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The Effectiveness of Resilience Training on Affective Control and Academic Well-being among Students with Clinical Symptoms of Aggression

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Abstract

Introduction: Adolescence is a critical developmental period characterized by substantial emotional changes, during which maladaptive aggression frequently arises from difficulties in emotion regulation. The present study aimed to examine the effectiveness of resilience training on reduced fear of affective dysregulation (affective control) and academic well-being in female middle school students displaying clinical symptoms of aggression.

Method: This randomized clinical trial was conducted in Ahvaz, Iran, during the 2024–2025 academic year, employing a pretest-posttest design with a one-month follow-up. Using cluster random sampling, 30 students were selected based on elevated scores on the Barratt Impulsiveness Scale and subsequent clinical interview confirmation of aggressive symptoms. Participants were then randomly allocated to either an experimental group (n=15) that received resilience training or a waitlist control group (n=15). Outcome measures included the Affective Control Scale and the Academic Well-being Questionnaire. Data were analyzed using repeated-measures ANOVA in SPSS version 27.

Results: Resilience training produced significant improvements in affective control (reduced fear of losing control over emotions) and academic well-being relative to the control group (time × group interaction for affective control: $F=42.18$, $P<0.001$, $\eta p^2=0.61$; for academic well-being: $F=38.65$, $P<0.001$, $\eta p^2=0.58$). These large effects were largely maintained at the one-month follow-up assessment.

Conclusion: Resilience training represents an effective intervention for reducing fear of affective dysregulation and enhancing academic well-being among female adolescents with clinical symptoms of aggression. These findings support the incorporation of resilience-based programs into school psychological services and highlight the need for replication in larger, multi-center trials.

Keywords: Resilience Training, Affective Control, Academic Well-being, Adolescent Aggression, Students

Introduction

Adolescence represents one of the most pivotal and sensitive developmental stages, serving as a transitional bridge from childhood to adulthood [1]. During this period, individuals experience a diverse array of intense emotions and affects, with anger being among the most prevalent. This emotional state often arises when adolescents encounter obstacles in achieving their goals, subsequently manifesting as aggression—a reactive response to frustration [2]. Aggression is defined as verbal or physical behavior intended to cause harm to oneself or others, frequently accompanied by violence and argumentative conduct [3]. Recent national surveys in Iran indicate that 35–55% of middle school students, including a substantial proportion of girls, report involvement in physical fighting or verbal aggression in the past year, with emotional dysregulation frequently identified as a key contributing

factor [4]. This trend, observed both in Iran and globally, underscores the need for targeted interventions, particularly among female adolescents in whom aggression may be expressed differently due to gender-specific socialization patterns.

Because this stage is fundamental to the development of personal and social identity, unresolved behavioral issues can have profound, long-lasting impacts on a person's future life stages.

A critical factor associated with adolescent aggression is affective control. As adolescence coincides with the onset of puberty, individuals often face heightened emotional challenges and negative experiences, such as shame, guilt, and sadness [5]. Affective control refers to the ability to identify, express, and manage emotions effectively across various situations [6]. The Affective Control Scale (ACS) specifically measures the fear of losing control over intense affects (anger, depression, anxiety, and positive emotions), which is considered a vulnerability factor that can exacerbate maladaptive responses such as reactive aggression when emotion regulation capacities are overwhelmed [7]. Research indicates that the ability to regulate emotions effectively is vital for mental health, as intense or abnormal negative affects can lead to maladaptive behaviors, including hatred, anxiety, and persistent anger [7]. Furthermore, the quality of affective management significantly influences interpersonal interactions and physical well-being. When these emotional states remain unregulated, they pose a serious threat to the psychological hygiene of the student, often exacerbating aggressive impulses [8].

Another essential correlate of student behavior is academic well-being, a multidimensional construct within positive psychology. It encompasses school satisfaction, engagement in academic tasks, and a sense of competence in one's performance [9]. Academic well-being assists learners in navigating the inherent challenges of educational life, such as academic decline, stress, and diminished motivation [10]. Students who possess high levels of well-being are better equipped to maintain effective social interactions and overcome threats to their self-esteem. Conversely, a lack of academic well-being is often linked to school evasion, delinquency, and a lack of responsibility [11]. Given that students are the core of the educational system, addressing their psychological well-being is paramount for fostering academic success and long-term resilience.

To address these challenges, resilience training has emerged as a potent intervention, focusing on the individual's capacity to maintain bio-psycho-spiritual balance in the face of adversity [12]. Resilience is conceptualized here as a dynamic process involving self-repair, cognitive flexibility, impulse control, empathy, and the ability to transform obstacles into opportunities for growth [13]. The present resilience training protocol draws on positive psychology principles and emphasizes key protective factors such as emotional awareness, self-regulation, prosocial behavior, positive self-concept, problem-solving, and future orientation. Previous studies have demonstrated that resilience training can significantly enhance mental health, increase positive affects, and improve anger control among students [14-16]. For instance, research by Dehghani and Hasani [14] showed that resilience training effectively improved stress management and affective behavior in students with learning disabilities. Similarly, Naderpour et al. [15] highlighted that promoting resilience helps individuals confront unpleasant life events in a positive and efficient manner. By fostering protective factors like self-confidence and impulse control, this intervention mitigates the destructive impact of environmental stressors.

The necessity of this research stems from the rising prevalence of aggression and its severe social and psychological consequences for adolescents. While various interventions have been explored, there is a continuous need to identify which structured programs most effectively improve affective control and academic well-being in clinical populations. Enhancing these variables can reduce risks such as delinquency and school dropout while promoting overall mental health. Given the gaps in comparative intervention efficacy, this study addressed a critical need in educational psychology. The objective of the present study was to investigate the effectiveness of a 10-session resilience training program on fear of affective dysregulation (affective control) and academic well-being in female middle school students in Ahvaz exhibiting clinical symptoms of aggression.

Method

The present study employed a randomized clinical trial design consisting of a pre-test, post-test, and a one-month follow-up with a waitlist control group. The statistical population comprised all female middle school students in Ahvaz, Iran, during the 2024–2025 academic year.

Using a multi-stage cluster random sampling technique, two schools were initially selected from four educational districts, and three classes were randomly chosen from each school. Screening was conducted by school counselors using the Barratt Impulsiveness Scale (BIS-11). Students scoring at or above the 75th percentile on the total BIS score (corresponding to the clinical range frequently associated with reactive aggression) were invited to participate in a semi-structured clinical interview. The interview was conducted by a licensed clinical psychologist and included questions adapted from DSM-5 criteria for intermittent explosive disorder and oppositional defiant disorder (aggressive features) to confirm the presence of clinically significant aggressive symptoms. From the screened population, 30 students meeting the inclusion criteria were selected and randomly assigned to either the experimental group (n=15) or the waitlist control group (n=15).

Inclusion criteria included: (a) confirmation of clinical aggression symptoms based on screening scores and interview, (b) lack of concurrent participation in other psychological interventions, and (c) informed consent from both students and parents. Exclusion criteria involved: (a) more than two absences from training

sessions and (b) the presence of severe comorbid psychiatric disorders requiring immediate medical intervention. Ethical considerations were strictly observed, ensuring participant confidentiality, the right to withdraw from the study at any time, and the provision of the training package to the control group upon completion of the research.

Randomization was performed using a computer-generated random sequence (simple randomization in blocks of four) by an independent researcher not involved in recruitment or intervention delivery. Allocation concealment was ensured through sequentially numbered, opaque, sealed envelopes. Due to the nature of the intervention, blinding of participants and the therapist was not possible; however, outcome assessors (who administered and scored the questionnaires) were blinded to group assignment.

The experimental group participated in a structured 10-session resilience training program. Sessions were held twice weekly, each lasting 90 minutes, in a dedicated counseling room at the participating schools after regular school hours. The program was delivered by a licensed clinical psychologist with eight years of experience in adolescent group interventions, who had received specific training in resilience-based protocols and was supervised biweekly by a senior clinical psychologist. Session adherence and fidelity were monitored using a standardized fidelity checklist assessing delivery of core content, time allocation, and participant engagement; the mean fidelity rating across all sessions was 92%. Attendance rate in the experimental group was 93.3% (mean sessions attended=9.33, SD=0.72); no participant was excluded due to excessive absences. Homework compliance was encouraged through weekly review and discussion but was not formally quantified.

The control group remained on a waitlist and received no intervention during the study period but was offered the complete training package after the one-month follow-up assessment, as the level of aggression reported did not indicate immediate risk of serious harm. Data were collected at three stages: baseline (pre-test), immediately after the 10th session (post-test), and one month later (follow-up). The summary of the intervention protocol is presented in Table 1.

The study was designed and conducted as a pilot randomized controlled trial. No formal a priori power analysis was performed. However, post hoc sensitivity analysis indicated that the obtained sample size (n=30) provided >85% power to detect large time × group interaction effects ($\eta p^2 \geq 0.50$) at $\alpha=0.05$ in repeated-measures ANOVA.

Table 1. Summary of Resilience Training Sessions

Session	Primary objective	Content and activities
1	Introduction to the program	Familiarization with key concepts, program structure, implementation stages, procedures, and assigned homework tasks.
2	Emotional identification and control	Focus on recognizing and regulating emotions.
3	Developing empathy	Instruction in methods to cultivate and enhance empathy; training in prosocial behaviors, including altruism, sharing, helping, acceptance, consideration, and consoling others.
4	Self-regulation and resilience	Introduction to the concepts of self-regulation and resilience, along with their distinctions. Self-regulation was presented as the ability to delay immediate gratification and inhibit impulses to achieve longer-term goals. Resilience was defined as the capacity for adaptation, flexibility, and adjustment to the demands of diverse situations.
5	Building and maintaining Positive relationships	Discussion of skills for forming and sustaining positive relationships, including effective verbal and nonverbal communication.
6	Sense of humor and effective group participation	Training in developing a sense of humor and engaging in productive group collaboration.
7	Positive self-concept	Learning components of self-awareness, positive self-perception, and self-efficacy.
8	Metacognition and problem-solving	Instruction in metacognitive strategies, problem-solving skills, identifying cycles of negative thinking, and fostering efforts to develop positive attitudes.
9	Preserving beliefs and future orientation	Exploration of maintaining religious or spiritual beliefs and expectations, alongside setting future goals.
10	Consolidation and integration	Reinforcement and integration of acquired skills across emotional, social, and cognitive domains of resilience. Administration of the posttest.

The tools used in this study were as follows: **Affective Control Scale (ACS):** Developed by Williams et al. [17], this 42-item instrument assesses an individual's fear of losing control over four major domains of affect: anger, depressed affect, anxiety, and positive affect. Items are scored on a seven-point Likert scale, ranging from 1 (very strongly disagree) to 7 (very strongly agree). Higher total scores indicate a greater fear of emotions and a higher perceived risk of losing control over them, which is often associated with maladaptive emotion regulation and increased susceptibility to mood disorders. In Persian linguistic and cultural adaptations, Cronbach's alpha for the subscales has ranged from 0.76 to 0.89 [18]. In the current study, the total internal consistency was calculated at 0.84, demonstrating high reliability and robust psychometric properties for the Iranian student

population.

Academic Well-being Questionnaire: This composite scale, based on the work of Tuominen-Soini et al. [19], consists of 31 items measuring four distinct dimensions: school burnout (10 items), schoolwork engagement (9 items), satisfaction with educational choice/school (4 items), and school value/perceived competence (8 items). Responses are recorded on a Likert scale (ranging from 1=strongly disagree to 6 or 7=strongly agree, depending on the subscale). Higher total scores, calculated after reverse-scoring the burnout items, represent a higher level of academic well-being. Previous research in Iran has reported Cronbach's alpha coefficients exceeding 0.80 for all subscales [20]. In the current study, the internal consistency for the total scale was 0.82, confirming its validity and reliability as a measure of student psychological health in educational settings.

Statistical analyses were conducted using IBM SPSS Statistics version 27. Descriptive statistics, including means and standard deviations, were computed to summarize the scores on the outcome measures. To evaluate the effects of the intervention over time, repeated-measures analysis of variance (ANOVA) was employed, with time (pretest, posttest, and one-month follow-up) as the within-subjects factor and group (experimental vs. waitlist control) as the between-subjects factor. No missing data were present at any time point; complete-case analysis was therefore used. The significance level was set at $\alpha=0.05$.

Results

Participants were female middle school students with a mean age of 14.32 years (SD=0.84) in the experimental group and 14.47 years (SD=0.76) in the control group. An independent-samples t-test revealed no significant difference in age between groups (t=0.54, P=0.593), confirming baseline homogeneity.

Descriptive statistics for affective control and academic well-being across the three assessment phases are presented in Table 2. In the experimental group, mean ACS scores decreased substantially from pretest (M=177.27, SD=15.34) to posttest (M=156.93, SD=13.17) and remained stable at follow-up (M=156.67, SD=9.63). In contrast, scores in the control group showed minimal change across phases. For academic well-being, the experimental group exhibited a marked increase from pretest (M=75.40, SD=5.27) to posttest (M=85.53, SD=5.04), with slight attenuation at follow-up (M=83.00, SD=4.62), whereas control group means remained largely unchanged.

Prior to inferential testing, assumptions for repeated-measures ANOVA were examined. Shapiro-Wilk tests confirmed normality of the distributions for both dependent variables at all-time points (all P>0.05). Levene's tests supported equality of variances across groups (all P>0.05), and Box's M test indicated homogeneity of variance-covariance matrices (P>0.05). Mauchly's test of sphericity was non-significant for both variables (P>0.05); thus, no corrections were applied.

Results of the repeated-measures ANOVA (Table 3) revealed significant time × group interactions for both affective control (F=42.18, P<0.001, $\eta p^2=0.61$) and academic well-being (F=38.65, P<0.001, $\eta p^2=0.58$). These large effect sizes indicate that resilience training produced substantially greater changes over time in the experimental group compared to the waitlist control group.

To explore the nature of these interactions, Bonferroni-adjusted post-hoc pairwise comparisons were conducted within the experimental group (Table 4). For affective control, a significant reduction was observed from pretest to posttest (mean difference=20.34, SE=3.12, P<0.001), with no significant difference between posttest and follow-up (mean difference=0.26, SE=1.88, P=0.999). Similarly, academic well-being showed a significant increase from pretest to posttest (mean difference=–10.13, SE=1.46, P<0.001), followed by a non-significant change at follow-up (mean difference=2.53, SE=1.21, P=0.132). These results demonstrate that the intervention yielded significant immediate improvements that were largely maintained at one-month follow-up.

Table 2. Descriptive Statistics for Affective Control and Academic Well-being by Group and Assessment Phase

Variable	Group	Pretest M (SD)	Posttest M (SD)	Follow-up M (SD)
Affective control	Experimental	177.27 (15.34)	156.93 (13.17)	156.67 (9.63)
	Control	175.87 (11.13)	176.27 (10.37)	175.20 (10.87)
Academic well-being	Experimental	75.40 (5.27)	85.53 (5.04)	83.00 (4.62)
	Control	76.27 (4.11)	75.40 (3.71)	76.47 (3.96)

Table 3. Summary of Repeated-measures ANOVA Results (time × group interaction)

Source	Variable	df	MS	F	P	ηp^2
Time × Group	Affective control	2	2415.42	42.18	0.001	0.61
	Academic well-being	2	1842.10	38.65	0.001	0.58

Table 4. Bonferroni Post-hoc Pairwise Comparisons in the Experimental Group

Variable	Comparison	Mean Difference	SE	P
Affective control	Pretest – Posttest	20.34	3.12	0.001
	Posttest – Follow-up	0.26	1.88	0.999
Academic well-being	Pretest – Posttest	–10.13	1.46	0.001
	Posttest – Follow-up	2.53	1.21	0.132

Between-group comparisons at posttest showed significantly lower affective control scores in the experimental group compared to the control group ($t=4.82$, $P<0.001$, Cohen's $d=1.76$) and significantly higher academic well-being scores ($t=5.61$, $P<0.001$, Cohen's $d=2.05$). These group differences remained significant at the one-month follow-up assessment (both $P<0.001$).

Mean attendance in the experimental group was 9.33 sessions (SD=0.72, range 8–10), corresponding to an attendance rate of 93.3%. No adverse events or negative reactions to the intervention were reported by participants or facilitators during the study period.

Discussion

The present study provides preliminary evidence that a 10-session resilience training program can significantly reduce fear of affective dysregulation (as measured by the Affective Control Scale) and enhance academic well-being in female middle school students exhibiting clinical symptoms of aggression. The obtained large interaction effects and the relative stability of gains at the one-month follow-up are encouraging, particularly considering the brevity of the intervention and the characteristics of the target population.

These results are broadly consistent with previous Iranian studies demonstrating the beneficial effects of resilience-based interventions on emotion-related outcomes and behavioral adjustment in adolescents [14, 23, 26]. The substantial reduction in fear of losing control over emotions likely arises from several key mechanisms embedded in the training protocol. Early sessions targeting emotional identification, physiological awareness, and impulse control enabled participants to recognize early signs of escalating anger and to interrupt automatic reactive patterns. Subsequent sessions emphasizing cognitive reframing, metacognitive strategies, and self-compassion facilitated more adaptive appraisal of stressors and a less self-critical response to academic and interpersonal setbacks [22, 25, 26]. Together, these processes appear to have lowered the perceived threat associated with intense affective states, thereby reducing the internal pressure that often escalates into aggressive behavior [6, 7].

The concurrent improvement in academic well-being — particularly in the domains of school engagement and perceived competence — may reflect a decrease in emotional exhaustion and an increase in psychological resources available for coping with academic demands [23, 25]. The multidimensional structure of the program (addressing cognitive, emotional, and social domains) likely created reciprocal reinforcement: improved emotion modulation reduced school-related frustration and conflict, while higher levels of school satisfaction and self-efficacy further bolstered participants' sense of resilience [27].

Compared to similar resilience interventions conducted in Iran, the effect sizes observed in the present study fall in the upper range of those typically reported for outcomes related to emotion regulation, stress management, and aggression proxies in adolescent samples [14, 23, 26]. The average reduction of approximately 20 points on the ACS and 10 points on the academic well-being measure suggests clinically meaningful change, although formal benchmarking against minimal clinically important differences remains to be established in future research.

Several important limitations must be considered when interpreting these findings. First, the relatively small sample size (N=30) increases the risk of effect size overestimation and limits the statistical power and precision of the estimates; the results should therefore be regarded as preliminary and in need of replication in larger samples. Second, the exclusive reliance on self-report measures introduces the possibility of social desirability bias and expectancy effects, particularly in an open-label trial with a waitlist control condition. Third, the study did not include a direct behavioral measure of aggression (e.g., teacher observations, disciplinary records, or peer nominations), so it remains unclear whether improvements in affective control and academic well-being translated into observable reductions in aggressive behavior. Fourth, the one-month follow-up period is too short to determine the durability of effects across longer developmental windows or under conditions of sustained stress; re-emergence of difficulties cannot be ruled out. Fifth, the sample was restricted to female students from a single city, which limits generalizability and precludes examination of potential gender-specific or regional moderators of treatment response (e.g., differences in emotional socialization or cultural norms surrounding aggression expression).

Future research should address these limitations by conducting larger, multi-center randomized controlled trials with extended follow-up periods (e.g., 6–12 months), active control conditions, multi-informant assessment strategies (including teacher and parent reports), and direct behavioral outcomes of aggression. Inclusion of male adolescents and systematic exploration of cultural and contextual moderators would further enhance the external validity and applicability of the findings.

Despite these constraints, the current results suggest that group-based resilience training — when delivered by trained school psychologists — may represent a feasible, acceptable, and potentially effective adjunct to existing mental health supports within Iranian public-school systems. Given the promising magnitude of effects and relatively low resource requirements, further development and pragmatic testing of such programs appear warranted to determine their scalability, cost-effectiveness, and long-term impact on adolescent psychological health and educational outcomes.

Conclusion

The present study provides preliminary evidence supporting the effectiveness of a 10-session resilience training program in significantly reducing fear of affective dysregulation (as measured by the Affective Control Scale) and enhancing academic well-being among female middle school students exhibiting clinical symptoms of aggression. The observed improvements were substantial (with large effect sizes), occurred rapidly following the

intervention, and were largely sustained at the one-month follow-up assessment. These therapeutic gains appear to result from the internalization of core resilience skills taught during the program, including emotional awareness, impulse control, cognitive reframing, self-compassion, and improved social competence. Such skills likely contributed to a decreased sense of threat from intense emotions and greater psychological resources for engaging with the academic environment. School administrators, counselors, and policymakers are encouraged to consider the integration of structured, evidence-informed resilience training programs into routine psychological support services for adolescents. At the same time, larger-scale, multi-center randomized controlled trials with longer follow-up periods, multi-informant assessments, and inclusion of diverse populations (including male students) are needed to confirm the generalizability, durability, and broader clinical impact of this approach.

Conflict of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethical Approval

The study was approved by the Ethical Committee of Islamic Azad University (code: IR.IAU.AHVAZ.REC.1403.480; IRCTID: IRCT20250304064924N1).

Declaration of Generative AI and AI-Assisted Technologies

During the preparation of this work the authors did not use any generative artificial intelligence (AI) or AI-assisted technologies in any part of the manuscript writing, figure generation, data analysis, or other aspects of the work.

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