

Comparison of the Effectiveness of Reality Therapy and Acceptance and Commitment Therapy on Work Engagement and Adjustment to Disability Among Persons with Disabilities Covered by the Welfare Organization

Leila Sadat. Modaresi^{1*}, Parisa. Kolahi², Arsalan. Barekat³, Tayebbeh. Delshad¹, Soheila. Rahmani⁴, Amine. Jalali⁵

¹ MA, Department of Rehabilitation Counseling, TeMS.C., Islamic Azad University, Tehran, Iran

² Department of Psychology, TeMS.C., Islamic Azad University, Tehran, Iran

³ Department of Health Psychology, To.C., Islamic Azad University, Mazandaran, Iran

⁴ Department of Health Psychology, TeMS.C., Islamic Azad University, Tehran, Iran

⁵ Department of Psychology, Si.C., Islamic Azad University, Sirjan, Iran

* Corresponding author email address: lmodarresi@gmail.com

Article Info

ABSTRACT

Article type:

Original Research

How to cite this article:

Modaresi, L. S., Kolahi, P., Barekat, A., Delshad, T., Rahmani, S., & Jalali, A. (2027). Comparison of the Effectiveness of Reality Therapy and Acceptance and Commitment Therapy on Work Engagement and Adjustment to Disability Among Persons with Disabilities Covered by the Welfare Organization. *Iranian Journal of Neurodevelopmental Disorders*, 5(1), 1-16.

<https://doi.org/10.61838/kman.jndd.954>



© 2027 the authors. Published by Iranian Association for Intelligence and Talent Studies, Tehran, Iran. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0) License.

Purpose: The present study aimed to compare the effectiveness of Reality Therapy and Acceptance and Commitment Therapy on work engagement and adjustment to disability among persons with disabilities covered by the Welfare Organization.

Methods and Materials: This quasi-experimental study employed a pretest-posttest-follow-up design with two intervention groups and one control group. The statistical population consisted of persons aged 18–35 years with physical-motor, sensory, or other disabilities receiving services from the Welfare Organization of Tehran in 2025. A total of 45 eligible participants were selected through convenience sampling and randomly assigned to Reality Therapy, Acceptance and Commitment Therapy, and control groups, with 15 participants in each group. The intervention groups received eight structured group sessions of their respective treatments, whereas the control group received no intervention during the study period. Data were collected using the Utrecht Work Engagement Scale and the Raymond Adjustment to Disability Questionnaire. Data were analyzed in SPSS-26 using repeated-measures analysis of variance and Bonferroni post-hoc comparisons.

Findings: Repeated-measures analysis showed significant effects of time, group, and the time-by-group interaction for work engagement, $F(4,84) = 31.76, p < .001$, partial $\eta^2 = .602$, and adjustment to disability, $F(4,84) = 39.58, p < .001$, partial $\eta^2 = .653$. Bonferroni comparisons indicated that both Reality Therapy and Acceptance and Commitment Therapy significantly outperformed the control group at posttest and follow-up on both outcomes ($p < .001$). Acceptance and Commitment Therapy was also significantly more effective than Reality Therapy in improving work engagement at posttest ($p = .039$) and follow-up ($p = .034$), as well as adjustment to disability at posttest ($p = .033$) and follow-up ($p = .031$).

Conclusion: Both Reality Therapy and Acceptance and Commitment Therapy were effective in improving work engagement and adjustment to disability, but Acceptance and Commitment Therapy produced stronger and sustained effects and may therefore be particularly useful in psychological and vocational rehabilitation programs for persons with disabilities.

Keywords: *Reality Therapy, Acceptance and Commitment Therapy, Work Engagement, Adjustment to Disability, Persons with Disabilities, Rehabilitation*

1. Introduction

Disability is a multidimensional condition that extends beyond physical or sensory impairment and intersects with psychological functioning, social participation, autonomy, access to services, and employment. Contemporary approaches to disability increasingly emphasize participation, self-determination, environmental accessibility, and the realization of social and occupational rights rather than defining disability exclusively in terms of individual limitations. Nevertheless, persons with disabilities may continue to encounter structural, interpersonal, and psychological barriers that restrict their participation in education, employment, health care, and community life. Recent literature has emphasized the importance of rights-based and person-centered systems capable of supporting autonomy and meaningful participation among people with disabilities, particularly in health, rehabilitation, and social-service contexts (Cong et al., 2026; Gordon et al., 2026). At the same time, people with disabilities may be disproportionately affected by adverse environmental and social circumstances, including reduced access to supportive resources, difficulties in receiving appropriate services, exposure to abuse, and vulnerability during disasters and emergencies (Andreae et al., 2026; Ogunlade et al., 2026). These conditions demonstrate that rehabilitation should not be limited to improvement of physical functioning but should also address psychological adaptation, participation in meaningful roles, and opportunities for productive engagement in social and occupational life.

Employment represents one of the most important domains of participation for adults with disabilities because work provides not only financial resources but also opportunities for autonomy, social integration, competence, identity development, and a sense of contribution. However, entering and remaining in employment may be considerably more complicated for people with disabilities than for individuals without functional limitations. Accessibility barriers, social stigma, reduced employment opportunities, concerns regarding dependence, and negative perceptions of personal capability can influence occupational functioning. Research on employment among persons with disabilities

has increasingly emphasized psychological strengths and personal resources in addition to policy and environmental conditions. Character strengths, for example, have been examined as relevant psychological assets associated with employment among persons with disabilities, suggesting that occupational participation may partly depend on the capacity to recognize and mobilize adaptive personal characteristics (Lee et al., 2026). At the policy level, efforts to facilitate self-employment and economic participation among people with disabilities further demonstrate that employment is closely connected with empowerment, inclusion, and social independence (Monareng et al., 2025). Consequently, psychological interventions designed for this population should ideally contribute not only to the reduction of distress but also to the enhancement of constructive engagement with occupational roles.

One construct particularly relevant to this purpose is work engagement. Work engagement refers to a positive, fulfilling, and persistent psychological state in which individuals approach their occupational activities with energy, dedication, and absorption. Engaged individuals tend to experience work as meaningful, invest psychological and behavioral resources in their tasks, and sustain greater involvement despite challenges. For persons with disabilities, work engagement may have particular importance because occupational participation can be influenced simultaneously by functional restrictions, environmental barriers, self-perceptions, emotional responses, and previous experiences of exclusion. When individuals perceive themselves as capable of pursuing meaningful occupational goals and are able to remain behaviorally engaged despite difficult internal experiences, their relationship with work may become more active and constructive. Conversely, withdrawal from occupational activities, persistent perceptions of incapacity, avoidance of challenging situations, or excessive focus on uncontrollable limitations may undermine motivation and engagement. Therefore, strengthening adaptive psychological resources may help persons with disabilities maintain a more purposeful and value-consistent relationship with employment.

Alongside work engagement, adjustment to disability is a fundamental psychological outcome in rehabilitation. Adjustment to disability involves the gradual psychological and social integration of disability into one's life without allowing the condition to completely define personal identity, perceived competence, relationships, or expectations for the future. This adjustment does not imply denial of limitations or passive acceptance of difficulties. Rather, adaptive adjustment involves acknowledging the reality of disability while maintaining self-respect, autonomy, social participation, realistic hope, and commitment to meaningful activities. Rehabilitation studies have increasingly recognized that outcomes such as independence, quality of life, acceptance, psychological well-being, and participation are interrelated components of successful adaptation. For example, studies involving individuals recovering from stroke and other disabling conditions have shown the importance of interventions that target both functional outcomes and psychological adaptation (Dąbrowska et al., 2023; Patchwood et al., 2024). Similarly, contemporary rehabilitation models increasingly integrate psychological and behavioral dimensions with physical rehabilitation because improvement in functional capacity alone may not necessarily translate into satisfactory adaptation or social participation.

The expansion of rehabilitation approaches also demonstrates that adjustment to disability is influenced by the way individuals interact with their experiences and environments. Technological interventions such as virtual reality have been increasingly incorporated into rehabilitation to improve motor performance, self-sufficiency, quality of life, and participation among people with neurological or developmental disabilities (Fu & Ji, 2023; Micheluzzi et al., 2025). Systematic work on virtual reality interventions has likewise illustrated the growing interest in innovative therapeutic environments within behavioral and rehabilitation services (Bin et al., 2025). Importantly, virtual reality therapy should be distinguished from Reality Therapy as a psychotherapeutic approach; however, the growing literature on technologically supported rehabilitation is relevant because it reflects a broader movement toward active, experiential, individualized, and participation-oriented interventions. These developments reinforce the proposition that successful rehabilitation should address how individuals respond behaviorally and psychologically to restrictions, opportunities, and life demands rather than focusing solely on impairment.

One psychotherapy that may be particularly appropriate for strengthening adaptive functioning is Reality Therapy, which is grounded in Choice Theory and emphasizes personal responsibility, purposeful behavior, need satisfaction, and evaluation of current choices. From this perspective, individuals possess basic psychological needs and continuously attempt to behave in ways that bring their lived experiences closer to what they want from life. Psychological difficulties may emerge or persist when individuals rely on ineffective behavioral patterns, focus excessively on circumstances they cannot control, or repeatedly use strategies that fail to satisfy important needs. Reality Therapy directs attention toward present behavior rather than prolonged analysis of past difficulties and encourages individuals to examine what they want, what they are currently doing, whether their behavior is helping them achieve desired outcomes, and what realistic plan they can implement. This emphasis may be especially relevant for persons with disabilities, who often confront circumstances that cannot simply be removed but who may nevertheless retain meaningful choices regarding relationships, occupational participation, help-seeking, skill development, self-care, and goal pursuit.

Reality Therapy can therefore provide a framework for separating uncontrollable aspects of disability from controllable behavioral responses. By emphasizing personal agency without denying objective limitations, it may help individuals identify realistic occupational and interpersonal goals, evaluate avoidant or dependent behavioral patterns, and replace ineffective responses with more responsible and attainable actions. Evidence indicates that Reality Therapy based on Choice Theory can positively influence psychological outcomes such as mental health and emotion regulation, supporting the potential utility of this approach for improving adaptive functioning (Omidi et al., 2025). Moreover, comparative research has begun to examine Reality Therapy alongside Acceptance and Commitment Therapy. In elderly individuals attending rehabilitation centers, both interventions have been compared in relation to meaning in life, indicating the relevance of these approaches for populations confronting age-related or functional challenges (Azimi et al., 2025). Likewise, research among women with multiple sclerosis has compared Acceptance and Commitment Therapy and Reality Therapy in relation to illness perception, directly supporting the potential relevance of comparing these therapies among individuals coping with chronic disabling conditions (Bagheri et al., 2024).

Acceptance and Commitment Therapy (ACT) represents another theoretically relevant intervention for persons with disabilities. ACT is a contextual behavioral approach that seeks to increase psychological flexibility, defined broadly as the capacity to remain in contact with present experiences while choosing behaviors that serve personally meaningful values. Rather than attempting to eliminate all unpleasant thoughts, emotions, memories, or bodily sensations, ACT teaches individuals to alter their relationship with these experiences. Its core therapeutic processes include acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, and committed action. These processes are intended to reduce behavioral restriction associated with experiential avoidance and to promote action based on chosen values even when discomfort is present. Early clinical development of ACT across complex psychiatric populations demonstrated its adaptability to individuals experiencing substantial psychological difficulties (Gaudiano et al., 2017), while subsequent research has extended its application across a wide variety of medical, psychiatric, rehabilitation, and health-related contexts.

The relevance of ACT for individuals with disabilities can be understood through the concept of experiential avoidance. Disability may be accompanied by painful thoughts about loss, dependency, employability, social judgment, bodily limitations, or uncertain futures. Attempts to completely eliminate these thoughts and emotions can sometimes narrow behavior, resulting in avoidance of social interactions, rehabilitation activities, employment opportunities, or other meaningful roles. ACT does not require the individual to consider disability positively or to ignore legitimate barriers. Rather, it encourages willingness to experience difficult internal states while continuing to move toward personally valued directions. This approach may facilitate adjustment because it allows individuals to acknowledge limitations without equating those limitations with a totalized negative identity. It may also support work engagement by helping participants pursue occupationally meaningful behavior despite anxiety, discouragement, self-doubt, or discomfort.

Evidence supporting ACT has accumulated across conditions that involve persistent distress, functional limitations, and rehabilitation needs. A systematic review and meta-analysis examining individuals with neurological disorders found ACT relevant to outcomes including depression, anxiety, pain, quality of life, acceptance, and functional impairment (Han et al., 2023). ACT-based

clinical guidance has also highlighted psychological flexibility and resilience in individuals experiencing chronic pain, a condition frequently associated with restrictions in daily and occupational functioning (Moens et al., 2022). In post-stroke rehabilitation, group ACT has been evaluated for the prevention of depression, suggesting that acceptance-based group interventions may be useful during adaptation to major changes in functioning (Niu et al., 2022). Feasibility research on ACT following stroke has similarly emphasized psychological adjustment as an important rehabilitation target rather than treating emotional consequences as secondary to physical recovery (Patchwood et al., 2024). These findings are particularly pertinent to the present study because adjustment to disability involves many of the same processes of acceptance, identity reconstruction, behavioral adaptation, and engagement in meaningful life directions.

ACT has also demonstrated applicability to populations facing significant physical injury and rehabilitation demands. A randomized controlled study of rehabilitation patients following burns investigated ACT in relation to both psychological well-being and physical functioning, reflecting the capacity of the approach to bridge emotional and functional rehabilitation goals (Ruan et al., 2025). Among adolescents and adults who stutter, an intervention integrating fluency treatment with ACT further illustrated how acceptance-based methods can complement condition-specific rehabilitation by addressing the psychological processes surrounding a persistent functional difficulty (Hart et al., 2024). ACT has additionally been investigated in populations with severe psychiatric and behavioral difficulties, including bipolar disorder, where improvements in clinically important outcomes have been examined (El-Sayed et al., 2023), and in individuals with obsessive-compulsive symptoms, where ACT-related approaches have been associated with psychological resources such as resilience, cognitive flexibility, and distress tolerance (Baniasadi et al., 2025). Adaptations of ACT incorporating culturally or spiritually relevant elements have also been explored, demonstrating the flexibility of the therapeutic model across different contexts (Dehaghi et al., 2022).

An additional advantage of ACT is its adaptability to different modes of delivery and stages of health care. Internet-based ACT has been evaluated in randomized controlled research, with follow-up assessment used to examine maintenance of psychological effects over time (Wang et al., 2024). Large pragmatic trials have also incorporated ACT into rehabilitation and survivorship care, as illustrated by the SURECAN research program

comparing enhanced ACT plus usual aftercare with usual aftercare among individuals living with or beyond cancer (Robinson et al., 2025). Collectively, such studies suggest that ACT is not restricted to narrowly defined psychiatric symptoms but can be applied to broader questions of adaptation, functioning, resilience, meaningful activity, and quality of life. This breadth may make ACT particularly relevant for persons with disabilities whose needs often cross traditional boundaries between mental health treatment, rehabilitation, vocational functioning, and social participation.

Despite the strengths of ACT, Reality Therapy may influence similar outcomes through a conceptually different route. Whereas ACT focuses on psychological flexibility, acceptance of private experiences, values, and committed action, Reality Therapy emphasizes present choices, satisfaction of basic needs, responsibility, behavioral evaluation, and realistic planning. Both approaches therefore encourage active engagement with life rather than passive withdrawal, but they differ substantially in how they conceptualize the mechanisms that interfere with adaptive behavior. ACT proposes that rigid attempts to control internal experiences and cognitive fusion can restrict meaningful action, while Reality Therapy places greater emphasis on ineffective choices, unmet needs, and the evaluation of present behavior. These theoretical differences make comparative research valuable, particularly when outcomes involve both subjective adaptation and active participation. Comparative findings in individuals with multiple sclerosis suggest that both ACT and Reality Therapy can be meaningfully examined in relation to perceptions of chronic health conditions (Bagheri et al., 2024), while comparative findings among older adults in rehabilitation settings further indicate that the two treatments may influence meaning-oriented psychological outcomes (Azimi et al., 2025).

For persons with disabilities receiving welfare and rehabilitation services, determining which intervention more effectively strengthens work engagement and adjustment to disability has direct clinical and service implications. Psychological rehabilitation programs are often required to operate within limited time and resources, making evidence regarding relative treatment effectiveness especially important. The broader literature increasingly supports rehabilitation models that integrate psychological adjustment, autonomy, functional participation, access to services, and social rights (Cong et al., 2026; Gordon et al., 2026). At the same time, continuing evidence regarding

vulnerability, help-seeking barriers, environmental threats, and participation restrictions highlights the need for interventions that strengthen individuals' capacity to act adaptively within complex social conditions (Andreae et al., 2026; Ogunlade et al., 2026). Improving work engagement may support more sustained involvement in productive roles, whereas enhancing adjustment to disability may promote acceptance, autonomy, positive self-evaluation, social interaction, and future orientation. Examining these outcomes together can therefore provide a more comprehensive understanding of psychological rehabilitation than focusing exclusively on symptom reduction.

Although previous research has supported ACT across neurological, medical, psychiatric, pain, and rehabilitation contexts and has provided evidence for Reality Therapy in relation to mental health, emotion regulation, meaning in life, and illness-related perceptions, relatively limited research has directly compared the two approaches with respect to occupational engagement and adjustment to disability among young adults receiving welfare services. Existing studies have established the importance of psychological flexibility, resilience, acceptance, personal strengths, autonomy, and meaningful participation (Han et al., 2023; Lee et al., 2026; Moens et al., 2022), but further comparative intervention research is required to clarify whether therapies grounded in different mechanisms produce comparable or differential benefits for persons with disabilities. Such evidence may assist rehabilitation psychologists, counselors, social-service professionals, and welfare organizations in selecting interventions that not only reduce psychological difficulties but also enhance active participation in work and improve adaptation to disability.

Accordingly, the aim of the present study was to compare the effectiveness of Reality Therapy and Acceptance and Commitment Therapy on work engagement and adjustment to disability among persons with disabilities covered by the Welfare Organization.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental research design with a pretest-posttest-follow-up structure and a control group to compare the effectiveness of Reality Therapy and Acceptance and Commitment Therapy on work engagement and adjustment to disability among persons with disabilities receiving services from the Welfare

Organization. The statistical population consisted of all individuals with physical-motor, sensory, or other types of disabilities who were covered by the Welfare Administration of Tehran during 2025. Eligible participants were between 18 and 35 years of age, had sufficient physical and psychological capacity to participate in group intervention sessions, and provided informed consent to participate in the study. The study sample consisted of 45 eligible participants who were assigned to three groups of 15 participants each. The first experimental group received Reality Therapy, the second experimental group received Acceptance and Commitment Therapy, and the third group served as the control group and did not receive either of the study interventions during the intervention period. Because attrition could occur during the treatment sessions or follow-up phase, recruitment of a slightly larger initial pool of eligible participants was considered when necessary to preserve the intended final sample size. Participants were recruited using convenience sampling from among eligible service recipients and were subsequently assigned randomly to the three study groups. Before the intervention began, the purpose and general procedures of the research were explained to all participants, and written informed consent was obtained. Participants were assured that their personal information and responses would remain confidential, that the collected data would be used exclusively for research purposes, and that they could withdraw from the study at any stage without adverse consequences. The outcome variables were assessed before the interventions, after completion of the intervention sessions, and during the follow-up phase in order to examine both immediate and sustained treatment effects.

2.2. Instruments

The Utrecht Work Engagement Scale was used to assess participants' level of work engagement. The instrument was developed by Schaufeli and Bakker in 2003 and is one of the most widely used measures of work engagement in industrial and organizational psychology. The full version of the scale consists of 17 items and assesses three major dimensions of work engagement: vigor, measured by six items; dedication, measured by five items; and absorption, measured by six items. Items are scored on a seven-point Likert-type scale ranging from 0, indicating "never," to 6, indicating "always." A total work engagement score can be calculated by averaging the scores obtained across the items, with higher scores representing greater engagement with

occupational activities and greater psychological investment in work. The instrument conceptualizes work engagement as a positive, fulfilling, work-related psychological state characterized by high levels of energy, persistence, enthusiasm, significance, concentration, and involvement in occupational tasks. Previous studies have reported satisfactory internal consistency for the scale, with Cronbach's alpha coefficients generally ranging from approximately .85 to .92. Evidence has also supported its construct, convergent, and discriminant validity. The Persian version of the measure has been examined in Iranian samples, and acceptable psychometric properties have been reported, including an overall Cronbach's alpha coefficient of approximately .87.

Adjustment to disability was measured using the Raymond Adjustment to Disability Questionnaire, developed by Raymond in 1995 to assess the degree to which individuals adapt psychologically and socially to living with a disability. The questionnaire contains 25 items organized around five dimensions, including acceptance of disability, positive self-attitude, social interaction, independence and autonomy, and hopefulness regarding the future. Responses are scored on a five-point Likert scale ranging from 1, representing "strongly disagree," to 5, representing "strongly agree." Several items are reverse scored, and the overall score is obtained by summing the item scores after appropriate reverse scoring. Total scores can range from 25 to 125, with higher scores indicating more favorable psychological and social adjustment to disability. The questionnaire is intended to capture individuals' capacity to integrate disability into their self-concept, preserve constructive interpersonal relationships, maintain autonomy and functional independence, and develop positive expectations about their future despite limitations associated with disability. The original instrument demonstrated satisfactory reliability, with a Cronbach's alpha coefficient of approximately .87 for the total scale and coefficients ranging from .76 to .84 for its subscales. Construct, convergent, and discriminant validity have also been reported. Studies conducted with Iranian samples have supported the applicability of the instrument and have reported internal consistency coefficients of approximately .84 for the overall questionnaire.

2.3. Interventions

The Reality Therapy intervention was delivered in eight structured group sessions and was organized around the

major principles of Choice Theory and Reality Therapy, particularly identification of basic needs, clarification of wants, evaluation of present behavior, personal responsibility, and development of realistic action plans. During the first session, participants were introduced to the objectives and rules of the intervention, confidentiality requirements, expectations regarding regular attendance, and principles of constructive group participation. A therapeutic relationship was established, and participants explored their major needs and expectations concerning personal life, employment, independence, and adaptation to disability. In the second session, the five basic needs of survival, love and belonging, power, freedom, and fun were introduced, and participants examined the extent to which disability and current employment conditions facilitated or restricted satisfaction of these needs. They also clarified important occupational, familial, interpersonal, and independence-related wants. The third session focused on examination of current behaviors used when dealing with disability-related difficulties and employment problems. Participants were encouraged to identify the relationship between their stated goals and their present actions. In the fourth session, participants evaluated whether current behavioral patterns, including social withdrawal, hopelessness, excessive dependence, or avoidance of occupational activity, were effectively helping them move toward their desired outcomes. The fifth session emphasized the development of short-term, specific, realistic, and achievable behavioral plans aimed at improving employment-related functioning and adjustment to disability. These plans could include pursuing employment opportunities, strengthening social relationships, increasing participation in enjoyable activities, developing personal competencies, or seeking appropriate forms of support. During the sixth session, emphasis was placed on commitment to action plans and acceptance of personal responsibility for behavioral choices. Participants identified anticipated obstacles and generated practical strategies for managing them. The seventh session reviewed progress in carrying out the proposed plans, and plans were revised where necessary. The therapist emphasized persistence in responsible behavior, reduction of self-blame and blaming others, and increased attention to controllable choices. In the eighth and final session, the major concepts and skills taught throughout the intervention were reviewed, participants evaluated perceived changes in responsibility, behavioral choice, work engagement, and adjustment to disability, and individualized plans were developed for maintaining

treatment gains and applying the acquired skills to future occupational and disability-related challenges.

The Acceptance and Commitment Therapy intervention was also implemented in eight structured group sessions and focused on increasing psychological flexibility through the core processes of acceptance, present-moment awareness, cognitive defusion, self-as-context, values clarification, and committed action. During the first session, participants were introduced to the aims and rules of the intervention, confidentiality principles, the importance of regular participation, and the general concept of psychological flexibility. The distinction between attempting to control unwanted internal experiences and learning to manage behavior effectively in the presence of those experiences was discussed, and participants were introduced to acceptance as an alternative to persistent experiential control. The second session focused on mindful awareness of the present moment. Participants practiced observing thoughts, emotions, and bodily sensations without judgment and were encouraged to record daily experiences while applying mindful attention between sessions. During the third session, experiential avoidance was introduced, and participants examined how efforts to avoid difficult thoughts, emotions, social situations, or occupational activities could progressively distance them from personally meaningful life directions. They identified specific situations they commonly avoided because of disability-related concerns, fear, distress, or negative self-evaluation. The fourth session emphasized cognitive defusion. Participants learned to recognize negative thoughts about disability, personal abilities, employment prospects, or future functioning as mental events rather than objective facts that necessarily had to determine behavior. In the fifth session, self-as-context was introduced, and participants were encouraged to experience the self as broader than disability, painful emotions, negative cognitions, past experiences, or socially imposed labels. The sixth session was devoted to clarification of personal values in major life domains, including employment, family relationships, autonomy, personal development, interpersonal relationships, and social participation. Participants learned to distinguish enduring values from finite goals and identified life directions that were most consistent with their chosen values. During the seventh session, committed action was emphasized. Participants translated their identified values into small, observable, realistic, and achievable behavioral steps designed to increase occupational participation and adaptive functioning in relation to disability. They were

encouraged to continue value-consistent behavior even when unpleasant thoughts and feelings were present. In the eighth session, the intervention skills were consolidated through a comprehensive review of acceptance, mindfulness, cognitive defusion, self-as-context, values clarification, and committed action. Participants developed individualized continuation plans for sustaining value-based behavior, increasing work-related participation, and responding adaptively to future disability-related and occupational difficulties.

2.4. Data Analysis

After completion of data collection, the data were coded, entered, and analyzed using SPSS version 26. Descriptive statistical indices, including means and standard deviations, were calculated to summarize participants' scores on work engagement and adjustment to disability across the pretest, posttest, and follow-up assessments. Before conducting inferential analyses, the principal assumptions underlying repeated-measures analysis were examined, including the distributional characteristics of the dependent variables, homogeneity of variances, and the sphericity assumption for within-subject comparisons. To evaluate the effectiveness of Reality Therapy and Acceptance and Commitment Therapy and to compare the magnitude and persistence of their effects over time, repeated-measures analysis of variance was used with group as the between-subjects factor and measurement occasion as the within-subjects factor. The analysis therefore examined the main effect of time, the main effect of group, and particularly the group-by-time interaction, which indicated whether changes in work

engagement and adjustment to disability differed across the Reality Therapy, Acceptance and Commitment Therapy, and control conditions. When statistically significant omnibus effects were observed, appropriate pairwise and post hoc comparisons were used to identify differences between treatment groups and assessment stages. Statistical significance was evaluated at the conventional alpha level of .05.

3. Findings and Results

The final sample consisted of 45 participants with disabilities receiving services from the Welfare Organization of Tehran, who were equally allocated to the Reality Therapy group, Acceptance and Commitment Therapy group, and control group, with 15 participants in each condition. The participants ranged in age from 18 to 35 years, with an overall mean age of 27.18 years ($SD = 4.62$). In the Reality Therapy group, the mean age was 27.40 years ($SD = 4.51$), whereas the mean ages in the Acceptance and Commitment Therapy and control groups were 26.93 years ($SD = 4.77$) and 27.20 years ($SD = 4.69$), respectively. Overall, 24 participants (53.3%) were male and 21 participants (46.7%) were female. Regarding type of disability, 24 participants (53.3%) had physical-motor disabilities, 12 participants (26.7%) had sensory disabilities, and 9 participants (20.0%) had other forms of disability. Examination of demographic characteristics indicated that the three groups were generally comparable in terms of age, sex distribution, and type of disability, and no statistically meaningful baseline demographic differences were observed between the study groups.

Table 1

Descriptive Statistics for Work Engagement and Adjustment to Disability Across Measurement Stages

Variable	Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Follow-up M	Follow-up SD
Work Engagement	Reality Therapy	2.71	0.54	3.78	0.50	3.69	0.52
Work Engagement	Acceptance and Commitment Therapy	2.68	0.57	4.18	0.47	4.11	0.49
Work Engagement	Control	2.74	0.55	2.80	0.56	2.77	0.58
Adjustment to Disability	Reality Therapy	67.47	8.31	82.20	7.54	80.87	7.71
Adjustment to Disability	Acceptance and Commitment Therapy	66.93	8.56	87.53	7.12	86.27	7.35
Adjustment to Disability	Control	67.80	8.19	68.73	8.23	68.20	8.34

As shown in Table 1, the three groups had relatively similar mean scores on both dependent variables at the

pretest stage. For work engagement, the pretest means were 2.71, 2.68, and 2.74 in the Reality Therapy, Acceptance and

Commitment Therapy, and control groups, respectively. Following the interventions, work engagement increased to 3.78 in the Reality Therapy group and 4.18 in the Acceptance and Commitment Therapy group, whereas only a negligible increase to 2.80 was observed in the control group. At follow-up, the mean scores remained relatively stable in both intervention groups, indicating maintenance of treatment gains. A similar pattern was observed for adjustment to disability. The Reality Therapy group increased from a pretest mean of 67.47 to 82.20 at posttest and maintained a mean of 80.87 at follow-up. The Acceptance and Commitment Therapy group demonstrated a larger increase, from 66.93 at pretest to 87.53 at posttest, with a follow-up mean of 86.27. In contrast, the control group showed only minimal changes across the three measurement occasions. These descriptive findings suggested that both interventions improved work engagement and adjustment to disability, with larger improvements evident in the Acceptance and Commitment Therapy group.

Before conducting repeated-measures analysis of variance, the statistical assumptions were examined. The Shapiro-Wilk test indicated that the distributions of work engagement and adjustment to disability scores did not significantly deviate from normality across the three groups and measurement occasions, with all p values greater than .05. Levene's test was nonsignificant for work engagement at pretest, posttest, and follow-up, F values ranging from 0.36 to 1.12, $p > .05$, and was also nonsignificant for adjustment to disability, with F values ranging from 0.41 to 1.27, $p > .05$, supporting homogeneity of variances. Box's M test was also nonsignificant, Box's $M = 16.84$, $F = 1.21$, $p = .271$, indicating equality of the variance-covariance matrices across groups. Mauchly's test of sphericity was nonsignificant for work engagement, $W = .92$, $\chi^2 = 3.38$, $p = .184$, and for adjustment to disability, $W = .94$, $\chi^2 = 2.51$, $p = .285$. Therefore, the assumption of sphericity was satisfied and no Greenhouse-Geisser correction was required. Collectively, these findings indicated that the principal assumptions necessary for repeated-measures analysis of variance were adequately met.

Table 2

Repeated-Measures Analysis of Variance for Work Engagement and Adjustment to Disability

Variable	Effect	df	F	p	Partial η^2	Observed Power
Work Engagement	Time	2, 84	92.64	<.001	.688	1.000
Work Engagement	Group	2, 42	18.91	<.001	.474	1.000
Work Engagement	Time $\times$ Group	4, 84	31.76	<.001	.602	1.000
Adjustment to Disability	Time	2, 84	118.42	<.001	.738	1.000
Adjustment to Disability	Group	2, 42	22.37	<.001	.516	1.000
Adjustment to Disability	Time $\times$ Group	4, 84	39.58	<.001	.653	1.000

The repeated-measures analysis of variance presented in Table 2 demonstrated a significant main effect of time on work engagement, $F(2, 84) = 92.64$, $p < .001$, partial $\eta^2 = .688$, indicating that work engagement scores changed significantly across the pretest, posttest, and follow-up assessments. The main effect of group was also significant, $F(2, 42) = 18.91$, $p < .001$, partial $\eta^2 = .474$. More importantly, the interaction between time and group was statistically significant, $F(4, 84) = 31.76$, $p < .001$, partial $\eta^2 = .602$, indicating that changes in work engagement over time differed significantly among the Reality Therapy, Acceptance and Commitment Therapy, and control groups.

For adjustment to disability, the main effect of time was significant, $F(2, 84) = 118.42$, $p < .001$, partial $\eta^2 = .738$, and the main effect of group was also significant, $F(2, 42) = 22.37$, $p < .001$, partial $\eta^2 = .516$. In addition, a significant time-by-group interaction was obtained, $F(4, 84) = 39.58$, $p < .001$, partial $\eta^2 = .653$. The effect sizes were large for both dependent variables, showing that a substantial proportion of variance in changes over time was associated with the intervention conditions. These findings demonstrated that the trajectories of work engagement and adjustment to disability differed significantly between the intervention and control groups.

Table 3

Bonferroni Post-Hoc Comparisons Between Study Groups at Posttest and Follow-up

Variable	Stage	Comparison	Mean Difference	SE	p
Work Engagement	Posttest	Reality Therapy – Control	0.98	0.19	<.001
Work Engagement	Posttest	ACT – Control	1.38	0.19	<.001
Work Engagement	Posttest	ACT – Reality Therapy	0.40	0.18	.039
Work Engagement	Follow-up	Reality Therapy – Control	0.92	0.20	<.001
Work Engagement	Follow-up	ACT – Control	1.34	0.20	<.001
Work Engagement	Follow-up	ACT – Reality Therapy	0.42	0.19	.034
Adjustment to Disability	Posttest	Reality Therapy – Control	13.47	2.84	<.001
Adjustment to Disability	Posttest	ACT – Control	18.80	2.84	<.001
Adjustment to Disability	Posttest	ACT – Reality Therapy	5.33	2.41	.033
Adjustment to Disability	Follow-up	Reality Therapy – Control	12.67	2.91	<.001
Adjustment to Disability	Follow-up	ACT – Control	18.07	2.91	<.001
Adjustment to Disability	Follow-up	ACT – Reality Therapy	5.40	2.47	.031

Bonferroni-adjusted post-hoc comparisons indicated that both active interventions produced significantly better outcomes than the control condition. At posttest, work engagement was significantly higher in the Reality Therapy group than in the control group, with a mean difference of 0.98, $p < .001$, and was also significantly higher in the Acceptance and Commitment Therapy group than in the control group, with a mean difference of 1.38, $p < .001$. The Acceptance and Commitment Therapy group additionally demonstrated significantly greater work engagement than the Reality Therapy group, with a mean difference of 0.40, $p = .039$. The same pattern remained significant at follow-up, indicating maintenance of intervention effects. For adjustment to disability, the Reality Therapy group scored significantly higher than the control group at posttest, with a mean difference of 13.47, $p < .001$, while the Acceptance and Commitment Therapy group exceeded the control group by 18.80 points, $p < .001$. Acceptance and Commitment Therapy also resulted in significantly higher adjustment to disability than Reality Therapy at posttest, with a mean difference of 5.33, $p = .033$. These differences remained significant at follow-up, with the Acceptance and Commitment Therapy group continuing to show the highest scores. Overall, the post-hoc results indicated that both interventions were effective in enhancing work engagement and adjustment to disability, but Acceptance and Commitment Therapy demonstrated significantly greater effectiveness than Reality Therapy on both study outcomes, and the therapeutic gains were largely maintained during the follow-up period.

4. Discussion and Conclusion

The present study aimed to compare the effectiveness of Reality Therapy and Acceptance and Commitment Therapy on work engagement and adjustment to disability among persons with disabilities covered by the Welfare

Organization. The findings showed that both Reality Therapy and Acceptance and Commitment Therapy significantly improved work engagement and adjustment to disability from pretest to posttest compared with the control group. These improvements were largely maintained at follow-up, indicating that the effects of both interventions were not restricted to the immediate post-intervention period. In addition, the significant group-by-time interactions for both dependent variables demonstrated that the pattern of change over time differed across the three groups. Bonferroni comparisons further showed that Acceptance and Commitment Therapy produced significantly greater improvements than Reality Therapy in both work engagement and adjustment to disability at posttest and follow-up. Therefore, although both interventions appeared clinically beneficial, Acceptance and Commitment Therapy demonstrated comparatively stronger effectiveness for the psychological and occupational outcomes examined in this study.

The first major finding was that Reality Therapy significantly increased work engagement compared with the control condition. This result can be explained on the basis of Choice Theory, according to which individuals are motivated by fundamental needs and continuously make behavioral choices intended to satisfy those needs. In the context of employment and disability, individuals may experience a sense of reduced control because of environmental barriers, limitations associated with disability, dependence on others, or repeated experiences of occupational rejection. Reality Therapy redirects attention from uncontrollable circumstances toward choices that remain available in the present. Through identifying needs, clarifying wants, evaluating current behaviors, and developing realistic plans, participants may become more active in relation to occupational goals. Rather than perceiving employment difficulties as entirely determined

by external conditions, participants are encouraged to identify specific actions that can increase involvement, competence, autonomy, and participation. This shift from passive appraisal to intentional behavior can plausibly increase vigor, dedication, and psychological investment in work.

The effectiveness of Reality Therapy in enhancing work engagement is also consistent with evidence that Choice Theory-based interventions can improve adaptive psychological functioning. Omidi et al. reported that Reality Therapy training based on Choice Theory improved mental health and emotion regulation, suggesting that the intervention can strengthen individuals' capacity to manage internal experiences and make more adaptive behavioral choices (Omidi et al., 2025). Although their population differed from the participants in the present study, improvements in emotional regulation and mental health may support greater persistence and involvement in occupational activities. In addition, comparative research has demonstrated that Reality Therapy can affect important meaning-related and illness-related outcomes. Azimi et al. found that Reality Therapy was effective in improving meaning in life among older adults attending rehabilitation centers (Azimi et al., 2025), while Bagheri et al. reported beneficial effects of Reality Therapy on illness perception among women with multiple sclerosis (Bagheri et al., 2024). These findings support the interpretation that Reality Therapy may help individuals reinterpret their current circumstances, identify personally meaningful goals, and develop more constructive responses to chronic limitations, all of which can contribute to increased engagement in occupational roles.

Reality Therapy also significantly improved adjustment to disability. One possible explanation is that the intervention encourages individuals to distinguish between aspects of life that can and cannot be changed. Disability itself may not always be modifiable, but individuals retain choices regarding social participation, self-care, occupational effort, relationships, help-seeking, and interpretation of their current behavior. By focusing on controllable choices, Reality Therapy may reduce helplessness and encourage greater personal responsibility without denying the objective difficulties associated with disability. Participants in the present study were also taught to assess whether behaviors such as withdrawal, excessive dependence, avoidance of employment-related activities, or persistent self-blame brought them closer to or further from desired life outcomes. This self-evaluation process may have

facilitated more adaptive behavioral patterns and contributed to greater acceptance, autonomy, social interaction, and hope about the future.

This interpretation is consistent with the comparative findings of Bagheri et al., who showed that Reality Therapy was capable of improving illness perception among women with multiple sclerosis (Bagheri et al., 2024). Illness perception and adjustment to disability are not identical constructs, but both involve how individuals understand, evaluate, and behaviorally respond to a chronic or disabling condition. Similarly, the findings of Azimi et al. regarding meaning in life suggest that Reality Therapy may promote a more coherent and purposeful orientation toward life despite age-related or functional limitations (Azimi et al., 2025). From a rehabilitation perspective, such changes are important because psychological adjustment is not simply equivalent to symptom reduction. Rather, it involves developing an effective way of living with existing limitations while preserving agency, dignity, social participation, and future orientation.

The second major finding was that Acceptance and Commitment Therapy significantly increased work engagement compared with the control group. The magnitude of this effect was greater than that observed for Reality Therapy. This finding can be explained through the central ACT construct of psychological flexibility. Individuals with disabilities may experience persistent thoughts such as being incapable of performing occupational tasks, being judged by employers or colleagues, or having limited prospects for advancement. They may also experience anxiety, frustration, shame, sadness, or physical discomfort when entering work-related situations. If behavior becomes organized around avoiding these internal experiences, occupational participation may progressively narrow. ACT seeks to weaken this pattern by teaching participants to accept difficult internal experiences, distance themselves from unhelpful thoughts, remain aware of the present moment, clarify personally important values, and continue taking value-consistent action. These processes may increase engagement because occupational behavior is no longer made contingent on the absence of negative thoughts or emotions.

The present finding is consistent with a broad body of ACT research demonstrating that psychological flexibility can improve functioning across medical, neurological, psychiatric, and rehabilitation populations. Han et al., in a systematic review and meta-analysis of individuals with neurological disorders, found that ACT was associated with

improvements in depression, anxiety, pain, quality of life, acceptance, and functional impairment (Han et al., 2023). Such findings are relevant to work engagement because reductions in functional and emotional interference may enable individuals to invest more energy in meaningful activities. Moens et al. similarly emphasized the value of ACT for increasing resilience among individuals with chronic pain, a population in which persistent physical discomfort can interfere substantially with work and daily activity (Moens et al., 2022). The capacity to behave in accordance with values despite pain or distress is conceptually close to the behavioral persistence required for sustained work engagement.

The effectiveness of ACT on work engagement can also be interpreted through values clarification and committed action. In the intervention used in the present study, participants were encouraged to identify personally meaningful values related to employment, independence, family life, personal growth, social relationships, and participation in society. Work may therefore have been reframed not merely as an obligation or economic necessity but as a possible expression of autonomy, contribution, competence, or personal growth. Once occupational activity is linked to valued life directions, greater persistence may occur even when difficulties remain. This interpretation is consistent with the broader application of ACT across different delivery formats and clinical contexts. Wang et al. showed that an internet-based ACT intervention produced beneficial effects on mental well-being that were evaluated over follow-up, supporting the durability and adaptability of the model (Wang et al., 2024). Robinson et al. have also incorporated enhanced ACT into rehabilitation and survivorship care, reflecting the relevance of the approach for populations managing persistent health-related challenges while attempting to resume meaningful life activities (Robinson et al., 2025).

Acceptance and Commitment Therapy also significantly improved adjustment to disability, and this improvement was greater than that obtained through Reality Therapy. This finding is highly compatible with the theoretical foundations of ACT. Adjustment to disability requires individuals to integrate the reality of a chronic limitation into their lives while continuing to participate in meaningful activities. ACT directly targets this process by differentiating acceptance from resignation. Acceptance involves willingness to experience thoughts, emotions, bodily sensations, and memories without unnecessary attempts to control or eliminate them. For a person with a disability, this

may reduce the energy expended in struggling against unavoidable aspects of the condition and make greater psychological resources available for valued living. Cognitive defusion may further help individuals avoid treating thoughts such as “I am incapable,” “my future is limited,” or “others only see my disability” as literal truths that dictate behavior.

Evidence from rehabilitation populations provides substantial support for this explanation. Patchwood et al. examined a co-developed ACT intervention designed specifically to support psychological adjustment following stroke, demonstrating the feasibility and relevance of ACT within rehabilitation contexts (Patchwood et al., 2024). Niu et al. also reported beneficial effects of group ACT in individuals after stroke, showing that acceptance-based intervention can help address psychological difficulties following major changes in functioning (Niu et al., 2022). Similarly, Ruan et al. found ACT effective for psychological well-being and physical functioning among patients undergoing rehabilitation after burns (Ruan et al., 2025). These studies converge with the present findings by indicating that ACT may be particularly appropriate when individuals must adapt to conditions that cannot be fully eliminated but can be approached with greater flexibility and value-directed behavior.

Additional evidence supports the usefulness of ACT in conditions involving persistent functional or health-related challenges. Hart et al. evaluated an intervention integrating fluency treatment and ACT for adolescents and adults who stutter and demonstrated the applicability of acceptance-based strategies to a condition that can influence social participation, self-concept, and functional communication (Hart et al., 2024). Gaudiano et al. showed that ACT could be adapted even for individuals with severe psychiatric presentations, emphasizing its transdiagnostic focus on behavioral flexibility and engagement rather than symptom elimination alone (Gaudiano et al., 2017). El-Sayed et al. also demonstrated ACT-related improvements in clinically significant behavioral and emotional outcomes among individuals with bipolar disorders (El-Sayed et al., 2023). Although these populations differ from the present sample, the consistent applicability of ACT across heterogeneous conditions supports the proposition that increasing psychological flexibility can improve adaptive functioning even when distressing experiences remain present.

The superiority of ACT over Reality Therapy in the present study may be explained by the specific nature of the two dependent variables. Reality Therapy primarily focuses

on behavioral choices, responsibility, needs, and realistic planning. These processes are highly relevant to occupational functioning and adaptive behavior, but ACT additionally targets the individual's relationship with difficult internal experiences. Persons with disabilities may face not only practical barriers but also persistent thoughts, emotions, physical sensations, stigma-related concerns, and memories that cannot be easily changed through direct behavioral planning. ACT teaches individuals to make room for these experiences while continuing to act in accordance with chosen values. Consequently, ACT may influence a broader range of psychological processes that directly contribute to adjustment to disability and sustained occupational engagement.

Comparative studies provide support for examining this difference. Bagheri et al. directly compared ACT and Reality Therapy among women with multiple sclerosis and found both approaches useful for improving illness-related psychological outcomes (Bagheri et al., 2024). Azimi et al. also compared the two interventions in older adults attending rehabilitation centers and showed that both could influence meaning in life (Azimi et al., 2025). The present study extends this comparative literature by suggesting that ACT may have an advantage when the outcomes are work engagement and adjustment to disability. This superiority may result from ACT's simultaneous emphasis on acceptance, cognitive defusion, values, self-as-context, and committed behavior. The intervention may therefore alter not only what participants do but also how they relate to thoughts and emotions that might otherwise interfere with participation.

The maintenance of treatment effects at follow-up is another important finding. Both experimental groups retained most of their posttest gains, although the ACT group continued to show higher scores than the Reality Therapy group. Maintenance of improvement suggests that participants were able to generalize acquired skills beyond the intervention sessions. In Reality Therapy, individualized behavioral plans and continued evaluation of choices may have provided a practical framework for sustaining adaptive behavior. In ACT, the emphasis on values and committed action may have been particularly conducive to maintenance because these processes are designed to guide ongoing behavior rather than merely provide short-term symptom relief. Evidence from follow-up and rehabilitation studies supports the importance of examining persistence of ACT effects over time (Robinson et al., 2025; Wang et al., 2024). The sustained effects observed in the present study therefore

reinforce the potential relevance of both approaches for rehabilitation services, while indicating a comparatively stronger long-term pattern for ACT.

The results should also be interpreted within the broader context of disability rehabilitation. Contemporary disability research increasingly emphasizes participation, autonomy, rights, service accessibility, and integration into community life. Studies examining health services, employment policies, and social participation have demonstrated that persons with disabilities often encounter barriers that cannot be addressed solely through individual psychotherapy (Cong et al., 2026; Monareng et al., 2025). Likewise, research on help-seeking behaviors has highlighted vulnerabilities and obstacles experienced by persons with disabilities in accessing support (Ogunlade et al., 2026). Therefore, the effectiveness of psychological interventions should not be interpreted as implying that adjustment difficulties arise exclusively from individual psychological deficits. Rather, Reality Therapy and ACT may provide individuals with adaptive psychological and behavioral resources while structural, occupational, accessibility, and policy-level interventions are simultaneously required.

The present results are also consistent with the broader movement toward multidimensional rehabilitation. Research involving virtual reality and technologically assisted rehabilitation has shown that functional recovery, self-sufficiency, quality of life, and participation can be enhanced through active and individualized rehabilitation experiences (Dąbrowská et al., 2023; Fu & Ji, 2023; Micheluzzi et al., 2025). At the same time, increasing professional interest in novel therapeutic modalities demonstrates the importance of integrating psychological approaches with broader rehabilitation programs (Bin et al., 2025). From this perspective, the current findings indicate that psychotherapeutic interventions such as ACT and Reality Therapy can complement vocational, physical, and social rehabilitation by targeting the psychological processes that influence participation, persistence, self-evaluation, and adaptation.

Overall, the findings indicate that both Reality Therapy and Acceptance and Commitment Therapy are effective interventions for enhancing work engagement and adjustment to disability among persons with disabilities receiving welfare services. Reality Therapy appears to facilitate improvement by strengthening personal responsibility, clarifying needs and goals, evaluating ineffective behavioral patterns, and encouraging realistic action planning. ACT appears to facilitate improvement by

increasing psychological flexibility, reducing experiential avoidance, promoting cognitive defusion and acceptance, clarifying values, and strengthening committed action. The greater effectiveness of ACT observed in the present study suggests that interventions that directly address the relationship between difficult internal experiences and value-based behavior may be particularly useful for individuals adapting to disability while attempting to sustain meaningful occupational participation.

Several limitations should be considered when interpreting the findings of this study. First, the sample was relatively small and consisted of individuals receiving services from the Welfare Organization in Tehran, which may limit the generalizability of the results to persons with disabilities living in other regions, those who do not receive welfare services, or individuals with different socioeconomic and occupational circumstances. Second, the sample included individuals with different forms of disability, including physical-motor, sensory, and other disabilities, and the relatively limited sample size did not permit separate analyses according to disability type, severity, duration, or functional limitation. Third, participants were recruited through convenience sampling before random assignment, which may have introduced selection bias at the recruitment stage. Fourth, the primary outcomes were assessed through self-report instruments and may therefore have been influenced by social desirability, response tendencies, or participants' expectations regarding treatment. Fifth, although a follow-up assessment was conducted, the follow-up period was relatively limited and may not fully demonstrate the long-term stability of the observed changes. Finally, potentially relevant variables such as employment status, job type, income, social support, perceived discrimination, severity of disability, previous rehabilitation history, and concurrent psychological services were not examined as moderators of treatment response.

Future studies should replicate the present research with larger and more diverse samples drawn from different cities, rehabilitation settings, and disability groups in order to improve generalizability. Stratified designs could be used to examine whether the effectiveness of Reality Therapy and Acceptance and Commitment Therapy differs according to type, severity, onset, or duration of disability. Longer follow-up periods, such as six months or one year, would provide a clearer understanding of whether improvements in work engagement and adjustment to disability remain stable over time. Future researchers should also incorporate objective or multi-source indicators of occupational

functioning, including attendance, job retention, return to work, employment acquisition, supervisor ratings, or actual occupational participation. Examining mediating mechanisms such as psychological flexibility, experiential avoidance, personal responsibility, self-efficacy, resilience, hope, and perceived control could clarify why each treatment produces change. It would also be valuable to investigate moderators such as age, gender, employment status, social support, socioeconomic condition, and perceived discrimination. Future studies may further compare individual and group formats, face-to-face and online delivery, or combined psychological and vocational rehabilitation programs.

Rehabilitation centers, welfare organizations, vocational counselors, and mental health professionals working with persons with disabilities can consider incorporating structured psychological interventions into routine rehabilitation services rather than limiting support to financial, medical, or occupational assistance. Acceptance and Commitment Therapy may be particularly useful when clients experience persistent negative thoughts, emotional distress, avoidance of social or occupational situations, identity-related difficulties, or reduced engagement with meaningful life activities. Reality Therapy may be especially useful when treatment goals involve increasing responsibility, evaluating current behavior, clarifying needs, and developing concrete and achievable occupational plans. Practitioners can also integrate components of these approaches with vocational rehabilitation by connecting therapeutic goals to actual employment behaviors, such as applying for jobs, developing workplace communication skills, seeking appropriate accommodations, increasing independence, and maintaining participation despite psychological discomfort. Intervention programs should remain individualized and should account for the type of disability, accessibility needs, communication requirements, functional capacity, occupational circumstances, and personal values of each participant.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We hereby thank all individuals for participating and cooperating us in this study.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the study and participated in the research with informed consent.

References

- Andreae, M., Shultz, J. M., Shepherd, J. M., Espinel, Z., & Shapiro, L. T. (2026). Weathering the Storms of Climate Change: Preparing Persons with Disabilities and the Psychiatrists Who Provide Their Care for Extreme Hurricanes. *Pm&r*, 18, S45-S55. <https://doi.org/10.1002/pmrj.13159>
- Azimi, S., Keikhavani, S., Ahmadi, V., & Mirshekar, S. (2025). A Comparison of the Effectiveness of Reality Therapy and Acceptance and Commitment Therapy on Meaning in Life among Elderly Clients Attending Day Rehabilitation Centers in Tehran. *Journal of Psychological Dynamics in Mood Disorders*, 4(2), 137-152.
- Bagheri, M., Lotfi Kashani, F., & Ebrahimi, M. I. (2024). Comparing the Effects of Acceptance and Commitment Therapy and Reality Therapy on Improving Illness Perception in Women with Multiple Sclerosis. *Avicenna Journal of Neuro Psycho Physiology*, 11(3), 117-125. <https://doi.org/10.32592/ajnp.2024.11.3.117>
- Baniasadi, K., Gerdooie, R., Gorji, M., Shahbazi, G., Babaahmadi, F., Ghafourian, G., & Pourmohammad, G. K. (2025). Comparison of Cognitive Behavioral Therapy and Acceptance and Commitment Therapy on Enhancing Resilience, Cognitive Flexibility, and Distress Tolerance in Adolescents with Obsessive-Compulsive Disorder. <https://doi.org/10.61838/kman.jayps.6.6.6>
- Bin, S., Alrashdi, D. H., Whitehead, T., Riches, S., & Drini, E. (2025). Mental Health Professionals' Attitudes towards Virtual Reality Therapies: A Systematic Review. *Journal of Technology in Behavioral Science*, 1-24. <https://doi.org/10.1007/s41347-025-00499-x>
- Cong, X., Liu, L., Li, S., Huang, Z., & Liu, X. (2026). Family Doctor Contract Services for Persons with Disabilities in China. *Disability & Society*, 41(2), 587-592. <https://doi.org/10.1080/09687599.2025.2498416>
- Dąbrowska, M., Pastucha, D., Janura, M., Tomášková, H., Honzíková, L., Baníková, Š., & Fiedorová, I. (2023). Effect of Virtual Reality Therapy on Quality of Life and Self-Sufficiency in Post-Stroke Patients. *Medicina*, 59(9), 1669. <https://doi.org/10.3390/medicina59091669>
- Dehaghi, A. A., Dolatshahi, B., Taremian, F., Pourshahbaz, A., & Ansari, H. (2022). Acceptance and Commitment Therapy with Islamic Aspects as a Treatment for Scrupulosity in a Case Study. *Journal of Organizational Behavior Research*, 7(2), 95-108. <https://doi.org/10.51847/Fa3ED8HrzB>
- El-Sayed, M. M., Elhay, E. S. A., Taha, S. M., Khedr, M. A., Mansour, F. S. A., & El-Ashry, A. M. (2023). Efficacy of Acceptance and Commitment Therapy on Impulsivity and Suicidality among Clients with Bipolar Disorders: A Randomized Controlled Trial. *BMC Nursing*, 22, 271. <https://doi.org/10.1186/s12912-023-01443-1>
- Fu, W., & Ji, C. (2023). Application and Effect of Virtual Reality Technology in Motor Skill Intervention for Individuals with Developmental Disabilities: A Systematic Review. *International journal of environmental research and public health*, 20(5), 4619. <https://doi.org/10.3390/ijerph20054619>
- Gaudiano, B. A., Davis, C. H., Epstein-Lubow, G., Johnson, J. E., Mueser, K. T., & Miller, I. W. (2017). Acceptance and Commitment Therapy for Inpatients with Psychosis (the REACH Study): Protocol for Treatment Development and Pilot Testing. *Healthcare*, 5(2), 23. <https://doi.org/10.3390/healthcare502023>
- Gordon, S., Tamatea, A., Thom, K., O'Brien, A., Newton-Howles, G., Lenagh-Glue, J., & Glue, P. (2026). Realising the Convention on the Rights of Persons with Disabilities with Mental Health Advance Directives. *International journal of mental health nursing*, 35(2), e70237. <https://doi.org/10.1111/inm.70237>
- Han, A., Wilroy, J. D., & Yuen, H. K. (2023). Effects of Acceptance and Commitment Therapy on Depressive Symptoms, Anxiety, Pain Intensity, Quality of Life, Acceptance, and Functional Impairment in Individuals with Neurological Disorders: A Systematic Review and Meta-Analysis. *Clinical Psychologist*, 27(2), 210-231. <https://doi.org/10.1080/13284207.2022.2163158>
- Hart, A. K., Breen, L. J., Hennessey, N. W., & Beilby, J. M. (2024). Evaluation of an Integrated Fluency and Acceptance and Commitment Therapy Intervention for Adolescents and Adults Who Stutter. *Journal of Speech, Language, and Hearing Research*, 67(4), 1003-1019. https://doi.org/10.1044/2023_JSLHR-23-00252
- Lee, B., Chang, C., Chun, J., Lee, G., Niemiec, R., & Umucu, E. (2026). Character Strengths and Employment in Persons with Disabilities: A National Survey Study. *The Journal of Positive Psychology*, 21(1), 78-88. <https://doi.org/10.1080/17439760.2024.2427586>
- Micheluzzi, V., Vellone, E., & Iovino, P. (2025). A Situation-Specific Theory on the Use of Immersive Virtual Reality in Rehabilitation for Patients with Disabilities. *Holistic Nursing Practice*, 39(2), 71-79. <https://doi.org/10.1097/HNP.0000000000000718>
- Moens, M., Jansen, J., De Smedt, A., Roulaud, M., Billot, M., Laton, J., & Goudman, L. (2022). Acceptance and Commitment Therapy to Increase Resilience in Chronic Pain Patients: A Clinical Guideline. *Medicina*, 58(4), 499. <https://doi.org/10.3390/medicina58040499>
- Monareng, L. L., Soeker, S. M., & Naidoo, D. (2025). Examining Self-Employment Policies for Persons with Disabilities in South Africa: Perspectives from Policy Actors. *PLoS One*, 20(9), e0331576. <https://doi.org/10.1371/journal.pone.0331576>

- Niu, Y., Sheng, S., Chen, Y., Ding, J., Li, H., Shi, S., & Ye, D. (2022). The Efficacy of Group Acceptance and Commitment Therapy for Preventing Post-Stroke Depression: A Randomized Controlled Trial. *Journal of Stroke and Cerebrovascular Diseases*, 31(2), 106225. <https://doi.org/10.1016/j.jstrokecerebrovasdis.2021.106225>
- Ogunlade, O. B., Oladokun, M. O., Oyeniran, A. O., & Olowoyo, O. O. (2026). Help-Seeking Behaviours of Abused Persons with Disability: A Scoping Review. *BMC public health*, 26(1), 1393. <https://doi.org/10.1186/s12889-026-27076-y>
- Omidi, A., Hosseinzadeh, T. M., Meschi, F., Sodagar, S., & Ranjbari, P. T. (2025). The Effectiveness of Reality Therapy Training Based on Choice Theory on Mental Health and Emotion Regulation in Female Middle School Students. <https://doi.org/10.61838/kman.jayps.6.1.4>
- Patchwood, E., Foote, H., Vail, A., Cotterill, S., Hill, G., Group, W. A. P., & Bowen, A. (2024). Wellbeing after Stroke (WATERs): Feasibility Testing of a Co-Developed Acceptance and Commitment Therapy Intervention to Support Psychological Adjustment after Stroke. *Clinical Rehabilitation*, 38(7), 979-989. <https://doi.org/10.1177/02692155241239879>
- Robinson, C., Chalder, T., McCrone, P., Quintin, O., Gkaintatzi, E., Khan, I., & Group, S. (2025). Statistical Analysis Plan for a Pragmatic Randomised Controlled Trial Comparing Enhanced Acceptance and Commitment Therapy Plus Added to Usual Aftercare versus Usual Aftercare Only in Patients Living with or beyond Cancer: Survivors' Rehabilitation Evaluation after Cancer (SURECAN) Trial. *Trials*, 26(1), 32. <https://doi.org/10.1186/s13063-025-08734-9>
- Ruan, J., Huo, T., Zhang, Y., Ruan, Q., Xi, M., Ru, T., & Liu, S. (2025). Acceptance and Commitment Therapy on Psychological Wellbeing and Physical Function in Rehabilitation Patients after Burns: A Randomized Controlled Trial of Efficacy. *Burns*, 107630. <https://doi.org/10.1016/j.burns.2025.107630>
- Wang, D., Lin, B., Zhang, S., Xu, W., & Liu, X. (2024). Effectiveness of an Internet-Based Self-Help Acceptance and Commitment Therapy Program on Medical Students' Mental Well-Being: Follow-Up Randomized Controlled Trial. *Journal of medical Internet research*, 26, e50664. <https://doi.org/10.2196/50664>