ISSN: 2951-6641 (paper) 2951-8156 (online)
https://doi.org/10.54790/rccs.65

ARTICLE/ARTÍCULO

Evaluation of a Positive Psychology Programme for the Promotion of Well-Being and Emotional Health in Rural Elderly People

Evaluación de un programa de psicología positiva para la promoción del bienestar y la salud emocional en personas mayores del ámbito rural

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Received/Recibido: 15/05/2023
Accepted/Aceptado: 04/1/2024

ABSTRACT

Population ageing is one of the primary challenges contemporary society faces. In particular, older people living in rural areas may face additional barriers when accessing mental health resources and services, thereby increasing the risk of social isolation, depression and other emotional health problems. The aim of the study is to evaluate an intervention for the improvement of well-being and emotional health in older people. A quasi-experimental investigation was conducted with pre-intervention and post-intervention measures. The sample consists of 24 people aged 65 to 85 years. The programme consisted of a total of six sessions. The efficacy of the intervention programme was evaluated. The findings reveal a significant increase in scores among the experimental group compared to baseline measures, relative to the control group. It could be suggested that the intervention programme based on positive psychology promotes an increase in emotional well-being, which favours healthy ageing.

KEYWORDS: emotional well-being; healthy ageing; elderly people; positive psychology; perceived health.

HOW TO REFERENCE: Pérez Herrero, S. *et al.* (2024). Evaluación de un programa de psicología positiva para la promoción del bienestar y la salud emocional en personas mayores del ámbito rural. *Revista Centra de Ciencias Sociales, 3*(1), 77–97. https://doi.org/10.54790/rccs.65.

The Spanish (original) version can be read at https://doi.org/10.54790/rccs.65

RESUMEN

El envejecimiento de la población es uno de los principales retos de la sociedad actual. En particular, las personas mayores que viven en zonas rurales pueden encontrarse con barreras adicionales para acceder a recursos y servicios de salud mental, lo cual aumenta el riesgo de aislamiento social, depresión y otros problemas de salud emocional. El objetivo del estudio es evaluar una intervención, desde la perspectiva de la psicología positiva, para la mejora del bienestar y la salud emocional en personas mayores. Se llevó a cabo una investigación cuasi experimental con medidas preintervención y posintervención. La muestra está formada por 24 personas de 65 a 85 años. El programa consta de un total de seis sesiones de 90 minutos de duración y se realizó de manera presencial. Los resultados señalan que el grupo experimental incrementó significativamente sus puntuaciones con respecto al inicio, y en relación al grupo de control. Se podría sugerir que el programa de intervención basado en psicología positiva promueve un incremento del bienestar emocional, lo cual favorece un envejecimiento saludable.

PALABRAS CLAVE: bienestar emocional; envejecimiento saludable; personas mayores; psicología positiva; salud percibida.

1. Introduction

Population ageing is one of the primary challenges contemporary society faces. According to Pérez Díaz *et al.*'s report (2022), nearly 20% of Spain's population were elderly in 2021, with a majority residing in urban areas. Nonetheless, the proportion of elderly individuals relative to the total population is significantly higher in rural regions. Indeed, 28.3% of residents in rural municipalities (with 2,000 or fewer inhabitants) are elderly. Castile and León emerges as one of Spain's regions with the highest elderly population proportions. As per data from the National Institute of Statistics (INE, 2022), this community ranks third nationwide in terms of age, with its inhabitants being on average 48.14 years old. Various studies (Dean *et al.*, 2008; Grunert *et al.*, 2007; Schnettler *et al.*, 2014) suggest that socioeconomic and demographic factors, along with lifestyle choices, play a role in shaping the quality of life among older adults. Consequently, disparities in the quality of life may exist based on whether individuals reside in rural or urban settings. In rural areas, accessing essential resources like healthcare services, food, transportation and social support can be challenging. This adversely affects the overall physical, psychological and social well-being of the population, especially older adults (Galea *et al.*, 2018). While this scenario could impact both quality of life and the adoption of health-promoting behaviours, the precise influence of urban versus rural environments remains incompletely understood within the scientific community (Mohd *et al.*, 2010). Delving into health behaviours, some studies propose that various psychological factors, such as social context, symptom perception, health beliefs and emotional states, may influence these behaviours (Amigo, 2020; Pinto *et al.*, 2021). Regarding emotional states, the authors highlight their significant impact on health behaviour, suggesting that a general sense of well-being encourages greater engagement in healthy behaviours.

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Considering all the above, this research is grounded in positive health psychology, which explores positive elements and acknowledges that individuals bear some responsibility for maintaining their health (Amigo, 2020; Danis *et al.*, 2019). Hence, it is believed that individuals can cultivate and embrace healthy lifestyle habits linked to their emotional well-being through psychological and social factors. In this context, the evolution of positive psychology has been instrumental in incorporating positive elements like strengths or positive emotions, previously overlooked in clinical health psychology research (Vázquez *et al.*, 2006). Positive psychology is a field of study that focuses on the positive aspects of personality, well-being (Seligman, 2011) and optimal experience (Csikszentmihalyi, 1997). Its pillars encompass positive emotion, engagement, interpersonal relationships, meaning and accomplishment. The PERMA theory, proposed by Seligman (2002; 2011), upholds the central axis of character virtues and strengths, viewing well-being as a multidimensional and relational construct. Within contemporary positive psychology, the concept of psychological capital is prominent, denoting cognitive, affective and psychosocial resources (Casullo, 2006). The authors underscore the relevance of considering this construct, which encompasses emotional capacities like self-esteem and resilience, as well as skills for forming emotional connections with others, such as emotional intelligence and empathy, alongside values-related abilities such as gratitude (*ibid.*). According to Lombardo (2013), initial findings emphasise the importance of studying psychological capital in old age, both for deepening understanding and for designing interventions that integrate its associated positive aspects.

In this context, and in connection with positive psychology's approach to addressing health in older adults, the "well-being paradox in old age" is proposed. This paradox stems from the observation that despite ageing involving various losses at emotional, physical and cognitive levels, among others, levels of well-being and life satisfaction remain similar or even higher than those of younger individuals (Carstensen, 1993). Ortiz and Castro (2009) suggest that older adults not only manage to adapt to the changes and deficits inherent in ageing, but they also learn to reassess their priorities and set new goals, thereby enhancing their personal competencies. In another study, Scheibe and Carstensen (2010, cited in Lombardo, 2013) assert that older adults can maintain high levels of emotional well-being despite biological decline, psychological and social losses and social prejudices that stigmatise them. Conversely, Ruch *et al.*'s study (2010) concludes that positive psychology can promote healthy ageing by facilitating adaptation to the changes inherent in this life cycle and by nurturing positive experiences, traits and connections (happiness, pleasure, well-being with the past and hope for the future, strengths, etc.). Therefore, considering the findings of prior research, it appears evident to suggest that older adults could benefit from a health promotion and emotional well-being programme, given that this stage of life offers positive aspects, such as having more leisure time, thereby providing greater opportunities for personal

fulfilment (Lombardo, 2013). Cassullo *et al.* (2019) highlight psychology's role in identifying and addressing social and environmental issues that impact the quality of life of older adults. They also stress the importance of developing a positive psychology programme, as it could foster positive emotions and coping strategies amidst daily challenges.

Therefore, in light of the conclusions drawn from this research, the researchers aim to implement initiatives that enhance the health and emotional well-being of older adults, emphasising the positive aspects of health and appreciating individual strengths (Wikler, 2019). It is noteworthy that two primary focuses of health psychology, as outlined by Matarazzo (1980), include health promotion and maintenance, as well as disease prevention and treatment. As highlighted by Jiménez *et al.* (2016), programmes directed at older adults from the perspective of positive psychology incorporate techniques designed to enhance emotional well-being. In the study by Avia *et al.* (2012), engagement in autobiographical memory work yielded improvements in self-esteem and life satisfaction. Conversely, Killen *et al.* (2015) contend that fostering gratitude resulted in heightened well-being, increased resilience and a notable reduction in stress. In other studies exploring interventions aimed at fostering gratitude, an increase in resilience was observed, resulting in heightened positive affect and levels of happiness, alongside a reduction in both negative affect and depression following the intervention (Salces-Cubero, 2018). Alternative approaches incorporating various elements, such as strengths practice, forgiveness and gratitude, yielded a significant decrease in anxiety and depression states, as well as an increase in specific memory levels, life satisfaction and perceived happiness (Killen et al., 2015; Ramírez *et al.*, 2014).

However, despite the evident benefits and scientific interest, interventions based on positive psychology targeting older adults remain scarce; authors like Ranzijn (2002) underscore the necessity to study their application in this demographic due to the association of ageing with stereotypes of loss and decline, often overlooking gains and areas of growth. Moreover, they suggest that positive psychology can enhance mental and physical health, leading to a reduction in dependence and the costs of care associated with ageing. Lastly, given the increase in longevity in the population, a rise in demand for psychological care for this group is anticipated, underscoring the importance of anticipating the potential and limitations of developing and applying interventions based on positive psychology with older adults.

In summary, positive psychology seems to provide an ideal framework for a health promotion programme tailored to older adults, aiming to enhance their understanding of health and well-being from an optimistic standpoint, highlighting their capabilities rather than limitations. In this context, the concept of subjective well-being, which pertains to how individuals experience their emotions, holds relevance. Vázquez and Hervás (2009) connect subjective well-being with the significance of emotions throughout an individual's life. This subjective well-being will be one of the factors considered when assessing the

effectiveness of an intervention programme specifically designed for older adults in rural areas, with the objective of fostering their well-being and emotional health. The outcomes obtained could hold significant implications for the formulation of mental health policies and initiatives targeting older adults in rural regions. From this perspective, the programme aims not to dwell on shortcomings but rather to contemplate the positive aspects of each individual's health, thereby nurturing their strengths.

2. Method

2.1. Design

A quantitative research study was conducted employing a quasi-experimental design with non-randomised pretest-posttest and cross-sectional measures. A convenience non-probabilistic sampling method was used to select the independent groups.

2.2. Participants

The sample comprised 24 older adults, including 20 women and 4 men, aged between 65 and 85 years (M = 73.91; SD = 6.80). Of the total (N = 24), participants residing in the Tiedra municipality (Valladolid) (n = 14) were allocated to the experimental group, while those in the Villamuriel de Cerrato municipality (Palencia) (n = 10) formed the control group. All participants from both groups completed all evaluations.

2.3. Procedure

We proposed conducting a six-session workshop titled "Living My Emotions Healthily" (see Appendix A), offered free of charge to the town councils, as part of the regional active ageing initiative funded by the Social Services Management of the Castile and León Regional Government through regional income tax allocation. Both town councils responded positively, facilitating the organisation of the workshop, including scheduling dates, times and venue. Additionally, posters and infographics were designed to promote the activity among the over-65 population in both municipalities.

Two requirements were established in the inclusion criteria, given that the activity was funded as part of the active ageing programme. It was stipulated that the group must consist of at least 10 people and that participants must be over 65 years old, aligning with the definition of seniors put forth by Fernández-Ballesteros *et al.* (2004), which considers individuals as seniors from that age in the European context. Another inclusion criterion was that all participants attended all six sessions

of the intervention programme and completed the required documents, including informed consent forms, pre- and post-intervention evaluation questionnaires and inter-session questionnaires. Regarding exclusion criteria, older adults with severe illnesses and/or dementia were not eligible to participate. Individuals who did not meet the age requirement of 65 years were referred to other programmes tailored to their needs.

2.4. Instruments

Two *ad hoc* questionnaires were selected, each containing a limited number of items (13 and 9) and employing a Likert-type scale ranging from 1 (Not at all) to 4 (Very much), to encourage participation and simplify the process for participants, considering the sociodemographic characteristics of the sample.

For evaluation purposes, an *ad hoc* questionnaire was distributed, collecting sociodemographic details (age, gender, municipality and living arrangements), comprising 11 Likert-type items assessing the participant's health and emotional well-being at the workshop's outset. Subsequently, the same questionnaire will be readministered upon completion of the activity to gauge changes compared to the initial responses (*Ad hoc evaluation questionnaire at the end of each session*). Additionally, at the end of each session, a satisfaction evaluation questionnaire comprising 9 Likert-type items is being distributed, assessing the level of satisfaction with the activities conducted in each session. The aim is to evaluate which activities are better received and prove most beneficial for health and emotional well-being in this population.

2.5. Data analysis

Analyses were conducted to assess normality and homoscedasticity assumptions. Descriptive measures were calculated for the overall sample and intervention groups (experimental and control) to confirm pre-intervention equivalence in sociodemographic variables. The paired samples *t*-test was used to compare pretest and posttest scores of the experimental and control groups, assessing improvements and significant differences. Mixed-design factorial analysis of variance (ANOVA) and Cohen's *d* coefficient were applied to evaluate effect size. A descriptive analysis of perceived quality and satisfaction with each session of the programme was performed using the "End of Session Questionnaire". SPSS Statistics version 25 software was employed for analysis.

2.6. Results

The variables were verified to meet the statistical assumptions of normality and homoscedasticity. As depicted in Table 1, the Shapiro-Wilk test was conducted, confirming the normality hypothesis ($p > 0.05$) for both the age and pre-intervention result variables. Moreover, to assess the assumption of homoscedasticity, the

https://doi.org/10.54790/rccs.65

Levene test for equality of variances was initially performed for the Age variable (data with p < 0.05 are presented in Table 2 and illustrated in Figure 1), indicating equal variances with a p-value of p = 0.746. Subsequently, the Box M test yielded a p-value of p = 0.195 (Table 3), exceeding 0.05, thereby allowing us to assume equality and proceed with the corresponding parametric test analyses.

Table 1

Shapiro-Wilk normality tests for N<49

	Intervention group	Shapiro-Wilk		
		Statistic	df	Sig.
Participant age	Experimental	0.922	14	0.238
	Control	0.932	10	0.465
PRETEST results	Experimental	0.956	14	0.651
	Control	0.897	10	0.201

Table 2

Levene test for equality of variances to check homoscedasticity assumption

		F	Sig.
Participant age	Equal variances assumed	0.108	0.746

Figure 1

Representation of homoscedasticity assumption for the Age variable

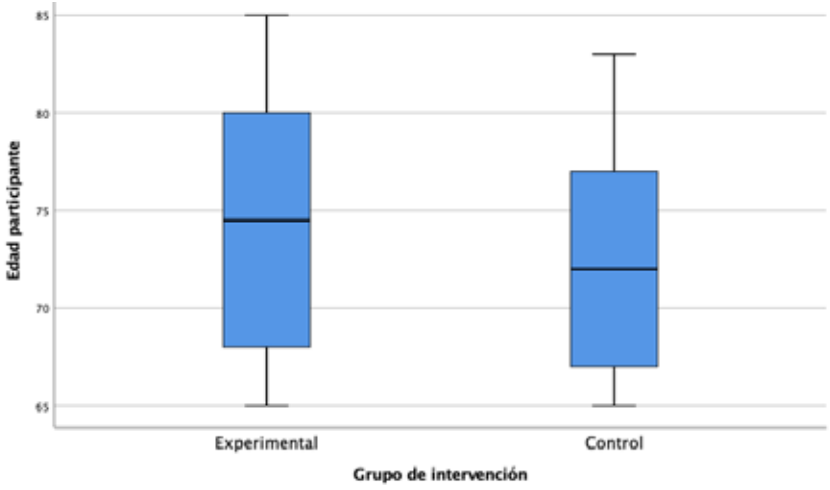

Table 3

Box's M test for equality of covariance matrices

Box's M	5.243
F	1.567
df1	3
df2	25,755.6
Sig.	0.195

Tests the null hypothesis that observed covariance matrices of the dependent variables are equal across groups. Design: Intersection + INTERVENTION_GROUP Within-subjects design: PRE_POST

Descriptive information about the sample, specifically the intervention groups (experimental and control), is presented in Table 4, including descriptive statistics such as mean, standard deviation and range, as well as the quantitative variables of age and pre- and post-intervention scores, both for the overall sample and within the experimental and control groups.

Table 4

Descriptive statistics (Mean, SD and Range) for sample, experimental group and control group on quantitative variables age, pre-intervention results and post-intervention results

	Intervention group	N	Minimum	Maximum	Mean	Deviation
Participant age	Sample	24	65	85	73.92	6.801
	Experimental	14	65	85	74.71	7.151
	Control	10	65	83	72.80	6.477
Pretest results	Sample	24	25	44	35.00	5.413
	Experimental	14	27	44	36.29	4.268
	Control	10	25	42	33.20	6.512
Posttest results	Sample	24	31	49	40.33	5.105
	Experimental	38	49	43.00	3.464	38
	Control	10	31	43	36.60	4.766

Figures 2 and 3 depict normal Q-Q plots for the Age variable of the participants in the experimental and control groups, respectively.

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Figure 2

Q-Q plot of the Age variable for the experimental group

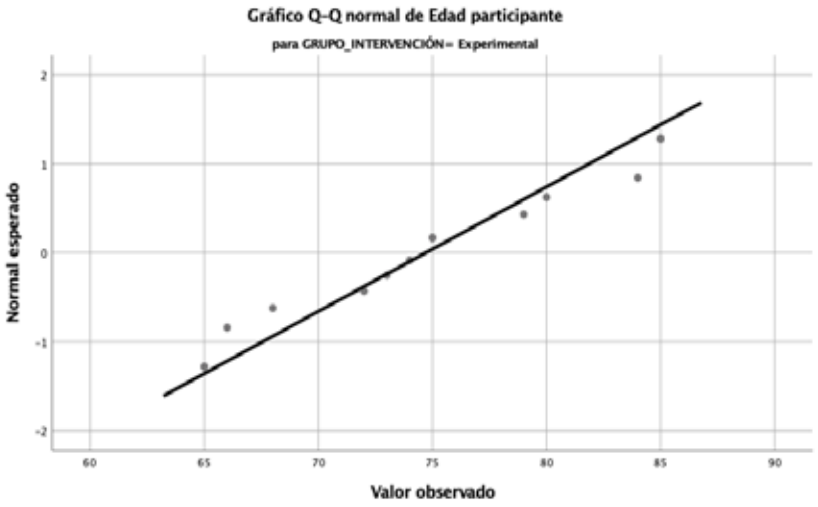
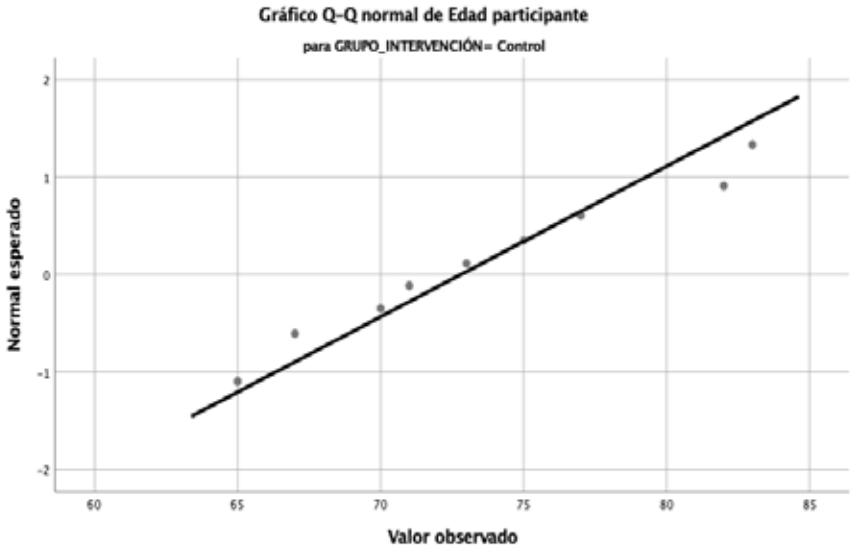


Figure 3

Q-Q plot of the Age variable for the control group



Figures 4 and 5 illustrate the distribution of pretest scores obtained before the intervention by participants in both the experimental and control groups.

Figure 4

Pretest scores for the experimental group

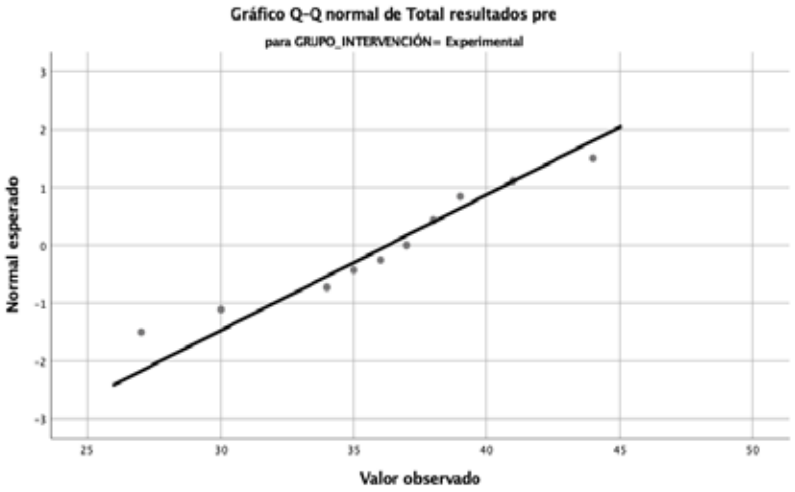
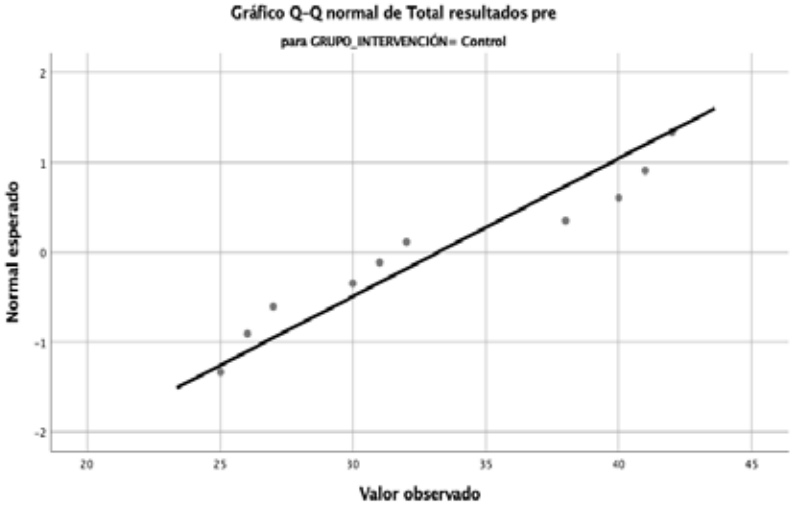


Figure 5

Pretest scores for the control group



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Figures 6 and 7 display the distribution of posttest scores obtained by participants after the intervention, with each graph representing the respective experimental and control groups.

Figure 6

Posttest scores for the experimental group

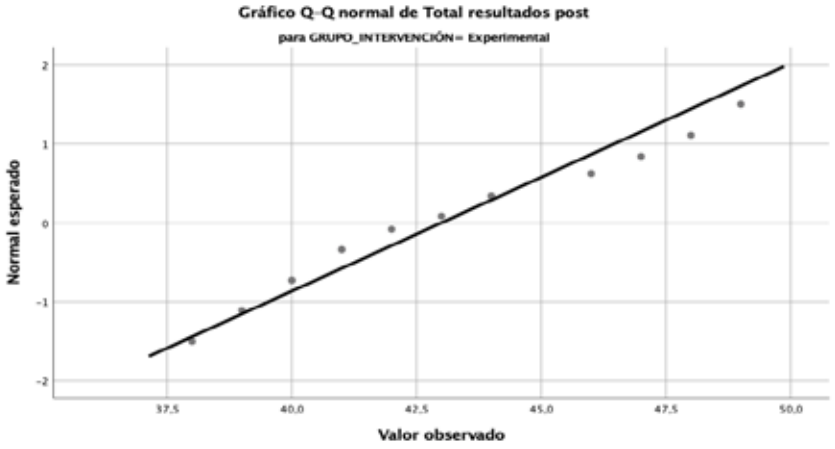
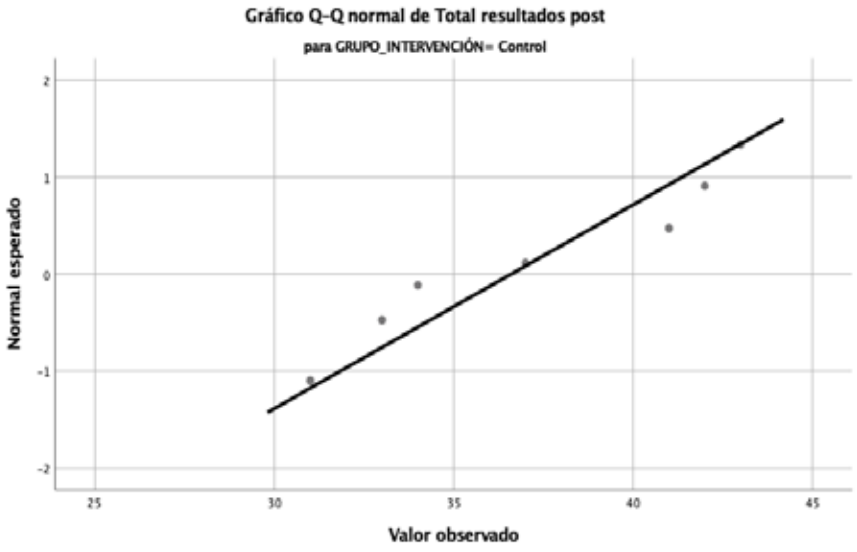


Figure 7

Posttest scores for the control group



In the Student's paired samples *t*-test for mean comparison, it was assessed whether there were differences in pre-intervention and post-intervention scores. This test was conducted separately for each group and for different dimensions of the questionnaire: emotional understanding, subjective well-being, social factors and total scores at the beginning and end. Table 5 presents the changes in each group and for each dimension at pre- and post-intervention. The significance level scores reveal differences in all dimensions of the experimental group, suggesting that the intervention programme led to improvement in emotional understanding, subjective well-being, social relationships and overall health and emotional well-being for the participants. On the other hand, the control group's scores indicate significant differences in posttest results compared to pretest results in subjective well-being and total score. However, no differences were observed in emotional understanding and social factors. Therefore, it cannot be affirmed that the reminiscence programme resulted in an improvement in their health and emotional well-being.

Table 5

Student's paired samples t-test for measures in the experimental and control groups, difference of paired samples

G[1]	Mean		Deviation		t		df		Sig. (bilateral)	
	EG	CG	EG	CG	EG	CG	EG	CG	EG	CG
EU[2] Pre-Post	-1.786	-1.000	2.392	1.826	-2.794	-1.732	13	9	0.015	0.117
SW[3] Pre-Post	-2.786	-1.500	2.119	1.650	-4.920	-2.875	13	9	0.000	0.018
SOC[4] Pre-Post	-2.143	-0.900	1.610	1.595	-4.979	-1.784	13	9	0.000	0.108
TOT[4] Pre-Post	-6.714	-3.400	3.950	2.914	-6.360	-3.690	13	9	0.000	0.005

1 EG and CG: experimental group and control group. 2 Subjective well-being. 3 Emotional understanding. 4 Total test scores.

The ANOVA results revealed a significant interaction between pre- and post-intervention groups in Emotional understanding ($F = 0.759$; $p = 0.393$), Subjective well-being ($F = 2.560$; $p = 0.124$), Social factors ($F = 3.502$; $p = 0.75$) and total scores ($F = 5.048$; $p = 0.035$), indicating improvements in health and emotional well-being due to the programme implementation. These findings suggest distinctions between participants in the experimental and control groups (refer to Table 6). Moreover, the effect size calculations in Table 6 demonstrate a higher impact in the experimental group.

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Table 6

Means, standard deviation of variables in each group and analysis of intervention group x moment interaction

Scores	Experimental group		Control group		F	Sig.	Partial Eta squared	Cohen's d		effect-size r	
	Pre M (SD)	Post M (SD)	Pre M (SD)	Post M (SD)				Pre	Post	Pre	Post
Emotional understanding	17.43 (2.563)	19.21 (1.805)	16.00 (2.906)	17.00 (2.309)	0.759	0.393	0.033	0.521	1.06	0.252	0.470
Subjective well-being	11.07 (2.093)	13.86 (1.657)	9.40 (2.914)	10.90 (2.558)	2.560	0.124	0.104	0.658	1.373	0.312	0.566
Social factors	7.79 (1.051)	9.93 (0.997)	7.80 (1.814)	8.70 (1.160)	3.502	0.075	0.137	-0.006	1.137	-0.003	0.494
Total score	36.29 (4.268)	43.00 (3.464)	33.20 (6.512)	36.60 (4.766)	5.048	0.035	0.187	0.561	1.536	0.270	0.609

The subsequent graphs illustrate the results obtained from repeated measures ANOVA analyses, depicting the marginal means before and after the intervention in Emotional understanding (see Figure 8), Subjective well-being (see Figure 9), Social factors (see Figure 10) and Total scores (see Figure 11) for both experimental and control groups. Therefore, the reminiscence programme may not be as effective in enhancing health and emotional well-being as the positive psychology-based programme.

Figure 8

Mean scores in emotional understanding

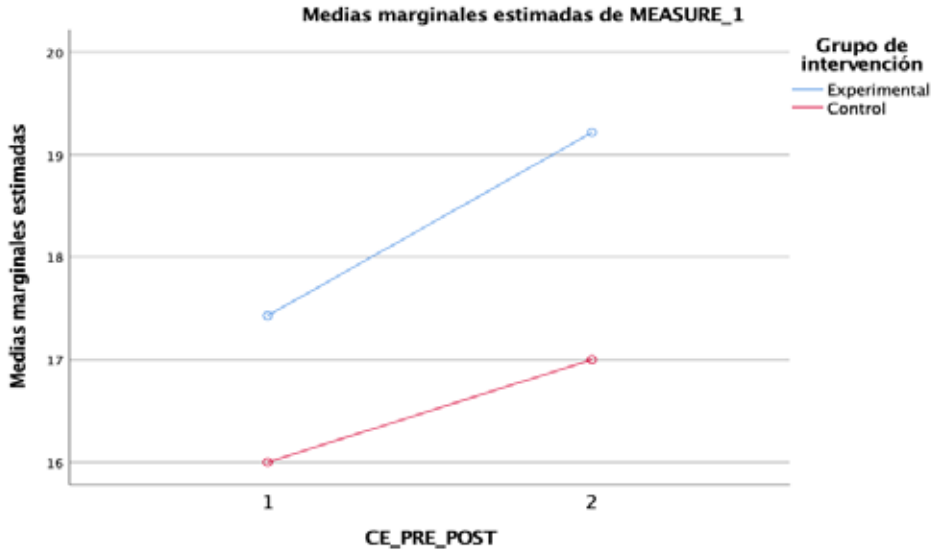

Figure 9

Mean scores in subjective well-being

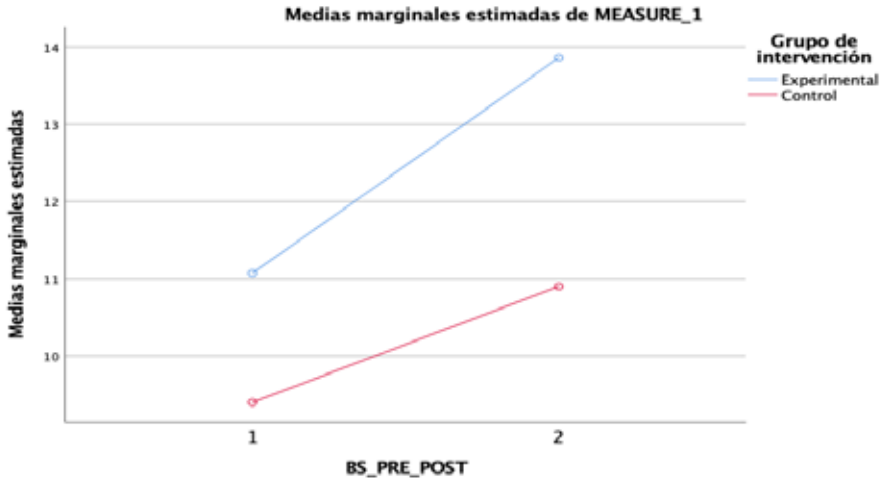

Figure 10

Mean scores in social factors

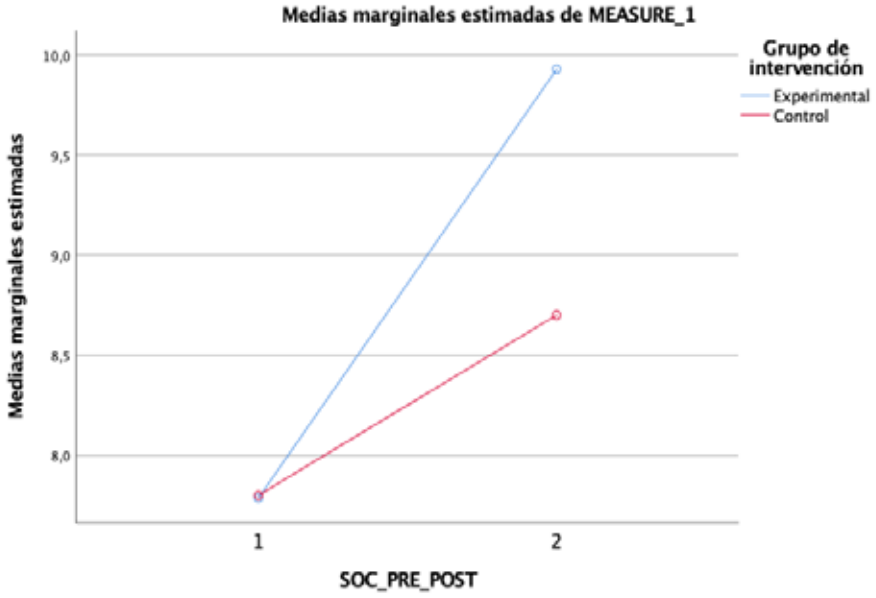

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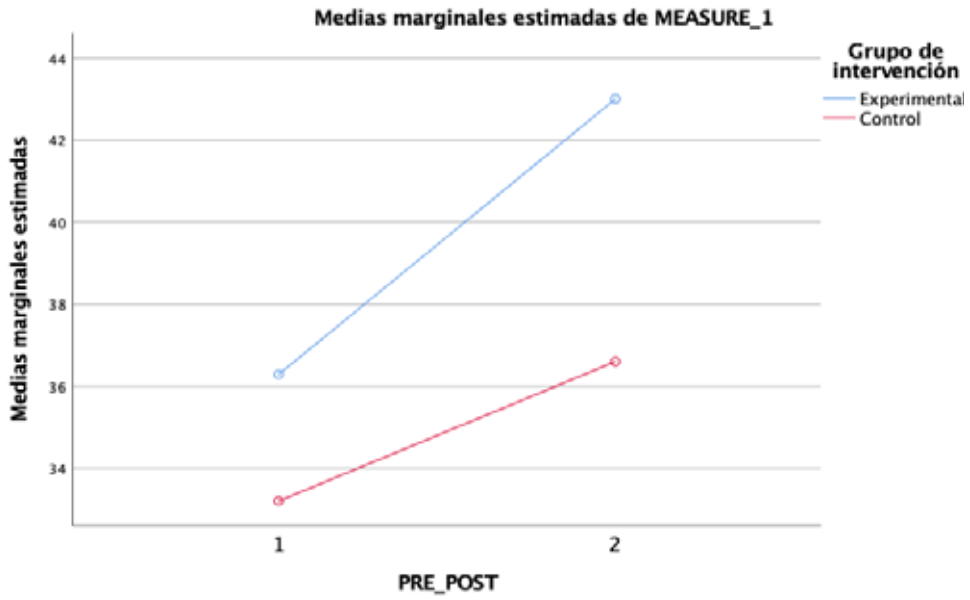
Figure 11

Mean scores in total health and emotional well-being



The results validate the three hypotheses posited at the outset of the study. The evaluation of the perceived quality of each intervention session was conducted at the conclusion of every session, utilising a brief questionnaire to gauge participants' satisfaction levels with each session. All sessions received high ratings.

3. Discussion

The aim of this study was to evaluate the effectiveness of an intervention targeting older adults, particularly those living in rural areas of Castile and León, using a positive psychology programme to ascertain its impact on their well-being and emotional health. The results, obtained by comparing scores from the *ad hoc* questionnaire administered at the beginning and end of the intervention between the experimental and control groups, suggest that the observed improvements may be attributed to the programme.

Participants in the control group underwent a reminiscence-based programme, and although some improvement in the results was observed, it was not as significant as the scores of participants in the experimental group, which may be more attributable to the placebo effect than to the specific content of the programme itself (Amigo, 2020). It is noteworthy that initially, there was concern that conducting only six sessions might be limiting, given the short period to assess the programme's effectiveness in improving emotional well-being. However, upon

completion, it was found that this duration actually proved advantageous, as all participants continued to attend without absenteeism, facilitating the involvement of everyone and ultimately preventing programme drop-out.

It is important to acknowledge the limitations of this study. Firstly, the time constraint is significant due to the limited time available for developing and implementing the pilot programme. Consequently, the primary limitation of the study is the small sample size (n = 24). With a longer timeframe, the programme could have been expanded to include more groups, thereby increasing the sample size. The small sample size hampers the generalisability of the results and impacts the achievement of statistically significant outcomes. Secondly, the measurement instruments used is identified as a limitation. As highlighted by Jiménez *et al.* (2016), there are still few appropriate and specific measurement instruments for older adults, despite the increasing interest in positive psychology and the development of valid and reliable tools in this area. Moreover, in rural areas, older adults may have lower levels of literacy and reading comprehension, and they may perceive completing a test or questionnaire as an assessment, potentially leading to participation without careful reading or adding additional stress. It would be beneficial to precisely define the evaluation protocol and adapt measurement instruments to the elderly population.

Despite the mentioned limitations, it is crucial to emphasise that research related to intervention programmes for the prevention of illness and promotion of well-being and health is particularly noteworthy. Therefore, it is valuable to find ways to measure the impact of these activities on the elderly and how they affect their emotional well-being, as it encourages them to socialise, interact with peers and engage in meaningful projects, thereby preventing illnesses.

In conclusion, the programme offers several additional benefits that may not be easily quantifiable but are perceived by participants through the feedback they provide. The programme fosters social engagement and enables older adults to connect with individuals of different ages, fostering significant intergenerational relationships. Moreover, it promotes active ageing by encouraging participants to participate in diverse activities that enhance flexibility and cognitive stimulation, which is especially beneficial as they age. Lastly, it is essential to note that the programme brings various resources closer to the elderly, which is particularly crucial in the rural context of Castile and León, where emotional education may be lacking. Engaging in these programmes can assist older adults in normalising and accepting their emotions, thereby enhancing their quality of life and emotional well-being.

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Appendix A

Summary table of programme session content

Session and objective	Activities
Session 0. PRE Presentation and evaluation. In this session, the group is greeted to foster connections among participants, and vital information about the programme's operation is provided. Concurrently, evaluation questionnaires for the study variables are distributed.	- Welcome. - Programme presentation. - Informed consent. - Evaluation protocol. - Commencement of exploring our strengths.
Session 1. What do we mean by health?	- Greeting and welcoming participants. - Psychoeducation: Health from a biopsychosocial perspective. - Experiential part: Gratitude and health. - Presentation of cross-sectional dynamics. - Experimental group activity: "The jar of gratitude".
Session 2. How can I take care of my self-esteem? In this session, we delve into the concept of self-esteem, experiencing how it can aid and support us in everyday challenges.	- Greeting and welcoming participants. - Cross-sectional activity. Theoretical part: - Psychoeducation: What is self-esteem? - Experiential part: Self-esteem within groups. Empathy and emotional intelligence. - Compassion and self-compassion: "I'm kind to myself". - Experimental group activity: "I admire myself/you because…". - Control group activity: "The circle of virtues". - Session 2 evaluation questionnaire. - End of session and farewell.
Session 3. How do my thoughts influence my mood? The goal of this session is to comprehend the impact of thoughts on our lives.	- Greeting and welcoming participants. - Psychoeducation: Thoughts. - Positive thoughts versus negative thoughts. - Mindfulness as an ally. Experiential part: - Thought-related activities: Mindfulness and thoughts. - Experimental group activity: "Mr Positive and Mr Negative". - Control group activity: "Hey, I succeeded!" - Session 3 evaluation questionnaire. - End of session and farewell.
Session 4. I live my emotions healthily In this session, we present some "mental blocks" and provide resources to help the mind function for the individual's benefit. Speaking kindly, refraining from getting lost in thought and gratitude as an antidote to negative biases are effective coping tools.	- Greeting and welcoming participants. Theoretical part: - Psychoeducation: Essential elements for understanding my emotions. Emotional regulation. Values. Experiential part: - Activities related to emotional regulation and values. - Mindfulness and metaphors. - Session 4 evaluation questionnaire. - End of session and farewell.
Session 5. I create healthy bonds with my environment The objective of this session is to learn how to communicate assertively. Addressing acceptance and cognitive flexibility will also contribute to improving resilience.	- Greeting and welcoming participants. - Cross-sectional activity. - Psychoeducation: Assertive communication and boundary management. - Acceptance and flexibility. - Resilience. - Experiential part: Activities related to social skills and resilience. - Experimental group activity: "What a difficult situation". - Role-playing. - Control group activity: "Letter to my past". - Session 5 evaluation questionnaire. - Conclusion and farewell.
Session 6: Closing session The objective of this session is to conduct a post-intervention measurement of the programme participants for evaluation purposes. It also provides a space for participants to share their experiences during the sessions and discuss how they can continue their practice once the programme is completed.	- Greeting and welcoming participants. - Conclusion of cross-sectional activity. - Final programme evaluation questionnaire. - End of session and farewell.

https://doi.org/10.54790/rccs.65

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Susana, a licensed general health psychologist, has been with the Colectivo para el Desarrollo Rural de Tierra de Campos Association since 2017. Her work revolves around developing initiatives to foster psychological, emotional, occupational and social well-being across diverse demographics, including older adults, individuals facing social exclusion, those with disabilities and people in dependency situations. Alongside conducting workshops on emotional management and personal assistance courses, she provides individual psychotherapy. Her approach is influenced by humanistic and positive psychology, and she holds training in EMDR Level II.

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With a PhD in psychogerontology, Jesús heads the master's programme in general health psychology at the Valencian International University. His research delves into psychogerontology, covering psychological assessment, treatment and intervention for older adults. Jesús has spearheaded numerous projects aimed at enhancing the quality of life for older adults through intervention programmes. He specialises in social intervention and research methodologies in social and health sciences.

Francisco Rivera Rufete

Francisco, a licensed general health psychologist, serves as the director of Centro de Psicología y Neuropsicología La Garena, focusing on organisational development management. His practice encompasses clinical work within the cognitive-behavioural theoretical framework and third-generation therapies. Francisco offers supervision for general health psychologists and facilitates personal development within organisations and companies. Engaged in research in health and organisational psychology, he contributes to designing and implementing health programmes in immunology and rare diseases.

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With a PhD in psychology, María is a contracted professor in the Department of Psychology at Universidad a Distancia de Madrid (UDIMA). Her research covers health psychology, psychological assessment, treatment and intervention across the lifespan. María has developed and executed various intervention programmes targeting resilience enhancement in cancer patients and individuals with chronic illnesses, employing third-generation therapy approaches. Specialising in health psychology, she brings extensive experience to the field of psychogerontology.