argue that such disposition is an evidence of their diminished or dysfunction of cognitive executive and self-regulatory processes, hence, the distortion of sense of self as an executive agent (Beck, 1979/1985; Kendall et al., 2000; Kendall et al., 2003).

The findings in this study also resonate with the mentalisation theory which offers that aggressive behaviours in young adults are linked to mentalisation difficulties (Fonagy et al., 2002). Exploring reflective function as part of mentalisation skills, mentalisation theorists maintained that proactive aggressors have average reflective functions and tend to be conflicted about their aggressive behaviours, hence, they acknowledge the suffering of their victims but maintain that their victims deserved what they got (Griffin and Gross, 2004; Stevens, Charman, and Blair, 2001; Taubner and Curth, 2013). The reactive aggressors, on the other hand, have low reflective functions, consequently, tend to engage in behavioural change without

acknowledging their victims' psychological pain and suffering (Hill et al., 2007;

Taubner et al., 2012).

The participants' common disposition of blame-shifting could also be linked to their

lack of empathy was a common disposition found among most of the participants.

Most of the participants showed no empathy to the suffering of others which resulted

from their behaviours. Godswill, for instance said, '*I can hurt people really bad but it*

didn't bother me that much because if you don't hurt them, they would hurt you' (8 –

11). Amanda, lamented that '*people usually focus on my behaviours and nobody*

cared to listen to my version of the story' (49 – 52). Sharing similar view on the use

of aggression as a weapon, Larrisa asserted that '*if you do not attack, you will be*

attacked; attack is the best defence' (Larrisa, 44 – 46). This disposition tend to

support their believe that the recipients of their aggressive behaviours deserved what

they got and they (the aggressors) were, therefore, justified.

These findings seem to agree with numerous previous studies which have

documented strong association between lack of empathy and aggressive behaviours

(e.g. De Wied et al., 2005; Gini et al., 2007; Strayer and Roberts, 2004). Studies

showed that empathy plays a significant part in modulating or regulating

psychological processes responsible for social perception and smooth social

interactions (Decety, 2010). Allemand, Steiger and Fend (2015) noted that empathic

development in adolescence predicts social competence in adulthood. Hence,

empathy-related responses such as caring and sympathetic concern for others tend

to motivate prosocial behaviours, restrain aggressive behaviours and promote moral

reasoning (Eisenberg and Eggum, 2009). People that lack empathy would, therefore be less bothered about other people's feelings or wellbeing, and are less likely to show remorse and guilt about their aggressive and violent behaviours (Decety, 2010; De Wied et al., 2006). In an attempt to share more light on the link between empathy and aggressive behaviours, it has been suggested that it is vital that the concept of empathy needs to be understood. Decety (2010) described empathy as 'shared interpersonal experience' (p. 257). The study opined that the shared interpersonal experience has four main components: a) affective sharing or communication, b) emotion understanding, c) emotion regulation and d) awareness of self – other differentiation.

For the participants in this study, there seemed to be some level of distortion in their exhibition of these empathic components. They all acknowledged using aggression as a communication of how they were feeling but they did not seem to have awareness or willingness to acknowledge the feelings of others. Melisa said that aggression *was 'my way of showing how I felt ….., was a way to let it out, let people know I'm not happy' (4-7).* The participants also acknowledge that they were unable to regulate (control) their emotions. Fiona, for instance, said: '*when I get angry I cannot stop myself…. I didn't know when to stop in arguments and I didn't know how to speak without being angry/aggressive' (58-60).* More so, their level of self – other differentiation was questionable since they assumed that their internal distresses were to be projected onto others. Many other scholars conceptualized empathy as a multi-dimensional construct consisting of two major components which have different developmental trajectories: a) affective and b) cognitive components (Decety and

Jackson, 2004; Eisenberg and Eggum, 2009; Gini et al., 2007; Yeo, Ang, Loh, Fu, and Karre, 2011). In accordance to this perspective, the affective components of empathy referred to an individual's ability to feel and share the emotional state of others which is more related to the others' situation than it is with the individual (Dadds et al., 2008). The cognitive component of empathy, on the other hand, referred to an individual's ability to identify and understand the emotional states and perceptions of others (De Wied, Goudena, and Matthys, 2005; Gerdes, Segal, and Lietz, 2010). De Wied, Goudena, and Matthys (2005) therefore, suggested that for people to be empathic, they need to have the ability to identify, understand, feel and share emotional states of others.

Some studies explained that lack of cognitive empathy was significantly linked to aggressive behaviours which occur as a result of the individual's deficiency in perspective-taking (Carlson et al., 2004; Tonks et al., 2007). The lack of perspective – taking meant that the individuals would not be able to imagine or project themselves into others' position, hence, unable to understand what they were feeling, unable to tolerate others' perspectives and often misinterpret others' intentions and social cues as threatening or hostile (Gini et al., 2007). Such individuals often have some degree of dysfunctions in their executive functions and self-regulation system and would be socially incompetent to maintain appropriate interpersonal relationship (Allemand, Steiger and Fend, 2015; Carlson et al., 2004). Based on their misinterpretation of social cues, they tend to judge their behaviours towards others as justified. Amanda said that '*I am only defending myself, so they deserve what they got'.*

Some scholars would argue that lack of cognitive empathy may be more related to the reactive than proactive aggression (Decety and Michalska, 2010; Dewall et al., 2007; Rathert et al., 2011). Other studies supposed that lack of affective empathy was more strongly associated with aggressive behaviours than the cognitive empathy (De Wied et al., 2005; Shechtman, 2002). Many aggressors have been shown to have normal level of cognitive empathy, hence, they can identify and understand perspectives and emotions of others. They, however, lacked affective empathy and as a result they do not feel or share the negative emotions of others cause by their aggressive behaviours (Gini et al., 2007; Sutton and Koegh, 2000). The studies suggested that this may be the reason why aggressors continue to act aggressively towards their victims despite their distress. The lack of affective empathy may also be more linked to the proactive than reactive aggression (DeWall et al., 2011; Zhou et al., 2011).

From this current study, many of the participants exhibited significant degree of deficiency in both the cognitive and affective empathy, hence, expressed proactive and reactive aggression at different events and situations. This is in line with the studies that opined that the proactive – reactive aggression classification was not dichotomously clear-cut because people often have attributes of both proactive and reactive aggression (Barker et al., 2006; Bushman and Anderson, 2001; Dodge, Coie, and Lynam, 2006; Fite et al., 2008; Leonard, Quigley and Collins, 2002; Little et al., 2003). The participants' degree of deficiency in their cognitive and affective empathy may, therefore, vary from person to person and may depend on their level of developmental adaptation (Kroger, 2000; Newman and Newman, 2001; Preston

and De Waal, 2002).

Another common theme in the way participants interpreted the response of others towards their aggressive behaviours was that they were <u>miss-understood and often unjustly treated</u>. Amanda, for instance, said *'people usually focus on my behaviours and nobody cared to listen to my version of the story'* (49 – 52). Most participants suggested that they were often victims of social injustice and prejiduces. They offered that the societal attitude towards them frequently made them assumed a defiant disposition to any contrary opinion and rejected or underplayed any change assistance. Melisa said that she would think *'Well, I'm doing it so it's none of your* business' (L51 – 52). Previous studies have also documented similar findings wherein young adult maintained that the strategies used by the authorities to deal with their aggressive behaviours were unjust (Brendgen et al, 2001; McAdams and Schmidt, 2007; Sanders, 2004). Based on the findings of previous and current studies, it may be plausible to infer that lack of social support and understanding as well as lack of personal basic virtues for self-regulation and developmental adaptation may have contributed to the pre-therapy ineffective appraisal and management of aggressive behaviours among young adults.

5.2.1.2. Helpful and Unhelpful Factors in Managing Aggressive Behaviours

This section discusses some of the factors that participants identified as helpful and unhelpful in managing their aggressive behaviours.

5.2.1.2.1. Helpful factors for managing aggressive behaviours

The helpful and unhelpful factors identified by participants in the study seemed to fall

into the following groups: therapy-related factors, client-related factors, and social/others-related factors. Starting with the therapy-related factors, majority of the participants found the following things helpful: skills training for behaviour management, knowledge acquisition on aggression, normalisation of experience, assistance in identifying personal strengths. Most participants suggested that skills-training was helpful because the skills offered them the performance strategies ('how to') for managing their behaviours. The participants offered that prior to therapy, people had suggested that they needed to change their behaviours but nobody had shown then how to do so.

In accordance to the psychosocial theory, the lack or dysfunction of performance skills may be an indication of developmental problems at the industry stage (5 – 12 years) of their development where competence and method skills are developed (Erikson, 1968). The malfunctioning of this stage of development may explain the difficulties most of the participants reported with regards to meeting the demands of schools, work, family, etc. It has been shown that people with low internal resources such as the cognitive executive ability for solving personal problems and resolving interpersonal conflicts, tend to be more prone to aggressive behaviours (Ellis, Weiss and Lochman, 2009; Séguin and Zelazo, 2005). The participants noted that group therapy offered them opportunity to acquire the necessary skills for dealing with life challenges. Lambert et al (2002) also indicated that interpersonal learning and feedback giving in a group can be a helpful source of skills acquisition for the recipient and the rest of the group members.

Knowledge acquisition was another therapeutic factor that was found helpful by most of the participants. They offered that therapy helped them to learn more about aggression and its impacts on self and others. They suggested that the increased awareness enabled them to be more reflective of their actions and the probable consequences of their intended action(s). The reflective practice has enabled them to have better control of their emotions and make more effective decisions, hence, reduce the frequency of their aggressive behaviours. The cognitive theorists would argue that the acquisition of knowledge and problem-solving skills could trigger brain plasicity processes and consequently enable people to overcome some of the defects in their developmental adaptation which may have occurred as early as the initiative stage (3 – 6 years) when executive functions of decision making and purposive actions are formed (Bandura, 1986).

Linking aggressive behaviours to individual's cognitive executive functions, Tanti et al. (2011) suggested that those with the high cognitive executive ability for managing interpersonal conflicts are less prone to use aggressive behaviour as a conflict management tool than their counterpart. Some studies argued that reflective practice may be more relevant than the executive function in the management of aggressive behaviours because proactive aggressors often have highly developed executive functions which they used to manipulate their situations and people but they are usually low in reflection (Halberstadt, Denham, and Dunsmore, 2001; Sutton and Keogh, 2001).

Normalisation of experience was the next factor that was identified as helpful. Participants mentioned that prior to therapy, they thought that they were the only ones in such situation and always felt like an outsider and alone. Meeting other people with similar problem in therapy gave them a sense of belonging and the feeling that these people understand their plight because they have similar experiences.They explained that they felt that there was no longer the need to prove self to other or force their voice to be heard because the other group members '*have lived it and they get it'* (Fiona, 199). Many participants noted that therapy offered them the opportunity to learn that they are normal people responding to challenging situations ineffectively. They explained that this knowledge gave them hope and courage for change.

Sense of belonging and acknowedgement of experiences were also found in this study as necessary developmental adaptation virtues for young people. They mentioned that one of the trigers of their aggressive behaviours was 'being left out'. This is in line with studies that suggested that lack of social inclusion may be contributory to aggressive behaviours in young adults (Kroger, 2000; Newman and Newman, 2001). The findings also resonate with the attachment theory which emphasized the need for connectedness between people for an effective and stable development of sense of self (Becker-Stoll, 2002; Bowlby, 1969; Hardy, 2007; Kroger, 2000). Studies have also showed some associations between attachment injuries in early child – caregiver relationship (resulting in either avoidant or disorganized attachment style) and negative impact on future relationships and sense of belonging with others (Allen et al., 2007; Feeney, Cassidy and Ramos-

Marcuse, 2008; Seiffge-Krenke and Beyers, 2005). From attachment theory

perspective, the aggressive behaviours exhibited by the participants may be

explained as internalized, maladaptive and insecure relational strategies for

regulating and managing unpleasant feelings or overwhelming negative experiences

such as helplessness, rejection or exclusion (Allen et al., 2007; Hardy, 2007).

The assistance in <u>identifying and acquiring personal strengths/qualities</u> was also

found helpful. They reported that prior to therapy, they did not see any good in

themselves and neither did others. It was, therefore, helpful to have someone who

believed in them and willing to look beyond their behaviours to see qualities of value

in them. The therapeutic environment, therefore, served as a enabling environment

which faciliate reparative and reparenting process needed to heal the attachment

injuries that they may have incured in their early years (Hardy, 2007; Makinen and

Johnson, 2006). The therapy also provides them the environment to develop and

master their reflective functions which enables them to understand their behaviours

and those of others (Fonagy et al., 2002).

With regards to <u>self-related factors</u>, most of the participants identified the following

as helpful: self-determination, willingness and readiness for change, resilience, and

commitment. Many of the participants identified self-determination as the core quality

that has been consistent in their life and has helped them to stay focused during their

therapy. They suggested that their self-determination was the foundation upon which

their resilience and commitment to the therapeutic process was built. They also

admitted that without willingness and readiness for change, the changes they

observed in their behaviours and self-function would not have been possible. Godswill, for instances, stated that *'change will never happen until you want it to'* (219). These self-related helpful factors were also documented in other existing studies which argued that 'external others' or 'inner drives' may supply the grounds or motivation for the self-determined act, but the self or ''ego-center'' must authorise the external promptings for such acts to happen (Dattilio and Freeman, 2007; Ryan and Deci, 2006).

5.2.1.2.2. Unhelpful Factors for Managing Aggressive Behaviours

The participants also identified some factors that were unhelpful to the management of their aggressive behaviours. These were also grouped into: therapy-related, self-related and social -related factors. In relation to therapy-related factors, the factors are divided into three groups: *therapy, therapist, and procedural factors*. The therapy factors that were identified as unhelpful were: lack of explorative work, poor therapeutic relationship, non-inclusive therapeutic environment (competition rather than collaboration). The participants suggested that it would have been more beneficial if the therapy placed more emphasis on the background issues that may be driving their aggressive behaviours. They suggested that the skills are useful but not sufficient. They reasoned that skills taught them how to manage the aggressive behaviours but not how to deal with the pain/hurt which the aggressive behaviours were covering.

The participants' suggestion that 'skills are useful but not sufficient' seemed to echo the integrationist assertion that there is no one answer for all problem/persons

(Anderson & Bushman, 2005; Guerra and Huesmann, 2004). The finding, therefore, indicated the importance of the integrative approach to therapy where various aspects of clients' problems can be explored, consequently achieving longer lasting and effective therapeutic outcome (Barry and Lockman, 2004). Though therapeutic integration has been shown to be effective in providing holistic and long-lasting outcome especially in group setting, some studies warned that the extent of work done by many group therapies could be restricted by the limited time often allocated for therapy (Brech and Agulnik, 2007; Stone and Roback, 1984). These studies suggested that the limitation of therpy time could largely undermine any meaningful deep exploration, skills training and level of therapeutic integration.

The participants also suggested that the lack of stable *therapeutic relationship* (member-to-member and members-to-therapist relationships) was unhelpful. They reported that the frequency of turnover of group members, the often non-inclusive *therapeutic environment* (competition rather than collaboration) made bonding between members and therapist challenging. Many of the participants viewed therapeutic relationship and enabling environment as vital factors for meaningful change and lasting therapeutic outcome. They, however, noted that there were often some degree of favouritism within the group with those clients who comply to the therapists' prescription receiving more attention. The findings regarding the importance of member – to – member and member – to – therapist relationship are in line with the existing studies which established significant association between therapeutic relationship/environment and the therapeutic outcome (Kivlighan and Tarrant, 2001; Klein et al, 2013; Lambert and Bergin, 1994; Tapson, 2015). The lack

of these relationships could therefore affect adversely the group dynamics and process as well as make some of the members feel left out and devalued (Harpaz, 1994; Roback, 2000; Shechtman, 2009).

The participants identified some *procedural factors* as unhelpful because they added to the instability of the therapeutic relationship and environment. The participants believed that the 16 weeks – duration of therapy was too short for any meaningful work bearing in mind that the ever-changing nature of the group (open-ended group). They also suggested that the roll-on roll-off (open) therapy system created uncertainties (unpredictability), instability and lack of bonding in the group, consequently was found to be unhelpful. These findings echoed previous studies which showed some negative impact of open ended type of group therapy. Miller and Manson (2012), for instance, suggested that in an open-ended type of group therapy, members were often distressed of 1) not knowing from session-to-session who would be joining or leaving the group, 2) the re-visitation of the already covered topic and 3) the resultant lack of sense of progress for existing members.

Studies showed that there are two main reasons for open ended group therapy: member free access and agency's financial management (Miller and Mason, 2012). The first reason for open-ended group was that it enables members to enter and leave the group as their life circumstances dictate their availability and willingness (Schopler and Galinsky, 1984/2006). This was found helpful in transitioning members in times of crisis because there is always continuous screening and immediate availability of space in the group. The second reason for open ended

group was to save money. Agencies are often of the view that they cannot afford to keep groups exclusive and run the risk of running nearly empty group due to absences from varied and changing circumstances (Miller and Mason, 2013).

These reasons notwithstanding, few participants suggested that members' lack of commitment and poor attendance were linked to the unreliability of the group cohesion and lack of progress in the group work. They offered that they were reluctant to establish relationship with any member because they did not know whether they were staying or not. Few of the participants offered that they were absent from the group for at least three sessions but did not feel that they missed out because there was always a new member and the therapist had to repeat some of the things covered in the previous sessions. Just as other studies noted, the roll -on, roll-off system seemed to encourage absenteeism of participants (group members). The absenteeism of member would 1) undermine the therapeutic relationship (bonding) in the group and 2) put greater demand on human (therapists) and material resources (Brock et al., 2013; Tourigny and Hebert; 2007). On a long-term, the open-ended model would have a higher cost on organisation.

The therapist factors: The detached attitude of some of the therapists was identified as unhelpful. Many of the participants reported that they sometimes felt that their therapists were just doing their job because they were often serious, talked straight to the point with no warmth or emotional connection with them (participants). The participants reported feeling as though they were in a classroom performing to their teachers and that they subtly resisted the therapist's attitude by not turning up to the

meeting. Studies have argued that therapists are constructing a social system when working with groups, hence, their role within such system in constructing group norms and bond as well as therapeutic change is critical/significant (Chung and Sun, 2001; Lieberman and Golant, 2002).

Other studies also asserted that, in terms of therapist's effects on therapeutic outcome, empathy and ability to facilitate a warm and attentive relationship with clients were the most robust predictors (Ackerman and Hilsenroth, 2003; Lambert, 2013; Lambert and Barley, 2001). Similar to this line of thought, Lieberman and Golant (2002) found that therapists' caring and support had 28% significant impact on therapeutic outcome in group work. As found in this study, lack of warmth and emotional connection between therapist and group members, therefore, have negative impact on participants' therapeutic process.

The therapist's' experience was also highlighted. Few participants mentioned that some of the therapists appeared inexperienced and that they often talked in an idealistic (out of the books) way. They suggested that it will be helpful for therapists working with young adults to get some specialist training before facilitating the programme. While these findings did not correspond to some studies which suggested that therapist's therapeutic orientation and level of experience do not predict the effectiveness of therapy (Beutler et al, 2004; Skovholt and Jennings, 2004; Sandell et al., 2007), other studies found that therapist's lack of executive – management skills in providing appropriate structure and protection for group members can be unhelpful to clients' therapeutic process and outcome (Kellish,

2014; Schofield and Roedel, 2012).

Lieberman and Golant (2002) explained that pertinent to the effectiveness of group process is the therapists' ability to provide both structure and cognitive framework which enable participants (group members) to explore and understand their beliefs, feelings and consequences of their actions. Lieberman and Golant (2002) suggested that these structure and framework could include things like: blocking toxic interactions and feedbacks; suggesting procedures; managing time; exploring rules, norms, goals and limits; giving directions, forming decision tasks; and assisting in decision making. Few other studies also noted that for an effective cross – cultural therapy, the therapist must be competent in the following: 'a) an understanding or knowledge of the client's experience as a culturally different person, (b) an awareness of his or her own assumptions about culturally diverse people, and (c) culturally appropriate therapeutic interventions and skills (Quinn, 2012; Ridley, Mollen, and Kelly, 2011; Sue et al., 1992). Bearing in mind that young people often have age-sensitive way of viewing and expressing ideas, it is important that therapists are familiar with these subliminary communications and language.

The self-related factors identified as unhelpful were: lack of self-acceptance, lack of self-value and respect, lack of belief in self and capacity, not reflective on impact of action on others and poor decision-making. The participants mentioned that due to the lack of some of these personal qualities, the progress they made with therapy and their ability to adapt to the situation were slower. Considering that many of these personal qualities have self-regulatory and developmental adaptation function, some

studies argued that the absence or ineffectiveness of these qualities will hamper their ability to cope with challenging situations (Armitage and Conner, 2002; Rutter and Quine, 2002). These studies also suggested that confidence in self and in capability are vital for achieving behaviour change which is often part of clients' therapeutic goals. It, therefore, implies that the variation in the degree of young people's abilities to manage their aggressive behaviours prior to therapy and their post-therapeutic behaviour change could be linked to the level of development in participants' personal qualities.

Most participants identified <u>social-related factors</u> most unhelpful. The factors identified included lack of support system, general stereotyping and apathy, communication barrier, dysfunctional background, pressure (peer, family, school, work). In describing the social-related unhelpful factors, there seemed to be a common theme of dichotomous power-relations of 'powerful versus powerlessness'. Majority of the participants' perception of power – relation between young people and society was that of asymmetrical dynamics of 'all' (powerful) or 'nothing' (powerless) with the 'otherness' assuming almost/all the power and the 'self' (participants/young people) left with little or no power. Power is, therefore, viewed to be embodied in the society's institutional structures and can easily be used to curtail or control their behaviours and if they resist the power, such attempts would be met with severe punishment (Lillevik and Øien, 2012).

Most of the participants, for instance, suggested that the society determines 1) when people's behaviours are acceptable or not, and 2) when change has occurred or not. They explained that while they were making effort to change, the society is not

changing to accommodate them, consequently, it appears that the only people that needed change are the young adults. They offered that the general negative and steroetypical attitude towards young people made it difficult for many of the participants to embrace change and exercise their learnt skills outside of therapy. The participants' perception of power – relation and aggressive behaviours among peers also had dichotomous dynamcs of 'all' (powerful) or 'nothing' (powerless). The dominantly reactive aggressors assumed the powerless position and according the other the powerful position. The proactive aggressors, on the other hand, accord self the powerful position and the others are left with the powerless position.

Contrary to the participants' 'all or nothing' view of *power* and the suggestions that power is used by people in authority as an instrument of coercion or dorminance, some studies argued that 'power is everwhere' and within everyone (Foucault, 1977; Rabinow, 1991). Sutton and Smith (1999) asserts that power – relations are evident in all social groups, interactions and every social structure. The power is constantly negotiated but in some situations misused. From this perspective, power is neither an agency nor a structure; it is rather embodied in discourse, knowledge and 'regimes of truth' (Foucault, 1991). With regards to the participants in this current study, it may be inferred that their view about power may be coloured by their lack of knowledge about power and its appropriate use. Their lack of awareness and knowledge that power is discursive in nature meant that their role in power interaction was either under- or over-performing, hence, enabling flow of power-relations to be uni-directional rather than bi-directional (Dalal, 2001; Foucault, 1991). For lasting change to occur in the management of aggressive behaviours in young

adult, the societal perception of power and its use will have to be addressed and the young people will need to be educated on effective strategies for negotiating power.

5.2.1.3. The Role(s) of Group-Therapy (especially Age-Specific Group-Therapy) in Managing Aggressive Behaviours

5.2.1.3.1. Role of group-therapy in managing aggressive behaviours in young adults

Most participants presented group-therapy as the environment that made their behaviour change and self-discovery possible. Few of the participants indicated that as they continued to attend therapy, they began to appreciate group therapy as a place for second chance to grow and be themselves without fear of being judged and looked down on. Many of them suggested that with increased knowledge and engagement with the process, they gradually became aware of their abilities and with time started to belief in self and their capability.

The participants also identified group therapy as a <u>training ground</u> that provided the participants life skills for managing their aggressive behaviours and life situations. This is one of the factors that all the participants (including few that viewed aggression as a label) seemed to agree on. They said that prior to therapy, people often described them 'as trouble-some youths' but therapy helped them put the situation in a better perspective and understand that 'we are just deskilled young people' (Melisa, 449). The skills of communication, reflection, evaluation of cause and effect were mentioned as invaluable for managing their aggressive behaviours and improving their interpersonal relationships. These findings are in line with

previous studies which offered that group therapy can offer members the following dimensions of therapy: relational, reflective, and reparative (Schlapobersky, 2016; Barwick and Weegman, 2017). These studies suggested that the therapeutic relationships in group therapy can assist members to develop reflective understanding of self and others in interactions, consequently, enabling a reparative experience that fosters psychological growth and change. The group therapy, therefore, acted as a secure base for reparation to take place (Ainsworth, 1991; Bowlby, 1969). The group therapy was also said to provide them an environment that is similar in many ways to the ones they live outside therapy, hence, their ability to relate and manage behaviours gave them the confidence to interact with the external world.

The group therapy may, therefore, be described as a 'transitional space' (Winnicott, 1986/1971); an intermediate context between the outside reality and their internal world which is located neither within the self nor in the world (Sandahl, Lindgren, and Herlitz, 2000; Scheinfeld, Rochlen, and Buser, 2011; Tasca et al., 2007). Eleven out of twelve participants offered that group therapy gave them the context to test their learnt skills and exhibit new behaviours before applying it to their external social environment. It also enabled them to learn from the others as they share how they managed their situation. They mentioned that the group members' feedback can sometimes be useful especially when given with tact and constructively. These views corresponded to the previously identified roles of group therapy (Yalom, 1995).

5.2.1.3.2. The participants' experiences/perception of age-specific group therapy

In relation to the age-specific therapy, there were divided opinions among participants. Few participants who had age-specific therapy suggested that their experience of it was good, consequently, would prefer age-specific group therapy. They explained that age-specific group therapy gave them a sense of belonging and normality without the fear of being judged by older member of the group as immature and their views not acknowledged or seen as less important. They reckoned that this type of group therapy reduces the age barrier in needs and therapy goals. Majority of the participants, however, indicated that they attended a mixed group therapy. They were sceptic about the age-specific group therapy and suggested that age-specific therapy would mean propagating the already existing segregation of this age-group. They suggested that their main need is to be included/accepted and respected as adults by the rest of the society *'and not to be boxed into another glorified label'* (Shirida, 233).

From this perspective, the age-specific group therapy would only encourage the replication in therapy the in-group/outgroup fights and authority struggles they experienced outside. This view corresponded with other studies which indicate that there is a higher likelihood of reenacting the 'triangular transferences' of sibling rivalry, jealousy, and envy among age-specific group members than those in open group (Rutan and Stone, 2001). All the participants in the age-specific group acknowledged that sometimes there seemed to be rivalry and feeling of "us versus "them" among members especially when it appeared that the therapist was showing some favouritism. They offered that this, occasionally, stirred up negative emotions

such as anger, envy, jealousy against the favoured ones thereby recapitulating their outside of therapy relational experiences.

The opposing participants also argued that age-specific group does not represent the world/societal reality where there are various age groups that they need to contend with. They reasoned that age-specific therapy would, therefore, offer them false context which cannot be reproduced outside of therapy. They also argued that the age-specific group therapy has the potential of easily becoming very unserious, consequently, nothing much would be learnt. These participants, however, acknowledged that the talks in mixed group could sometimes feel too general. They, therefore, suggested that it would be more beneficial to have mixed group with the needs of each age-group being incorporated in the programme. They explained that the mixed age-groups offered them the opportunity to glean from the wisdom and experiences of the old members as well as the now-experience of their peers.

Reflecting on the opinions of these two groups of perspectives on age-specific group therapy, two key points emerged: stage of development and familiarity factors. With regards to the stage of development, it appeared that those that opted for age-specific group therapy were the younger participants (18 - 19 years) while the older participants (20 - 25 years) in the study opted for a mixed group. The divide among the group could be linked to the stage of their developmental adaptation needs (Armitage and Conner, 2002; Erikson, 1968; Rutter and Quine, 2002). It seemed that the older participants may have gradually started to settle into adulthood and have developed some strategies for coping with life challenges, consequently, do not feel

as much threatened by the society as the younger participants (Arnett, 2000; Hawley, 2007; Heilbron and Prinstein, 2008; Kroger, 2000; Marcia, 1989; Tanti et al., 2011). The second point that emerged was the familiarity factor. Each participant group seemed to approve the experience that they were familiar with and tend to reflect the developmental need 'to belong' (intimacy) which many studies have identified as crucial for the developmental stage of young adulthood (Kroger, 2000; Tanti et al., 2008; Tarrant, 2001).

The higher ratio of participants that favoured mixed group was an interesting finding. One would have thought that the participants' voice in their management would include the need to have statutory transitory treatment system that cater specifically for young adults aged 18 – 25 years. Contrary to this line of thought, the study found that many young adults wished that their needs acknowledged and incorporated in already established management plan. They hoped to be supported and accepted and not isolated or stigmatized by the large society as they transit into adulthood. This finding highlighted the need to allow the young adults to voice their opinion rather than us researchers, therapist or the rest of society assuming full knowledge of their needs.

5.2.2. Research Question 2: What is the Experience, in terms of Common Themes of the Meaning of Aggression and any Changes in their Understanding of it after Group Therapy for Managing their Aggressive Behaviours?

The fourth objective of the study is linked to the research question 2. It aims to identify young adults' pre-therapy perspective on the meaning of aggression and to explore if therapy had any change impact on their perspective. This study found that prior to therapy, the participants had varied understanding of the meaning of aggression. Few participants suggested that the word aggression is *a label and weapon of oppression* embedded in the social norms and values and it is used by people in authority to control the behaviours of the members of the society and punish those that do not conform to the social set rules. The concept of aggression is, therefore, viewed as a power-tool in the hands of few people in authority. This perspective on aggression seemed to align with the Labelling Theorist (social constructionist) view of the concept of aggression which offered that labelling and language are used by society to moderate citizens' behaviours (Gergen, 2009; Persson, 2005).

Some studies showed that labelling can increase the likelihood of people accepting and adapting to the label (Bernburg, 2009; Bernburg, Krohn and Rivera, 2006; Kaufman and Johnson, 2004; Gergen, 2009). Persson (2005) suggested that 'labelling' people aggressive could be either disabling or enabling depending on whether the perpetrators of aggression interpreted the outcome of such behaviour as positive (beneficial) or negative (detrimental). For the young adults in the study, the label was interpreted as negative and was attributed to their feeling of

powerlessness, isolation and low self-esteem. The participants that viewed the concept of aggression as a label maintained that they still hold same belief post-therapy but admitted that in relation to skills training, they have learnt few skills that will help them stay safe during interpersonal conflict. They believe that there is need for social enlightenment on how to accommodate diversity and individuality in the general social norms and values. Though these few participants' perspective on the meaning of aggression remained unchanged, they acknowledge that they lacked the required internal qualities for dealing with difficult situations involving interpersonal conflicts as well as lack the required skills for managing their emotions. The skills that they learnt were, therefore, useful for negotiating social encounters and moderating their emotional state.

For the rest of the participants, they acknowledged the concept of aggression but offered that their aggression was used to achieve specific purpose. They mentioned that they often used aggression as a communication tool 1) to let people know that they are distressed/frustrated, 2) to make people listen and respect them, 3) to demonstrate dominance and authority, and 4) to gain popularity among peers. In this respect, aggression is still a power-tool but now in the hands of the participants against their peers. This is in line with Persson's (2005) assertion that when aggression is viewed as positive or beneficial, perpetrators tend to become more confident in using such behaviours to achieve their desired goals. With regards to change of perspectives, these participants noted that there have been some significant changes in their perspective on aggression after attending therapy. They offered that currently, they believe that aggression could be a means of

communication but there are better and healthier ways of communication. They attributed the change in perspective to their newly acquired knowledge about aggression and the skills on how to better interact with their peers.

The above findings seemed to follow the dichotomy of views among scholars with regards to the meaning of aggression. While few participants' views of aggression as a label align with the label theorists (Bernburg, 2009; Kaufman and Johnson, 2004; Gergen, 2009), the other participants' perspectives resonate with the rest of the scholarly stand which studies that view aggression as concrete concept that requires better understanding and management (Anderson and Bushmann, 2002; Barker et al., 2006; Dodge, Coie, and Lynam, 2006; Farrington, 2003; Fite et al., 2008; Leonard, Quigley and Collins, 2002; Little et al., 2003 etc.). They viewed their aggressive behaviours as communication (power) tool; communicating various things depending on the need and situation at hand. The common theme between these two groups of participants was the *relationship between aggression and use/communication of power*. For earlier group, aggression is *a language – power* in the hands of people-in-authority to control citizens (i.e. a label for control), but for the later group, aggression is *a behavioural/action-oriented – power* in the hands of the actors (self or others): it was viewed as either survival (reactive aggression) or dominance (proactive aggression).

5.3. IMPLICATION OF STUDY: THE RELATIONAL INTEGRATIVE MODEL OF THERAPY

This study found that aggression in young adults is often underscored by a sense of powerlessness. As discussed earlier, the participants' experiences of managing aggressive behaviours after group therapy had moderation – mediation interactive relationships. While powerlessness mediated their aggressive behaviours, the group-therapy moderated both powerlessness and aggressive behaviours. The helpful and unhelpful factors that influenced young people's powerlessness and aggressive behaviours were found to fall into the following three groups: 1) personal factors (P), 2) Social factors (S), and 3) Person – Social interaction (P-S).

Based on the findings in this study, there are three emerging key points in relation to participants' experiences of therapy: 1) what was provided, 2) what they expected/needed, and 3) what should be provided. The findings showed that the group therapies that participants received were more of skills training and reflective practice but little or no exploration of the casual and contextual conditions for their aggressive behaviours. Participants suggested that though skills training and reflective practice provided them the necessary skills for managing their behaviours and the increased awareness of the impact of their behaviours on self and others, these skills and reflective practice did not deal with the background (e.g. relational, societal, childhood, family) problems that often triggered and maintained their aggressive behaviours. They acknowledged that due to the number of members in the group, it may not be possible to deal with all their past problems that led to their current behaviours but they had hoped that some of those deeper issues were addressed in the group therapy to enable them to reconcile with some of the hurts

and pains that often underpinned their behaviours. They also highlighted the need for change in societal attitude towards them and the increased support system as they effect the required behaviour changes. In order to bridge the gap between 'what was provided' and 'what was needed', the relational integrative model of therapy using S.K.I.P.S Framework is proposed.

Just as Thomas (1992) noted, participants in this study commonly seemed to have two binary extremes of conflict – handling modes: 1) '*competition versus collaboration'* or 2) '*avoidance versus accommodation'*. The primary aim of RIMOT using S.K.I.P.S is to empower young adults to develop a conflict – handing mode of *'compromise'* which would enable them to engage in a healthy negotiated (give-and-take) interactions with others. This would be achieved through 1) problem-solving and interpersonal skills training, and 2) self- exploration, reconciliation and reparation processes. The second aim of RIMOT is to create better social awareness of the developmental challenges young adults face, the phenomenon and impacts of aggression and the possibly management. The third aim is to advocate for changes in policies within school and workplace to offer support and professional help to young adults especially those with aggressive behaviours. The S.K.I.P.S model, therefore, addressed the following relational conflicts: Internal (self-to-self) conflicts, external (self-to-others) conflicts, and resource (self-to-adaptation) crisis (Anderson and Bushman 2002; Tedeschi and Felson, 1994).

As an integrative model, S.K.I.P.S is flexible and open to allow therapists draw from variety of theoretical orientations that may be necessary in assisting young adults manage the underlying psycho-social problems as well as their aggressive

behaviours. As a prototype, S.K.I.P.S. model integrates the following theoretical / therapeutic orientations: Humanistic (Person Centred) Theories (Rogers, 1959), Psychodynamic (Psychosocial Learning) Theories (Erikson, 1968/1994), Cognitive Behavioural Theories (Beck et al., 1979), and Public enlightenment theories (Coffman, 2002; Dungan-Seaver, 1999). The theories are discussed below in relation to S.K.I.P.S framework.

The Person Centred Therapy (PCT) is used as a model for creating enabling environment for clients' self-reconciliation and personal growth as well as for establishing therapeutic relationship between the therapist and the group members. With regards to self-reconciliation, Rogers (1951) opined that psychological distresses and their associated presentations are products of dissonance between the individual's organismic self and self-concept. Many of the participants in this study acknowledged that their aggressive behaviours were means of communicating/expressing their internal discord. As noted by many humanistic theories, the discords, disorientation or distortion of self-experience (self – to - self conflict) would if unchecked affect the individuals sense of reality and in turn their ability relate with others (interpersonal conflicts) (Mearns, 2003).

For the management of such dysfunction of self-experience, Rogers (1959) suggested that therapy should be focused on creating caring environment which would enable clients to identify and deal with the possible conditions of worth (attachment injuries) that may have contributed to the distortion of their sense of self. This would help them reconcile with self, consequently, able to effectively employ their organismic valuing process in developing a balanced personal view of

powerlessness which underpinned their behaviours and a better subjective sense of reality of the world around them (Gillon, 2007). To deal with the self-discord in young adults, S.K.I.P.S framework suggests that therapists incorporate into their practice Rogers (1959) core conditions for therapeutic change: empathy, congruence and unconditional positive regards (UPR) (Rogers, 1959).

These core conditions will enable therapists to 1) become more in tune with the reparative needs of the young adults (Mearns, 2003), 2) create a therapeutic environment that allows clients to explore and possibly resolve their internal conflicts without fear of being judged (Feltham and Horton, 2006; Lambert et al., 2002; Mearns, 2003; Woolfe et al., 2010). Clients will be encouraged to rely on their organismic valuing process (an innate regulatory system) and their actualizing tendency (internal motivation) (Rogers, 1961; Schultz and Schultz, 2005). The therapist's Unconditional **P**ositive Regard is viewed to be essential for facilitating clients' ability to re-evaluate the conditions of worth from their significant other (Roger, 1961) and to repair their distorted self-experience (dysfunctional internal working model) (Feeney, Cassidy and Ramos-Marcuse, 2008; Hardy, 2007).

Bearing in mind that UPR refers to the attitude of accepting, prizing, and valuing another, and empathy – the ability to understand other's subjective reality (Gillon, 2007; Lietaer, 2001), therapist's use of self in modeling these core conditions in therapy could be particularly crucial in enabling clients to learn how to exercise these qualities in their relationship with group members and other (Bandura, 1973; McAdams and Foster, 2009). As mentioned earlier, empathy was one of the key personal qualities that most of the participants seemed to lack, hence their continued

aggressive behaviours despite the suffering of their victims. Applying PCT in S.K.I.P.S model will allow clients to **i**mprove their personal qualities such as self-acceptance and self-value/respect as well as provide them opportunity to develop empathy for others.

 The Psychodynamic theories (PD) are used to explore the unconscious processes that perpetuate patterns from past experiences into people's present life situations (Doumen, et al, 2012). Theories such as attachment theory (Bowlby, 1969), mentalization theory (Fonagy, 2003) and developmental adaption theory (Erikson, 1968) have been used to explain these processes and used to show the connections between people's past experiences of relationships on their current relational difficulties. Though many theories have attempted to explain human development and identity wherein link between past and present experiences have been made, Erikson's (1968/1993) concept of identity and development have been viewed as the most general and broad explanation of identity across life span (Ragelienė, 2016). Erikson (1968) suggested that identity is a core organising process which provides people with 1) the sense of relatedness (sameness) with self and between self and others, as well as 2) a frame for uniqueness (autonomy) which differentiates self from others. The theory supposed that the primary tasks of adolescents and young adulthood are to effectively deal with the identity versus role confusion crisis, develop their own unique sense of identity, establish their social connections and maintain meaningful relationship with others (Chen et al, 2007; Ragelienė, 2016).

This current study found that the participants lacked the necessary personal qualities, thus, were unable to execute the required tasks for their developmental

stage. This seemed to result in their constant sense of helplessness and the resultant aggressive behaviours. The **I** in the S.K.I.P.S. focuses on **i**mproving clients' personal qualities which could be done through skills and knowledge acquisition but also through self-discovery. The explorative work using as a guide Erikson's (1968) psychosocial stages can help the therapist and clients collaboratively identify the possible stage that clients' attachment injuries (relational rupture) occurred and the contextual factors that may be influencing clients' current situations (Doumen, et al, 2012). The exploration will enable therapists to incorporate into their therapy the appropriate therapeutic interventions that will address common themes and help young adults achieve some level of emotional adjustment (Dumas et al, 2009), and great emotional stability (Crocetti et al., 2008). This will, in turn allow clients to deal with the stuckness and helplessness associated with their aggressive behaviours. Lack of exploration into the possible contextual and causal conditions for their aggressive behaviours was one of the main factors that participants found unhelpful in the therapy that they received. Integrating developmental adaptation concepts in the therapy would, therefore, offer structure for exploration into past experiences.

Cognitive Behavioural Theories (e.g. CBT) play significant part in the S.K.I.P.S model. The model draws from the following CBT assumptions: 1) people's cognition influences their behaviours and feeling (Beck et al., 1979; Dryden and Branch, 2013), and 2) cognitive inflexibility is the root of people's behavioural and emotional difficulties (Hayes et al., 1999). Dryden and Mytton (2005) explained that cognitive inflexibility could be caused by factors such as lack of adequate resources for making decisions and malfunctioning of the executive functions of the brain. The

integration of CBT into the S.K.I.P.S will provide clients resourceful skills/techniques for managing behavioural problems (e.g. communication and negotiation skills, conflict resolution), and cognitive problems such as negative thoughts and self-doubt (e.g. self-talk, distraction techniques, action-consequence evaluation) (Dryden and Branch, 2013). Through psycho-education, CBT will also provide young people appropriate knowledge regarding aggression and its impact. The knowledge acquired will help young adults to effectively appraise situations and make informed decisions on their line of actions. The skills and knowledge acquisition are represented as **S.** and **K**. in the S.K.I.P.S framework. Most of the participants identified these as crucial and helpful in their behaviour change.

The social awareness campaign (SAC) is the second **S** in the S.K.I.P.S. framework. It serves as a feedback loop in the RIMOT. Social awareness campaign is often grouped into two parts: 1) Individual Behaviour Change Awareness, and 2) Public-Will and Political-Change Awareness (Coffman, 2014; Dungan-Seaver, 1999). The individual behaviour change awareness campaign focuses on effecting change to people's behaviours that lead to social problems and educating them on the behaviours that will improve their personal and social well-being. Much of these functions are already contained in the therapeutic work with clients using different models and approaches. The Public-Will and Political-Change Awareness Campaign focuses on creating public awareness that would motivate policymakers and government officials to take policy actions (Henry and Rivera, 1998). It focuses less on the individual who is performing the behaviour and more on the public's responsibility to do something that will create an environment for change. The social

awareness campaign in S.K.I.P.S, therefore, aims to not only hold the young adults responsible for their behaviour change but also holds the policymakers, parents, and significant others accountable for the policies and standards set out for young adults in various settings (Hopper and Weinberg, 2016).

The campaign includes recommendations for therapists, service managers, people in decision-making positions and other staff in contact with young adults to attend social awareness training as part of their Continuous Professional Development. The public awareness campaign also involves using school's PSHE (Physical, Social, and Health Education) and any organized social events to educate young people on the meaning and impact of aggression on self, others and the society. The campaign focuses on creating awareness of how to identify and respond to aggressive behaviours among peers (Anderson and Bushman, 2002; Anderson and Huesman, 2003) as well as how to provide peer support to the victims of such aggressive behaviours (Cowie and Jennifer, 2008).

5.4. LIMITATIONS OF STUDY AND METHODOLOGY

5.4.1. Limitations to the Study

As mentioned in chapter 3, one of the reasons for choosing a purposeful sampling was to save time spent on data collection (Guest et al., 2006) but it has been critiqued to have the propensity to produce a biased sample (Becker, 1993; Bodgan and Biklen, 2006). Rather than purposive sampling, studies suggested that having a more randomized sampling was a better approach in capturing the nuances of the phenomenon under discussion and the heterogeneity of participants' views (Stark

and Trinidad, 2007). Though there are some level of heterogeneity in the participant group in this study especially with their demographic data, they seemed to have homogeneous high intensity presentation of aggressive behaviours. This may possibly be the reason why they were referred to NHS and not community-based counselling services. This meant that the views of the young adults with medium and low intensity aggressive behaviours would be missed in the study.

Admittedly the participants in the study provided extensive material for this research and are willing to take part in any future study involving aggressive behaviours, during the analysis of data, however, it became clear that the nuances of participants' meaning and management of aggressive behaviours may have been wider had this study been open to centres and organisations outside of the clinical setting. It may, therefore, be worth-the-while for a similar or comparative study to be conducted drawing participants from community-based counselling centres. This could enable spectrum of presentations of aggressive behaviours as well as varied perspectives on meaning and management of aggressive behaviours to be captured.

The second limitation to the study relates to the scope of study. The scope of the study covered only aggressive behaviours that are viewed as problematic to self and society. It, therefore, excluded aggressive behaviours as an attractive attribute in gang-culture among young adults (14 – 25 years). As current studies showed, gang aggression/violence 'is not necessarily a deviant or antisocial act; rather, it is a result of the conflicting narratives between the gang-cultures and the culture-at-large' (Shap, 2014, p.78). Better understanding of these narratives will help therapists in

effecting a longer lasting therapeutic outcome in the management of aggressive behaviours among young adults as well as developing effective care plan which addresses identities, cultures, values instead of problems and punishments (Akiyama, 2012; Bradshaw et al., 2013). More studies on this area will also bring more insight on the how various members of the society (the gangs, law enforcements and community) interpret the behaviours and where their divergent point is located (Shap (2014).

5.4.2. Limitations of the Methodology

Just like other research methodology, grounded theory methodology (GTM) has been shown to have limitations. GTM is described as a very complex and time-consuming methodology due to the tedious coding process and memo writing involved in the analysis (Walker and Myrick, 2006). I initially attempted to cut down on the process by using specialised software for analysing data. I attended the recommended training on how to use qualitative analysis software but the software turned out to be too complex for an amature like me. Substantive time was lost while trying to navigate the software and eventually I had to conduct the coding and analysis of data manually. This could increase biases especially on question of which concepts were selected for integration into the emerging theory. Hence, it may be helpful for training institutes to include in the study of research methods, teaching on how to use software for qualitative analysis. This would remarkedly reduce the time spent on coding data manually.

GTM has also been critiqued for being a subjective process because it relies heavily on a researcher's abilities to conceptualise abstract ideas (Collet-Klingenberg and Kolb, 2011). It also means that the researcher would have to have some level of conceptual ability for him/her to effectively conduct the research. Fortunately, though the use of abstract is still involved, this study followed the methodological guidance of Strauss and Corbin (1998) on data collection and analysis, as a result, embraced the flexibility but rigorous process of generating theory.

5.5. CONCLUSION, RECOMMENDATIONS AND SUGGESTIONS FOR FURTHER STUDIES

5.5.1 CONCLUSION

From the results of the literatures reviewed in this study, it is apparent that there are varied scholarly views regarding meaning and management of aggressive behaviour. These diverse scholarly opinions have been shown to be as a result of the complexities involved in the phenomenon of aggression (Anderson and Bushman, 2002). The complexities in aggression span from its nature, sources, presentation, continuity, to its models and modes of management. This current study was geared to add to the on-going discourse on aggression by investigating perpetrators' perspectives on meaning and management of aggressive behaviours. The overall goal of the study was to identify and describe factors that young adults found helpful and unhelpful in managing their aggressive behaviours following a group therapy.

At the beginning of the project, the study stated the following three main issues: 1) current services available, 2) current sources of information, and 3) model of therapy available. The first issue stated that the services currently available to young people with aggressive behaviours are either CAMHS or AMHS. The study, therefore, explored whether young adult would preferred to have services specifically tailored to them. The result showed that majority of the participants were not in favour of age-specific services, rather, they preferred mix-age group therapy. They reasoned that age-specifc therapy would only propagate the already existing segregation and marginalisation of young people not only in their everyday life but also within the healthcare services. The second stated issue was the current sources of information used in therapy. The review of literature indicated that a large proportion of the resources on meaning and management of aggressive behaviours were based on the report of either the victims or third parties such as therapists, teachers, parents etc. A growing number of studies were also based on the perpetrators' perspectives. There is, however, need for more studies from the aggressors – so as to gain better understanding of these behaviours and be more able to manage them.

This current study found that prior to therapy, participants focus was primarily on the underlying emotion of powerlessness and not on aggressive behaviours. Their aggressive behaviours were, therefore, strategies for managing the powerlessness albeit ineffective. This denotes that for aggressive behaviours in young people to be effectively managed, the mediating emotions (e.g. powerlessness) as well as the casual/contextual conditions will need to be addressed. The effective management of aggressive behaviours among young adults was found, in this current study, to

have a three-prong approach: 1) involvement of professional help through group therapy, 2) personal resilience and commitment to change process, 3) flexibility and tolerance of societal norms/values. The participants, therefore alluded that in addition to holding them responsibility for their actions, the society and people in authority are also to be held accountable for the policies they pass and work with.

The third issue explored was the therapeutic models currently available. Most therapeutic models used in group-therapy were found to be primarily simple model approach where the therapy is either highly CBT based focusing mainly on skills training with little emphasis on the causal/contextual conditions, or its mainly Psychodynamic (explorative) with no skills training. This study found that the aggressive behaviours in young adults were a defective antidote for powerlessness, consequently, the management of these behaviours would require models that can deal with the behaviours through skills and knowledge acquisition as well as deal with the powerlessness through explorative and reparative work targeting the underlying causal and contextual conditions.

The Relational Integrative Model of Therapy (RIMOT) using S.K.I.P.S provides a framework that can be used to bring these two aspects of therapeutic needs into focus. In relation to identity crisis and interpersonal conflicts, Erikson's (1968/1993) theory was viewed as the most general and broad concept for identity across life span (Ragelienė, 2016), hence, it could be used as a structural guide for explorative aspect of the therapeutic work.

5.5.2 RECOMMENDATIONS

The overall goal of this study was to identify and describe young adults' perspectives of helpful and unhelpful factors in the management of their aggressive behaviours, as well as their pre- and post- therapy understanding of the meaning of aggression. Based on the findings from this study, the following recommendations are made:

1. *Effective Therapeutic Model*: Rather than the single model approach to therapy that is currently offered within the clinical setting to clients with aggressive behaviours, an integrative relational model of therapy using framework such as S.K.I.P.S. is recommended. While the CBT provides the helpful skills and knowledge on how to identify and use personal qualities to manage their aggressive behaviours, the explorative models such as Psychodynamic and Person Centred Therapy would provide the needed explorative work into the casual/contextual conditions. While the Person Centred Therapy is focused on creating the therapeutic environment for self-growth (Rogers, 1959) and facilitating the acquisition of empathy (which is found to reduce desire to bully, and increase the desire to protect the victims of bullying) (Gini et al, 2007), the Psychodynamic is focus on exploring the unconscious processes and patterns underpinning the aggressive behaviours. The developmental framework such as Erikson's (1968) identity framework will also provide the structure for the explorative work.

2. *Therapeutic procedural adjustment*: Rather than open-ended therapy which was found to be ineffective and motivated absenteeism, lack of trust and non-progressive work, a closed group with intensity focus on identified group

therapeutic needs is recommended. The closed group would run for the same duration of sixteen week with a group-size of eight and facilitating therapists of two maximum. This will on the long run safe more money than what is currently in offer. If there are many people in the waiting list, another group can be started on another day by same or another set of therapists. The clients would be made to understand the need and benefit of committing to the programme. This would count as part of their self-control and responsibility taking training.

3. *Staff Development*: Lack working-experience of therapists and staff (school or workplace) in managing aggressive behaviours were found to be unhelpful in the management of aggressive behaviours. To further the advancement of aggression management among young adults, these points need to be addressed. Staff training in the form of continuous professional development (CPD) on variety of integrative skills and techniques for effective management of aggressive behaviours in young adults is recommended. Though many therapists have adequate skills training to manage diversity of client issues, CPD training will provide a refresher opportunity to such experienced therapists, but it will also be an opportunity for the less experienced therapists to be equipped with the necessary skills and techniques. For staff at schools and work-place, such CPD training provides them skills on how to identify early signs of aggressive behaviours and how to manage such situations. When planning the CPD training, emphasis need to be placed on 1) the person – social interactional nature of aggression and 2) the possible emotions underpinning such behaviours. These will enable professionals to offer balanced and appropriate help to these young people.

4. *Social flexibility*: Lack of social inclusion and social support system, rigid policies and prejudices against young people were found to be unhelpful. Social reform and public enlightenment campaign on social attitude towards young people as well as local and central government investment into support systems that enhance the psychological health of young adults are recommended. Funds to be made available for schools and community-based counselling services to engage qualified counsellors and psychologists rather than what currently obtains where many schools and community-based counselling services tend to engage mainly the free services of trainees because they do not have the needed funds to invest in things terms extra-curricular activities.

Funding community activities such as mentorship programmes and peer-support group activities are also recommended. The mentorship programme will provide avenue where young adults who had no role-models in their lives could be mentored and they will feel part of a community of respected people. As shown by many studies, this type of high quality relationships with significant others have positive impact on the mental health and psychological wellbeing of young adults and as a result reduce their need to resort to aggressive behaviours as a means of establishing their identity (Chen et al, 2007; Dumas et al, 2009; Walsh et al, 2010). The peer-support group activities such as monitored after school clubs, on the other hand, will provide opportunity for young people to carry out group works and learn team building, communication and conflict resolution skills. It has also been shown that relationship with peers are associated with better mental health of young adults and in turn better adaptation to their environment (La Greca and Harrison, 2005; Yeung and Leadbeater, 2010).

5.5.3. SUGGESTIONS FOR FURTHER STUDIES

1. More emphasis is needed on aggressors' perspective on the aggression and its management. Emphasis may be on the low to medium at-risk young people

2. Future research may also focus on service provision – how best to meet the needs of the young adult population at the grassroots level, with a view of reaching low to medium at-risk young people within the community before it gets to the intensity seem within the clinical setting.

3. More studies are also needed on the impact of staff training and experience in the management of aggressive behaviours in young adults. This could include therapists, teachers, people in authority and others in decision-making positions.

4. Finally, there is a need for more international research collaboration to improve management of aggressive behaviours and produce more evidence – based knowledge on best practice.

REFERENCES

Abelson, R. (1981). Psychological status of the script concept. *American Psychologist,* 36, 715 – 729

Ackerman, S., and Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clin. Psychol. Rev.* 23, 1–33.

Aiken, L., and West, S. (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park, CA: Sage.

Ainsworth, M. (1991). Attachments and other affectional bonds across the life cycle. In C. Parkes, J. Stevenson-Hinde, and P. Marris (Eds.), Attachment across the life cycle. London: Routledge.

Ainsworth, M., Blehar, M., Waters, E. and Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Ajzen, I. (1985). From intentions to actions: A theory of planned behaviour. In Kuhl, J. & Beckman, J. (Eds.) *Action-control: From Cognition to Behaviour*. Heidelberg, Germany, Springer.

Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behavior and Human Decision Processes*, 50, 179-211.

Ajzen, I., and Fishbein, M. (1975). *Belief, Attitude, Intention and Behaviour: An introduction to theory and research*. Reading, Mass: Addison-Wesley.

Ajzen, I., and Madden, T. (1986). Prediction of goal-directed behaviour: Attitudes, intentions and perceived behavioural control. *Journal of Experimental Social Psychology*, 15, 173-189.

Akiyama, C. (2012). Understanding youth street gangs. *Journal of Emergency Nursing*, 38 (6), 568-70.

Allemand, M., Steiger, A., and Fend, H. (2015). Empathy development in adolescence predicts social competencies in adulthood. *J Pers.,* 83 (2), 229-41.

Allen, J., Fonagy, P., and Bateman, A. (2008). *Mentalizing in Clinical Practice*. Washington, DC: American Psychiatric Publishing.

Allen, J., Marsh, P., McFarland, C., McElhaney, K., Land, D., Jodl, K., and Peck, S. (2002). Attachment and autonomy as predictors of the development of social skills and delinquency during mid-adolescence. *Journal of Consulting and Clinical Psychology*, 70(1), 56–66.

Allen, J., Porter, M., McFarland, C., McElhaney, K., and Marsh, P. (2007). The Relation of attachment security to adolescents' paternal and peer relationships, depression, and externalizing behavior. *Child Development*, 78(4), 1222–1239

American Academy of Paediatrics (2011). *Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home*, 182 - 200

Anderson, C. (1983). Imagination and expectation: the effect of imagining behavioural scripts on personal intentions. *Journal of Personality and Social Psychology,* 45, 293–305

Anderson, C., and Bushman, B. (2002). Human Aggression. *Annual Review of Psychology*, 53 (1), 27 – 51.

Anderson, C. and Carnagey, N. (2004). Violent evil and the general aggression model. In A. Miller (Ed.). *The Social Psychology of good and evil*. New York: Guilford.

Anderson, C., and Dill, K. (2000). Video games and aggressive thoughts, feelings, and behaviour in the laboratory and in life. *Journal of Personality and Social Psychology*, 78, 772 – 790.

Anderson, C. and Godfrey S. (1987). Thoughts about actions: the effects of specificity and availability of imagined behavioural scripts on expectations about oneself and others. *Soc. Cogn.,* 5, 238 – 258.

Anderson C. and Huesmann, I. (2003). Human Aggression: A Social – Cognitive View. In M. Hogg & J. Cooper. *The Sage Handbook of Social Psychology*. Thousand Oak CA: Sage.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research*, 6, 379-393.

Annells, M. (1997a). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, 4(2), 120-129.

Annells, M. (1997b). Grounded theory method, part II: Options for users of the method. *Nursing Inquiry*, 4(3), 176-180.

Archer, J. (1991). The influence of testosterone on human aggression. British Journal of psychology, 82 (1), 1–28.

Archer, J. (2004). Sex Differences in Aggression in Real-World Settings: A Meta-Analytic Review. *Review of General psychology*, 8 (4), 291–322.

Archer, J., and Coyne, S. M. (2005). An integrated review of indirect, relational, and social aggression. *Personality and Social Psychology Review*, 9(3), 212-230.

Archer, J., and Webb, I. (2006). The relation between scores on the Buss-Perry Aggression Questionnaire and aggressive acts, impulsiveness, competitiveness, dominance, and sexual jealousy. Aggressive Behavior, 32, 464-473.

Archer, M., Bhaskar, R., Collier, A., Lawson, T., and Norrie, A. (1998). *Critical Realism: Essential Readings*, London: Routledge

Archer, S. (1989). The status of identity: reflections on the need for intervention. *Journal of Adolescence*, 12, 345–359

Armitage, C. and Conner, M. (2001). Efficacy of the Theory of Planned Behaviour: a meta-analytic review. *British Journal of Social Psychology*, 40, 471-99.

Arnett, J. (2000). Emerging Adulthood: A theory of development from the late teens through the twenties. American Psychologist, 55(5), 477.

Arnett, J. (2006). Emerging adulthood: Understanding the new way of coming of age. In J. J. Arnett & J. L. Tanner (Eds.), Emerging adults in America: Coming of age in the 21st century. Washington, DC: American Psychological Association

Artinian, B., Giske, T., and Cone, P. (2009) *Glaserian grounded theory in nursing research: Trusting emergence.* New York, NY: Springer Publishing.

Babbie, E. (1997). *The Practice of Social Research.* Belmont, CA: Wadsworth Publishing Company

Baert, P. (1998). *Social theory in the twentieth century*. New York: New York University Press.

Baldry, A., and Farrington, D. (2000). Bullies and delinquents: Personal characteristics and parental styles. Journal of Community and Applied Social Psychology, 10, 17-31.

Bandura, A. (1973). Aggression: A social learning analysis. Oxford: Prentice-Hall.

Bandura, A. (1991a). Self-regulation of motivation through anticipatory and self-reactive mechanisms. In R. A. Dienstbier (ed.), Nebraska symposium on motivation: Vol. 38. Perspectives on motivation. Lincoln: University of Nebraska Press.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman & Co.

Bandura, A., Ross, D., and Ross, S. (1961). Transmission of aggression through the imitation of aggressive models. *Journal of Abnormal and Social Psychology*, 63, 575-582

Bandura, A., and Walters, R. (1966). *Adolescent aggression*. New York: Rowland.

Barker, E., Oliver, B., and Maughan, B. (2010). Co-occuring problems of early onset persistent, childhood limited, and adolescent onset conduct problem youth. *Journal of Child Psychology and Psychiatry*, 51, 1217–1226.

Barker, E., Seguin, J., White, H., Bates, M., Lacourse, E., Carbonneau, R., et al. (2007). Developmental trajectories of male physical violence and theft: Relations to Neurocognitive Performance. *Archives of General Psychiatry*, 64, 592–599.

Barker, E., Tremblay, R., Nagin, D., Vitaro, F., and Lacourse, E. (2006). The development of male proactive and reactive aggression in adolescence. *Journal of Child Psychology*, 47, 783–790

Barkley, R. (2001). The executive functions and self-regulation: an evolutionary neuropsychological perspective. Neuropsychology Review, 11,1 – 29.

Barry, T. and Lochman, J. (2004). Aggression in Adolescents: Strategies for Parents and Educators. National Association of School Psychologists, 4, 1 – 4.

Barwick, N., and Weegman, M. (2017). *Group therapy: A group – analytic approach*. London: Routledge.

Baumeister, R., Heatherton, T., and Tice, D. (1994). *Losing control: How and why people fail at self-regulation*. San Diego, CA: Academic Press

Bateman, A., and Fonagy, P. (2004). Psychotherapy for borderline personality disorder. Mentalisation-based treatment. Oxford: University Press.

Bateman, A., and Fonagy, P. (2008). Comorbid antisocial and borderline personality disorders: Mentalization-based treatment. *Journal of Clinical Psychology*, 64(2), 181–194.

Bateman, A., and Fonagy, P. (2012). Antisocial Personality Disorder. In A.W. Bateman and P. Fonagy (Eds.). Handbook of Mentalizing in Mental Health Practice. Arlington: American Psychiatric Publishing

Beaver, K., Shutt, J., Boutwell, B., Ratchford, M., Roberts, K., and Barnes, J. (2009) Genetic and environmental influences on levels of self-control and delinquent peer affiliation: results from a longitudinal sample of adolescent twins. *Criminal Justice Behaviour,* 36, 41-60

Beck, A., Emery, G., and Greenberg, R. (1985). *Anxiety Disorders and Phobias: A Cognitive Perspective.* New York: Basic Books.

Beck, A., Rush, J., Shaw, B., and Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Becker, P. (1993). Common pitfalls in published grounded theory research. *Qualitative Health Research,* 3(2), 254-260.

Becker-Stoll, F. (2002). *Bindung und Psychopathologie im Jugendalter.* In B. Strauss, A. Buchheim & H. Kächele (Eds.), Klinische Bindungsforschung. Stuttgart: Schattauer.

Bednar, R., and Kaul, T. (1994). Experimental group research: Can the cannon fire. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 631-663). New York: Wiley.

Beebe, L. (2007). What Can We Learn from Pilot Studies? *Perspectives in Psychiatric Care*, 43 (4), 213–18

Benoliel, J. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research,* 6(3), 406-428.

Berkowitz, L. (1969). The frustration- aggression hypothesis revisited. in L. Berkowitz (Ed.), *Roots of aggression: A re-examination of the frustration - aggression Hypothesis.* New York: Atherton Press.

Berkowitz, L. (2001). *Affect, Aggression and Antisocial Behavior*. In R. Davidson, K. Scherer and H. Goldsmith. Oxford: Oxford University Press.

Bernburg, J. (2009). Labeling theory. In: M. Krohn, A. Lizotte and G. Hall (eds.), *Handbook on Crime and Deviance* (187-207). Springer Science+Business Media

Bernburg, J., and Krohn, M. (2003). Labeling, life chances, and adult crime: The direct and indirect effects of official intervention in adolescence on crime in early adulthood. *Criminology,* 41, 1287-1318.

Bernburg, J., Krohn, M., and Rivera, C. (2006). Official labeling, criminal embeddedness, and subsequent delinquency: A longitudinal test of labeling theory. *Journal of Research in Crime and Delinquency*, 43, 67 – 88.

Beutler, L., Malik, M., Alimohamed, S., Harwood, T., Talebi, H., Noble, S., et al. (2004). Therapist variables. In Bergin and Garfield (eds*.), Handbook of Psychotherapy and Behavior Change*. New York, NY: Wiley.

Bhaskar, R. (1975). *A Realist Theory of Science.* Leeds: Leeds Books.

Bhaskar, R. (1998). Philosophy and Scientific Realism. In M. Archer, R. Bhaskar, A. Collier, T. Lawson, and A. Norrie (eds.). *Critical Realism: Essential Readings.* London: Routledge.

Birks, M., and Mills, J. (2011). *Grounded theory: A practical guide*. Los Angeles, CA: Sage.

Björkqvist, K., Lagerspetz, K., and Kaukiainen, A. (1992). Do girls manipulate and boys fight? Developmental trends in regard to direct and indirect aggression. *Aggressive Behavior*, 18, 117-127.

Birks, M., Chapman, Y., and Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, 13, 68-75.

Birks, M., and Mills, J. (2015). *Grounded Theory: A Practical Guide*. London: Sage.

Blaikie, N. (2007). *Approaches to Social Inquiry*. Cambridge: Polity.

Blair, J. (2008). Empathic dysfunction in psychopathy. In C. Sharp, P. Fonagy and I. Goodyer (Eds.), *Social cognition and developmental psychopathology*. Oxford: Oxford University Press.

Blair, R. (2005). Responding to the emotions of others: dissociating forms of empathy through the study of typical and psychiatric populations. *Conscious Cogn*, 14 (4), 698-718.

Blodgett, C. S. (2008). *A grounded theory study of the process of accessing information on the World Wide Web by people with Mild Traumatic Brain Injury* (PhD). The University of Nebraska - Lincoln, Ann Arbor.

Blood, E., and Neel, R. (2007). From FBA to implementation: A look at what is actually being delivered. *Education and Treatment of Children*, 30 (4), 67-80

Blumer, H. (1962). Society as Symbolic Interaction. In A. M. Rose. *Human Behavior and Social Process: An Interactionist Approach*. Houghton-Mifflin.

Blumer, H. (1969). *Symbolic Interactionism; Perspective and Method*. Englewood Cliffs, NJ: Prentice-Hall.

Blumstein, A., and Cohen, J. (1987). Characterizing criminal careers. *Science*, 237, 985-991

Bobadilla, L., Wampler, M., and Taylor, J. (2012). Proactive and Reactive Aggression are Associated with Different Physiological and Personality Profiles. *Journal of Social and Clinical Psychology*, 31, 5, 458-487.

Bogdan, R. and Biklen, S. (2006). *Qualitative research for education: An introductory to theory and methods* (5th ed.). Needham Heights, MA: Allyn and Bacon.

Bogdan, R. and Biklen, S. (2003). *Qualitative research for education: An introduction to theories and methods* (4th ed.). New York: Pearson Education Group.

Bowman, L. and Fine, M. (2000). Client perceptions of couple's therapy: The helpful and unhelpful aspects. *American journal of Family Therapy, 28* (4), 295-310.

Bor, W., Najman, J., O'Callaghan, M., Williams, G., and Anstey, K. (2001). Aggression and the development of delinquent behaviour in children. *Australian Institute of Criminology: Trends & Issues in Crime and Criminal Justice*, Australian Institute of Criminology.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-Child Attachment and Healthy Human Development.* New York: Basic Books

Bowlby, J. (1988). *A Secure Base. Clinical Applications of Attachment Theory.* Routledge: London.

Bowlby, J. (2002). Bindung: Historische Wurzeln. In G. Spangler & P. Zimmermann

(Eds.), *Die Bindungstheorie: Grundlagen, Forschung und Anwendung* (pp. 17–26). Stuttgart: Klett-Kotta

Bradshaw, C., Waasdorp, T., Goldweber, A. and Johnson, S. (2013). Bullies, gangs, drugs, and school: understanding the overlap and the role of ethnicity and urban city. *Journal of Youth and Adolescence*, 42 (2), 220-34.

Brendgen, M., Vitaro, F., Boivin, M., Dionne, G., and Pérusse, D. (2006). Examining genetic and environmental effects on reactive versus proactive aggression. *Developmental Psychology*, 42(6), 1299-1312

Brendgen, M., Vitaro, F., Tremblay, R. and Lavoie, F. (2001). Reactive and proactive aggression: Predictions to physical violence in different contexts and moderating effects of parental monitoring and caregiving behavior. *Journal of Abnormal Child Psychology,* 29, 293–304.

Bretherton, I., and Munholland, K. (2008). Internal working models in attachment relationships: Elaborating a central construct in Attachment Theory. In J. Cassidy and P. Shaver (Eds.), *Handbook of Attachment* (pp. 103–129). New York: Guilford Press.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, C. T. Hendrix, T. Reid, and C. Jenny (Eds). *The APSAC handbook on child Maltreatment* (2nd ed.). Newbury Park, CA: Sage

British Psychological Society (2006b). *Code of ethics and conduct.* Leicester: The British Psychological Society.

Brock, D., Marek, L., Matteo-Kerney, C., and Bagby, T. (2013). Open Groups: Adaptations in Implementing a Parent Training Program. *Health Promotion Perspectives,* 3 (2), 230-241

Brocki, J., and Wearden, A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21(1), 87-108.

Bryan, J. (2005). Fostering educational resilience and achievement in urban schools through school-family-community partnerships. *Professional School Counseling*,

8(3), 219-228.

Bryant, A. (2009). Grounded theory and pragmatism: The curious case of Anselm Strauss. *Forum: Qualitative Social Research*, 10 (3).

Bryant, A., and Charmaz, K. (eds.) (2007). *The Sage Handbook of Grounded Theory*. London: Sage.

Bryman, A. (2001). *Social Research Methods*. New York: Oxford University Press.

Budman, S., Soldz, S., Demby, A., Feldstein, M., Springer, T., & Davis, M. (1989).

Cohesion, alliance, and outcome in group therapy. *Psychiatry*, 52, 339–350.

Burlingame, G., Fuhriman, A., McRoberts, C., Hoag, M., & Anderson, E. (1995).

Group psychotherapy efficacy: A meta-analytic review. In A. Fuhriman (Chair),

Group psychotherapy efficacy: A meta-analytic perspective. Symposium

Burr, V. (2003). *Social Constructionism.* London: Routledge.

Burt, S. (2009). Are there meaningful etiological differences within antisocial

behavior? Results of a meta-analysis. *Clinical Psychology Review*, 29, 163–178.

Burt, S., Donnellan, M., Iacono, W., and McGue, M. (2011). Age-of-onset or

Behavioral Sub-types? A Prospective Comparison of Two Approaches to

Characterizing the Heterogeneity within Antisocial Behavior. *Journal of Abnormal Child Psychol.*, 39(5), 633–644.

Burt, S., and Hopwood, C. (2010). A comparison of two different approaches to

characterizing the heterogeneity within antisocial behavior: Age-of-onset versus

behavioral sub-types. *Journal of Personality Disorders*, 24, 272–283.

Bushman, B., and Anderson, C. (2001). Is it time to Pull the Plug on the Hostile

Versus Instrumental Aggression Dichotomy? *Psychological Review*, 108, 273 – 279.

Bushman, B., and Baumeister, R (1998). Threatened Egotism, Narcissism, Self-Esteem, and Direct and Displaced Aggression: Does Self-Love or Self-Hate Lead to Violence? *Journal of Personality and Social Psychology*, 75 (1), 219 – 229.

Butler, G., Fennell, M., and Hackmann A. (2008). *Cognitive behavioral therapy for anxiety disorders: Mastering clinical challenges*. New York: Guilford Press.

Campbell, A. (1999). Staying alive: Evolution, culture and women's intra-sexual aggression. *Behavioral and Brain Sciences*, 22, 203–252.

Campbell, S. (1995). Behaviour problems in preschool children: A review of recent research. *Journal of Child Psychology and Psychiatry*, 36 (*1)*, 115-119.

Card, N., Stucky, B., Sawalani, G., and Little, T. (2008). Direct and indirect aggression during childhood and adolescence: A meta-analytic review of gender differences, intercorrelations, and relations to maladjustment. *Child Development*, 79, 1185–1229.

Carlson, S., Mandell, D., Williams, L. (2004). Executive function and theory of mind: stability and prediction from ages 2 to 3. *Dev Psychol.*, 40, 1105–1122.

Carrillo, M., Ricci, L., Coppersmith, G., and Melloni, R. (2009). The effect of increased serotonergic neurotransmission on aggression: A critical meta-analytical review of preclinical studies. *Psychopharmacology,* 205(3), 349–368.

Cartwright, D., and Zander, A. (1970). *Group Dynamics: Research and Theory (3rd ed.)*. London: Tavistock Publications.

Caspi, A. (2000). The child is father of the man: Personality continuities from childhood to adulthood. *Journal of Personality and Social Psychology*, 78, 158–172.

Caspi, A., and Moffitt, T. (1991). Individual differences are accentuated during periods of social change: The sample case of girls at puberty. *Journal of Personality and Social Psychology*, 61, 157-168

Cavell, T., Henington, C., Hughes, I., and Thompson, B. (1998). The role of relational aggression in identifying aggressive boys and girls. *Journal of School Psychology,* 36,457-477.

Chamberlain-Salaun, J., Mills, J., and Usher, K. (2013). Linking Symbolic Interactionism and Grounded Theory Methods in a Research Design: From Corbin and Strauss' Assumptions to Action. *Sage Open,* 1 – 10.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin and Y. Lincoln (eds.). *Handbook of qualitative research*. Thousand Oaks, CA:

Sage.

Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In J. Gubrium and J. Holstein (eds.). *Handbook of Interview Research: Context and Method*. London: Sage.

Charmaz, K. (2003). Grounded theory - Objectivist and constructivist methods. In N. Denzin and Y. Lincoln (eds.). *Strategies of qualitative inquiry*. London: Sage

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.

Charmaz, K. (2008). Grounded Theory. In J. A. Smith (ed.). *Qualitative psychology: A practical guide to research methods*. Los Angeles: SAGE

Charon, J. (2007). *Symbolic interactionism: An introduction, an interpretation, an integration*. Upper Saddle River, NJ: Prentice Hall.

Chassman, L., Kottler, J., and Madison, J. (2010). An exploration of counselor experiences of adolescents with sexual behavior problems. *Journal of Counseling and Development*, 88, 269–276.

Chen, K., Lay, K., Wu, Y., and Yao, G. (2007). Adolescent self-identity and mental health: The function of identity importance, identity firmness, and identity discrepancy. *Chinese Journal of Psychology*, 49, 53–72.

Cherek, D., Moeller, F., Dougherty, D., and Rhoades, H. (1997). Studies of violent and nonviolent male parolees: II. Laboratory and psychometric measurements of impulsivity. *Biological Psychiatry*, 41, 523–529.

Cheung, S., and Sun, S. (2000). Effects of self-efficacy and social support on the Mental health conditions of mutual-aid organization members. *Social Behavior and Personality*, 28, 413-422.

Cheung, S., and Sun, S. (2001). Helping processes in a mutual aid organization for persons with emotional disturbance. International. *Journal of Group*

Psychotherapy, 51, 295–308

Chiovitti, R., and Piran, N. (2003). Rigour and grounded theory research. *Journal of Advanced Nursing*, 44 (4), 427-435.

Chiricos, T., Barrick, K., Bales, W., and Bontrager, S. (2007). The labeling of convicted felons and its consequences for recidivism. *Criminology*, 45, 547-581.

Chon, K. (2000). Towards an improved understanding of anger: A control theory approach. *Korean Journal of Health Psychology*, 5, 146 - 170

Corbin, J., and Strauss, A. (1990). Grounded Theory Research: Procedures, Canons, and Evaluative Criteria. *Qualitative Sociology*, 13 (1) 3 – 21.

Corbin, J., and Strauss, A. (2008). *The basics of qualitative research* (3rd ed.) Los Angeles, CA: Sage

Cochran, J., Wood, P., Sellers, C., Wilkerson, W., and Chamlin, M. (1998). Academic dishonesty and low self-control: An empirical test of a general theory of crime. *Deviant Behavior*, 19, 227–255.

Cohen. D., and Nisbett, R. (1994). Self-protection and the culture of honour: Explaining southern violence. *Personality and Social Psychology Bulletin*. 20, 551-567

Coie, J., and Dodge, K. (1998). Aggression and antisocial behavior. In W. Damon & N. Eisenberg (Eds.), *Handbook of child psychology: Social, emotional, and personality development*. Toronto: Wiley.

Coie, J., Dodge, K., Terry, R., and Wright, V. (1991). The role of aggression in peer relations: An analysis of aggression episodes in boys' play groups. *Child Development,* 62, 812–826

Collet-Klingenberg, L., and Kolb, S. (2011). Secondary and transition programming for 18-21-year-old students in rural Wisconsin. *Rural Special Education Quarterly*,

30(2), 19-27.

Cook, K., James, M., and Lee, R. (2006). *Law Matters Publishing*. Exeter, UK: Core statutes on criminal law.

Corey, G. (1990). *Theory and Practice of Group Counseling*. California: Brooks/Cole.

Couvillon, M., Bullock, L., & Gable, R. (2009). Tracking behavior assessment methodology and support strategies: A national survey of how schools utilize functional behavioral assessments and behavior intervention plans. *Emotional & Behavioural Difficulties,* 14(3), 215-228.

Cowger, C. (1979). Conflict and Conflict Management in Working with Groups. *Social Work with Groups,* 2, 309 – 320.

Cowie, H. (2012*). From Birth to Sixteen: Children's Health, Social, Emotional and Linguistic Development.* London: Routledge.

Cowie, H. and Jennifer, D. (2008). *New Perspectives on Bullying.* Berkshire: Open University Press.

Crabb, P. (2000). The material culture of homicidal fantasies. *Aggressive Behavior*, 26, 225–234.

Creswell, J. (2007). *Qualitative Inquiry and research design: Choosing among five approaches.* Thousand Oaks: Sage

Creswell, J., and Miller, D. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-131.

Crick, N., and Dodge, K. (1994). A review and reformulation of social information-processing mechanisms in children's social adjustment. *Psychological Bulletin,* 115, 74-101.

Crick, N., and Grotpeter, J. (1995). Relational Aggression, Gender and Social – Psychological Adjustment. *Child Development*, 66 (7), 10 – 22.

Crick, N., Ostrov, J., and Kawabata, Y. (2007). Relational aggression and gender: An overview. In D. J. Flannery, A. T. Vazsonyi, & I. D. Waldman (Eds.), *The*

Cambridge handbook of violent behavior and aggression. New York, NY: Cambridge University Press

Crick, N., Ostrov, J., and Werner, N. (2006). A longitudinal study of relational aggression, physical aggression, and children's social-psychological adjustment. *Journal of Abnormal Child Psychology*, 34(2), 131-142.

Crocetti, E., Rubini, M., Luyckx, K., Meeus, W. (2008). Identity formation in early and middle adolescents from various ethnic groups: From three dimensions to five statuses. *Journal of Youth and Adolescence*, 37, 983–996.

Crockett, M., Clark, L., Tabibnia, G., Lieberman, M., and Robbins, T. (2008). Serotonin modulates behavioral reactions to unfairness. *Science*, 320, 1739

Crone, D., & Horner, R. (2003). *Building positive behavior support systems in schools*. New York, NY: Guilford Press.

Crotty, M. (1996). *Phenomenology and nursing research*. Melbourne: Churchill Livingston.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* London: Sage.

Dabbs, J., Jurkovic, G., and Frady, R. (1991). Salivary testosterone and cortisol among late adolescent offenders. *Journal of Abnormal Child Psychology*, 19(4), 469–478.

Dadds, M., Hunter, K., Hawes, D., Frost, A., Vassallo, S., Bunn, P., …El Masry, Y. (2008). A measure of cognitive and affective empathy in children using parent ratings. *Child Psychiatry and Human Development*, 39, 111-122.

Dalal, F. (2001). The social unconscious: a post-Foulksian perspective. *Group Analysis,* 34 (4), 539–55.

Daly, M., and Wilson, M. (1990). Killing the competition: Female/female and male/male homicide. *Human Nature*, 1, 81–107.

Dancey, C., and Reidy, J. (2011). *Statistics without Maths for Psychology.* Harlow: Pearson Education Limited.

Dattilio, F., and Freeman A. (2003). *Cognitive Therapy with Children and Adolescents*. New York: Guilford Press,

Dattilio, F., and Freeman A. (2007). *Cognitive-behavioral strategies in crisis*

intervention. New York: Guilford Press

Davis, E., and Marler, C. (2003). The progesterone challenge: steroid hormone changes following a simulated territorial intrusion in female Peromyscus californicus. *Horm. Behav.,* 44, 185 – 198

Day, D., Bream, L., and Paul, A. (1992). Proactive and reactive aggression: An Analysis of Sub-types based on teacher perceptions. *Journal of Clinical Child Psychology*, *21*, 210 – 217.

Deater-Deckard, K., Sewell, M., Petrill, S., and Thompson, L. (2010). Maternal working memory and reactive negativity in parenting. *Psychological Science*, 21, 75 –79.

Decety, J. (2010). The Neurodevelopment of Empathy in Humans. *Developmental NeuroScience,* 32 (4) 257–267.

Decety, J., and Jackson, P. (2004). The functional architecture of human empathy. *Behav Cogn Neurosci Rev.*, 3, 71–100.

Decety, J., Michalska, K., Akitsuki, Y., and Lahey, B. (2009). Atypical empathic responses in adolescents with aggressive conduct disorder: A functional MRI investigation. *Biological Psychology*, 80(2), 203–211.

Decety, J., Michalska, K.. (2010). Neurodevelopmental changes in the circuits underlying empathy and sympathy from childhood to adulthood. *Developmental Science*, 13 (6), 886-99

Deci, E., and Ryan, R. (1985b). *Intrinsic motivation and self-determination in human behavior.* New York: Plenum.

Deci, E., and Ryan, R. (1995). Human autonomy: The basis for true self-esteem. In M. Kernis (Ed.), *Efficacy, agency, and self-esteem*. New York: Plenum.

Deci, E., and Ryan, R. (2000). The ''what'' and ''why'' of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11, 227–268

Deklyen, M., and Greenberg, M. (2008). Attachment and psychopathology in childhood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment. Theory, reserach, and clinical applications*. New York: Guilford

Dellasega, C., and Nixon, C. (2003). *Girl wars: 12 strategies that will end female bullying.* Michigan: Touchstone

Del Vecchio, T., and O'Leary, K. (2004). Effectiveness of anger treatments for

specific anger problems: A meta-analytic review. *Clinical Psychology Review,* 24, 15-34.

Denzin, N. (2004). The art and politics of interpretation. In N. K. Denzin & Y. S. Lincoln (eds.). *Collecting and interpreting qualitative materials*. Thousand Oaks, CA: Sage.

Denzin, N., and Lincoln, Y. (2003). *The landscape of qualitative research: Theories and issues* (2nd ed.). Thousand Oaks, CA: Sage.

Denzin N., and Lincoln Y. (2005). Introduction: The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (eds.). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.

Dewey, J. (1938). *Logic: The theory of Inquiry*. NY: Holt, Rinehart, & Winston.

Dew, I. (1999). *Grounding Grounded Theory: Guidelines for Qualitative Inquiry.* Bingley, UK: Emerald

DeWall, C., Anderson, C., and Bushman, B. (2011). The general aggression model: Theoretical extensions to violence. *Psychology of Violence*, 1, 245–258.

DeWall, C., Baumeister, R., Stillman, T., and Gailliot, M. (2007). Violence restrained: Effects of self-regulation and its depletion on aggression. *Journal of Experimental Social Psychology*, 43, 62–76

DeWall, C., Finkel, E., and Denson, T. (2011). Self-control inhibits aggression. *Social and Personality Psychology Compass*, 5, 458–472.

De Wied, M., Goudena, P., and Matthys, W. (2005). Empathy in boys with disruptive behavior disorders. *Journal of Child Psychology and Psychiatry*, 46, 867-880.

Dey, I. (1993). *Qualitative Data Analysis: A User-Friendly Guide for Social Scientists*. London: Routledge.

Dies, R., and Teleska, P. (1985). Negative outcome in group psychotherapy. In D. Mays and C. Franks (eds.). *Negative Outcome in Psychotherapy*. New York: Springer.

Dodge, K. (1991). The structure and function of reactive and proactive aggression. In D. Pepler and K. Rubin (eds.). *The development and treatment of childhood aggression.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Dodge, K., Coie, J., Pettit, G., and Price, J. (1990). Peer status and aggression in boys' groups: Developmental and contextual analyses. *Child Development*, *61*, 1289 –1309.

Dodge, K., Coie, J., and Lynam, D. (2006). Aggression and antisocial behavior in youth. In W. Damon & R. Lerner, & N. Eisenberg (eds.). *Handbook of child psychology: Social, emotional, and personality development*. New York: Wiley.

Dodge, K., and Crick, N. (1990). Social Information-Processing Bases of Aggressive Behavior in Children. *Personality and Social Psychology Bulletin*, 16, 8 – 22.

Dodge, K., Lochman, J., Harnish, J., Bates, J., and Pettit, G. (1997). Reactive and proactive aggression in school children and psychiatrically impaired chronically assaultive youth. *Journal of Abnormal Psychology*, 106, 37 – 51.

Dodge, K., and Newman, R. (1981). Biased decision-making processes in aggressive boys. *Journal of Abnormal Psychology*, 90, 375-379.

Dollard, J., Miller, N., Doob, L., Mowrer, O., and Sears, R. (1939). *Frustration and Aggression.* New Haven: Yale University Press.

Doumen, S., Smits, I., Luyckx, K., Duriez, B., Vanhalst, J., Verschueren, K., Goossens, L. (2012). Identity and perceived peer relationship quality in emerging adulthood: The mediating role of attachment-related emotions. *Journal of Adolescence*, 35,1417–1425.

Dreier, O. (2008). *Psychotherapy in everyday life*. New York: Cambridge University Press.

Dryden, W. (2015). *How to help your client get the most out of CBT: A Therapist's Guide.* London: Routledge

Dryden, W., and Branch, R. (2012). *The CBT Handbook. London: Sage*

Dryden, W., and Mytton, J. (2005). *Four Approaches to Counselling and Psychotherapy*. London: Routledge.

Dumas, T., Lawford, H., Tieu, T., Pratt, M. (2009). Positive parenting and its relation to identity status in young adulthood: A longitudinal study. *Developmental Psychology*, 45,1531–1544.

Eagly, A., Wood, W., and Diekman, A. (2000). Social role theory of sex differences and similarities: A current appraisal. In T. Eckes & H. M. Trautner (Eds.), *The developmental social psychology of gender.* Mahwah, NJ: Erlbaum.

Edwards, J., and Lambert, L. (2007). Methods for integrating moderation and mediation: A general analytical framework using moderated path analysis. *Psychological Methods,* 12, 1-22.

Eisner, E. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice.* New York, NY: Macmillan Publishing Company.

Eisenberg, N., and Eggum, N. (2009). Empathic responding: sympathy and personal distress. In: Decety J, Ickes W, editors. *The Social Neuroscience of Empathy.* Cambridge: MIT Press.

Elekonich, M., Wingfield, J. (2000). Seasonality and hormonal control of territorial aggression in female song sparrows. *Ethology*, 106, 493 – 510

Ellis, M., Weiss, B., and Lochman, J. (2009). Executive functions in children: associations with aggressive behavior and appraisal processing. *Journal of Abnormal Child Psychology*, 37, 945–956

Elliott, D., Huizinga, D., and Ageton, S. (1985). *Explaining delinquencies and drug use.* Beverly Hill, CA: Sage.

Elliott, J. and Place, M. (2004). *Children in Difficulty: A Guide to Understanding and Helping.* London: RoutledgeFarmer.

Elliott, R. (2010). Psychotherapy change process research: realizing the promise. *Psychotherapy Research*, 20 (2), 123-135.

Elliot, R. (2012). Qualitative Methods for Studying Psychotherapy Change Processes. In Thompson and D. Harper (Eds.), *Qualitative research methods in mental health & psychotherapy: An introduction for students & practitioners*. Chichester, UK: Wiley-Blackwells

Elliott, R. (1996). *Client Change Interview Schedule. Unpublished Research Instrument* Department of Psychology, University of Toledo.

Elliott, R., Bohart, A., Watson, J., and Greenberg, L. (2011). Empathy. *Psychotherapy*, 48 (1), 43-49.

Elliott, R., Slatick, E., and Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D. L. Rennie (eds.), *Qualitative psychotherapy research: Methods and methodology*. Lengerich, Germany: Pabst Science

Epstein, J. (2001). *School, Family, and Community Partnerships: Preparing Educators and Improving Schools.* Boulder, CO: Westview Press

Erikson, E. (1963). *Youth: Change and challenge.* Basic books.

Erikson, E. (1964). *Insight and Responsibility.* New York: Norton and Company.

Erikson, E. (1993). Childhood and society. New York: Norton and Company

Erikson, E. (194). *Identity: Youth and Crisis.* New York: Norton and Company.

Eron, L., and Huesmann, L. (1984). The control of Aggressive Behavior by Changes in Attitudes. Values, and the Conditions of Learning. In R. Blanchard and D. Blanchard (Ed.). *Advances in the study of Aggression.* Orlando: Academic Press.

Esterberg, K. (2002). *Qualitative methods in social research.* Boston, MA: McGraw-Hill.

Farber, B., Berano, K., and Capobianco, J. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51,* 340-346.

Farrington, D. (1996). *Understanding and Preventing Youth Crime.* London: York Publishing Service.

Farrington, D. (2003). Key results from the first 40 years of the Cambridge Study in Delinquent Development. In Thornberry T. P. & Krohn, M.D. (Eds.) *Taking Stock of Delinquency: An Overview of Findings from Contemporary Longitudinal Studies.* New York: Kluwer/Plenum.

Farrington, D. (2007). Childhood risk factors and risk-focused prevention. In M. Maguire, R. Morgan and R. Reiner (eds.). The Oxford handbook of criminology. Oxford, UK: Oxford University Press.

Farrington, D., and Coid, J. (2003). *Early prevention of adult antisocial behaviour.* Cambridge: Cambridge University Press.

Farrington, D., Gallagher, B., Morley, L., St. Ledger, R. and West D. (1988a). A 24 year follow-up of men from vulnerable backgrounds. In Jenkins, R. L. and Brown, W. K. (Eds.). *The Abandonment of Delinquent Behaviour: Promoting the Turnaround.* New York: Praeger.

Farrington, D., Gallagher, B., Morley, L., St. Ledger, R. and West, D. (1988b). Are there any successful men from criminogenic backgrounds? *Psychiatry*, 51, 116–130.

Fassinger, R. (2005). Paradigms, praxis, problems, and promise: grounded theory in counseling psychology research. *Journal of Counseling Psychology*, 52, 156 – 166.

Feeney, B., Cassidy, J., and Ramos-Marcuse, F. (2008). The generalization of attachment representations to new social situations: predicting behavior during initial interactions with strangers. *Journal of Personality and Social Psychology*, 95(6), 1481–1498.

Feltham, C. and Horton, I. (2006). *The SAGE Handbook of Counselling and Psychotherapy* (Eds.). London: Sage.

Fergusson, D., Horwood, L., and Ridder, E. (2005). Show me a child at seven: consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology and Psychiatry*, 46, 837– 49.

Filstead, W. (1979). Qualitative methods: A needed perspective in evaluation research. In T. D. Cook & C. S. Reichardt (Eds.), *Qualitative and quantitative methods in evaluation research.* Beverly Hills, CA: Sage.

Fishbein, M., and Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Fite, P., Colder, C., Lochman, J., and Wells, K. (2008). Developmental trajectories of proactive and reactive aggression from fifth to ninth grade. *Journal of Clinical Child and Adolescence,* 37, 412–421.

Fives, C., Kong, G., Fuller, J., and DiGiuseppe, R. (2011). Anger, aggression, and irrational beliefs in adolescents*. Cognitive Therapy and Research*, 35, 199-208

Fleetwood, S. (1999). Situating Critical Realism in Economics. In S. Fleetwood (ed.). *Critical Realism in Economics*. London: Routledge.

Floody, O. (1993). Hormones and Aggression in Female Mammals. In B. B. Svare (ed.). *Hormones and Aggressive behaviour*. US: Springer

Fonagy, P., Bateman, A., and Luyten, P. (2012). Introduction and Overview. In A.W. Bateman and P. Fonagy (Eds.). *Handbook of Mentalizing in Mental Health*

Practice. Arlington: American Psychiatric Publishing

Fonagy, P., Gergely, G., Jurist, E., and Target, M. (2002). *Affect regulation, mentalization and the development of self*. New York: Other Press.

Fonagy, P., Gergely, G., and Target, M. (2007). The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology & Psychiatry*, 48, 288–328.

Foucault, M. (1977). *Discipline and Punish*. New York: Pantheon

Foucault, M. (1980). Two Lectures. *In Colin Gordon (ed.). Power/Knowledge: Selected Interviews*. New York: Pantheon.

Foucault, M. (1991). *Discipline and Punish: the birth of a prison*. London: Penguin.

Fox, N. (2009). *Using interviews in a research project.* The NIHR RDS for the East Midlands

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M., and Grimshaw, J. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, 25, 229–1245.

Frey, L., Botan, C., and Kreps, G. (2000). *Investigating Communication: An Introduction to Research Methods*. Boston: Allyn and Bacon.

Frost, N. (2011). *Qualitative Research Methods in Psychology: combining core approaches*. London: Open University Press.

Fuhriman, A., and Burlingame, G. (1990). Consistency of matter: A comparative analysis of individual and group process variables. *The Counseling Psychologist*, 18, 6-63

Fuhriman, A., and Burlingame, G. (1994b). *Handbook of group psychotherapy*. New York: Wiley.

Fung, A. (2008). *Group Intervention Programs for Proactive Aggressors and Aggressive Victims in Secondary Schools: Research, Assessment, and Practice*. Hong Kong: Project Care.

Fung, A., and Wong, J. (2007). *Group intervention programs for reactive aggressors and passive victims*. Hong Kong: Project Care.

Geen, R. (2001). *Human Aggression. Buckingham*: Open University Press.

Gentile, D., Coyne, S., and Walsh, D. (2011). Media violence, physical aggression, and relational aggression in school-age children: A short-term longitudinal study. *Aggressive Behavior*, 37, 193-206.

Gentile, D., Groves, C., and Gentile, J. (2013). The general learning model: Unveiling the learning potential from video games. In F. C. Blumberg (Ed.), *Learning by playing: Frontiers of video gaming in education*. New York, NY: Oxford University Press.

George, C., and West, M. (2008). *Adult Attachment Projective Picture System*. Unpublished manuscript. Mills college, Oakland, CA.

Gerdes, K., Segal, E., and Lietz, C. (2010). Conceptualising and measuring empathy. *British Journal of Social Work*, 40, 2326-2343.

Gergen, K. (2013). *An invitation to Social Construction*. London: Sage.

Ghanbari-Hashemabadi, B., Maddah-Shoorcheh, R. and Maddah-Shoorcheh, E. (2014). The Effectiveness of Integrative Group Therapy on Improving Problem-Solving Skills. *Zahedan Journal of Research in Medical Sciences*, 16(5), 1-5

Gibbs, G. (2002). *Qualitative data analysis: Explorations with NVivo*. Buckingham and Philadelphia: Open University Press.

Gibbs, J., Giever, D., and Martin, J. (1998). Parental management and self-control: An empirical test of Gottfredson and Hirschi's general theory. *Journal of Research in Crime and Delinquenc*y, 35, 40–70.

Gibson, B., Gregory, J. and Robinson, P. (2005). The intersection between systems theory and grounded theory: The emergence of the grounded systems observer. *Qualitative Sociology* Review, 1, 2

Giddens, A. (1990). *The consequences of modernity*. Cambridge: Polity.

Gilbert, D., Fiske, S., and Lindzey, G. (1998). *The Handbook of Social Psychology*. Oxford: Oxford University Press.

Gillon, E. (2007). *Person-Centred Counselling Psychology. London: Sage*

Gini, G., Albiero, P., Benelli, B., and Altoè, G. (2007). Does empathy predict adolescents' bullying and defending behavior? *Aggressive Behavior*, 33, 1467-1476.

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological

method as a qualitative research procedure. *Journal of Phenomenological Psychology*, 28, 235- 260.

Giorgi, A. (2011). IPA and science: A response to Jonathan Smith. *Journal of Phenomenological Psychology*, 42, 195-216.

Glaser, B. (1978). *Theoretical Sensitivity.* Mill Valley, CA: Sociology Press

Glaser, B. (1992). *Emergence V Forcing Basics of Grounded Theory Analysis.* Mill Valley, CA: Sociology Press

Glaser, B. (1998). *Doing grounded theory: Issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B. (2002). Constructivist Grounded Theory? (Online Journal) *Forum Qualitative Sozialforschung. Forum: Qualitative Social Research*, *3*(3) [47 para]. Retrieved Jan, 2016, from the World Wide Web: http://www.qualitative-research.net/index.php/fqs/article/view/825/1792

Glaser, B., and Strauss, A. (1967). *Discovery of grounded theory: Strategies for qualitative research.* Hawthorne, NY: Aldine

Glenn, A., Raine, A., Schug, R.., Gao, Y., and Granger, D. (2011). Increased

testosterone-to-cortisol ratio in psychopathy. *J Abn. Psychology*, 120(2), 389–399.

Golmaryami, F., and Barry, C. (2010). The associations of self-reported and peer reported relational aggression with narcissism and self-esteem among adolescents in a residential setting. *J Clinical Child and Adolescent Psychology*, 39, 128-133.

Gottfredson, M., and Hirschi, T. (1990). *A general theory of crime.* Stanford, CA: Stanford University Press

Goulding, C. (1998). Grounded theory: The missing methodology on the interpretivist agenda. *Qualitative Market Research: An International Journal*, 1(1), 50-57

Goulding, C. (2001). Grounded theory: A magical formula or a potential nightmare. *The Marketing Review*, 2(1), 21-33

Goulding, C. (2005). Grounded theory, ethnography and phenomenology: A comparative analysis of three qualitative strategies for marketing research. *European Journal of Marketing*, 39, (3/4) 294-309.

Green, D., and Price, D. (2016). *Multiple Perspectives in Persistent Bullying: Capturing and listening to young people's voices.* London: Routledge

Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004.* London: Palgrave.

Greenberg, M. (1999). Attachment and psychopathology in childhood. In J. Cassidy and P. Shaver (eds.). *Handbook of Attachment.* New York: Guilford

Greenstein, T. (2006). *Methods of family research.* Thousand Oaks, CA: Sage.

Griffin, R., and Gross, A. (2004). Childhood bullying: Current empirical findings and future directions for research. *Aggression and Violent Beh.*, 9, 379 – 400.

Groger, L., and Mayberry, P. (1999). What we didn't learn because of who would not talk to us. *Qualitative Health Research*, 9(6), 829-835.

Grossmann, K., and Grossmann, K. (2004). Bindungen. Das Gefüge psychischer Sicherheit. Stuttgart, Klett-Cotta.

Guardian (2016) https://www.theguardian.com/politics/2016/jun/24/young-remain-voters-came-out-in-force-but-were-outgunned).

Guerra, N., and Huesmann, R. (2004). A Cognitive-Ecological Model of Aggression. *Review of International Social Psychology*, 17 (2), 177-203

Guest, G., Bunce, A., and Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59-82.

Halberstadt, A., Denham, S. and Dunsmore, J. (2001). Affective social competence. *Social Development*, 10, 79–119.

Hallberg, L. (2006). The "core category" of grounded theory: Making constant comparison. *Inter. J. Qualitative Studies on Health and Well-being*, 1, 141–148.

Hardeman, W., Johnston, M., Johnston, D., Bonetti, D., Wareham, N. and

Kinmonth, A. (2002). Application of the Theory of Planned Behaviour in Behaviour Change Interventions: A Systematic Review. *Psychology & Health*, 17, 123-158

Hardy, L. (2007). Attachment theory and reactive attachment disorder: theoretical perspectives and treatment implications. *J Child Adolesc Psychiatr*, 20 (1), 27-39.

Harpaz, N. (1994). Failures in group psychotherapy: the therapist variable. *International Journal of Group Psychotherapy*, 1994 (44), 3–19

Harter, S. (1998). The development of self-representations. In N. Eisenberg (Ed.), Social, emotional, and personality development (5th ed.). *Handbook of child Psychology.* New York: John Wiley

Hartley, D., Roback, H., and Abramowitz, S. (1976). Deterioration effects in encounter groups. *American Psychology*; 31, 247–255

Hawes, D., Brennan, J., and Dadds, M. (2009). Cortisol, callous-unemotional traits, and pathways to antisocial behavior. *Cur opi. psyc.*, 22(4), 357–362

Hawley, P. (2007). Social dominance in childhood and adolescence: Why social competence and aggression may go hand in hand. In P. H. Hawley, T. D. Little, and P. C. Rodkin (Eds.) *Aggression and Adaptation: The Bright Side to Bad Behavior*. New Jersey: Lawrence Erlbaum

Hayes, A. (2013). *Introduction to mediation, moderation, and conditional process analysis.* New York: Guilford Press.

Hayes, S., Strosahl, K., and Wilson, K. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford

Heath, H., and Cowley, S. (2004). Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies,* 41, 141–150.

Heidegger, M. (1962). *Being and Time*. Translated by John Macquarrie & Edward Robinson. London: SCM Press.

Heilbron, N., and Prinstein, M. (2008). A review and reconceptualization of social aggression: Adaptive and maladaptive correlates. *Clinical Child and Family Psychology Review*, 11(4), 176-217.

Henretty, J., Levitt, H. and Mathews, S. (2008). Clients' experiences of moments of sadness in psychotherapy: a grounded theory analysis. *Psychotherapy Research*, 18(3), 243–255.

Hill, J., Fonagy, P., Lancaster, G., and Broyden, N. (2007). Aggression and intentionality in narrative responses to conflict and distress story stems: an investigation of boys with disruptive behaviour problems. *Attachment and Human Development,* 9 (3), 223–237.

HM Government (2005). *Securing the future: The UK Government Sustainable Development Strategy.* London, HM Government.

Hoag, M., and Burlingame, G. (1997). Evaluating the effectiveness of child and adolescent group treatment: A meta-analytic review. *Journal of Clinical Child Psychology,* 26, 234-246.

Hofmann, S. (2011). *An Introduction to Modern CBT: Psychological Solutions to Mental Health Problems. Chichester*. UK: Wiley-Blackwell.

Holmes, E. and Kivlighan, J. (2000). Comparison of Therapeutic Factors in Group and Individual Treatment Processes. *Journal of Counseling Psychology, 4*, 478-484.

Holton, J. (2008). Grounded Theory as a General Research Methodology. *Grounded Theory Review: An International Journal*, 2, (7)

Hood, A. and Johnson, R. (1997). *Assessment in counseling: A guide to psychological assessment procedures* (2nd ed.). Alexandria, VA: American Counseling Association

Hopper, E. (1996). The social unconscious in clinical work. *Group*, 20 (1), 7–42.

Hopper, E. (2002). The social unconscious: a post-Foulkesian perspective. *Group Analysis*, 35 (2), 333–35.

Hopper, E., and Weinberg, H. (2016). *The social unconscious in persons, groups, and societies: mainly foundation matrices*. London: Karnac

Hornsey, M., Dwyer, L., Oei, T., and Dingle, G. (2009). Group processes and outcomes in group therapy: Is it time to let go of cohesiveness? *International Journal of Group Psychotherapy*, 59(2), 267-278.

Howarth, C., and Street, C. (2000). *Sidelined: Young Adults' Access to Services. London*, New Policy Institute.

Hu, J., Zhang, Z., Shen, W., and Azhar, S. (2010). Cellular cholesterol delivery, intracellular processing and utilization for biosynthesis of steroid hormones. *Nutrition & Metabolism,* 7 (47), 1 – 25.

Hubbard, J., Dodge, K., Cillessen, A., Coie, J., and Schwartz, D. (2001). The dyadic nature of social information processing in boys' reactive and proactive aggression. *Journal of Personality and Social Psychology*, 80, 268–280.

Huesmann, L. (1988). An information processing model for the development of aggression. *Aggressive Behavior, 14*, 13–24.

Huesmann, L., Dubow, E., Eron, L., and Boxer, P. (2006). Middle childhood family-contextual and personal factors as predictors of adult outcomes. In: Huston AC, Ripke MN (eds.) *Developmental Contexts in Middle Childhood: Bridges to Adolescence and Adulthood.* Cambridge, UK: Cambridge University Press.

Huesmann, L., Dubow, E., Eron, L., and Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictor of Life Outcomes: Implications for the Adolescent-Limited and Life-Course-Persistent Models. *Aggressive Behavior*, 35, 136–149.

Huesmann, L., Eron, L., and Dubow, E. (2002). Childhood predictors of adult criminality: Are all risk factors reflected in childhood aggressiveness? *Crim Behav Ment Health*, 12,185–208.

Huesmann, L., Eron, L., Lefkowitz, M., and Walder, L. (1984). Stability of aggression over time and generations. *Developmental Psychology*, 20, 1120–1134.

Huizinga, D., and Henry, K. (2008).The effect of arrest and justice system sanctions on subsequent behavior: Findings from longitudinal and other studies. In A.M. Liberman (Ed.), *The Long view of crime: A synthesis of longitudinal research*. New York: Springer.

Humfress, H., O'Connor, T., Slaughter, J., Target, M., and Fonagy, P. (2002). General and relationship-specific models of social cognition: explaining the overlap

and discrepancies. *Journal of Child Psychology and Psychiatry*, 43(7), 873–883.

Hyde, J. (1984). How large are gender differences in aggression? A developmental meta-analysis. *Developmental Psychology*, 20 (4), 722-736.

Jackson, T. (2005). Motivating Sustainable Consumption: a review of evidence on consumer behaviour and behavioural change. *Sustainable Development Research Network.*

Johnson, J., Burlingame, G., Olsen, J., Davies, D., and Gleave, R. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of Counseling Psychology*, 52, 310–321

Jones, M., and Alony, I (2011). Guiding the Use of Grounded Theory in Doctoral Studies – An Example from the Australian Film Industry. *International Journal of Doctoral Studies*, 6, 95 – 114.

Jones, R., and Noble, G. (2007). Grounded theory and management research: a lack of integrity? *Qualitative Research in Organizations and Management*, 2, (2), 84-96.

Jurist, E. (2005). Mentalized Affectivity. Psychoanalytic Psychology, 22(3), 426–444

Kalat, J. (1998). *Biological psychology* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Kassinove, H., and Tafrate, R. (2002). *Anger Management: The complete treatment guidebook for practitioners*. California: Impact Publishers

Kaufman, J., and Johnson, C. (2004). Stigmatized individuals and the process of identity. *The Sociological Quarterly*, 45,807-833

Kellish, A. (2014). *Leadership Styles of Clinical Coordinators and Clinical Instructors in Physical Therapy Clinical Education*. Seton Hall University Dissertations and Theses (ETDs).

Kelly, B. (2007). Methodological Issues for Qualitative Research with Learning Disabled Children. *Internal Journal of Social Research Methodology*, 10 (1), 21–35.

Kendall, P., Aschenbrand, S., and Hudson, J. (2003). Child-focused treatment of anxiety. In A. Kazdin (ed.). *Evidence-Based Psychotherapies for Children and Adolescents*. New York: Guilford

Kendall, P., Chu, B., Pimentel, S., and Choudhury, M. (2000). Treating anxiety disorders in youth. In P. Kendall (ed.). *Child and Adolescent Therapy: Cognitive Behavioral Procedures*. New York: Guilford.

Kennedy, A., and Sawyer, S. (2008). Transition from paediatric to adult services: are we getting it right? *Curr. Opin. Pediatr*, 20(4):403-409.

Kivlighan, D., Coleman, M., & Anderson, D. (2000). Process, outcome, and methodology in group counseling research. In S. D. Brown & R. W. Lent (Eds.), *The assessment of psychotherapy outcome*. New York: Wiley.

Kivlighan, D., and Holmes, S. (2004). The importance of therapeutic factors. In J. DeLuciaWaack, D. Gerrity, and M. Riva (Eds.), *Handbook of counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Kivlighan, D., and Tarrant, (2001). Does group climate mediate group leadership – group member outcome relationships? A test of Yalom'shypothesis about leadership priorities. *Group Dynamics: Theory, Research, and Practice*, 5,220 – 234.

Klein, A., Markowitz, J., Rothbaum, B., Thase, M., Fisher, A., and Kocsis, J. (2013). The Relationship between the Therapeutic Alliance and Treatment Outcome in Two Distinct Psychotherapies for Chronic Depression*. Journal of Consulting and Clinical Psychology,4*, 627-638.

Kline, F., Adrian, A., and Spevak, M. (1974). Patients Evaluate Therapists. *General Psychiatry*, 31, 113 – 117.

Kochanska, G., Murray, K., and Harlan, E. (2000). Effortful control in early childhood: Continuity and change, antecedents, and implications for social development. *Developmental Psychology*, 36, 220–232

Kozarić-Kovacić, D. (2008). Integrative psychotherapy. *Psychiatr Danub*, 20(3), 352-63.

Kroger, J. (2000). *Identity development: Adolescence through adulthood*. Thousand Oaks, CA: Sage.

Krueger, R., Caspi, A., Moffitt, T., White, J., and Stouthamer-Loeber, M. (1996).

Delay of gratification, psychopathology, and personality: Is low self-control specific to externalizing problems? *Journal of Personality*, 64, 107–129

Kuepper, Y., Alexander, N., Osinsky, R., Mueller, E., Schmitz, A., Netter, P., et al. (2010). Aggression—interactions of serotonin and testosterone in healthy men and women. *Behavioural Brain Research*, 206(1), 93–100.

Kumpulainen, K., and Rasanen, E. (2000). Children involved in bullying at elementary and school age: Their psychiatric symptoms and deviance in adolescence. *Child Abuse & Neglect,* 24, 1567-1577.

Lagerspetz, K., Björkqvist, K., and Peltonen, T. (1988). Is indirect aggression typical of females? Gender differences in aggressiveness in 11- to 12-year-old children. *Aggressive Behavior*, 14, 403– 414.

La Greca, A., and Harrison, H. (2005). Adolescent peer relations, friendships, and romantic relationships: Do they predict social anxiety and depression*? Journal of Clinical Child and Adolescent Psychology*, 34, 49–61.

Lambert, M. (2013). Therapist effects. Findings and methods. In M. J. Lambert (ed.), Handbook of Psychotherapy and Behavior Change. New York, NY: John Wiley & Sons).

Lambert, M., and Barley, D. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy* 38, 357–361.

Lambert, M., and Bergin, A. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.

Lambert, M., Whipple, J., Smart, D., Vermeersch, D., Nielsen, S., and Hawkins, E. (2001). The effects of providing therapists with feedback on client progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49–68.

Lambert, M., Whipple, J., Vermeersch, D., Smart, D., Hawkins, E., Nielsen, S., and Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology and Psychotherapy*, 9, 91–103.

Lancaster, G.., Dodd, S., and Williamson, P. (2004). Design and Analysis of Pilot Studies: Recommendations for Good Practice. *Journal of Evaluation in Clinical Practice,* 10 (2), 307–12

Lane, R., and Garfield, D. (2005). Becoming aware of feelings: Integration of

cognitive developmental, neuroscientific and psychoanalytic perspectives. *Neuropsychoanalysis*, 7, 5–30.

Langer, E. (1975). The Illusion of Control. *Journal of Personality and Social Psychology,* 32(2), 311 - 328

Larke, I., and Beran, T. (2006). The relationship between bullying and social skills in primary school students. *Issues in Educational Research*,16, 38–51.

Larrivee, B. (2008). Meeting the Challenge of Preparing Reflective Practitioners. *The New Educator*, 4(2), 87—106.

Larson, J., and Lochman, J. (2002). *Helping schoolchildren cope with anger: A cognitive behavioral intervention.* New York: Guilford.

Laucht, M., Brandeis, D., and Zohsel, K. (2014). Gene-environment interactions in the etiology of human violence. *Current Top Behavioural Neuroscience*, 17, 267 – 295.

Le Breton, D. (2008). *L'Interactionnisme symbolique [Symbolic interactionism].* Paris, France: Quadrige/Puf.

Leonard, K., Quigley, B., and Collins, R. (2002). Physical aggression in the lives of Young adults: Prevalence, location, and severity among college and community samples. *Journal of Interpersonal Violence,* 17, 533–550.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, 4 (3), 324 – 327.

Levenson, R., and Ruef, A. (1992). Empathy: A physiological substrate. *Journal of Personality and Social Psychology*, 63, 234-246.

Levers, M. (2013). Philosophical Paradigms. G*rounded Theory, and Perspectives on Emergence. SAGE Open*, 1-6.

Lieberman, M. (1980) Growth groups in the 1980s. In *Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis*. A. Fuhriman and G. Burlingame. New York: Wiley.

Lieberman, M. and Golant, M. (2002). Leader behavior as perceived by cancer patients in professionally directed support groups and outcomes. *Group Dynamics: Theory, Research, and Practice*, 6, No. 4, 267–276

Lieberman, M., Yalom, I., and Miles, M. (1973). *Encounter Groups: First Facts*. New York: Basic Books.

Lightdale, J., and Prentice, D. (1994). Rethinking sex differences in aggression: Aggressive behaviour in the absence of social roles. *Personality and Social Psychology Bulletin*, 20, 34–44.

Lincoln, Y., and Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications, Inc.

Little, T., Jones, S., Henrich, C., and Hawley, P. (2003). Disentangling the "whys" from the "whats" of aggressive behavior. *International Journal of Behavioral Development*, 27, 122–133.

Llorca-Mestre, A., Malonda-Vidal, E., and Samper-Garcia, P. (2017). Prosocial reasoning and emotions in young offenders and non-offenders Prosocial reasoning and emotions in delinquent and non-delinquent adolescents. *The European Journal of Psychology Applied to Legal Context*, 9 (2), 65-73

Lochman, J., Boxmeyer, C., Powell, N., Barry, T., and Pardini, D. (2010). Anger control training for aggressive youth. In A.E. Kazdin & J.R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Publications.

Locke, L., Spirduson, W., and Silverman, S. (2000). *Proposals that Work: A Guide for Planning Dissertations and Grant Proposals.* Thousand Oaks, CA: SAGE.

Loeber, R., Pardini, D., Homish, D., Wei, E., Crawford, A., Farrington, D., et al. (2005). The prediction of violence and homicide in young men. *Journal of Consulting and Clinical Psychology, 73*, 1074–1088.

Longa, C. (2011). Social Aggression in Children and Adolescents: A Meta-Analytic Review. *Open Access Dissertations*. Paper 625.

Longshore, D., and Turner, S. (1998). Self-control and criminal opportunity: Cross-sectional test of the general theory of crime. *Criminal Justice and Behavior*, 25, 81–98.

MacKenzie, K. (1990) *Time-Limited Group Psychotherapy.* Washington, DC: American Psychiatric Press.

Makinen, J., and Johnson, S. (2006). Resolving attachment injuries in couples using emotionally focused therapy: steps toward forgiveness and reconciliation. *J Consult Clin Psychol., 74 (6), 1055-64.*

Malle, B. (2011). Attribution Theories: How People Make Sense of Behavior. In D.

Chadee (ed.), *Theories in social psychology*. Blackwell: Wiley

Marcia, J. (1987). The identity status approach to the study of ego identity development. In T. Honess, and K. Yardley (Eds.), *Self and identity: Perspectives across the lifespan.* London: Routledge & Kegan Paul.

Marsee, M., Childs, K., Frick, P., Fassnacht, G., Kunimatsu, M., and Lau, K. (2011). Assessing the Forms and Functions of Aggression Using Self-Report: Factor Structure and Invariance of the Peer Conflict Scale in Youths. *Psychological Assessment*, 23 (3), 792– 804.

Marsee, M., and Frick, P. (2007). Exploring the cognitive and emotional correlates to proactive and reactive aggression in a sample of detained girls. *Journal of Abnormal Child Psychology*, 35, 969 –981.

Marsee, M., and Frick, P. (2010). Callous-unemotional traits and aggression in youth. In W. Arsenio & E. Lemerise (Eds.), *Emotions, aggression, and morality in children: Bridging development and psychopathology*. Washington, DC: American Psychological Association.

Marsh, R., Hicks, J., and Bink, M. (1998). Activation of completed, uncompleted, and partially completed intentions. *J. Exp. Psychol. Learn,* 24, 350 – 361

Masten, A., Burt, K., Roisman, G., Obradovic´, J., Long, J., and Tellegen, A. (2004). Resources and resilience in the transition to adulthood: Continuity and change. *Development and Psychopathology*, 16, 1071–1094

Maxwell, J. (1996). Qualitative Research Design: An Interactive Approach. Thousand Oaks, California: Sage Publications

Mayer, J., and Timms, N. (1970). *The Client Speaks*. London: Routledge & Regan Paul.

McAdams, C., Foster, V., Dotson-Blake, K., and Brendel, J. (2009). Dysfunctional Family Structures and Aggression in Children: A Case for School-Based, Systemic Approaches with Violent Students. *Journal of School Counseling*, 7 (9)

McAdams, C., and Lambie, G. (2003). The changing face of youth aggression in schools: Its impact and implications for school counselors. *Preventing School Failure*, 47, 122–130.

McAdams, C., and Schmidt, C. (2007). How to help a bully: Recommendations for counseling the proactive aggressor. *Professional School Counseling*, 11(2), 120 –

128.

McCluskey, U. (2002). The dynamics of Attachment and Systems-Centered Group Psychotherapy. *Group Dynamics: Theory, Research, and Practice, 6*,131-142.

McEvoy P., and Richards D. (2003). Critical realism: A way forward for evaluation research in nursing? *Journal of Advanced Nursing*, 43, 411 – 420.

McGuire, J. (2005). Social problem solving: basic concepts, research and applications. In McMurran M, McGuire J, (eds). *Social problem-solving and offending: evidence, evaluation and evolution.* Chichester, UK: Wiley

McGuire, J. (2008). A review of effective interventions for reducing aggression and violence. *Phil. Trans. R. Soc. B.*, 363, 2577–2597.

McLeod, J. (2011). *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

McRoberts, C., Burlingame, G. and Hoag, M. (1998). Comparative Efficacy of Individual and Group Psychotherapy: A Meta-Analytic Perspective. *Group Dynamics: Theory, Research, and Practice*, 2 (2),101-117

Mead, H. (1934*). Mind, Self, and Society: From the Standpoint of a Social Behaviorist.* Charles W. Morris (ed.), with an Introduction. Chicago: University of Chicago Press.

Mead, G. (1959). *The philosophy of the present*. La Salle, IL: The Open Court Company.

Mearns, D. (2003). *Developing Person-Centred Counselling.* London: Sage

Mearns, D., and Copper, M. (2005). *Working at Relational Depth in Counselling and Psychotherapy.* London: Sage.

Mearns, D., and Thorne, B. (2002). *Person-Centred Counselling in Action*. London: Sage

Mehta, P., and Beer, J. (2010). Neural mechanisms of the testosterone–aggression relation: The role of orbitofrontal cortex. *Journal of Cognitive Neuroscience*, 22(10), 2357–2368.

Mehta, P., Jones, A., and Josephs, R. (2008). The social endocrinology of dominance: Basal testosterone predicts cortisol changes and behavior following

victory and defeat. *Journal of Personality and Social Psychology*, 94(6), 1078–1093.

Mehta, P., and Josephs, R. (2010). Testosterone and cortisol jointly regulate dominance: Evidence for a dual-hormone hypothesis. *Hormones and Behavior*, 58(5), 898–906.

Melia, K, (1996). Rediscovering Glaser. *Qualitative Health Research*, 6 (3), 368-373.

Meysamie, A., Ghalehtaki, R., Ghazanfari, A., Daneshvar-fard, M., and Mohammadi, M. (2013). Prevalence and Associated Factors of Physical, Verbal and Relational Aggression among Iranian Preschoolers. *Iran Journal of Psychiatry*, 8 (3), 138-14.

Michie, S., Van Stralen, M. and West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6.

Mikulincer, M., and Shaver, P. (2007). *Attachment in Adulthood: Structure, Dynamics, and Change*. New York: Guilford.

Miles, M., and Huberman, A. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks, CA: Sage.

Miller, N. (1941). The frustration-aggression hypothesis. *Psychological Review*, 48, 337-342.

Miller, R., and Mason, S. (2013). Open-ended and Open-door Treatment Groups for Young People with Mental Illness. *Social Work Groups*, 35(1), 50–67.

Milliken, P., and Schreiber, R. (2012). Examining the nexus between grounded theory and symbolic interactionism. *International Journal of Qualitative Methods*, 11, 684-696.

Mills, J., Bonner, A., and Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5, 25-35.

Millon, T. (1991). Classification in psychopathology: Rationale, alternatives,

and standards. *Journal of Abnormal Psychology*, 100, 245-261

Moffitt, T. (1993). Adolescent-limited and life-course persistent antisocial behavior: A developmental taxonomy. *Psychological Review*, 100, 674 –701.

Moffitt, T. (2003). Life-course persistent and adolescence-limited antisocial behavior: A research review and a research agenda. In B. Lahey, T. Moffitt, A. Caspi, (eds.). *The causes of conduct disorder and serious juvenile delinquency*. New York: Guilford.

Moffitt, T., Caspi, A., Harrington, H., Milne, B. (2002). Males on the life-course persistent and adolescence-limited antisocial pathways: Follow-up at age 26. *Development and Psychopathology*,14, 179–207.

Moffitt, T., Caspi, A., Rutter, M., and Silva, P. (2001). *Sex Differences in Antisocial Behaviour*. Cambridge, UK: Cambridge University Press.

Montoya, E., Terburg, D., Bos, P. et al. (2012). Testosterone, cortisol, and serotonin as key regulators of social aggression: A review and theoretical perspective. M*otivation and Emotion*, 36, 65 – 73.

Morgan, S. (2013). Social Pedagogy within Key Worker Practice: Community Situated Support for Marginalised Youth. *The International Journal of Social Pedagogy,* 2 (1),17 – 32.

Morrow, G., Andrews, P., Hickock, J. et al. (2002). Fatigue associated with cancer and its treatment. *Supportive Care in Cancer,* 10 (5), 389-398.

Morrow, S. and Smith, M. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal of Counseling Psychology*, 42(1), 24 – 33.

Munro, S., Lewin, S., Swart, T. and Volmink, J. (2007). A review of health behaviour theories: how useful are these for developing interventions to promote long-term medication adherence for TB and HIV/AIDS? *Bmc Public Health*, 7.

Murphy, A. (1959). Introduction. In A. Murphy (Ed.), *Philosophy of the present*. La

Salle, IL: The Open Court Company

Myers, S., Johnson, C. and Council Children, D. (2007). Management of children

with autism spectrum disorders. *Pediatrics*, 120(5), 1162-1182.

Newman, B., and Newman, P. (2001). Group identity and alienation: giving the we its

due. *Journal of Youth and Adolescence*, 30, 515–538.

Newman, P., and Newman, B. (1976). Early adolescence and its conflict: group

identity versus alienation. *Adolescence*, 11, 261–274.

Nietzel, M., Russell, R., Hemmings, K., and Gretter, M. (1987). Clinical significance

of psychotherapy for unipolar depression: A meta-analytic approach to social

comparison. *Journal of Consulting and Clinical Psychology*, 55, 156-161.

Nisbet, E., and Gick, M. (2008). Can Health Psychology Help the Planet? Applying

Theory and Models of Health Behaviour to Environmental Actions. *Canadian

Psychology,* 49, 296-303.

Nolas, S. (2011). Grounded Theory Approach. In N. Frost (ed.). *Qualitative Research

Methods in Psychology: combining core approaches*. London: Open Uni. Press

O'Connor, D., Archer, J., Hair, W., and Wu, F. (2002). Exogenous testosterone,

aggression, and mood in eugonadal and hypogonadal men. *Physiology and

Behavior*, 75, 557–566

O'Connor, R. and Waddell, S. (2015). What Works to Prevent Gang Involvement,

Youth Violence and Crime: A Rapid Review of Interventions Delivered in the UK and

Abroad. [Online] Available at http://www.eif.org.uk/wp-content/uploads/2015/11/Final-

R2-WW-Prevent-Gang-Youth-Violence-final.pdf [accessed 10 November, 2017].

O'Connor, T. and Scott, S. (2007). *Parenting and outcomes for children*. London:

Joseph Rowntree Foundation

Øien, L., and Lillevik, G. (2013). Prevention of aggressive behaviour and violence in

childcare institutions. *Social Work and Social Sciences Review*, 17(1), 88 – 101.

Ojala. K. and Nesdale. D. (2004). Bullying as a group process: The effects of group

norms and distinctiveness threat on attitudes towards bullying. *British Journal of Developmental Psychology*. 22, 19-35.

Ojala, K., and Nesdale. D. (2010). *Group belongingness and intra- and intergroup attitudes in children.* Griffith University, Queensland.

Olweus, D. (1979). Stability of aggressive reaction patterns in males: A review. *Psychological Bulletin*, 86, 852–875.

Olweus, D. (1991). Bully/victim problems among schoolchildren: basic facts and effects of a school based intervention program. In D. J. Pepler and K. H. Rubin (eds.). *The Development and Treatment of Childhood Aggression*: Hillsdale, NJ: Lawrence Erlbaum.

Olweus, D. (2004). The Olweus Bullying Prevention Programme: design and implementation issues and a new national initiative in Norway. In P. K. Smith, D. Pepler and K. Rigby (eds.). *Bullying in Schools: How Successful Can Interventions Be?* Cambridge: Cambridge University Press.

O'Neill, P. (2002). Tectonic change: The qualitative paradigm in psychology. *Canadian Psychology,* 43, 190–194.

Orlinsky, D., Grawe, K., and Parks, B. (1994). Process and outcome in psychotherapy – noch einmal. In A. Bergin and S. Garfield (Eds.), The working alliance: Theory, research and practice. New York: Wiley.

Ostrov, J., and Crick, N. (2007). Forms and functions of aggression during early childhood: A short-term longitudinal study. *School Psychology Review*, 36, 22– 43.

Ostrov, J., and Houston, R. (2008). The utility of forms and functions of aggression in emerging adulthood: Association with personality disorder symptomatology. *Journal of Youth and Adolescence,* 37, 1147– 1158.

Pajer, K., Tabbah, R., Gardner, W., Rubin, R., Kennethczambel, R., and Wang, Y. (2006). Adrenal androgen and gonadal hormone levels in adolescent girls with conduct disorder. *Psychoneuroendocrinology*, 31(10), 1245–1256

Palmer, R. (1969). *Hermeneutics.* Evanston: Northwestern University press.

Partington, D. (2002). *Essential skills for management research*. London: Sage.

Patterson, G. (1996). Some characteristics of a developmental theory for early onset delinquency. In M.F. Lenzenweger and J.J. Haugaard (eds). *Frontiers of Developmental Psychopathology*. New York: Oxford University Press

Patterson, G., DeBaryshe, B., and Ramsey, E. (1990). A Developmental Perspective on anti-social behavior. *American Psychologist*, 44, 329 – 335.

Patton, M. (1990). *Qualitative Evaluation and Research Methods*. Newbury Park, CA: Sage Publications Inc.

Patton, M. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publications.

Parahoo, K. (2006). *Nursing research: Principles, process and issues*. Basingstoke: Palgrave Macmillan

Parke, R., and Slaby, R. (1983). The development of aggression. In P. H. Mussen & M. Hetherington (Eds.), *Handbook of child psychology: Socialization, personality, and social development*. New York, NY: Wiley.

Paylo, M. J. (2005). Helping families search for solutions: Working with adolescents. *The Family Journal: Counseling and Therapy for Couples and Families*, 13(4), 456-458.

Peat, J., Mellis, C., Williams, K. and Xuan W. (2002), *Health Science Research: A Handbook of Quantitative Methods*, London: Sage.

Pellegrini, A., and Bartini, M. (2001). Dominance in early adolescent boys: Affiliative and aggressive dimensions and possible functions. *Merrill-Palmer Quarterly*, 47, 142–163.

Perry, S. (2001). Appropriate Use of Pilot Studies. *Journal of Nursing Scholarship*, 33 (2), 107.

Persson, G. (2005). Young Children's Prosocial and Aggressive Behaviors and their Experiences of Being Targeted for Similar Behaviors by Peers. *Social Development*, 14 (2), 206 – 228.

Pervin, L., Cervone, D., and John, O. (2005). *Personality: Theory and Research*. Danvers, MA: John Wiley & Sons Inc.

Pfander, A. (1967). *Phenomenology of willing and motivation* (H. Spiegelberg, Trans.). Evanston, IL: Northwestern University Press (Original work published 1908).

Polit, D., Beck, C., and Hungler, B. (2001). *Essentials of Nursing Research: Methods, Appraisal and Utilization*. Philadelphia: Lippincott Williams and Wilkins.

Ponterotto, J. (2005). Qualitative Research in Counseling Psychology: A Primer on

Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology,* 52 (2), 126–136

Ponterotto, J., Gretchen, D., Utsey, S., Rieger, B., and Austin, R. (2002). Revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural and Counseling Development*, 30, 153–180.

Pope-Davis, D., Toporek, R., Ortega-Villalobos, L., Ligiero, D., Brittan-Powell, C., Liu, W., . . . and Liang, C. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist*, 30, 355-393.

Popma, A., Vermeiren, R., Geluk, C., Rinne, T., Vandenbrink, W., Knol, D., et al. (2007). Cortisol moderates the relationship between testosterone and aggression in delinquent male adolescents. *Biological Psychiatry*, 61(3), 405–411.

Preston, S., and De Waal, F. (2002). Empathy: Its ultimate and proximate bases. *Behavioral and Brain Sciences*, 25, 1-20.

Prinstein, M., and Cillessen, A. (2003). Forms and functions of adolescent peer aggression associated with high levels of peer status. *Journal of Developmental Psychology*, 49, 310 –342.

Prochaska, J., and DiClemente, C. (1982). Transtheoretical Therapy. Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice*, 20, 161 – 173.

Prochaska, J., DiClemente, C., and Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102–1114.

Prochaska, J., and Prochaska, J. (1999). Why don't continents move? Why don't people change? *Journal of Psychotherapy Integration*, 9, 83–102.

Pulkkinen, L., and Pitkänen, T. (1993). Continuities in aggressive behavior from Childhood to adulthood. *Aggressive Behaviour.* 19, 249–263.

Quigley, B., and Leonard, K. (2004). Alcohol Use and Violence among Young Adults. *The National Institute on Alcohol Abuse and Alcoholism (NIAAA)*

Quinsey, V., Harris, G., Rice, M., and Cormier, C. (2006). *Violent offenders: Appraising and managing risk* (2nd Ed). Washington, DC: American Psychological Association.

Rabinow, P. (1991). *The Foulcault Reader: An introduction to Foulcault's*

thought. London: Penguin.

Ragelienė, T. (2016). Links of Adolescents Identity Development and Relationship with Peers: A Systematic Literature Review. *Jornal of Canadian Academy of the Child Adolescent Psychiatry*, 25 (2), 97–105.

Raine, A., Dodge, K., Loeber, R., Gatzke-Kopp, L., Lynam, D., Reynolds, C. et al (2006). The Reactive–Proactive Aggression Questionnaire: Differential correlates of reactive and proactive aggression in adolescent boys. *Aggressive Behavior*, 32,159–171.

Ramey, H., and Grubb, S. (2009). Modernism, Postmodernism and (Evidence-Based) Practice. *Contemporary Family Therapy*, 31(2), 75—86.

Raskauskas, J., and Stoltz, A. (2004). Identifying and intervening in relational aggression. *The Journal of School Nursing, 20(4), 209-215.*

Rathert, J., Fite, P., Gaertner, A., and Vitulano, M. (2011). Associations between Effortful control, psychological control and proactive and reactive aggression. *Child Psychiatry and Human Development,* 42(5), 609–621.

Reid, J., Patterson, G., and Snyder, J. (2002). *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention.* Washington DC: American Psychological Association.

Rennie, D., Watson, K., and Monteiro, A. (2002). The rise of qualitative research in psychology. *Canadian Psychology*, 43, 179–189.

Richards, J., and Gross, J. (2000). Emotion regulation and memory: the cognitive costs of keeping one's cool. *Journal of Personality and Social Psychology*, 79, 410–424.

Richardson, P., Goodwin, A., and Vine, E. (2011). *Research Methods and Design in Psychology*. London: LearningMatters

Richie, B., Fassinger, R., Linn, S., Johnson, J., Prosser, J., and Robinson, S. (1997). Persistence, connection, and passion: a qualitative study of the career development of highly achieving African American-Black and White women. *Journal of Counseling Psychology,* 44, 133-148

Roback, H. (2000). Adverse Outcomes in Group Psychotherapy: Risk Factors, Prevention, and Research Directions. *The Journal of Psychotherapy, Practice and research*, 9(3), 113–122.

Roback, H., and Smith, M. (1987). Patient attrition in dynamically oriented treatment groups. *American Journal of Psychiatry*, 144, 426–431

Robrecht, L. (1995). Grounded theory: evolving methods. *Qualitative Health Research*, 5, 169–77

Rogers, C. (1951). *Client-centered therapy*. London: Constable.

..... (1959) A Theory of Therapy, personality, and interpersonal relationship as Developed in the client-centred framework. In S. Koch (ed.) *Psychology, the study of a Science*, Vol. 3:

..... (1961). *On Becoming a Person: A Therapist's view of psychotherapy.* Boston: Houghton Mifflin.

….. (1975). Empathic: An unappreciated way of being. *Counseling Psychologist*, 5 (2), 2-10.

Roisman, G., Monahan, K., Campbell, S., Steinberg, L., Cauffman, E. (2010). The National Institute of Child Health and Human Development Early Child Care Research Network. Is adolescence-onset antisocial behavior developmentally normative? *Development and Psychopathology*, 22, 295–311.

Rollnick, S., Mason, P., Butler, C. (2000). *Health Behavior Change: A guide for practitioners*. London: Churchill Livingstone.

Rosenberg, M. (1986). Self-concept from middle childhood through adolescence. In J. Suls, & A. G. Greenwald (Eds.), *Psychological perspectives on the self*. New York: Lawrence Erlbaum.

Rothbart, M., and Bates, J. (2006). Temperament. In N. Eisenberg, W. Damon, & R. M. Lerner (Eds.), *Handbook of child psychology: Social, emotional, and personality development*. Hoboken: Wiley.

Rubenstein, D., and Wikelski, M. (2005). Steroid hormones and aggression in female Gala´pagos marine iguanas. *Hormones and Behavior*, 48, 329 – 341

Rubin, H., and Rubin, I. (2005). *Qualitative interviewing: The art of hearing data. London:* Sage.

Rubin, K., and Krasnor, L. (1986). Social-cognitive and social-behavior perspectives on problem-solving. In M. Perlmutter (Ed.), *The Minnesota Symposium on Child Psychology.* Hillsdale, NJ: Erlbaum.

Ruble, D., Alvarez, J., Bachman, M., Cameron, J., Fuligni, A., Garcia Coll, C., et al. (2004). The development of a sense of "we": the emergence and implications of children's collective identity. In M. Bennett, and F. Sani (Eds.), *The development of the social self*. New York: Psychology Press.

Ruble, D., and Seidman, E. (1996). Social transitions: Windows into social psychological processes. In E. T. Higgins and A. Kruglanski (Eds.), *Handbook of social processes.* New York: Guilford.

Russell, J., and Fehr, B. (1994). Fuzzy concepts in a fuzzy hierarchy. Varieties of anger. *Journal of Personality and social Psychology*, 67, 186 – 205.

Rutan, J., and Stone, W. (1984). Psychodynamic Group Psychotherapy. Boston, MA: Collamore Press.

Rutan, J., and Stone, W. (2001). Termination in group psychotherapy. In J. S. Rutan & W. N. Stone, *Psychodynamic group psychotherapy.* New York: Guilford Press.

Rutter, D., and Quine, L. (2002). Social Cognition Models and Changing Health Behaviours. In D. Rutter and L. QUINE (Eds.). *Changing Health Behaviour: Intervention and Research with Social Cognition Models*. Buckingham: Open University Press.

Ryan, A. (2001). The peer group as a context for the development of young adolescent motivation and achievement. *Child Development*, 72, 1135–1150

Ryan, R., and Deci, E. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68–78

Ryum, T., Hagen, R., Nordahl, H., Vogel, P., and Stiles, T. (2009). Perceived group climate as a predictor of long-term outcome in randomized controlled trial of cognitive behavioral group therapy for patients with comorbid psychiatric disorders. *Behavioural and Cognitive Psychotherapy*, 37, 497-510.

Salmivalli, C., and Nieminen, E. (2002). Proactive and reactive aggression among school bullies, victims, and bully-victims. *Aggressive Behavior*, 28, 30–44.

Sampson, H. (2004). Navigating the Waves: The Usefulness of a Pilot in Qualitative Research. *Qualitative Research*, 4 (3), 383–402.

Sanders, C. (2004). What is bullying? In C. E. Sanders & G. D. Phye (Eds.), *Bullying: Implications for the classroom*. San Diego, CA: Elsevier Academic Press.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., and Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychother. Res.,* 17, 196–204.

Sayer, A. (1992). *Method in Social Science: A Realist Approach*. London: Routledge.

Sayer, A. (2000). *Realism and Social Science*, London: Sage.

Scheinfeld, D., Rochlen, A. and Buser, S. (2011). Adventure therapy: A supplementary group therapy approach for men. *Psychology of Men and Masculinity,* 12(2), 188-194.

Schlapobersky, J. (2016). *From the Couch to the Circle: Group-Analytic Psychotherapy in Practice*. London: Routledge

Schoen, R., Landale, N., and Daniels, K. (2007). Family transitions in young adulthood. Demography, 44, 807–820.

Schofield, M. and Roedel, G. (2012). *Australian Psychotherapists and counsellors: A study of therapists, therapeutic work, and professional development.* Melbourne: La Trobe University.

Schopler, J., Galinsky, M. (1984/2006). Meeting practice needs: Conceptualizing the open-ended group. *Social Work with Groups*, 28 (3), 49–68.

Schultz, D., and Schultz, S. (2005). *Theories of Personality*. Wadsworth: Thomson.

Schuster, I. (1985). Female aggression and resource scarcity: A cross-cultural perspective. In M. Haug, D. Benton, P. F. Brain, B. Olivier, & J. Mos (Eds.), *The aggressive female*. Montreal: Eden Press.

Schwandt, T. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage

Scott, T., Anderson, C., and Spaulding, S. (2008). Strategies for Developing and Carrying out Functional Assessment and Behavior Intervention Planning. *Preventing School Failure*. 52 (3), 39-49.

Séguin, J., and Zelazo, P. (2005). Executive function in early physical aggression. In J. Archer, R. E. Tremblay, W. W. Hartup, & W. Willard (Eds.), *Developmental origins of aggression*. New York: Guilford.

Seiffge-Krenke, I., and Beyers, W. (2005). Coping trajectories from

adolescence to young adulthood: Links to attachment state of mind. *Journal of Research on Adolescence*, 15, 561–582.

Seo, D., Patrick, C., and Kennealy, P. (2008). The Role of Serotonin and Dopamine System Interactions in the Neurobiology of Impulsive Aggression and its Comorbidity with other Clinical Disorders. *Aggression and Violent Behavior*, 13(5), 383-395.

Shap, K. (2014). Island in the street: analyzing the function of gang violence from a culture and conflict perspective. *Journal of Aggression, Conflict and Peace Research*, 6 (2), 78-98.

Shapiro, D., and Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin*, 92, 581-604.

Shaw, M. (1932). A comparison of individuals and small groups in the rational solution of complex problems. *America Journal of Psychology*, 44, 491 – 504.

Shaw, D., Gilliom, M., and Giovanelli, J. (2000). *Aggressive behaviour disorders*. In C. H. Zeanah (Ed.). *Handbook of infant mental health*. New York: Guilford Press.

Shechtman, Z. (2002). Cognitive and affective empathy in aggressive boys: Implications for counselling. *International Journal for the Advancement of Counselling*, 24, 211-222.

Shechtman, Z. (2009). The effect of leader behavior on processes and outcomes in group counseling. *Group Dynamics: Theory, Research, and Practice,* 13 (3), 218-233

Shechtman, Z., Bar-El, O., and Hadar, E. (1997). Therapeutic factors in counseling and psycho-educational groups for adolescents: A comparison. *Journal for Specialists in Group Work*, 22, 203–213.

Shechtman, Z., Freidman, Y., Kashti, Y., & Sharabany, R. (2002). Group counseling to enhance adolescents' close friendships. *International Journal of Group Psychotherap*y, 52, 537–554.

Sheldon, K., Williams, G., and Joiner, T. (2003). *Self-Determination Theory in the Clinic. Motivating physical and mental health.* New Haven: Yale University Press.

Shuford, J. (2008). Empathy Talk/Handout. *The Transformer*, 1 – 12.

Silverman, D. (2011*). Interpreting qualitative data*. London, England: Sage

Simmons, R. (2002). *Odd girl out: The hidden culture of aggression in girls.*
   New York: Harcourt.

Singh, S., Paul, M., Ford, T., Kramer, T., and Weaver, T. (2008). Transitions of
   care from Child and Adolescent Mental Health Services to Adult Mental
   Health Services (TRACK Study): a study of protocols in Greater London.
   BMC Health Serv Res, 8,135

Singh, S., Paul, M., Ford, T., Kramer, T., Weaver, T., McLaren, S., Hovish, K.,
   Islam, Z., Belling, R., &White, S. (2010). Process, outcome and experience of
   transition from child to adult mental healthcare: multi-perspective study.
   British Journal of Psychiatry, 197(4), 305-312.

Skinner, B. (1953). *Science and human behaviour*. New York: MacMillan.

Skinner, B. (1974). *About Behaviourism*. New York: Knopf.

Skovholt, T. M., and Jennings, L. (2004). Master Therapists: Exploring Expertise in
Therapy and Counseling. Bosten, MA: Allyn & Bacon.

Smith, J., Flowers, P. and Larkin, M. (2009). *Interpretive Phenomenological Analysis:
   Theory, Method, and Research*. London: Sage.

Smith, J., Jarman, M., and Osborn, M. (1999). Doing interpretative
   phenomenological analysis. In M. Murray & K. Chamberlain (Eds.). *Qualitative
   health psychology: Theories & methods*. London: Sage.

Smith, J., and Osborn, M. (2003). Interpretative phenomenology analysis. In J. A.
   Smith (Ed.). *Qualitative psychology: A practical guide to research methods*.
   London: Sage

Smollar, J., and Youniss, J. (1985). Adolescent self-concept development. In R. L.
   Leahy (Ed.), *The development of the self*. Orlando, FL: Academic Press

Sonn, M. (1977). Patients' Subjective Experiences of Psychiatric Hospitalization. In
   A. M. Kleinman (ed.). *Renewal Journal of Psychiatry*. New York: Wiley.

Sque, M., and Payne, S. (2015) Critical Care Experiences and Bereavement among
   Families of Organ Donors: A Reflective Account of a Grounded Theory Study. In E.
   Lyons and A. Coyle (eds.). *Analysing Qualitative Data in Psychology*. London:
   Sage.

Star, S. (2007). Living grounded theory: cognitive and emotional forms. In A. Bryant

and K. Charmaz (eds.). *The Sage Handbook of Grounded Theory*. London: Sage.

Starks, H., and Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, 17 (10), 1372- 1380.

Steinberg, L., Reyome, N., and Bjornsen, C. (2001). *Study Guide for use with Adolescence: Relational aggression – intended to harm others through deliberate manipulation of their social standing and relationships*. London: McGraw-Hill Higher Education

Stern, P. (1980). Grounded theory methodology its uses and processes. *Image*, 12, (1), 20–23.

Stern, P. (1994). Eroding Grounded Theory. In J. M. Morse (ed.). *Critical Issues in Qualitative Research Methods*. Thousand Oaks, CA: Sage.

Stern, P. (2000). Toward a Coherent Theory of Environmentally Significant Behavior. *Journal of Social Issues*, 50, 65-84.

Stern, P., Dietz, T., Abel, T., Guagnano, G., and Kalof, L. (1999). A Value-Belief-Norm Theory of Support for Social Movements: the case of environmental concern. *Human Ecology Review*, 6, 81-97.

Stevens, D., Charman, T., and Blair, R. (2001). Recognition of emotion in facial expressions and vocal tones in children with psychopathic tendencies. *The Journal of genetic psychology*, 162(2), 201-211.

Stone, W., and Rutan, J. (1984). Duration of treatment in group psychotherapy. *International Journal of Group Psychotherapy*, 34, 93-109.

Strauss, A. (1987). *Qualitative Analysis for Social Scientists*. New Yolk: Cambridge University Press

Strauss, A., and Corbin, J. (1990). *Basics of Qualitative Research: Grounded theory procedures and techniques.* London: Sage

Strauss, A., and Corbin, J. (1994). Grounded theory Methodology: An Overview. In N. K. Denzin & Y. S. Lincoln (eds.). *Handbook of Qualitative Research*. Sage, Thousand Oak.

Strauss, A., and Corbin, J. (1998). *Basics of Qualitative Research: Grounded theory*

procedures and techniques. London: Sage

Strayer, J., and Roberts, W. (2004). Empathy and observed anger and aggression in five-year-olds. *Social Development*, 13, 1-13.

Stuss, D., and Benson, D. (1987). The frontal lobes and control of cognition and memory. In E. Perecman (Ed.), *The frontal lobes revisited.* New York: The IRBN Press.

Sue, D., Arredondo, P., and McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development,* 70, 477-486

Sukhodolsky, D., Golub, A., and Cromwell, E. (2001). Development and validation of the Anger Rumination Scale. *Personality and Individual Differences*, 31, 689–700.

Sutton, J., and Koegh, E. (2000). Social competition in school: The relationships with bullying, Machiavellianism and personality. *British Journal of Educational Psychology*, 70, 443-456

Sutton, J. and Keogh, E. (2001). Components of Machiavellian beliefs in children: Relationships with personality. *Personality and Individual Differences*, 30,137–148.

Sutton, J., Reeves, M. and Keogh, E. (2000). Disruptive behavior: Avoidance of responsibility and theory of mind. *British Journal of Developmental Psychology*, 10,1–11.

Sutton, J. and Smith, P. (1999). Bullying and Theory of Mind: A Critique of the Social Skills Deficit View of Anti-Social Behaviour. *Social Development*, 8 (1), 117 – 127.

Taft, C., Murphy, C., King, D., Musser, P., and DeDeyn, J. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, 71(4), 812-820.

Tangney, J., Baumeister, R., and Boone, A. (2004). High self-control predicts good adjustment, less pathology, better grades, and interpersonal success. *Journal of Personality,* 72, 271–322.

Tanti, C., Stukas, A., Halloran, M., and Foddy, M. (2008). Tripartite self-concept change: shifts in the individual, relational, and collective self in adolescence. *Self and Identity,* 7, 360–379

Tanti, C., Stukas, A., Halloran, M., and Foddy, M. (2011). Social identity change:

Shifts in social identity during adolescence. Journal of Adolescence, 34, 555 – 567.

Tapson, C. (2015). *An interpretative phenomenological study of young people who bully and their counsellors* (Doctoral thesis). Retrieved from Google Scholar /epubs.surrey.ac.uk

Tarrant, M., North, A., Edridge, M., Kirk, L., Smith, E., and Turner, R. (2001). Social identity in adolescence. *Journal of Adolescence*, 24, 597–609.

Tasca, G., Balfour, K. Ritchie, L., and Bissada, H. (2007). The relationship between attachment Scales and Group Therapy Alliance Growth Differs by Treatment Type for Women with Binge-Eating Disorder. *Group Dynamics, Theory, Research, and Practice,11*, 1-14.

Taube-Schiff, M., Suvak, M., Antony, M., Bieling, P. and McCabe, R. (2007). Group cohesion in cognitive-behavioral group therapy for social phobia. *Behavioral Research and Therapy,* 45, 687-698

Taubner, S. and Curth, C. (2013). Mentalization mediates the relation between early traumatic experiences and aggressive behavior in adolescence. *PSIHOLOGIJA*, 46 (2), 177–192.

Taubner, S., and Juen, F. (2010). Gewalt in der Spätadoleszenz. Perspektiven der Bindungsforschung. *Psychotherapie und Sozialwissenschaften*, 12(2). 59–77.

Taubner, S., Kächele, H., Visbeck, A., Rapp, A., and Sandell, R. (2010). Therapeutic attitudes and practice patterns among psychotherapy trainees in Germany. *Eur. J. Psychother. Couns.,* 12, 361–381

Taubner, S., White, L., Zimmermann, J., Fonagy, P., and Nolte, T. (2012). Mentalization moderates and mediates the link between psychopathy and aggressive behavior in male adolescents. *Journal of the American Psychoanalytic Association*, 60 (3) 605 - 612.

Teijlingen van, E., Rennie, A., Hundley, V., Graham, W. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey, *Journal of Advanced Nursing*, 34, 289-295.

Temcheff, C., Serbin, L., Martin-Storey, A., Stack, D., Hodgins, S., Ledingham, J., and Schwartzman, A. (2008). Continuity and Pathways from Aggression in Childhood to Family Violence in Adulthood: A 30-year Longitudinal Study. *Journal*

of Family Violence, 23 (4), 231–242

Teraguchi, T., and Kugihara, N. (2015). Effects of Labelling and Group Category of Evaluators on Evaluations of Aggression. *PLoS ONE,* 10(12)

Terburg, D., Morgan, B., and van Honk, J. (2009). The testosterone– cortisol ratio: A hormonal marker for proneness to social aggression. *International Journal of Law and Psychiatry*, 32(4), 216–223.

Thomas, K. (1992). Conflict and Conflict Management: Reflections and Update. *Journal of organisational Behavior*, 13, 265 – 274.

Thorne, B. (2007). Person Centred Therapy. In W. Dryden (ed.) *Dryden's Handbook of Individual Therapy.* London: Sage

Tourigny, M. and Hebert, M. (2007). Comparison of open versus closed group interventions for sexually abused adolescent girls. *Violence and Victims*, 22, 334-49

Tremblay, R. (2000). The development of aggressive behavior during childhood: What have we learned in the past century? *Int. J. Behav Dev,* 24,129–141.

Tremblay, R. (2003). Why socialization fails: The case of chronic physical aggression. In: Lahey B, Moffitt TE, Caspi A (eds.). *The causes of conduct disorder and serious juvenile delinquency*. New York: Guilford.

Tremblay, R. (2008). Anger and Aggression. In M.M Haith and J.B Benson (eds.). *Encyclopaedia of Infant and Early Childhood development*. Academic press.

Tremblay, R. (2010). Developmental origins of disruptive behaviour problems: The 'original sin' hypothesis, epigenetics and their consequences for prevention. *Journal of Child Psychology and Psychiatry*, 51, 341–367.

Tremblay, R., and Nagin, D. (2005). The Developmental origins of physical aggression in humans. In R. E. Tremblay, W. W. Hartup, J. Archer (ed.). *Developmental origins of aggression*. New York: Guilford.

Triandis, H. (1977). Interpersonal behaviour. Monterey, CA: Brooks/Cole,

Underwood, M., Galen, B., and Paquette, J. (2001). Top ten challenges for understanding gender and aggression in children: Why can't we all just get along? *Social Development*, 10(2), 248-266

Vitaro, F., Gendreau, P., Tremblay, R., and Oligny, P. (1998). Reactive and Proactive Aggression Differentially Predict Later Conduct Problems. *J. Child*

Psychol. Psychiat. 39, (3), 377 – 385.

Vitaro, F., and Brendgen, M. (2005). Proactive and reactive aggression. In R. E. Tremblay, W. H. Hartup, and J. Archer (eds.). *Developmental origins of aggression*. New York: Guilford.

Vitaro, F., Brendgen, M., and Barker, E. (2006). Subtypes of aggressive behaviors: A developmental perspective, *Inter. Journal of Beh. Dev.*, 30 (1), 12–19

Vitaro, F., Brendgen, M., and Tremblay, R. (2002). Reactively and proactively aggressive children: Antecedent and subsequent characteristics. *Journal of Child Psychology and Psychiatry*,43, 495–505.

Vohs, K., and Baumeister, R. (2004). Understanding self-regulation: an introduction. In R. F. Baumeister & K. D. Vohs (Eds.), *Handbook of self-regulation: research, theory, and applications.* New York: Guilford.

Walker, D. (2006). Toward productive design studies. In J. Van den Akker *et al.*, (eds.). *Educational Design Research*. London: Routledge

Walker, D., and Myrick, F. (2006). Grounded theory: An Exploration of process and procedure. *Qualitative Health Research*, 16(4), 547–559.

Walsh, S., Harel-Fisch, Y., and Fogel-Grinvald, H. (2010). Parents, teachers and peer relations as predictors of risk behaviors and mental well-being among immigrant and israeli born adolescents. *Social Science & Medicine*, 70, 976–984

Wanless, D., Appleby, J., Harrison, A., and Patel, D. (2007). *Our Future Health Secured? A review of NHS funding and performance*. London: King's Fund.

Webb, T., Sniehotta, F., and Michie, S. (2010). Using theories of behaviour change to inform interventions for addictive behaviours. *Addiction*, 105, 1879-1892.

Welsh, M., and Pennington, B. (1988). Assessing frontal lobe functioning in children: views from developmental psychology. *Dev. Neuropsychology*, 4, 199–230.

Winter, K., Spengler, S., Bermpoh, F., Singer, T., and Kanske, P. (2017). Social cognition in aggressive offenders: Impaired empathy, but intact theory of mind.

Scientific Report, 7, 1 – 9.

Winnick, T., and Bodkin, M. (2008). Anticipated stigma and stigma management among those to be labeled 'ex-con'. *Deviant Behavior*, 29, 295-333

Winnicott, D. (1986). *Home Is Where We Start From*. New York: W.W. Norton.

Winnicott, D. (1971). *Playing and Reality.* Middlesex, England: Penguin Books.

Wiseman, R. (2002). *Queen bees and wannabees: Helping your daughter survive cliques, gossip, boyfriends, and other realities of adolescence.* New York: Crown.

Wiswede, D., Taubner, S., Münte, T., Roth, G., Strüber, D., Wahl, K., et al. (2011). Neurophysiological correlates of laboratory-induced aggression in young men with and without a history of violence. *PLoS One*, 6(7),

Whipple, J., Lambert, M., Vermeersch, D., Smart, D., Nielsen, S., and Hawkins, E. (2003). Improving the Effects of Psychotherapy: The Use of Early Identification of Treatment Failure and Problem-Solving Strategies in Routine Practice. *Journal of Counseling Psychology*, 50 (1), 59–68.

Wolfgang, M., and Ferracuti, F. (1967). *The Subculture of Violence, Towards an Integrated Theory in Criminology*. London: Tavistock-Social Science.

Wood, C., and Gross, A. (2002). Behavioral response generation and selection of rejected reactive-aggressive, rejected non-aggressive, and average status children. *Child and Family Behavior Therapy*, 24(3),1–19.

Woolfe, R., Strawbridge, S., Douglas, B., and Dryden, W. (2010). *Handbook of Counselling Psychology.* London: Sage

World Health Organization (WHO) (2002). *World report on violence and health: Summary*. Geneva.

Xie, H., Smift, D., Cairns, B., and Cairns, R. (2002). Aggressive Behaviors in Social Interaction and Developmental Adaptation: A Narrative Analysis of Interpersonal Conflicts During Early Adolescence. *Social Development*, 11 (2), 205 - 224.

Yalom, I. (2005). *The Theory and practice of group psychotherapy.* New York: Basic Books.

Yeo, L., Ang, R., Loh, S., Fu, K., and Karre, J. (2011). The role of affective and cognitive empathy in physical, verbal, and indirect aggression of a Singaporean sample of boys. *The Journal of Psychology*, 145, 313-330.

Yeung, R., and Leadbeater, B. (2010). Adults make a difference: The protective effects of parent and teacher emotional support on emotional and behavioral problems of peer-victimized adolescents. J. Community Psyc, 38, 80–98.

Young, E., Boye, A., Nelson, D. (2006). Relational Aggression: Understanding, Identifying, and Responding in Schools. *Psych. in the Schools*, 43 (3), 297 – 312.

Zachariadis, M., Scott, S., and Barrett, M. (2013). Methodological Implications of Critical Realism for Mixed-Methods Research. *MIS Quarterly*, 37 (3), 855 – 879.

Zhou, Q., Chen, S., and Main, A. (2011). Commonalities and differences in the research on children's effortful control and executive function: a call for an integrated model of self-regulation. *Child Dev. Perspectives*, 6(2), 112–121.

Zimmermann, P., Maier, M., Winter, M., and Grossmann, K. (2001). Attachment and Emotion regulation of adolescents during joint problem-solving with a friend. *International Journal of Behavioral Development*, 25, 331–342.

Glossary of Terms

BPS	British Psychological Society
CAMHS	Children and Adolescents Mental Health Services
CBT	Cognitive Behavioural Therapy
DSM – 5	Diagnostic and Statistical Manual of Mental Disorders – 5
GTM	Grounded Theory Method
ICD – 10	International Classification of Diseases
AMHS	Adult Mental Health Services
NICE	National Institute of Clinical Excellence
NHS	National Health Service

Definition of Terms

*Aggression***:** Aggression is defined as an action directed at another person with the intention to cause harm while the besieged person is motivated to escape or avoid the attack (Geen, 2001)

Anger: Anger is described as a person's response to a threat or the perception of a threat against an individual or group (Lazarus, 1991).

Axial coding: Axial coding is 'the process of relating categories to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions' (Strauss & Corbin, 1998, p. 123). It is the second phase in Strauss & Corbin's grounded theory methodology.

Category: In grounded theory methodology, a category is a label given to a group of concepts, emerging themes, or variables related to some property or dimension (LaRossa, 2005)

Coding: Coding is described as an 'analytical process through which data are fractured, conceptualised, and integrated to form theory' (Strauss & Corbin, 1998, p. 3).

Concept: In grounded theory methodology, a concept is a label, emerging themes, codes, or variables given to a group of related indicators.

Conduct disorders: Conduct disorders are antisocial behaviours lasting at least 6 months in which basic rights of others and/or major age-appropriate norms and rules of society are repeatedly violated (APA, 1994)

Dimensions: Dimensions refer to the 'range along which general properties of a category vary, giving specification to a category and variation to the theory' (Strauss & Corbin, 1998, p. 101).

Epistemology (the study of knowledge) is described as "a way of understanding and explaining how I know what I know" (Crotty, 1998, p. 3).

Group therapy: Group therapy refers to a form of therapy whereby therapy is offered to three or more clients as a group with the purpose of facilitating the interpersonal relationship.

Indicator: In grounded theory methodology, an indicator refers to the smallest important element of analysis (such as a word, phrase, or sentence) in the interviewee speech. Many of such related indicators are grouped together to generate concepts.

Memos: Memos refer to the records of researcher's 'thoughts, interpretations, questions, and directions for further data collection' (Strauss & Corbin, 1998, p. 110).

Methodology: Methodology is 'a way of thinking about and studying social reality' (Strauss & Corbin, 1998, p.3).

Method: method is a set of procedures and techniques for gathering and analysing data. (Strauss & Corbin, 1998, p.3).

Ontology: Ontology is described as 'the study of being' (Crotty, 1998, p.10). It is believed to raise 'basic questions about the nature of reality and the nature of the human being in the world' (Denzin & Lincoln, 2005, p.183).

Open coding: Open coding is defined as the 'analytic process through which concepts are identified and their properties and dimensions are discovered in the data (Strauss & Corbin, 1998, p. 101). It is the first phase of analysis in grounded theory which involves an initial line by line identification of the indicators (i.e. the keywords, phrases, or sentences) contained in every line of the participants' transcript.

Phenomena: Phenomena are 'central ideas in the data represented as concepts' (Strauss & Corbin, 1998, p. 101).

Proactive aggression*:* Proactive aggression is described as an organised and premeditated attack on someone with the aim of achieving desired goals (Jelle, 2010).

Process: Process is described as 'sequence of actions/interaction pertaining to a phenomenon as they evolve over time' (Strauss & Corbin, 1998, p. 123).

Properties: In grounded theory, properties refer to the 'characteristics of a category, the delineation of which defines and gives it meaning' (Strauss & Corbin, 1998, p. 101).

Reactive aggression: Reactive aggression is described as a spontaneous or impulsive response to unpleasant situation or potential threat to one's sense of safety (Bushman & Anderson, 2001)

Relational aggression: Relational aggression is described as an intention to harm others through either actual or threatened damage to their social status and relationships (Saket, 2005).

Selective coding: Selective coding is the third phase of coding in Strauss & Corbin's (1994) grounded theory methodology. It is 'the process of integrating and refining categories' (Strauss & Corbin, 1998, p. 143). It, therefore, involves the selection of one or more core categories that connect categories and codes.

Theoretical Sampling: Theoretical sampling is described as a process of data collection based on the emerging concept and aimed at exploring the dimensional range or varied conditions (Strauss & Corbin, 1998, p.73).

Theoretical saturation: Theoretical saturation refers to 'the point in category development at which no new properties, dimensions or relationships emerge during analysis' (Strauss & Corbin, 1998, p. 143)

Theory: Theory is described as 'a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena' (Strauss & Corbin, 1998, p. 15).

Young adult: In this study, young adult refers to people between the ages of 18 and 25 years.

APPENDIX 1: Project Approval

Project Confirmation: Record of Research Student Review Board decision

This form should be used to record the decision of the Research Student Review Board and will be shown to the student and the members of the supervisory team in order to provide reasons for the decision and any feedback.

PART A: Student details

Name: Oby (Obiageli) Osuchukwu

ID number: 13353926

Department: Psychology

Title of research project: Taming The Tiger Within: Managing Aggression in Young Adults through Group – Therapy

PART B: Decision

☐   Project CONFIRMED

       Any feedback may be written in Part D.

☒   Project CONFIRMED SUBJECT TO ETHICAL APPROVAL

       Any feedback may be written in Part D.

☐   Project NOT CONFIRMED and the student must RESUBMIT within three months

       The reasons for the decision must be set out in Part C. Use Part C also to indicate if the student is to receive a formal warning as part of the Cause for Concern procedure. Feedback on how the project could be improved must be provided in Part D.

☐   Project NOT CONFIRMED and recommend that the student's registration is terminated

       This outcome is only available for resubmitted projects. The reasons for the decision must be set out in Part C. The recommendation to terminate the student's registration must be submitted to the Chair of the Research Degrees Board for approval.

For completion by department Administrator with responsibility for Research Degrees:

Date received in Department Office:

If approved by Chair's Action, the Research Degrees Convenor should sign this section.

Date of Research Student Review Board decision:

Signature of Research Degrees Convenor

If the RDC is a member of the supervisory team, s/he should appoint a nominee to sign

| Signed: _(signature)_ | Date: 29.04.15 |

APPENDIX 2

PEER REVIEW FORM

Project Title:

Taming the Tiger Within:

Managing Aggression in Young Adults through Group Therapy

Person completing form: Dr. Leigh Gibson

Job title: Reader in Psychology

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1) Appropriateness (potential to benefit patients, clinical services, clinical science)

This study is appropriate as it will benefit young people with anger and aggressive behaviour problems since it is based on the evaluation of a clinical service available to young people aimed at managing such behaviour. The study will analyse the views of young people who have actually taken part in this group therapy.

2) Resource Implications (Feasibility and realistic timescales and costings. Implications following completion of research.)

The time scale is reasonable, and we have the resources to support the student. Publication of the study is one of the intended outcomes after completion of the research.

3) Research Design (Validity of the proposed research methodology, completeness and presentation of the proposal, quality of research design.)

The study will use a qualitative design, using semi-structured interviews which will be analysed by Grounded Theory method. This study design has received extensive feedback which has been acted upon, so the proposal is now of acceptable standard. The methodology and design are appropriate for the area of research and research question.

4) Legal Liability

Sponsorship has been agreed by the University, and this is also a study done in collaboration with an NHS PI.

5) Competence of research team (Researcher, supervisor, and collaborators.)

The student is at the doctoral level and the PI is a qualified counselling psychotherapist based at the Trust. In addition, the student has support from an experienced academic supervisory team.

6) Proper accounting for money from pharmaceutical companies.

N/A

7) Other Comments

This is a worthwhile study as it is researching an under-researched area of clinical group therapy for young people from a vulnerable population – young people with anger and aggression management problems.

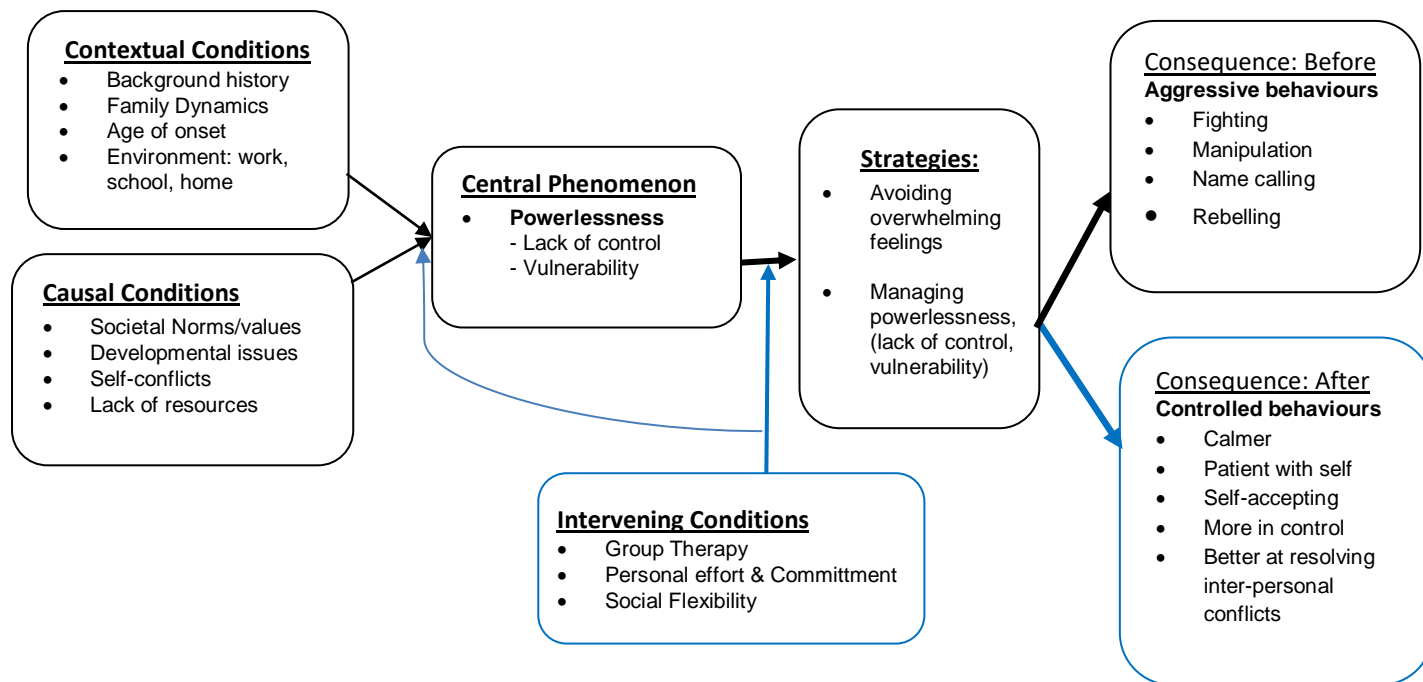**Date:**   28/05/15   **Signature:**

APPENDIX 3:

<u>BASIC SOCIAL PROCESS FORMAT</u>

Contextual Conditions
- Background history
- Family Dynamics
- Age of onset
- Environment: work, school, home

Causal Conditions
- Societal Norms/values
- Developmental issues
- Self-conflicts
- Lack of resources

Central Phenomenon
- **Powerlessness**
  - Lack of control
  - Vulnerability

Strategies:
- Avoiding overwhelming feelings
- Managing powerlessness, (lack of control, vulnerability)

Intervening Conditions
- Group Therapy
- Personal effort & Committment
- Social Flexibility

Consequence: Before
Aggressive behaviours
- Fighting
- Manipulation
- Name calling
- Rebelling

Consequence: After
Controlled behaviours
- Calmer
- Patient with self
- Self-accepting
- More in control
- Better at resolving inter-personal conflicts

Fig 4.5: Axial Coding: *Managing powerlessness of Aggression in Young Adults.*

Adapted from Morrow and Smith's (1995) application of Strauss & Corbin's (1990) Six 'C' of Basic Social Processes to their work: "A grounded theory study: Constructions of survival and coping by women who have survived childhood sexual abuse". In John Cresswell (Ed.), *Qualitative inquiry and research design: Choosing among five traditions* (pp. 297-321). Thousand Oaks, CA: Sage.