ORIGINAL ARTICLE Received 30 September. 2018 Accepted 3 July. 2019

Vol. 8, Issue 3, 149-159, 2019

Academic Journal of Psychological Studies

ISSN: 2333-0821

ajps.worldofresearches.com

Resiliency in Elderly persons referring to Qods Nursing Center of Tehran: The Effectiveness of Acceptance and Commitment therapy

Zahra Shakibee Sabet Langroodi*
Department of Clinical Psychology, Islamic Azad University, Tehran West Branch, Iran.

A B S T R A C T

The purpose of this study was to investigate the effect of admission and commitment training on resilience in the elderly. This research was conducted in a semi-experimental design with 30 participants, among whom 26 were male and 4 men from Tehran Qods elderly care center were randomly selected in two groups of 15 controls and tested. The elderly of the experimental group received 8 sessions of admission and commitment, and both groups filled out resilient questionnaires before and after the education sessions. To measure the effect of training in each group, paired t-test and independent t-test were used to compare the control and experimental groups. The results also showed that the difference between the mean change in resilience scores through admission and commitment training was 1.93 units, which was not significant ($p < 0.05$). Therefore, the research hypothesis that demonstrates the effectiveness of admission training and commitment to resilience in the elderly is not confirmed.

Keywords: Acceptance and Commitment, Resilience, Elder.

INTRODUCTION

One of the most important changes in the social structure of societies in the twenty-first century is the increase in the aging population(Antonucci et al., 2016; Olshansky, Goldman, Zheng, & Rowe, 2009). Today, 700 million people are aged over 60 and by 2020 they will reach more than a billion people. 60% of these elderly people live in developing countries. According to the census of the Iranian Center for Statistics and studies, the population over 60 years of age in Iran in 2021 is estimated to be more than 10% (Sadeghi, Haghdoost, Bahrampour, & Dehghani, 2017). The number and variety of stresses faced by people in their elderly years has become a necessity for mental health, especially for the elderly. The term "resonance", as defined by many scholars and experts, includes the concept of flexibility, improvement and return to the initial state after confronting the unpleasant conditions(Fletcher & Sarkar, 2013). For optimal use of cognitive capacity, coping with the lack of or obtaining appropriate solutions, and providing mental effort and proper function, as well as returning from the traumatic conditions in the process of any change in cognitive and new experiences, It seems that there is another item that helps one to achieve the goals set and to keep pace with that goal. It is a resilient item that, in difficult circumstances, helps the person to adapt himself / herself and his / her abilities and to cope with it and return to normal conditions(Meichenbaum, 2017). Studies that examine psychological resilience are scattered. A study reported that the resilience of

* . Corresponding Author: Shakibee Sabet Langroodi, Z.
DOI: In prossing
To cite this article: Shakibee Sabet Langroodi, Z. (2019). Resiliency in Elderly persons referring to Qods Nursing Center of Tehran: The Effectiveness of Acceptance and Commitment therapy. *Academic Journal of Psychological Studies*, 8 (3), 149-159.

mortality rates to 6% was lower for those who were more self-assertive, less anxious, and did not feel loneliness or isolation(Broderick et al., 2016). Two studies have shown that mental health resilience is predicted in elderly people(Gooding, Hurst, Johnson, & Tarrier, 2012; MacLeod, Musich, Hawkins, Alsgaard, & Wicker, 2016). One of the late developments is the adoption of change, a feature that older people often consider important to mental health. Most elderly people are flexible and, if they get overwhelmed, grow up again, especially if they've been in the past(Peterson, 2013). Resilience consists of a set of responsive cognitive, behavioral, and emotional responses to severe or chronic conditions that can be abnormal or every day. These answers can be learned and available to everyone; Resilience is not a rare attribute available to specific individuals(Mirea, 2013; Neenan, 2009).

Resilience as a whole has been defined as the process, capacity or result of successful adaptation, despite challenges or threatening conditions(Masten, 2001; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008). And the economic and social problems in human life have always required a resiliency feature as a shield resistant(Luthans, Avey, Avolio, Norman, & Combs, 2006; Masten, 2001). However, resilience, not stability against damage and conditions It is threatening and not passive in the face of dangerous situations, but is an active and constructive company in its perimeter environment. It can be said that the resilience of an individual's ability to establish a psychosocial equilibrium is difficult(Connor & Davidson, 2003; Madewell & Ponce-Garcia, 2016). In addition, researchers believe that resilience to a type of recovery is associated with positive emotional, emotional and cognitive outcomes. Resilience is a factor in helping individuals to cope with difficult and stressful situations in life and reduce depression(White, Driver, & Warren, 2010). Also, the ability to adapt to pain increases quality of life(Smith & Hollinger-Smith, 2015). Indeed, it is the ability of individuals to survive for survival and resistance in difficult and high-risk situations, which will make it possible not only to overcome those difficult situations, but also to become stronger during that, and this may be due to optimism about a better future(Wilens et al., 1999). Some of the studies that have been done with respect to perseverance have suggested some factors in predicting or enhancing effective resilience, including the economic and social deprivation associated with the upper class compared with the lower class of society and its relation with the warping(Hassani, Izadi-Avanji, Rakhshan, & Majd, 2017). The Styles of Inner and Outward Documents, Positive and Negative Emotions(Fredrickson, 2001; Tugade & Fredrickson, 2004), Mental Health(Genereux et al., 2017) and Source Control; Also, the results of previous studies on resonance show that increased resilience leads to more coping with problems. According to Luthar and Zelazo (2003), high-resilience people perceive stressful events less than threatening, and are more likely to seek help instead of suppressing them. Therefore, due to the importance of resilience to mental health of individuals(Hjemdal, Friborg, Stiles, Rosenvinge, & Martinussen, 2006). It is always trying to find out the effective factors in increasing it.

One of these treatments is treatment based on admission and commitment. In the treatment of admission and commitment, the goal is to change the relationship of one's person with his thoughts and feelings(Hayes, 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). As long as we label the thought or emotion as a sign, it implies that it is bad, false, negative, and harmful, and that it should get rid of it for being healthy. That is what causes our conflict with thoughts and feelings. A conflict that usually does not have a good result. The ultimate goal is to transform these thoughts and painful feelings of the old form, the abusive harmful signs that prevent meaningful and rich lives, in a newer form, and the natural human experiences that are parts of a rich and meaningful life(Ayduk & Kross, 2010). Treatment based on admission and delivery has a special attention to mental skill. Forman (1999), a pioneer in the design of the component of mind-consciousness, defines it as an unobtrusive attention to the present and momentary experience. This treatment is based on the idea that pathology is a kind of

psychological inflexibility and is caused by the avoidance of disturbing thoughts and emotions. This therapy helps individuals through increasing mental awareness, cognitive distraction (observing thoughts), and making a commitment to active engagement in the outside world, and trying to achieve meaningful and genuine life with the goal of increasing psychological flexibility to help with stressful situations To counteract(Hayes, 2004). Psychological flexibility is to increase the ability of clients to connect with their experience in the present so that they choose, in accordance with what is possible at that moment in their own way, in accordance with their chosen values. This treatment is an evidence-based intervention and encourages clients to test their negative thoughts, and, contrary to traditional cognitive therapy, explicitly reject cognitive restructuring because it focuses on performance rather than cognitive content(Bond, Hayes, & Barnes-Holmes, 2006). Many researches consider psychological acceptance as a quality of life(Tan & Martin, 2016), and even some of them introduce the acceptance and mindfulness of persuasive elements(Van Dam et al., 2018). Heidarian, Sajjadian, and Heidari (2017), in an internal research that increases group therapy based on the acceptance and rescue commitment of mothers with children with learning disabilities. The results of Azizi, Hsanabadi, Mahram, and Saeidi (2013), also indicate the effectiveness of a commitment and acceptance program based on the resilience of chronic headache patients.

Therefore, with increasing elderly populations, the number of stresses that age is facing, it is important to consider the mental health and especially resilience in the period. Therefore, this study suggests that group therapy based on acceptance and commitment to the elderly should help to increase their resilience. Most studies have been conducted in Iran about adolescence through middle age, and less study has been done to examine the elderly. Therefore, the present research tries to examine from another perspective some of the psychological conditions of the old age and their scientific recognition and reflection. The results refer to the elderly and relevant people.

METHODOLOGY

The research method was a semi-experimental design with pretest-posttest design with control group. The statistical population of this study was all elderly residents of Tehran's elderly homes. The age range of the elderly is defined by the Ministry of Health, Therapy and Medical Education in Iran, 60 years and older (Ministry of Health and Medical Education, 2013).

Acceptance and Commitment Education (ACT) was conducted in the form of 8 sessions of a 90-minute weekly exercise session for two groups of 15 elderly men and women. In the first session before the start of the training sessions, both groups were pre-test and during the course, the training and assignments were given to the experimental group, while the control group did not receive any training and assignment, and then at the end of the post-test period Was taken from both groups. The pretest and post-test materials were questionnaire "Resiliency" questionnaire, which was answered by the participants of the two groups after the interview.

The sample size of this study consisted of 30 elderly people who had the conditions for entering this research. The research conditions on this sample were confirmed by the management unit of the Residential Nursing Hospital of Qods (Kamrani), Tehran, where the administrative process was also carried out. Of the thirty, 15 were the experimental group and 15 others were the control group. The experimental group received 8 sessions of acceptance and commitment, and the control group received no training.

A sampling from a list of 60 aged people with vigilance was provided by the center to the researcher and 30 patients were selected through a clinical interview with the level of consciousness of place and time and ability to participate in the educational class. They were

randomly divided into two groups of 15 control subjects and 15 subjects were tested. To analyze the data, descriptive statistics were used to provide frequency, mean, standard deviation. In inferential statistics, Shapirovailk test was used to normalize the data. Meanwhile, in order to interpret and generalize the findings in inferential statistics, a t-test was used for comparison between the groups and paired t-test was used for intra-group comparison. All steps are done by SPSS software and the final analysis is presented.

Conor Diudson Rescue Instrument: This is a questionnaire to measure the power of coping with pressure and threat. The psychometric properties of this scale were evaluated in six groups: general population, referrals to primary care, outpatient psychiatric patients, patients with general anxiety disorder, and two groups of patients with post-traumatic stress. The response spectrum is 5-level Likert type, which is completely false (1) to perfectly correct (5). In order to obtain the overall score of the questionnaire, the sum of the points of all questions is combined together. The score will range from zero to 100. The higher the score, the greater the resilience of the respondent will be, and vice versa. A score of more than 50 markers will be resilient, and the higher the score is above 50, the same will be the same as the intensity of the person's resilience and vice versa. The authors of this scale believe that this questionnaire can well identify resilient people in clinical and non-clinical groups and can be used in clinical and research positions. The questionnaire has 25 sentences and although the results of exploratory factor analysis have seven factors (feeling individual ability, resistance to negative influences, positive acceptance of change, trust in individual instincts, social support, faith, and pragmatic approach to problem solving methods) for scale Resonance has been confirmed, since the validity and validity of the sub-scales have not yet been verified, only a resonance score is currently considered valid for research purposes. Treatment protocol. In this research, the experience of participating in the workshop and the integration of multi-treatment treatment protocols based on acceptance and commitment have been used in a group.

Elderly responded to the volunteering questionnaire by referring to the nursing home praising the city of Tehran and obtaining the necessary permissions. Among the people who scored a score of 50, DSM-5 (SCID-II) did not have any diagnosis of psychiatric disorder based on a semi-structured diagnostic interview, they were not given to them. After hearing the auditory and visual acuity status, 40 elderly residents were selected according to the list of subjects and then randomly placed in two experimental and control groups of 10. After explaining the purpose of the research and obtaining the consent of the participants and explaining that they could refrain from continuing cooperation at any time, the experimental group received nine training sessions by one of the specialist scholars based on the acceptance and commitment training, and the training control group received They did not. After the end of the training, both the experimental and control groups responded to the rescue questionnaire. At the end of the study, the control group was also trained based on acceptance and commitment. First, a descriptive statistical analysis of the resiliency variable is performed, then the probable difference between the groups in the different stages of the evaluation is examined. Accordingly, the mean and standard deviation of elderly resilience scores in the pre-test and post-test stages are reported in both the experimental and control groups.

RESULTS

Table 1 shows the results of the normal distribution test for the measured variables. The results of Shapirowilk test indicated the normal distribution of data for all measured variables in both pretest and post-test ($P < 0.05$). Therefore, a parametric test can be used to test the hypotheses.

Table (1): Shapirowilk test to verify the natural distribution of data

Dependent variable	level	Amount	P
Resilient	Pre-exam	0.934	0.063
	Post- exam	0.948	0.153
Individual competence and ability	Pre-exam	0.931	0.051
	Post- exam	0.945	0.121
Negative affective tolerance	Pre-exam	0.962	0.339
	Post- exam	0.955	0.236
Accept positive change	pre-exam	0.976	0.698
	Post- exam	0.965	0.417
control	pre-exam	0.929	0.050
	Post- exam	0.948	0.152
Spiritual Effects	pre-exam	0.955	0.236
	Post- exam	0.976	0.698

Hypothesis 1: Acceptance training and commitment to resilience in elderly people.

The results of in-group difference in the experimental group showed that the difference between the pre-test and the post-test was 1.66 units, which was not significant (P> 0.05). Therefore, in the experimental group, after the acceptance and commitment training, the resilience scores in elderly people did not change significantly. The results of intra-group differences for the control group showed that the difference between the pre-test and the post-test was 3.6. This difference was not significant (P> 0.05). Therefore, in the control group, there was no significant change in pre-test and post-test score (Table 2).

The results also showed that the difference between the mean change in resiliency scores through admission and commitment training was 1.93 units, which was not significant (P> 0.05). Therefore, the use of acceptance training and commitment did not significantly change the resilience score in the experimental group compared to the control group. Therefore, the research hypothesis that demonstrates the effectiveness of admission and commitment training on resilience in the elderly is not confirmed (Table 2).

Table 2. Comparison of the resonance score within and between the control and testing groups

Groups	**Resilient**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	73±8.04	-1.66	-0.84	0.415	1.93	0.574	0.571
	Post- exam	74.67±7.6						
Control	Pre-exam	66.2±7.06	-3.6	-1.323	0.207			
	Post- exam	69.8±10.96						

The primary part of the study: Acceptance and commitment training affects the competence and individual ability of the elderly:

The results of in-group difference in the experimental group showed that the difference between pre-test and post-test was 0.00 units, which was not significant (P> 0.05). Therefore, in the experimental group, after admission and commitment training, competency scores and individual ability in elderly people did not change significantly. The results of intra-group differences for the control group showed that the difference between pre-test and post-test was -0.73, but this difference was not significant (P> 0.05). Therefore, in the control group, there was no significant change in pre-test and post-test score (Table 4).

The results also showed that the mean difference between competency scores and individual ability through admission and commitment training was 733/0 between control and experimental groups, which was not significant (P> 0.05). Therefore, the use of admission and

commitment training did not change the competence and competence of the experimental group compared to the control group. Therefore, the research hypothesis that demonstrates the effectiveness of admission and commitment training on competence and individual ability in the elderly is not confirmed (Table 3).

Table 3. Comparison of competency score and individual ability within and between control and testing groups

Groups	**Individual competence and ability**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	23.93±4.5	0	0	1	0.733	0.394	0.696
	Post- exam	23.93±3.26						
Control	Pre-exam	21±3.68	-0.73	-0.533	0.602			
	Post- exam	21.73±4.98						

Secondary Finding: Acceptance and Commitment Training Affects Negative Affect Tolerance in the Elderly:

The results of in-group difference in the experimental group showed that the difference between the pre-test and the post-test was 2 units, which was significant (P <0.05). Therefore, in the experimental group, after admission and commitment training, negative affective tolerance scores in elderly people increased by an average of 2 units. The results of intra-group differences for the control group showed that the difference between the pre-test and the post-test was calculated to be 0.267, which was not significant (P> 0.05). Therefore, in the control group, a meaningful change in pre-test and post-test score did not occur (Table 4).

The results also showed that the difference between the mean change in negative affective tolerance scores through admission and commitment training was 2.27 in the control and experimental groups, which was significant (P <0.05). Therefore, admission and commitment training, on the average, increased the mean score of negative emotional bearing score of the elderly in the experimental group compared to the control group. Therefore, the research hypothesis that confirms the effectiveness of admission and commitment training on negative affective tolerance in the elderly is confirmed (Table 4).

Table 4. Comparison of the score of negative affect tolerance within and between the control and experimental groups

Groups	**Individual competence and ability**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	13.93±3.2	-2	-3.09	0.8	-2.27	-3.64	0.5
	Post- exam	19.93±2.76						
Control	Pre-exam	17.8±1.97	0.267	0.745	0.469			
	Post- exam	17.53±1.68						

The third part of the study: Acceptance and commitment training affects the positive acceptance of change and secure relationships in the elderly:

The results of in-group difference in the experimental group showed that the difference between pre-test and post-test was -0.2 units, which was not significant (P> 0.05). Therefore, in the experimental group, after admission and commitment training, positive change in change rates and secure relationships in elderly people did not change significantly. The results of intra-group differences for the control group showed that the difference between pre-test and post-test was -0.33, but this difference was not significant (P> 0.05). Therefore, in the control group, there was no significant change in pre-test and post-test score (Table 5).

The results also showed that the difference between the mean change in the scores of positive change and the safe relationship between the acceptance and commitment training was between the two groups of control and test (0.133), which was not significant (P> 0.05). Therefore, the use of admission and commitment training did not make a meaningful change in the positive admission score of change and secure relationships in the test group compared to the control group. Therefore, the research hypothesis that expresses the effectiveness of admission and commitment training on the positive admission of change and secure relationships in the elderly is rejected (Table 5).

Table 5. Comparison of positive change score scores within and between control and testing groups

Groups	**Accept positive change**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	15.07±2.79	-0.2	-0.264	0.796	0.133	0.138	0.891
	Post- exam	15.27±2.02						
Control	Pre-exam	13.93±2.05	-0.33	-0.587	0.758			
	Post- exam	14.27±2.69						

The fourth part of the study: Admissions and commitment training have an impact on control in the elderly:

The results of in-group difference in the experimental group showed that the difference between pre-test and post-test was -33.33, which was not significant (P> 0.05). Therefore, in the experimental group, after the acceptance and commitment training, the control scores in elderly people did not change significantly. The results of intra-group differences for the control group showed that the difference between pre-test and post-test was -0.87, which was not significant (P> 0.05). Therefore, in the control group, there was no significant change in pre-test and post-test score (Table 6).

The results also showed that the difference between the mean of change in control scores through admission and commitment training was 533/0 between control and experimental groups, which was not significant (P> 0.05). Therefore, the use of admission and commitment training did not significantly change the control score in the experimental group compared to the control group. Therefore, the research hypothesis that expresses the effectiveness of admission and commitment training on control in the elderly is not confirmed (Table 6).

Table 6. Comparison of the control score within and between the control and testing groups

Groups	**Accept positive change**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	9±1.77	-0.333	-0.607	0.554	0.533	0.838	0.409
	Post- exam	9.33±1.45						
Control	Pre-exam	8±1.56	-0.87	-1.68	0.114			
	Post- exam	8.87±1.55						

The fifth part of the study: Acceptance and commitment training has an impact on spiritual influences in the elderly:

The results of in-group difference in the experimental group showed that the difference between the pre-test and the post-test was -0.067, which was not significant (P> 0.05). Therefore, in the experimental group, after the training of acceptance and commitment, the scores of spiritual effects in elderly people did not change significantly. The results of intra-group differences for the control group showed that the difference between the pre-test and the post-test was calculated to be 0.266, which was not significant (P> 0.05). Therefore, in the control group, there was no significant change in pre-test and post-test score (Table 7).

The results also showed that the difference between the mean change in the scores of spiritual influences through acceptance and commitment training was between the two groups of control and experiment 0.333, which was not significant (P> 0.05). Therefore, the use of admission and commitment training did not create a significant change in the score of spiritual effects in the experimental group compared to the control group. Therefore, the research hypothesis that expresses the effectiveness of admission and commitment training on spiritual influences in the elderly is not confirmed (Table 7).

Table 7. Comparison of the score of spiritual effects within and between the control and experiment groups

Groups	**Accept positive change**		**Intragroup difference**			**Difference between groups**		
	Measurement stage	Mean ± SD	Mean Difference	t	p	Mean Difference	**t**	**p**
Experiment	Pre-exam	6.6±0.99	-0.067	-0.235	0.818	-0.333	-0.747	0.462
	Post- exam	6.67±0.72						
Control	Pre-exam	6.13±1.36	0.266	0.774	0.452			
	Post- exam	5.87±0.74						

CONCLUSION

The results of the fourth chapter indicated that the difference between the mean of change in dependency scores through admission and commitment training was not significant between the two groups (P> 0.05). Therefore, the use of acceptance training and commitment did not significantly change the resilience score in the experimental group compared to the control group. Therefore, the research hypothesis that demonstrates the effectiveness of admission training and commitment to resilience in the elderly is not confirmed.

According to the results obtained in the resonant factor, we can say that the hypothesis of zero has been confirmed and the second study hypothesis, ie admission training and commitment to resilience in elderly people, is rejected.

In explaining this finding, it can be said that the reason for this conclusion and the rejection of this hypothesis is that "the teaching of acceptance and commitment to the resilience of the elderly" is that the selected community of this research is from the elderly who are not aware of the illness and are in the way that harm Many of them have been brought into their lives since childhood and during all their time, they have kept all their power up to the ages and with all the troubles and periods of time, and they have been able to adapt to live in the form of dispositions of the surrounding people and show normal regeneration. And short-term tutorials like those used in this research to change and increase resilience they have not been enough to higher levels.

It is also likely that according to the study by MacLeod et al. (2016), the common mental, social and physical characteristics associated with resilience are one of the reasons for not resisting the population. In this study, high resiliency is strongly associated with positive outcomes including successful aging, depression, and life expectancy. Interventions to increase resilience in this population are possible, but there is little evidence of success. The research by MacLeod et al. (2016). Is consistent with the present study, indicating that the common characteristics mentioned, including mental and social, are resilient in nature, and it seems that changes in these characteristics yield different results and the community present in this The research lacks these factors.

Results of research sub-items:

In this section, subordinate questions that are components of interpersonal interdependence include "emotional reliance on others", "lack of self-confidence" and "self-determination" are answered.

First sub-question: Does the teaching of admission and commitment affect the emotional reliance on others in the elderly?

The results of chapter four showed that the difference between the mean change in emotional reliance on admission and commitment training was significant between the control and experimental groups ($P < 0.05$). Therefore, admission and commitment training, on average, reduces the emotional retention of the elderly in the experimental group compared with the control group. Therefore, the research hypothesis that confirms the effectiveness of admission and commitment training on emotional reliance on others in the elderly is confirmed.

This result is explained by the fact that, considering the recognition and acceptance of emotions and the psychological avoidance and admission that were taught and educated in the education of the elderly, the elderly can transform their interpersonal relationships from a sticky and needy to a state that is capable of They pay more attention to themselves and do not need to rely on others in life and do not get distracted and do not feel worthy only in close relationships and relying on them. It also has the ability to deal with issues such as loneliness and the occupation of children and the loss of loved ones and illness when needed.

Second Sub-Question: Does admission and commitment training affect the lack of self-confidence in the elderly?

The results of chapter four showed that the difference between the mean change in self-confidence scores due to acceptance and commitment training was significant between the two groups ($P < 0.05$). Therefore, admission and commitment training, on average, reduces the lack of self-confidence in the experimental group compared with the control group. Therefore, the research hypothesis that confirms the effectiveness of admission and commitment training on the lack of self-confidence in the elderly is confirmed.

This result is explained by the fact that due to the emotional awareness and wisdom and the strengthening of the sense of meaning and tolerance of distress that was taught and taught in the education of the aged, the elderly can save themselves from this stereotype that is deteriorating. And feel empowered. They can exchange the unpleasant feelings that are physically limited, with a good sense of cognitive, emotional and emotional capabilities. The feeling that they are capable of self-believers and making themselves effective will make them enjoy the rest of their lives and feel less depressed about their decisions.

Third sub-question: Is admission and commitment training affirming self-determination in the elderly?

The results of the fourth chapter indicated that the difference between the mean change in the scores of self-determination confirmed by admission and commitment training was significant between the two groups ($P < 0.05$). Therefore, admission and commitment training, on average, increases the self-determination of the elderly in the experimental group compared with the control group.

REFERENCES

Antonucci, Toni C, Berkman, Lisa, Börsch-Supan, Axel, Carstensen, Laura L, Fried, Linda P, Furstenberg, Frank F, . . . Olshansky, S Jay. (2016). Society and the Individual at the Dawn of the Twenty-First Century *Handbook of the Psychology of Aging* (pp. 41 :(۶۲-Elsevier.

Ayduk, Özlem, & Kross, Ethan. (2010). From a distance: implications of spontaneous self-distancing for adaptive self-reflection. *Journal of personality and social psychology, 98*(5), 809 .

Azizi, Maryam. , Hsanabadi, Hosein., Mahram, Behrouz., & Saeidi, Morteza. (2013). *The Effectiveness of ACT Acceptance and Commitment Group Therapy on Improving Resiliency in People with Chronic Headache*. Paper presented at the Second National Conference on Research and Treatment in Clinical Psychology, Tehran, Iran [In Persian] .

Bond, Frank W, Hayes, Steven C, & Barnes-Holmes, Dermot. (2006). Psychological flexibility, ACT, and organizational behavior. *Journal of Organizational Behavior Management, 26*(1-2), 25-54 .

Broderick, Joan E, Keefe, Francis J, Schneider, Stefan, Junghaenel, Doerte U, Bruckenthal, Patricia, Schwartz, Joseph E, . . . Gould, Elaine. (2016). Cognitive behavioral therapy for chronic pain is effective, but for whom? *Pain, 157*(9), 2115-2123 .

Connor, Kathryn M, & Davidson, Jonathan RT.(2013). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depression and anxiety, 18*(2), 76-82 .

Fletcher, David, & Sarkar, Mustafa. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European psychologist, 18*(1), 12 .

Forman, Robert KC. (1999). *Mysticism, mind, consciousness*: SUNY Press.

Fredrickson, Barbara L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American psychologist, 56*(3), 218 .

Genereux, Melissa, Maltais, Danielle, Roy, Mathieu, Maillet, Marie-Claude, Gosselin, Janot, & Petit, Geneviève. (2017). Post-disaster recovery, mental health and resiliency: the role of public health organizations. *Prehospital and Disaster Medicine, 32*(S1), S199-S200 .

Gooding, PA, Hurst, A, Johnson, J, & Tarrier, N. (2012). Psychological resilience in young and older adults. *International journal of geriatric psychiatry, 27*(3), 262-270 .

Hassani, Parkhide, Izadi-Avanji, Fatemeh-Sadat, Rakhshan, Mahnaz, & Majd, Hamid Alavi. (2017). A phenomenological study on resilience of the elderly suffering from chronic disease: a qualitative study. *Psychology research and behavior management, 10*, 59 .

Hayes, Steven C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior therapy, 35*(4), 639-665 .

Hayes, Steven C, Luoma, Jason B, Bond, Frank W, Masuda, Akihiko, & Lillis, Jason. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour research and therapy, 44*(1), 1-25 .

Heidarian, Andisheh, Sajjadian, Ilnaz, & Heidari, Somayeh. (2017). Effectiveness of group-base acceptance and commitment therapy on mindfulness and acceptance in mothers of children with autism spectrum disorders. *Middle Eastern Journal of Disability Studies, 7*(0), 28-28 .

Hjemdal, Odin, Friborg, Oddgeir, Stiles, Tore C, Rosenvinge, Jan H, & Martinussen, Monica. (2006). Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 13*(3), 194-201 .

Luthans, Fred, Avey, James B, Avolio, Bruce J, Norman, Steven M, & Combs, Gwendolyn M. (2006). Psychological capital development: toward a micro-intervention. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior, 27*(3), 387-393 .

Luthar, Suniya S, & Zelazo, Laurel Bidwell. (2003). Research on resilience: An integrative review. *Resilience and vulnerability: Adaptation in the context of childhood adversities, 2*, 510-549 .

MacLeod, Stephanie, Musich, Shirley, Hawkins, Kevin, Alsgaard, Kathleen, & Wicker, Ellen R. (2016). The impact of resilience among older adults. *Geriatric Nursing, 37*(4), 266-272 .

Madewell, Amy N, & Ponce-Garcia, Elisabeth. (2016). Assessing resilience in emerging adulthood: The resilience scale (RS), Connor–Davidson resilience scale (CD-RISC), and scale of protective factors (SPF). *Personality and Individual differences, 97*, 249-255 .

Masten, Ann S. (2001). Ordinary magic: Resilience processes in development. *American psychologist, 56*(3), 227 .

Meichenbaum, Donald .(۲۰۱۷) .Teaching thinking: A cognitive behavioral perspective *The Evolution of Cognitive Behavior Therapy* (pp. 85-104): Routledge.

Mirea, Daniel. (2013). Developing Resilience: A Cognitive-Behavioural Approach. *Existential Analysis, 24*(2), 342-347 .

Neenan, Michael. (2009). *Developing resilience: A cognitive-behavioural approach*: Routledge.

Norris, Fran H, Stevens, Susan P, Pfefferbaum, Betty, Wyche, Karen F, & Pfefferbaum, Rose L. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American journal of community psychology, 41*(1-2), 127-150 .

Olshansky, S Jay, Goldman, Dana P, Zheng, Yuhui, & Rowe, John W. (2009). Aging in America in the twenty-first century: demographic forecasts from the MacArthur Foundation Research Network on an aging society. *The Milbank Quarterly, 87*(4), 842-862 .

Peterson, Candida C. (2013). *Looking forward through the lifespan: Developmental psychology*: Pearson Higher Education AU.

Sadeghi, Masoumeh, Haghdoost, Ali Akbar, Bahrampour, Abbas, & Dehghani, Mohsen. (2017). Modeling the burden of cardiovascular diseases in Iran from 2005 to 2025: The impact of demographic changes. *Iranian journal of public health, 46*(4), 506 .

Smith, Jennifer L, & Hollinger-Smith, Linda. (2015). Savoring, resilience, and psychological well-being in older adults. *Aging & mental health, 19*(3), 192-200 .

Tan, Lucy BG, & Martin, Graham. (2016). Mind full or mindful: A report on mindfulness and psychological health in healthy adolescents. *International Journal of Adolescence and Youth, 21*(1), 64-74 .

Tugade, Michele M, & Fredrickson, Barbara L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of personality and social psychology, 86*(2), 320 .

Van Dam, Nicholas T, van Vugt, Marieke K, Vago, David R, Schmalzl, Laura, Saron, Clifford D, Olendzki, Andrew, . . . Gorchov, Jolie. (2018). Mind the hype: A critical evaluation and prescriptive agenda for research on mindfulness and meditation. *Perspectives on Psychological Science, 13*(1), 36-61 .

White, Brian, Driver, Simon, & Warren, Ann Marie. (2010). Resilience and indicators of adjustment during rehabilitation from a spinal cord injury. *Rehabilitation psychology, 55*(1), 23 .

Wilens, Timothy E, Biederman, Joseph, Spencer, Thomas J, Bostic, Jeff, Prince, Jefferson, Monuteaux, Michael C, . . . Rater, Michael. (1999). A pilot controlled clinical trial of ABT-418, a cholinergic agonist, in the treatment of adults with attention deficit hyperactivity disorder. *American Journal of Psychiatry, 156*(12), 1931-1937 .