Effectiveness of Resiliency Training in the Mental Health of the Red Crescent Health Care Teams

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Abstract: Background and Objectives: Iran is considered as a country prone to accidents due to its geographical situations. The health and medical teams at the National and International Crescent Society have always played a central role in responding to crises. In addition to financial and psychological damage, psychological damage is one of the indemnities that people living in affected areas and relief workers pay in natural and man-made disasters. Therefore, improving the mental health of emergency forces is essential. **Method:** This study was an experimental study with control group. The research community comprised 126 members of the Primary Care teams in the Red Crescent Health Care. Sampling was done randomly from among the health care teams of the Red Crescent society. Subjects in both experimental and control groups completed the Mental Health Questionnaire (GHQ) in the pre-test and post-test. At last, the data were analyzed using SPSS software and descriptive statistical tests such as Kolmogorov-Smirnov, Mann-Whitney U test and Wilcoxon. **Results:** The results of this study showed that resiliency training has been effective in promoting the mental health of members in the Red Crescent Health Care Teams. Indices of physical symptoms, anxiety, social performance and depression were not significantly different in the control group before and after the training. Indices of physical symptoms, anxiety and social performance were significant in the experimental group before and after the training. However, the depression index was not significant in the experimental group before and after the training ($55 = p$). Indices of physical symptoms, anxiety, social performance and depression were not significantly different in the pretest between the control and the experimental group. Indices of physical symptoms, anxiety and depression were significant in the post test between the control and experimental groups. However, social performance index was not significantly different between the two groups in the post test ($291 = P$). **Conclusion:** Regarding to the fact that the mental health of the members of Red Crescent health care teams have been enhanced by resiliency training and will ultimately affect the future performance of the health and medical personnel in crisis situations, it's recommended that coherent training courses be held in all the provinces.

Keywords: Training; Resilience; Mental Health; Primary Care teams.

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Introduction

The status of the Red Crescent Society is very important in the international arena. Currently, the Red Cross and the International Red Crescent are the largest non-political humanitarian and global relief networks. Today, at the international level, one of the criteria for assessing the extent of humanitarian and non-political activities in each country is the status of the National Red Cross or Red Crescent Society. Among the goals set for this organization are efforts to alleviate human suffering, strengthening friendship, mutual understanding, lasting peace among nations, endeavoring to respect human beings, and ultimately supporting the lives and health of humans. This is an issue that is undoubtedly targeted at reinforcing and optimizing the mental health of people in the society.

According to the World Health Organization, mental health is a state of complete physical, mental and social wellbeing. In the British encyclopedia, mental health refers to the person's continuous physical, emotional, mental and social ability to deal with the environment in which he or she lives. Psychological well-being is one of the basic human needs that plays a vital role in the sustainable development. In general, the main objective of mental health is to prevent discomfort and maintain health in order to create a healthy social and personal environment, as well as the treatment of minor disordered behavior that prevents the onset of intense mental illness (Wales, 2010). Mental health is the ability of individuals to achieve their goals (Papageorgiou & Wells, 1998).

On the other hand, resiliency is one of the important topics in positive-psychology, which is of great interest. The term resiliency is used for people who are more resistant to psychological stress; are less susceptible to illnesses and have longer life expectancy (Seyyedi , 2007). People who have this feature usually feel more controlmon their own lives, are more attached to what they are doing, and are more responsive to new ideas and changes (Ejehei, 2009).

In particular, it is believed that people with high resiliency define stressors and get involved in coping strategies that moderate or solve the problems (for example, problem-solving strategies or information seeking), and therefore, such individuals experience less negative outcomes. On the other hand, people with low resiliency are more likely to evaluate events as uncontrollable and use quick strategies to reduce negative outcomes (for example, avoidance), but they do not necessarily reduce the risk factors (Haan, 2014).

Newer research suggests a link between resiliency and increased psychological well-being. Therefore, having this characteristic can lead to increased mental health and protect the person from illness (Ejehei, 2009). It should be stated that mental health is to have adequate adaptation and to feel good from a psychological point of view in accordance with acceptable standards of human and social relationships (Saatchi, 2011).

On the other hand, Seligman (2005) as the founder of a positive thinking suggests that mental health is one of the most important areas of interest in psychology research which has recently been widely studied in psychology (as one of the theoretical foundations in the field of resiliency). They believe that resiliency is the development of the most basic capabilities and their use in everyday life and work, and these functions act as a protection against mischiefs and psychological disorders that can be the key to recovery. Regarding the components of mental health, it is believed that mental health has three main components: the degree of positive affection; the lack of negative emotions such as depression and anxiety, and a moderate level of satisfaction during a particular period of life (Satter, 2015).

The results of the research show that interventions that help resiliency in the person are effective in reducing and relieving depression and increasing well-being. For example, Beck, Steer, and Carbin (1998) in a research with positive therapeutic approach in clinically depressed populations found that identifying individual forces and finding ways to use them lead to a reduction and control of depression. Sidney and Allen (2015) also argue that the skills needed to have resiliency can be trained to help people cope with their problems and increase the mental health of the society. Now, according to Seligman (2005) and the domestic research in this area (Sidney & Allen, 2015), the researcher seeks to test the resiliency training in the Iranian community and respond to the fundamental question of the research. Will resiliency training be effective in increasing the mental health of members in the Red Crescent Health Care Teams in Iran?

Theoretical Foundations and Background

One of the most important basic educational topics in any community, after the development of education in the field of training, is to strengthen education in the Field of health and hygienic of Society. This education includes the general health and mental health of people of Society. Accordingly, education in the field of health should start at the same time as educational training at school and continue until the end of life. For this reason, with the emphasis of the World Health Organization (2001), School

health education has spread throughout the 21st Century. Typically, as a classroom education in relation to health and hygienic issues during the early years of education until the end of secondary education has been considered. The main change in the definitions of school health education is the ever-increasing emphasis on the concept of the impact of school education on adult behavior. In the 1990s, health education was seen primarily to communicate the medical functions for those who need to experience and apply them; health education is trying to fill the gap between what is considered to be a good state of health and what is normally done. (Griffiths, 2015).

In the definitions of the first decade of the twenty-first century (2000-2010), inserting this understanding that education means empowering the individual, or, in other words, started allowing individuals to study education for health decision-making. then Health education has become a process of helping people to make informed decisions about issues that affect individual and others' health. This definition was also created in relation to health education in schools, which ultimately led to a greater agreement on the country's youth education approach in relation to health issues.

Today, school health education is considered as a comprehensive health plan. This is a mix of community care, schools, and patients; continuing health education is a prevention of disease and optimal health promotion to identify diseases for treatment (Glanz, Rimer, & Lewis, 2012) involves Rehabilitation and long-term care from childhood to adulthood. This concept has recently been recommended in contemporary scientific literature as health promoting, an expression that changeably is used with health education, and, accordingly, in this area at the age of school teachers and counselors, and in adolescence, nurses, social workers and the experts of NGOs like the Red Crescent and Red Cross will play a major role. Definition of health education According to the WHO, maintaining health, encouraging people to actively participate in health measures individually and collectively in order to maintain their health.

Health education is a part of health care that relies on the impact of behavioral factors on health and begins with people who are healthy and who are interested in developing personal and social health standards and which help them to develop effective lifestyle in preserving and promoting Health.

Health education is a combination of learning experiences that facilitates the voluntary adoption of healthy behaviors, which results in the provision and maintenance and promotion of health and a combination of

educational, structural and environmental support for excellence of healthy behaviors, and health educators are pioneers who always want a new understanding of human behavior and new ways of applying their knowledge to solve social individual problems.

In today's competitive organizations, only those organizations are capable of survival that can upgrade their performance. On the one hand, human resources have played a significant role in the development and improvement of care and treatment and have always been emphasized by experts in HRM. It seems that the achievement of the organizations' goals depends to a large extent on the proper utilization of human resources capacity. This is of great significance in the service organizations, and one of the key managerial skills is to devote attention to the concepts of employees' health, both mentally and physically, in organizations where employees are compelled to do burdensome and low-paying jobs. Training and enhancement of abilities and skills, mental health, maintaining motivation and work ethics, job commitment, and related issues have become important current issues (Kashefi, Arab, & Houmanian, 2013).

The Red Crescent Society, as an international institute is committed to providing relief trainings and the know how to deal with disasters at various levels to the general public, and plays a central role in raising the awareness of communities in the context of natural and abnormal accidents. The organization is also prepared to deal with these disasters by training relief workers and organizing them in different groups.

One of the most important areas for sustainable development of human health in human societies is the mental health sector, which is directly related to the health of humans and its major task is to maintain and restore health to the human community. In other words, mental health is one of the axis of health assessment in different societies and plays an important role in ensuring the dynamism and efficiency of each society. One of the factors that leads to the adjustment and promotion of mental health is resiliency that has a special place in the field of growth psychology, family and mental health and the number of studies associated with this structure is added increasingly (Waller, 2001). In psychology, the individuals' positive capacity to respond to the stress and disasters is called resiliency. This concept is also used to determine the attribute of resistance to future events. In this sense, resiliency is considered as one of the protective factors and resistance to future risk factors. Resilience is known as a good idea with high pragmatism value for helping and strengthening individuals in the face of adversity and preserving them against the dangers they encounter throughout their lives (Fathi, 2009).

The mental health of people is influenced by negative consequences. Resilience is an intrinsic resource that can moderate stress levels in adverse conditions and lessen the negative effects of stress (Masen, 2001). Human beings respond with regard to their capacities and abilities versus the problems of life, and the tolerance of individuals varies according to their psychological power against the pressures of life. Therefore, one of the ways of achieving mental health and well-being can be to increase the capacity and ability of people to live up to the incidents and hardships of life. In general, the amount of physical and mental strength is measured in terms of the strength of each individual against the factors that provoke him (Faghihi, 2005).

The need is felt that people learn how to think and act in a more resilient way when confronting with stressful situations. Therefore, interventions aimed at influencing intellectual processes can be an important step in building resiliency skills and abilities. New innovations such as positive psychology have gained increasing attention in transformational psychology since the last decade. This has led to a model focusing on the development of abilities, rather than models focusing on shortages and problems. Accordingly, positive psychological approach has targeted at human talents and abilities rather than dealing with abnormalities and disorders. This approach seeks to identify the structures and practices that lead to human well-being and happiness. Hence, the factors that make people more adapted to the needs and threats of life are the most fundamental structures under the study in this approach (Samani, Jokar, & Sahragard, 2007). Mental health and resiliency are one of the key concepts of this approach that have been reviewed in this paper. In this section, previous studies will be presented.

In a study by Momeni and Alawi (2015) on adolescents with heart disease, it was concluded that resiliency training has a significant effect on the reduction of anxiety symptoms in these individuals and a follow up of the three months confirms this finding. Also, in Ahmadi and Sharifidemarami's research (2014), the results of the study showed that resiliency training has a significant and important role in improving the mental health of people with drug dependence. In other studies, Mohammadi, Aghajani, and Zahtabpour (2011), in a study titled "The Relationship between Addiction, Resilience and Emotional Components", showed that individuals with higher levels of resiliency experience less symptoms of depression, anxiety and stress. Therefore, raising the level of this protective factor in students can be effective in reducing the emotional problems.

Kabat Zein and et al (2003) has also shown the effectiveness of mental health education on quality of life. They about the impact, conducted health education programs on the quality of life of cancer patients. The results showed that after eight training sessions, people's quality of life has increased significantly.

Reeh & Hiebert (1998), with a survey of 480 school students, concluded that students due to health education that get through school counselors and teachers, is considered Their own mental and physical health was superior to those of their peers. Also, in the research of Rahimian and Asgharnejad (2008) carried out to investigate the relationship between psychological hardiness, self-resiliency and the mental health of youth and adults who survived the earthquake in Bam. The results of data analysis indicated that there is a positive relationship between psychological hardiness, resiliency and mental health. The results also showed that resiliency and mental hardiness can significantly predict mental health, and resiliency is the best predictor of mental health in this research. Studies in overseas have also highlighted the influence of resiliency in mental health. In this regard, Shiling, Mikulincer, and Yaubman (2014) pointed to the effect of resiliency training in couples who had marital problems. 39 women and 38 men were trained in the program for improving mental health. The results showed that their psychological well-being was significantly increased. Similarly, Rouni et al. (2013) found that there is a significant relationship between psychological well-being and anxiety, depression and resiliency dimensions. Arindel, Barlaug, Martinussen, Rosenvinge, and Hjemdal (2012) in investigating the relationship between social adjustment, psychological well-being and positive thinking found that with the increase of positive thinking, psychological well-being and social adjustment are also affected and increased.

Method

The present research has employed a semi-experimental method with pretest-posttest and control group design. Individuals were randomly assigned to the experimental and control groups. First, Goldberg and Williams's (1989) mental health questionnaire was administered for both groups. Then, the experimental group underwent the training. After training the resiliency skills, both groups were again subjected to post-test. The statistical population of the present study included all the members of the 22 Red Crescent Healthcare Centers in 2015-2016. The sampling method was simple random and 10 teams out of 22 teams were recruited for training. 5

teams out of 35 were selected using random numbers. The level of education and the type of disciplines were different; therefore, the list of each field was separately taken so that the chance would equal for each discipline. Among other remaining teams, the chance of having each discipline was equally divided by random control of the control group numbers. In Alborz Province, which had 19 teams, 10 teams were recruited for training, which was selected as the same as the province of Tehran, by equalizing the odds of the entire discipline, randomly, 4 teams equal 28. The team was also selected from the remaining team of 4 teams equal to 28 people. In this group, the chance of the presence of all disciplines was also unified. In order to maintain team form in Alborz province, instead of 30 people, 28 were selected. In order to analyze the data in this research, after extraction of the results and descriptive analysis of the data, Kolmogorov Smirnov test, Wilcoxon test and Mann-Whitney test were used to generalize the results and inferential statistics. To collect the data and information required by the present study, the general health questionnaire (GHQ), which is described below:

Among the other remaining teams, the chance of having each discipline was equally divided by the random table of the control group numbers. In Alborz Province which had 19 teams, 10 teams were recruited for training, which was selected the same as the province of Tehran by equalizing the chance of all the majors (4 teams=28 members). In this group, the chance of the presence of all the majors was also unified. Instead of 30 people, 28 were selected in order to maintain the team form in Alborz province. In order to analyze the data in this research, after the extraction of the results and descriptive analysis of the data, Kolmogorov Smirnov test, Wilcoxon test and Mann-Whitney test were used. To collect the data and information required for the present study, the General Health Questionnaire (GHQ) was employed which is described below:

Mental Health Questionnaire

The General Health Questionnaire was developed by Goldberg and Hiller (1979). This questionnaire consists of 28 questions of 4 options and has 4 sub-scales, each of which with 7 questions. The four scales are: physical symptoms, anxiety, social dysfunction and depression (Goldberg et al., 1997). To assess the validity of the General Health Questionnaire, the research has been analyzed and the results show that the mean sensitivity of the questionnaire is 84% (between .77 and .89) and the average feature is .82 (between .88 and .85). Also, Yaghoubi (1995) has assessed the reliability of

the total questionnaire to be .88 and the reliability of the subscales equal to .51 to .81.

Findings

In the following analysis, Wilcoxon test was used to compare the mediums of two groups in the pre-test and post-test and in the experimental and control groups.

Table 1 - Wilcoxon test for mental health subscales in the control group

Ranks		Mean Rank	Sum of Ranks
control group	physical symptoms (pre-test)	28.41	1136.50
	physical (post-test)-symptoms	35.93	754.50
	Statistics	-1.376	
	P value	.169	
	Anxiety(pre-test)	27.72	887.00
	- Anxiety (post-test)	25.90	544.00
	Statistics	-1.522	
	P value	.128	
	social dysfunction(pre-test)	31.79	1208.00
	social dysfunction(post-test)	29.70	683.00
	Statistics	-1.900	
	P value	.057	
	Depression(pre-test)	29.26	848.50
	Depression(post-test)	28.73	804.50
	Statistics	-.175	
	P value	.861	
	General health(pre-test)	30.04	1201.50
	General health(post-test)	32.83	689.50
	Statistics	-1.839	
	P value	.066	

In the table above, all the indices of mental health were compared before and after the test for the control group. As it is seen, the P value was

greater than .05. Therefore, 95% confidence level showed a significant difference between the physical symptoms index before and after the test. Moreover, this difference is not significant because the P value of all of them is greater than .05.

Table 2 - Wilcoxon test for mental health subscales in the experimental group

Ranks		Mean Rank	Sum of Ranks
experimental group	physical symptoms (pre-test)	1274.50	1274.50
	physical (post-test)-symptoms	378.50	378.50
	Statistics	1274.50	
	P value	378.50	
	Anxiety (pre-test)	1274.50	1118.50
	- Anxiety (post-test)	378.50	312.50
	Statistics	1274.50	
	P value	378.50	
	social dysfunction (pre-test)	1274.50	998.00
	social dysfunction (post-test)	378.50	433.00
	Statistics	1274.50	
	P value	378.50	
	Depression (pre-test)	1274.50	870.00
	Depression (post-test)	378.50	726.00
	Statistics	1274.50	
	P value	378.50	
	General health (pre-test)	35.90	1579.50
	General health (post-test)	22.97	436.50
	Statistics	-3.914	
	P value	<0.001	

According to the table, the subscales of physical symptoms, anxiety and social performance were compared before and after the intervention for the experimental group. As observed, the P value was less than .05; therefore, 95% confidence interval showed a significant difference between the subscales of physical symptoms, anxiety and social performance before and after the intervention for the experimental group. Hence, it can be concluded with 95% of confidence that the subscales of physical symptoms, anxiety and social performance have been decreased after the test. Also, the index of depression has been compared before and after the test for the experimental group. As it is seen, the P value is greater than .05 and equal to .555. Therefore, there is no significant difference between the depression indices before and after the intervention for the experimental group. It can be concluded with 95% of confidence that the values of depression index has not changed significantly. Finally, the total index of the questionnaire was compared before and after the intervention for the experimental group. As it is seen, the P value was less than .05 and equal to .001. Therefore, it can be concluded with 95% of confidence that there is significant difference between pre- and post- index test for the experimental group and the values of total performance index has decreased after the test.

Regarding the non acceptance of the assumption of variables' normality, the Mann-Whitney test was used to compare the two independent variables. The following table shows the results of the Mann-Whitney test that compared the indices in the experimental and control groups.

Table 3 - Mann-Whitney test for the subscales of mental health in the post-test

Ranks				
Sum of Ranks	Mean Rank	N		
4351.00	69.06	63	control groups	physical symptoms (pre-test)
3650.00	57.94	63	experimental groups	
		126	Total	
	-1.71		Statistics	conclusion
	.08		P value	
4249.50	67.45	63	control groups	Anxiety(pre-test)
3751.50	59.55	63	experimental groups	
		126	Total	
	-1.21		Statistics	conclusion
	.22		P value	

4175.50	66.28	63	control groups	social dysfunction(pre- test)
3825.50	60.72	63	experimental groups	
		126	Total	
	-.860		Statistics	conclusion
	.39		P value	
4296.00	68.19	63	control groups	Depression(pre -test)
3705.00	58.81	63	experimental groups	
		126	Total	
	-1.45		Statistics	conclusion
	.14		P value	
4366.50	69.31	63	control groups	pre-test
3634.50	57.69	63	experimental groups	
		126	Total	
	-1.78		Statistics	conclusion
	.07		P value	

In the table above, the subscales of physical symptoms, anxiety, social performance and depression were compared between the experimental and control groups in two stages of pretest. As observed, the P value obtained from the comparison of physical symptoms, anxiety, social performance and depression in the pre-test was grater than .05. Therefore, with 95% of confidence, there is no significant difference between the subscales of mental health and the overall mental health score in the pre-test of the experimental and control groups.

Table 4 - Mann-Whitney test for the subscales of mental health in the post-test

Ranks				
Sum of Ranks	Mean Rank	N		
4664.00	74.03	63	control groups	physical symptoms (post-test)
3337.00	52.97	63	experimental groups	
		126	Total	
	-3.25		Statistics	conclusion
	.001		P value	
4470.50	70.96	63	control groups	Anxiety(post-

3530.50	56.04	63	experimental groups	test)
		126	Total	
	-2.30		Statistics	conclusion
	.021		P value	
4216.00	66.92	63	control groups	social
3785.00	60.08	63	experimental groups	dysfunction(post-test)
		126	Total	
	-1.05		Statistics	conclusion
	.291		P value	
4719.50	74.91	63	control groups	Depression(post-test)
3281.50	52.09	63	experimental groups	
		126	Total	
	-3.54		Statistics	conclusion
	<0.001		P value	
4704.50	74.67	63	control groups	post-test
3296.50	52.33	63	experimental groups	
		126	Total	
	3.43		Statistics	conclusion
	0.001		P value	

As observed, the P value obtained from the comparison of the subscales of physical symptoms, anxiety and depression in the post-test stage is less than .05. Therefore, with 95% of confidence, there is significant difference between the subscales of physical symptoms, anxiety and depression in the post-test between the experimental and control groups. According to the results in the table above, the average rank of the experimental group is less than the control group. Therefore, the median of physical symptoms, anxiety and depression in the experimental group are less than the control group. However, the P value obtained from the comparison of social performance index in the post-test was greater than .05 and equal to .291. Therefore, there is no statistically significant difference between the social performance index in the post-test of the control and experimental groups. Also, the P value obtained from the comparison of the total index in the post-test was less than .05 and equal to .001, so with 95% of confidence, there is a significant difference between the total index in the post-test of the experimental and control groups. According to the results of the descriptive statistics table, the mean score of the experimental group

(52.33) was lower than that of the control group (74.67). Therefore, the mean of the total intervention group is less than that of the control group.

Discussion and conclusion

Based on the results of the study, significant differences between the experimental and control groups were confirmed. Physical symptoms in the experimental group are less than that of the control group. This result reflects the effects of training on resilient skills on participants' physical symptoms. The confirmation of this is to reject the results of Hosseini's (2010) research regarding the ineffectiveness of resiliency training in the components of physical function. Also, the significant difference of the anxiety between the experimental and control groups was confirmed. The level of anxiety in the experimental group is less than that of the control group. This result reflects the effects of training resiliency skills on the anxiety of the participants. This result is in line with the results of the research by Konoro & Davidson (2003) about the effects of resiliency on anxiety and illness which can affect the individual's ability to survive. Resilience is an intrinsic quality that makes it possible for the individual to survive under difficult conditions. This finding is also in line with the results of the research by Sibert (2007) who believes that a resilient individual has the flexibility to adapt to the changes in his environment and return to recovery as soon as the pressures are over. Individuals who have low levels of resiliency can't adapt themselves with new conditions and experience higher levels of anxiety while returning slowly from stressful to normal situations.

Similarly, the results of the research were confirmed by Momeni and Alawi (2015), Mohammadi et al. (2011) and Rouni et al. (2013). In addition, the results of the study by Jahed and Mansouri, in 2012, confirmed that resiliency training program could be used as an interventional method to reduce student stress. Also, there was no significant difference in the social performance of the experimental and control groups. This result suggests the lack of impact or the effect of resiliency skills training on the degree of social anomalies among the research participants. This finding is in line with the results of Inzlicht, Aronson, Good, and McKay (2006) research on comparing the multifaceted approaches based on resiliency and preventive approaches to social harms. Moreover, this finding rejects Maddi, Wadhwa, and Haier's (1996) opinion who also argues that there is a significant overlap between resiliency and the abandonment of substance use. In addition, the results of Zarrin's research (2009) based on resiliency training components

in creating negative attitude toward drug abuse is rejected. Zarin Kalak proved in his research that resiliency training program has been effective in three areas of individuals' readiness for addiction from the personality point of view, awareness of alcohol-related issues, and the tendency towards alcohol consumption.

Furthermore, significant difference was found in the depression of the experimental and control groups. The level of depression in the intervention group is less than that of the control group. This result reflects the effects of resiliency skills training on the participants' depression. The confirmation of this hypothesis is to confirm the results of the research by Besharat, Habib, and Geranmayeh (2008) on the relationship between resiliency and mental health.

Confirmation of the first hypothesis confirms Freud's view that mental health has two aspects: compatibility with external environment and internal environment. It also confirms Jung's opinion because he believes that a healthy human is a an individualized human who has some characteristics such as self-knowledge, self-acceptance, integration, self-expression, and patience; accepts the responsibility of his / her life and behavior and behaves responsibly; has a successful identity; devotes love and affection; has a sense of value; does not deny the reality. Ultimately, this finding is in harmony with Albert Alice's. He also sees features like self-interest, social interest, self-control, flexibility, acceptance of uncertainty, commitment to belonging to something beyond his own, self-acceptance, risk-taking and long-term pleasure seeking as signs of a healthy person.

The confirmation of the second hypothesis confirms the views of Alport, Adler, Jung and Freud. Alport believes that healthy people are at the right level and are free from the limitations of the past and fully aware of the forces that lead them and that they can overcome them. Such adults' guides are current time, goals and expectations of the future. So their anxiety is low. Adler also considers the healthy person to be aware of his concepts and goals and his social relationships with others are constructive and positive. In Freud's view, mental health has two aspects: compatibility with the external environment and the internal environment. The set of these measures reduces depression.

The rejection of the third hypothesis reflects Eric Forum's ideas' rejection. That is, the resiliency training failed to validate any of these comments based on the determination of a healthy person. The confirmation of the fourth hypothesis confirms the views of Maslow and Rogers.

Rogers considers the physiological needs to be the basis of growth and prosperity. In his view, a healthy person meets low level needs and does not have a psychological disorder and their knowledge of being is objective. Autonomy and independence, the need for solitude and loneliness, the ability of deep interpersonal communication, honesty to others, being autonomous, humorous are other characteristics of healthy people. Rogers also believes that the organism, in addition to preserving itself strives to lead itself towards integrity, unity, perfection and self-esteem. According to Rogers, a healthy person is aware of his social responsibilities and establishes friendly relationships with others. Instead of being self-fascinated, they make an informed relationship with others.

Also, the relationship between resiliency and depression was not confirmed in the experimental group. This could be due to the fact that the type of questions designed in the questionnaire was associated with severe depression and the participants did not have severe depression.

In addition, the relationship between resiliency and social performance was also rejected in the hypotheses. This result can also be attributed to the fact that subjects' abnormalities or social harms are not investigated in defining social performance. In other words, in social performance research, the inability to keep oneself in herself, inability to do things, dissatisfaction with activity, and forms of decision-making, may have been the perception of participants of social harm, abnormalities, and so on. You may also need to learn more about problem solving, effective communication, and more. Also, since the functional attribute of social performance is more intrusive than other dimensions, it seems difficult to make a change in it with several training sessions. It can be concluded that the results of this research can help us have a better understanding of the effects of resiliency skills on mental health (anxiety, depression, social performance and physical symptoms) and increase the awareness of researchers and authorities about these factors.

Although some of the results were confirmed with the assumptions and research hypotheses in this research, it can not be stated that these results are definitively correct and practical in any situation. This research provided a basis for individuals to study further factors outside this or in other circumstances. The methods and strategies employed in this research and its important results can be the basis for future studies in any part of the country and the world and enrich the existing knowledge in the field of the mental health and resiliency in different places and times. In general, the findings of this study provide more evidence for mental health threats and opportunities for officials to function better and more appropriately by

demonstrating the undeniable and effective role of resiliency to various aspects of mental health.

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