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Effect of Flourishing Promotion Program on Social Health in the Elderly

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Abstract

Background: Social health is considered of utmost importance as a social necessity. Thus, the Flourishing Promotion Program (FPP) can be effective in promoting social health.

Aim: To determine the effect of the FPP on social health in the elderly.

Method: A randomized controlled clinical trial of 60 elderly individuals residing in Toos Nursing Home and Salamati Nursing Home, Mashhad, Iran, was performed in 2017. The participants were assigned to intervention and control groups. The intervention group enrolled in the FPP for eight 90-minute sessions, and the control group only performed the routine activities. Keyes' Social Well-Being Scale was completed before, as well as immediately and one month after the intervention. To analyze the data, Mann-Whitney U test and Friedman test were run in SPSS, version 21.

Results: The mean ages of the control and intervention groups were 74.9 ± 11.4 and 78.1 ± 7.0 , respectively. According to the Mann-Whitney U test, the mean score of social health in the intervention (57.1 ± 6.3) and control (50.4 ± 9.0) groups were significantly different before the intervention ($P=0.001$). Given the findings of the analysis of covariance, the mean score of social health in the intervention (67.9 ± 5.5) and control (50.4 ± 9.0) groups immediately post-intervention were also significantly different ($P=0.001$). Such a significant difference was also observed between the intervention (66.8 ± 5.5) and control (49.3 ± 8.7) groups one month post-intervention ($P=0.001$).

Implications for Practice: The FPP could effectively enhance mental and social health and functioning in the elderly through providing a sense of belonging, positive excitement, and better interactions.

Keywords: Elderly, Health promotion, Mental health

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Introduction

The concept of social health in old age has been addressed as the foundation of successful aging and considered as an objective for providing social welfare and health care services to this age group (1). As a global concern in the present era, the world's population is increasingly aging, which has brought about numerous challenges for different societies across the world (2, 3). According to the estimates released by the United Nations (UN), the global rate of older population will rise from about 12% in 2012 to approximately 22% by 2050 (4-6). Old age is correspondingly known as a sensitive stage in human life span, thus, paying attention to its related issues and needs is a social necessity. Respecting special needs and health-promoting behaviors at this stage is of utmost importance even though it has been so far neglected (7).

Nowadays, the elderly population is growing owing to increased life expectancy, low mortality rates, and decreased birth rates (1). As a developing country, Iran has been similarly facing the same situation. In this regard, statistical and demographic indicators and tools have revealed that the older population growth in Iran has already started (8), therefore, it can be one of the fundamental challenges in this country in upcoming years wherein social health, the ability to play social roles effectively and efficiently, can be at risk as one of the health dimensions.

It should be noted that healthy older adults regard society as a meaningful, coherent, and potential complex for growth and flourishing and have a sense of belonging to it. They are correspondingly accepted by the society through having a share in its development (9). In this respect, Seifzadeh concluded that 56.5% of the elderly were endowed with social health and well-being and 43.5% of them had very little of this health dimension (10). It is noteworthy that social health, as one of the human health dimensions, can play an important role in social life balance. Thus, lack of attention to the dimensions of social health in the elderly in the era of communications and globalization is likely to increase social vulnerability in this age group within society. Moreover, considering the dimensions of social health and reinforcing social health indicators among older adults in each society can lead to the decreased burden of physical and psychological illnesses (11). Due to losing social support and having less participation in the society, the elderly residing in nursing homes have much more feelings of sorrow and depression, as well as lower health status. Accordingly, high levels of social health in this age group can meet their emotional needs and attachments and put their life in the right direction. Such a health status can also encourage the elderly to do all their best and make efforts to deal with their life problems and to cope with them as well as possible (12). Besides, social participation (engagement) is considered as one of the main components of social health, which can decrease mortality rates and levels of depression and disability in the old age and improve well-being, cognitive health, and health-related behaviors (13). Promoting social participation (engagement) and social health status in the elderly is also assumed as one of the key policies of the World Health Organization (WHO) (14).

It has been indicated that there is a proximity between the concepts of social health and mental health, and related studies have demonstrated a positive correlation between social health indicators and those of mental health (9). The highest level of mental health has been assumed as the flourishing level (15), and the main purpose of positive psychology is to increase flourishing in one's own life and that of others (16). High levels of flourishing can produce high levels of social and mental well-being, happiness (vitality), personal growth, purpose in life, as well as close and meaningful relationships (15). Thus, it can be argued that an individual endowed with mental flourishing is able to benefit from social health although the quality and quantity of this relationship needs to be further investigated. If such a relationship is strong enough, the skills affecting flourishing can be exploited to increase social health.

Psychological methods and treatments are assumed to be more effective in social groups of the elderly (17). One of the recent treatments in the domain of aging is positive psychotherapy (PPT), which can have an impact on moderating depression and increasing happiness (vitality) and satisfaction with life (16). PPT can initiate a balance in individuals' attention in a way that they can show their experiences associated with kindness, forgiveness, encouragement, and humanity in a voluntary manner (18). Attending educational sessions in this respect can also improve the sense of being sociable in older adults and affect their functioning and social coherence, and consequently, help them to get rid of the state of stagnation and loneliness (19). Furthermore, such positive interventions can reduce depression, increase happiness, and bring about mental and psychological well-being in an individual

(20). Therefore, positive-therapeutic interventions can be used in Flourishing Promotion Program (FPP) for the elderly.

In this regard, the findings of the study by Bahadori Khosroshahi et al. in 2016 showed that teaching group-based reality therapy could improve social well-being and its components in the elderly (12). According to the results of the investigation by Sadri Damirchi et al. in 2015, the emotional, mental, and social components of well-being could be similarly enhanced in the elderly through a reality therapy program (21). In the study by Farnam in 2016, quality of life as well as life expectancy was enhanced in a group of older adults via a positive thinking training program (22). It should be noted that research studies in the domain of elderly social health had been mostly conducted with qualitative, descriptive, and analytical designs and no interventional studies with codified and specific training programs aiming at improving social health in the elderly was found.

Improved health and well-being in older adults is considered as a research priority, especially when the determinants affecting the individual's abilities and social health are used. This issue highlights the fact that it is not only beneficial, but also necessary to administer interventions at the social level. Issues related to the elderly as one of the challenges in the health system are highly sensitive, and nursing role in training older adults as well as the prevention and improvement of mental well-being and social health in the elderly is very significant, which highlights the need for new programs including FPP. With this background in mind, we aimed to determine the effect of the FPP on social health status among the elderly.

Methods

The present study was a clinical trial comprised of two groups (intervention and control). The statistical population included the elderly residing in Toos Nursing Home and Salamati Nursing Home in the city of Mashhad, Iran. This research study was conducted from October to December 2017. The participants were 60 elderly individuals residing in the two centers who met the inclusion criteria. The standard sample size was calculated to be 11 individuals in each group according to the results of a similar study using two groups of 10 individuals and considering the comparison of two population means with a 95% confidence interval and an 80% test power. Given the probability of sample attrition, 30 individuals were included in each group. The participants were selected through the convenience sampling method. For this purpose, the nursing homes were divided into intervention (30 individuals) and control (30 individuals) groups through simple random allocation. The reason behind the allocation of the centers instead of the elderly individuals was to prevent the distribution and exchange of information among the participants.

The inclusion criteria in this study were age over 59 years, ability to establish communication, fluency in Persian, minimum of primary school education, scores lower than 75 from Keyes' Social Well-Being Scale (KSWBS), scores 7 and higher from Abbreviated Mental Test (AMT), no acute or chronic physical and psychological illnesses (including asthma, chronic renal failure, cancer, and heart failure), lack of addiction to narcotic drugs and psychedelics, and no vision and hearing disorders causing disrupted activities. The exclusion criteria included absence from two planned intervention sessions, hospitalization, and absence from nursing home for any reasons during the study.

The research instruments in this study included a demographic characteristics form, AMT, and KSWBS. The demographic characteristics form included 18 items developed according to the research objectives and the latest references and related articles. The AMT as a test appropriate for screening cognitive disorders in the elderly contained 10 items with true-false responses and minimum and maximum scores of 0 and 10, respectively. In this scale, higher scores reflected lower indicators of cognitive disorders. The validity of the translated version was similarly confirmed by Bakhtiari et al. (23). Content validity of this test was established in the present study by 10 professors from Mashhad University of Medical Sciences. To measure the internal consistency, Cronbach's alpha coefficient was employed, which confirmed the reliability of this scale ($\alpha=0.76$). Moreover, test-retest reliability was used to determine its external validity, in which the intra-rater correlation was calculated through correlation coefficient between the test-retest scores of 10 participants (ICC: 0.89).

The KSWBS was developed by Keyes in the Ellen MacArthur Foundation in the United States in

2004 to measure social health. This questionnaire contained 20 items investigating 5 dimensions of social integration, social actualization, social coherence, social contribution, and social acceptance, which are scored using a 5-point Likert-type scale. The total score of the questionnaire was between 20 and 100 (24). The validity and reliability of this instrument was confirmed in different demographic and age groups, particularly in the elderly with a Cronbach's alpha coefficient of 0.83. The validity and reliability of the translated version had been already verified by Saffarinia (2014) (25). To determine the validity of this questionnaire, content validity was used. To this end, the questionnaire was submitted to 10 professors from the Department of Internal Surgery and the School of Nursing and Midwifery affiliated to Mashhad University of Medical Sciences, and its validity was confirmed after the revisions and the suggestions were included. Cronbach's alpha reliability of this scale was determined to be 82.2.

Before the intervention, social health in the older adults was measured by KSWBS via interviews. In the intervention phase, which was conducted during November-December 2017, the FPP was administered by the researcher, who had acquired the required skills during some courses under the supervision of a professional consultant; after confirming the titles and contents by the consultant and faculty members, the intervention program was implemented using group discussion, collaborative learning method, and lecture during eight 90-minute sessions (two sessions per week) on 3 groups of 10 individuals in the meeting halls of the nursing homes. This program was implemented using Seligman's (2006) PPT guide translated by Kamakar and Hozhabrian (16). Given the extensiveness of the PPT sessions, the given sessions were reduced to 8 sessions and their contents were simplified by a professor as a professional consultant. During the sessions, in-person question and answer sessions were held as breaks. In each session, an assignment was also given to the elderly individuals about the issues raised to present during the next session. Considering the subject of each session, the assignments were read out by the elderly and discussed. The first session was associated with introductions and explanations about the FPP. The second session was about positive sources and excitement. The third, fourth, and fifth sessions were focused on recognizing personality strengths, reinforcing personality positive points, and forgiveness, respectively. Moreover, the sixth session was associated with appreciation. The seventh session was concentrated on the art of gaining pleasure, and finally the eighth session was related to optimism, positive thinking, hope, and reviews of the contents acquired during all previous sessions in the form of collaborative learning and group discussion. To ensure the regular presence of the participants, the researcher reminded the head of the center in-person or via telephone contacts. It should be noted that all the routine activities of the centers were conducted for all the participants with the coordination of the managers of the two nursing homes. It should be noted that the control group only conducted the routine activities of the centers including recreation and pilgrimage accompanied by an educational pamphlet of the FPP submitted to them by the researcher. During the implementation of the eight sessions of the FPP, the levels of social health in the elderly were measured using KSWBS immediately after and one month following the intervention in the intervention and control groups residing in Toos Nursing Home and Salamati Nursing Home (Table 1).

All the ethical considerations were observed, which included obtaining written permission from the Ethics Committee of Mashhad University of Medical Sciences, acquiring a letter of introduction from the School of Nursing and Midwifery and submitting it to the authorities of Toos Nursing Home and Salamati Nursing, getting written informed consent from the study participants, codification of the questionnaires to keep the confidentiality of data, and allowing the participants to withdraw from the study at any time.

The data were analyzed using SPSS version 21. Considering the demographic and underlying characteristics of the study samples, Kolmogorov-Smirnov (K-S) test and Shapiro-Wilk test were used to examine the normality of the quantitative data. To compare the two study groups with regard to non-normal quantitative and ranked variables, Mann-Whitney U test was employed. Nominal variables were also tested and compared via Chi-square test, exact Chi-square test, and Fisher's exact test. Social health and its dimensions in both intervention and control groups were examined and compared before, immediately after, and one month after the intervention. To compare the two study groups considering non-normal quantitative and ranked variables, Mann-Whitney U test was employed. For intragroup comparisons and to compare the three phases of before, immediately after,

Table 1. Flourishing Promotion Program

Sessions	Subject	Time
Session 1	Greeting the elderly and getting to know each other, introducing the FPP Assignment for the next session: Introduce yourself positively on one page with the help of your caregiver	90 minutes
Session 2	Positive sources and positive excitement Assignment for the next session: Getting help from your caregiver, check the page you have introduced yourself on and express your personality strengths aiding you in the past	90 minutes
Session 3	Understanding personality strengths Assignment for the next session: Make a list of ways to reinforce your personality strengths	90 minutes
Session 4	Reinforcing personality strengths Assignment for the next session: Write a letter of forgiveness to a guilty person with the help of your caregiver and swear to that person that he or she will be forgiven.	90 minutes
Session 5	Forgiveness Assignment for the next session: Getting help from your caregiver, write a letter of appreciation to the one not appreciated for any reasons. If possible, deliver the letter to that person.	90 minutes
Session 6	Appreciation Assignment for the next session: With the help of your caregiver, write down a list of fun activities in the center you are residing in and try to do them.	90 minutes
Session 7	Art of gaining pleasure Assignment for the next session: Getting help from your caregiver, write about three lifetime situations you have lost an important thing in; then, think about the blessings after these failures or achievements and note them down	90 minutes
Session 8	Optimism, positive thinking, and hope Assignment for the next session: Review the points acquired in all sessions in a group discussion	90 minutes

and one month after the intervention, Friedman test was used considering the non-normal distribution of the variables. During these tests, the confidence coefficient and the significant level were considered 95% and 0.05, respectively.

Results

The mean ages of the elderly in the intervention and control groups were 78.1 ± 0.7 and 74.9 ± 11.4 years, respectively, and 76.7% and 60.0% of the older adults in the intervention and control groups were female, respectively. Moreover, 76.7% of the participants in the intervention group and 73.3% of the elderly in the control group had lost their spouses. In addition, 83.3% and 70.0% of the individuals in the intervention and control groups had primary school education, respectively. The findings also showed that 76.7% of the older adults in the intervention group and 70.0% of them in the control group had a history of chronic diseases. In addition, 56.7% and 83.3% of the elderly in the intervention and control groups had not experienced any social activities during their lifetime, respectively. In addition, 83.3% of the participants in the intervention group and 66.7% of them in the control group had benefited from a social support system. Moreover, 56.7% and 43.3% of the elderly in the intervention and control groups had enough income, respectively. The mean lengths of stay in the nursing homes among the elderly in the intervention and control groups were 2.9 ± 1.7 and 2.9 ± 2.3 years, respectively. Furthermore, both intervention and control groups were homogenous in most cases in terms of demographic and underlying characteristics ($P=0.05$; Table 2).

The mean score of social health before the intervention was 57.1 ± 6.3 in the intervention group and it was 50.4 ± 9.0 in the control group, which was significantly different according to the results of Mann-Whitney U test ($P=0.001$). The mean score of social health immediately after the intervention was 67.9 ± 5.5 in the intervention group and 50.4 ± 9.0 in the control group, which was significantly different based on the findings of Mann-Whitney U test ($P=0.001$). Considering the lack of homogeneity of the mean scores of social health in the two groups before the intervention, analysis of covariance (ANCOVA) was used to remove its effect size. The results showed a

significant difference between the mean score of social health before the intervention and the total score of social health immediately after the intervention in both study groups ($P=0.001$). There was also a rising trend in the mean of changes in scores of social health immediately after and before the intervention in the intervention (10.8 ± 2.8) and control (0.1 ± 0.4) groups, which was reported as a significant difference according to the results of Mann-Whitney U test ($P=0.001$).

The mean score of social health in the intervention group was 66.8 ± 5.5 one month after the intervention, and it was 49.3 ± 8.7 in the control group. Mann Whitney U test reflected a significant difference between these two groups ($P=0.001$). Considering that the total score of social health status before the intervention was not homogenous in both groups, ANCOVA was run to remove the effect size, which indicated that the total score of social health one month after the intervention was significantly different between the two groups ($P=0.001$). The mean score of social health immediately after the intervention in the intervention and control groups were 67.9 ± 5.5 and 50.4 ± 9.0 , respectively. According to Mann-Whitney U test, such a difference was significant ($P=0.001$). The mean of total social health scores in the intervention and control groups one month after the intervention were 66.8 ± 5.5 and 49.3 ± 8.7 , respectively. Regarding the findings of Mann-Whitney U test, such a difference was significant ($P=0.001$).

The mean of changes in the scores of social health also reduced immediately and one month after the intervention to 1.1 ± 1.2 in the intervention group and to 1.1 ± 0.8 in the control group, which were not significantly different according to the results of Mann-Whitney U test ($P=0.589$). Considering that the total score of social health status before the intervention was not homogenous in both groups, the ANCOVA was used to remove the effect size, which indicated that the changes in the total score of social health one month after the intervention was significantly different in both study groups compared to before the intervention ($P=0.001$).

Given the intragroup comparison and the results of Friedman test, the total score of social health in the intervention group could entail significant changes at different phases, that is, before, immediately after, and one month following the intervention ($P=0.001$). Using Wilcoxon signed-rank test with Bonferroni correction to compare the phases in a pairwise manner, we found that changes in all the phases were significant. According to the results of Friedman test, the total score of social health before, immediately after, and one month following the intervention had significantly changed in the control group ($P=0.001$). The findings of Wilcoxon signed-rank test with Bonferroni correction for pairwise comparison also showed that the changes immediately after the intervention were not significant compared to those before the intervention; however, there was a significant difference between one month after the intervention and before the intervention and between one month post-intervention and immediately following the intervention (Table 3).

Table 2. Demographic characteristics of the participants in both intervention and control groups

Variable	Group		Test results
	intervention (30 individuals)	control (30 individuals)	
Age (year)	78.1 \pm 7.0	74.9 \pm 1.4	* $P=0.16$
Length of stay in the nursing home (year)	2.9 \pm 1.7	2.9 \pm 2.3	* $P=0.67$
Gender			
Male	7 (23.3)	12 (40.0)	** $P=0.16$
Female	23(76.7)	18 (60.0)	
Marital status			
Single	5(16.7)	2 (6.7)	*** $P=0.30$
Married	1(3.3)	5 (16.7)	
Deceased spouse	23(76.7)	22 (73.3)	
Divorced	1(3.3)	1 (3.3)	
Level of education			
Primary school	25 (83.3)	21 (70.0)	* $P=0.22$
Secondary school	4(13.3)	7 (23.3)	
Higher education	1(3.3)	2 (6.7)	

*Mann-Whitney U test **Chi-square test ***exact Chi-square test

Table 3. Comparison of participants' social health status in both intervention and control groups

Variable	Group		Intergroup Mann-Whitney U test results
	Intervention (30 individuals)	Control (30 individuals)	
	Mean±standard deviation	Mean±standard deviation	
Social health score before the intervention	57.1±6.3	50.4±9.0	P=0.001
Social health score immediately after the intervention	67.9±5.5	50.4±9.0	P=0.001
Social health score one month after the intervention	66.8±5.5	49.3±8.7	P=0.001
Intragroup Friedman test results	P=0.001	P=0.001	

Discussion

We sought to determine the effect of the FPP on the social health of the elderly residing in Toos Nursing Home and Salamati Nursing Home in the city of Mashhad, Iran.

Considering the results of the present study, the social health status in older adults in the intervention group was significantly higher than that in the control group before, immediately after, and one month after the implementation of the FPP. There was also a statistically significant increase in social health status in the intervention group immediately and one month after the intervention compared to that before the intervention. In this respect, the study by Bahadori Khosroshahi et al. (2016) in Iran on elderly subjects showed that the use of reality therapy for older adults led to an improvement in social well-being and its components. In the meantime, a significant increase was reported in social health dimensions in the elderly (26), which was consistent with the results of the present study since reality therapy was originated from the concepts of positive psychology and it was to some extent in line with the contents of the FPP. In other words, the implementation of the FPP could aid the elderly to establish better relationships with others, sustain and reinforce the positive features of their personality, and enhance their hope and positivism through group collaborations. Thus, the dimensions of social health could be promoted and the post-intervention effects could be highlighted.

The study by Sohrabi et al. (2016) also showed that well-being and health could be increased in the elderly as a result of practicing positive psychology techniques including those on friendship, appreciation, and writing down positive attributes (27). The older adults in the present study also practiced appreciation, forgiveness, and writing their own strengths throughout the FPP; they also established positive emotions and recollections during group discussions, and consequently, their social health was promoted.

The investigation by Sadri Demirchi et al. (2015) on the elderly also indicated increased emotional, psychological, and social well-being in the intervention group compared to the control group (21), which was consistent with the results of the present study. It should be noted that the older adults could participate in a group and discuss their strengths and listen to those of others in the course of the FPP, and consequently, experience sharing and have a sense of belonging to a community, which could affect and increase their social coherence. In this study, one of the reasons for reduced social coherence one month after the intervention was using the routine programs offered in the centers, no continuation of group sessions in the form of educational sessions, and reduced ability to retain the educational information in the elderly.

The results of the present study in terms of increased social health and its dimensions were in line with those of Sadri Demirchi et al. Although the types of interventions were different, the reality therapy program targeting increased positive feelings, as well as examining and identifying faulty and incompatible cognition in individuals could be considered among PPT interventions, thus, the obtained results could be expected. The study by Arabzadeh (2016) also demonstrated that the use of PPT could augment self-management abilities in older adults. It should be noted that different dimensions of elderly life are considered within PPT and the issues of prevention, promotion of mental health, self-management abilities, and satisfaction with life are also highlighted (28). The results of the present study were also consistent with the findings by Arabzadeh in terms of the types of interventions as well as the results of self-management dimensions. It was concluded that the use of educational programs for the elderly could improve all the dimensions of their life and health status. Therefore, the elderly can improve their social relationships and attitudes towards others, and ultimately, improve their social health if they try to associate their achievements, failures, and

conditions to themselves and their thoughts and believe that thoughts, behaviors, and emotions they experience are under their control (29).

Regarding social acceptance as one of the social health dimensions, a person can have a positive attitude and feeling to oneself and their past life and accept all their dimensions despite their weaknesses and disabilities (30). In line with the study by Sadri Demirchi et al., the elderly receiving the FPP in the present investigation could learn how to reinforce positive characteristics, appreciation, and forgiveness in their own groups, change their compatibility with others, establish interpersonal relationships with others, and accept the positive and negative aspects of their lives (31). The older adults receiving the FPP could also practice how to appreciate others and realize the importance of forgiveness in collective life in nursing homes; therefore, their social acceptance could be changed.

Yazdani et al. (2014) also outlined different levels of social participation in their study from being with others without doing any activities to assuming different roles in the society. It should be noted that most individuals aged 65 years and over feel a state of social isolation, which prevents them to have close and intimate relationships with others (1). In this study, social participation in the elderly could be increased through their presence in groups during the FPP as well as contribution to group discussions and establishment of social contacts with other elderly individuals residing in nursing homes. The study by Pietrowsky and Mikutta (2012) entitled as "Effects of positive psychology interventions in depressive patients: A randomized controlled study" (32) was to some extent in line with the present study in terms of its intervention program because social participation in the elderly had increased through using the FPP and practicing appreciation and positive thinking, reinforcing their strengths, and gaining pleasure via increasing social relationships and identifying their positive characteristics and those of others. Also, the contribution of the elderly to meaningful activities, usually in the form of organized friendship and collaboration such as taking part in different classes, can be one of the key elements in promoting quality of life and public health status (33).

Furthermore, there was a significant decrease in social health in older adults in the present study one month after the intervention compared to that immediately after the intervention in both groups due to the return of the elderly to normal activities in the nursing homes, information retention problems in the elderly, and non-implementation of the educational programs. In the study by Bahadori and Sadri, the follow-up phase was not carried out one month after the intervention and there was no possibility to compare these findings with those in the related articles. Among the distinct features of the present study compared with those conducted in the domain of social health in the elderly were simplified and comprehensible contents for the elderly, summarized educational subjects, as well as follow-up phases one month after the intervention.

The results of the present study showed that the FPP was capable of raising the level of knowledge, awareness, and skills in older adults, and consequently, increased social health and its dimensions; therefore, FPP as an accessible, effective, and low-cost program was recommended for teaching the elderly and promoting their social health. Accordingly, the elderly individuals, especially those residing in nursing homes, can reinforce their positive characteristics and practice appreciation, forgiveness, sense of pleasure, positive thinking, and sense of hope after implementing this program; thus, they can engage in public and have a sense of belonging to community, compatibility with others, increased objective activities, and improved interpersonal relationships. Given the growth in aging population in Iran and the importance of prevention and promotion of social and mental health status in older adults, the FPP as a simple, accessible, and non-pharmaceutical strategy with no complications, which is accepted by the elderly and is in accordance with their culture, can be an effective step contributing to the development of innovative programs improving geriatric health.

Among the limitations of this study was that this investigation was only conducted on elderly people residing in nursing homes and the intervention used had not been compared with other ones in this domain. Moreover, information about the participants' levels of education as well as Persian and English sources in the domain of social health was not available.

Implications for Practice

Considering the effect of the FPP on increased social health in the elderly, the results of this study could be used in planning for geriatric health care, improving public health, and preventing reduced social health status in the elderly residing in nursing homes and day care centers. Accordingly, the FPP can improve social health through increasing communications and interactions between older

adults, participating in significant activities, obtaining a sense of belonging to society, increasing objective activities, and establishing better interpersonal relationships. To improve generalizability, it was suggested to conduct the same study on the elderly residing at home and those with higher levels of education and compare this type of intervention with other health-related ones among the elderly.

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Conflicts of Interest

The authors declared no conflicts of interest concerning the publication of this article.

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