KMAN PUBLISHING INSTITUTE
Journal Website

Article history:
Received 05 September 2025
Revised 17 December 2025
Accepted 14 January 2026
Published online 01 March 2026

Psychological Research in Individuals with Exceptional Needs

Volume 4, Issue 1, pp 1-10

PRIEN
Psychological Research in Individuals with Exceptional Needs

E-ISSN: 3060-6713

The Effectiveness of Acceptance and Commitment Therapy on Rejection Sensitivity and Self-Acceptance in Individuals with Visual Impairment

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A r t i c l e I n f o

Article type:
Original Research

How to cite this article:
Oveysi, S., Karimi, Q., & Moradi, O. (2026). The Effectiveness of Acceptance and Commitment Therapy on Rejection Sensitivity and Self-Acceptance in Individuals with Visual Impairment. *Psychological Research in Individuals with Exceptional Needs*, *4*(1), 1-10.
https://doi.org/10.61838/kman.prien.5124

A B S T R A C T

The present study aimed to examine the effectiveness of Acceptance and Commitment Therapy (ACT) on rejection sensitivity and self-acceptance among individuals with visual impairment. The research employed a quasi-experimental design with a pretest–posttest–follow-up structure including a control group. The statistical population consisted of all visually impaired individuals who were members of associations supporting persons with visual impairment and the Welfare Organization of Kurdistan Province during Spring 2025. From this population, 45 participants were selected using convenience sampling and were randomly assigned to two experimental groups and one control group. Participants completed the Rejection Sensitivity Questionnaire developed by Downey and Feldman (1996) and the Unconditional Self-Acceptance Questionnaire designed by Chamberlain and Haaga (2001) at pretest, posttest, and follow-up stages. Group sessions of Acceptance and Commitment Therapy were conducted for the intervention group based on the treatment protocol proposed by Hayes and Strosahl (2005) across eight 90-minute sessions. Acceptance and Commitment Therapy significantly reduced rejection sensitivity in the intervention group compared with the control group ($p = .018$). Furthermore, Acceptance and Commitment Therapy significantly increased self-acceptance in the intervention group compared with the control group ($p = .005$). The findings indicate that Acceptance and Commitment Therapy can be utilized as an effective intervention for reducing rejection sensitivity and enhancing self-acceptance among individuals with visual impairment. The implementation of this therapeutic approach in rehabilitation centers and psychological service settings may play an important role in promoting mental health, emotional adjustment, and improving the quality of life of visually impaired individuals.

Keywords: *self-acceptance, rejection sensitivity, Acceptance and Commitment Therapy, visually impaired individuals*

1. Introduction

Visual impairment and blindness represent significant global public health concerns that extend far beyond sensory loss and profoundly influence psychological well-being, interpersonal functioning, and quality of life. Epidemiological evidence indicates that blindness remains prevalent in many regions of the world, particularly among vulnerable populations exposed to socioeconomic deprivation, limited healthcare access, and environmental inequalities, thereby highlighting the multidimensional nature of visual disability (Chagas Ferreira et al., 2025). The experience of blindness is not confined to functional limitations in vision; rather, it entails complex psychological, social, and identity-related challenges that influence emotional adjustment, self-perception, and social participation. Individuals with visual impairment frequently encounter barriers related to autonomy, communication, occupational participation, and social integration, which collectively shape their mental health trajectories and psychosocial adaptation processes.

Psychological adaptation to vision loss is often characterized by a demanding process of identity reconstruction and emotional adjustment. Research on acquired visual impairment shows that individuals must cope with grief reactions, altered self-concept, dependency concerns, and uncertainty regarding future functioning, all of which may increase vulnerability to psychological distress (Nakade et al., 2017). Adjustment difficulties may be intensified when individuals experience reduced social interaction or perceive themselves as socially marginalized. Social exclusion and deprivation have repeatedly been associated with adverse health outcomes, diminished well-being, and heightened psychological vulnerability, suggesting that disability-related stigma can function as a chronic psychosocial stressor (Chandola & Conibere, 2015). Similarly, social isolation has been identified as a key risk factor affecting psychological functioning, particularly when disability restricts opportunities for meaningful participation and interpersonal connection (Huisman & van Tilburg, 2021).

Among the psychological constructs affected by visual impairment, rejection sensitivity occupies a particularly important role. Rejection sensitivity refers to a cognitive–affective processing tendency characterized by heightened expectations of rejection combined with intense emotional reactivity to perceived interpersonal exclusion. Individuals who experience frequent social barriers or stigmatizing attitudes may develop anticipatory anxiety about negative evaluation, leading to avoidance behaviors, emotional withdrawal, and reduced interpersonal confidence. Studies comparing blind, visually impaired, and sighted individuals have demonstrated lower levels of self-acceptance and higher concerns about others' evaluations among visually impaired groups, underscoring the role of social feedback in shaping self-related cognition (Javaheri Moghanlou et al., 2024). Persistent exposure to perceived rejection may therefore contribute to maladaptive coping patterns, emotional distress, and diminished psychological resilience.

Self-acceptance represents another central psychological factor influencing mental health among individuals with disabilities. Conceptually, self-acceptance involves recognizing one's intrinsic worth independent of performance, external validation, or social comparison. Theoretical perspectives emphasize unconditional self-acceptance as a core component of psychological health, emotional stability, and adaptive functioning (Chamberlain & Haaga, 2001). From a clinical standpoint, self-acceptance reduces self-criticism, promotes emotional regulation, and facilitates engagement with valued life activities. Psychological models of mental health further describe self-acceptance as a dynamic process through which individuals integrate strengths and limitations into a coherent self-concept, thereby fostering psychological flexibility and well-being (Bowins, 2021). In populations with visual impairment, self-acceptance has been shown to mediate relationships between stigma experiences and loneliness, highlighting its protective role in psychosocial adaptation (Kong et al., 2021).

The emergence of third-wave behavioral therapies has provided new frameworks for addressing psychological challenges associated with chronic conditions and disability. Acceptance and Commitment Therapy (ACT) represents one of the most prominent approaches within this movement, emphasizing psychological flexibility rather than symptom elimination. ACT integrates mindfulness processes, acceptance strategies, cognitive defusion techniques, and value-based action to help individuals develop more adaptive relationships with internal experiences (Hayes & Smith, 2005). Unlike traditional cognitive-behavioral approaches that focus primarily on changing thought content, ACT targets the functional context of cognition and emotion, encouraging individuals to accept internal experiences while committing to meaningful behavioral change (Chin & Hayes, 2017).

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The theoretical foundation of ACT is rooted in relational frame theory and contextual behavioral science, proposing that psychological suffering often arises from experiential avoidance and cognitive fusion. Psychological flexibility—the ability to remain present, accept internal experiences, and act according to personal values—is therefore considered the primary mechanism of therapeutic change (Klimczak & Levin, 2023). ACT interventions cultivate acceptance, mindfulness, self-as-context, values clarification, and committed action processes, allowing individuals to disengage from maladaptive control strategies that perpetuate emotional distress (Flaxman et al., 2014). Clinical literature demonstrates that ACT effectively enhances adaptive functioning across a wide range of psychological conditions and populations, positioning it as a versatile intervention within contemporary psychotherapy (Gould & Wetherell, 2022).

Central to ACT is a reconceptualization of the self. Rather than viewing identity as fixed or defined by cognitive evaluations, ACT introduces the concept of self-as-context, enabling individuals to observe thoughts and emotions without overidentifying with them. This perspective fosters emotional openness and reduces self-stigmatization, particularly in individuals facing chronic health conditions or disability-related challenges (Zettle, 2016). Mindfulness and acceptance-based practices within ACT have also been applied successfully in clinical populations experiencing severe psychological distress, demonstrating improvements in emotional regulation and adaptive coping (Morris et al., 2017).

Evidence increasingly supports the effectiveness of ACT for individuals with visual impairment. Group-based ACT interventions have been shown to improve emotional maturity among adolescents with visual impairment, indicating that acceptance-based strategies facilitate psychological adjustment and resilience (Mirmohammadi & Pourmohammadreza-Tajrishi, 2024). Similarly, ACT has demonstrated effectiveness in enhancing self-esteem in visually impaired students, suggesting that acceptance processes may directly influence self-evaluative beliefs and self-worth (Mirmohammadi et al., 2021). Additional research has reported reductions in perceived stress and improvements in social adjustment following ACT interventions among youths with visual impairment, highlighting the therapy's capacity to address both emotional and interpersonal domains (Mirzaie Varzaneh et al., 2020). These findings collectively suggest that ACT may be particularly well suited for populations confronting persistent environmental limitations that cannot be easily altered but must instead be psychologically integrated.

Psychological flexibility gained through ACT may be especially relevant in reducing rejection sensitivity. By encouraging individuals to notice thoughts related to rejection without avoidance or overidentification, ACT reduces emotional reactivity and promotes adaptive interpersonal engagement. Acceptance-based strategies help individuals shift from defensive coping toward value-driven behavior, thereby enhancing social participation despite perceived vulnerability. Such mechanisms are consistent with broader theoretical perspectives emphasizing acceptance as a pathway toward resilience and psychological health across diverse clinical contexts (Gould & Wetherell, 2022). Furthermore, ACT's emphasis on experiential acceptance may foster greater self-compassion and reduce self-critical cognitions that undermine self-acceptance among individuals with disabilities.

Despite growing empirical support, research specifically examining the simultaneous effects of ACT on rejection sensitivity and self-acceptance in visually impaired adults remains limited. Previous studies have typically focused on isolated outcomes such as stress reduction, emotional maturity, or self-esteem, leaving an important gap concerning interpersonal vulnerability and self-related evaluation processes. Given that rejection sensitivity and self-acceptance represent interrelated constructs influencing social functioning and psychological well-being, investigating their modification through ACT may contribute to a more comprehensive understanding of therapeutic outcomes. Additionally, improving psychological functioning among visually impaired individuals aligns with broader rehabilitation goals emphasizing autonomy, emotional adaptation, and social inclusion.

Considering the psychological challenges associated with visual impairment, the protective role of self-acceptance, and the growing evidence supporting acceptance-based interventions, ACT appears to offer a theoretically coherent and empirically grounded approach for enhancing psychological adjustment in this population. By targeting experiential avoidance, cognitive fusion, and maladaptive self-evaluations, ACT may simultaneously reduce rejection sensitivity and strengthen unconditional self-acceptance, thereby promoting mental health and quality of life.

Therefore, the aim of the present study was to investigate the effectiveness of Acceptance and Commitment Therapy

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on rejection sensitivity and self-acceptance among individuals with visual impairment.

2. Methods and Materials

2.1. Study Design and Participants

The aim of the present study was applied in nature, and the research method was quasi-experimental using a pretest–posttest–follow-up design with a control group. The statistical population consisted of all visually impaired individuals who were members of associations supporting persons with visual impairment and the Welfare Organization of Kurdistan Province during Spring 2025. Considering a confidence level of 95%, an alpha error level of .05, statistical power of .70, and an effect size of .40, the required sample size for each group was determined to be 15 participants. Accordingly, 45 individuals were selected from the target population using convenience sampling based on inclusion and exclusion criteria and were randomly assigned to two experimental groups and one control group.

The research procedure was implemented after obtaining the necessary authorization from Islamic Azad University. A call for participation, including the researcher's contact number, was distributed through the Association for the Blind and the Welfare Organization of Kurdistan Province. Following participants' contact with the researcher, written informed consent was obtained. A demographic questionnaire was then manually provided to visually impaired participants. Inclusion and exclusion criteria were evaluated based on responses to the demographic questionnaire, resulting in the final selection of 45 participants. After random assignment, research instruments were administered as pretests to both the intervention and control groups prior to the initiation of the intervention. Participants in the intervention group received group-based Acceptance and Commitment Therapy sessions along with a social adjustment training package, whereas the control group received no educational or therapeutic intervention. At the end of the intervention, all participants in the three groups completed the questionnaires at the posttest stage and again one month later during the follow-up assessment. The entire study period lasted three months.

2.2. Measures

Rejection Sensitivity Questionnaire. This questionnaire was developed by Downey and Feldman (1996) and consists of 18 two-part items (Parts A and B) assessed on a six-point Likert scale. The first part measures the level of anxiety experienced by the individual in each hypothetical interpersonal situation, while the second part assesses the perceived likelihood of receiving a positive response from another person. Rejection sensitivity scores were calculated by first subtracting the acceptance expectancy scores (Part B) from the value of 7 to obtain rejection expectancy scores. Subsequently, the rejection expectancy score in each situation was multiplied by the corresponding anxiety level, and the mean score across the 18 situations was calculated. Downey and Feldman (1996) reported a reliability coefficient of .84 for the questionnaire. In the study conducted by Khoshkam et al., the validity and reliability coefficients were reported as .65 and .84, respectively.

Self-Acceptance Questionnaire. The Unconditional Self-Acceptance Questionnaire was developed by Chamberlain and Haaga (2001) to assess unconditional self-acceptance. The instrument consists of 20 items and two components: unconditional self-acceptance and conditional self-acceptance. Responses are measured using a five-point Likert scale with items such as: "It is not right to judge my worth and value solely based on the fact that I am a human being." Goldman (2006) confirmed the content validity of this questionnaire and reported a Cronbach's alpha coefficient of .75.

2.3. Intervention

The Acceptance and Commitment Therapy (ACT) intervention implemented in the present study was conducted based on the treatment protocol developed by Hayes and Smith (2005) and consisted of eight weekly group sessions, each lasting 90 minutes. Content validity of the intervention protocol was evaluated using the Content Validity Index (CVI) through expert review by five university faculty members, yielding a value of 0.80 for all sessions, indicating satisfactory content validity. The first session focused on establishing therapeutic rapport, introducing participants to ACT principles, explaining treatment goals, administering pretest measures, and discussing emotional suppression and its psychological consequences, with participants assigned to identify and record suppressed emotions. The second session aimed to reduce emotional control dominance through experiential exercises and metaphors (e.g., "person in a hole," "feeding the tiger," "driving while looking in the rearview mirror") to illustrate the costs of avoidance and control strategies,

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followed by homework identifying personal avoidance patterns. The third session emphasized acceptance, encouraging participants to acknowledge uncontrollable experiences, particularly illness-related challenges, through experiential metaphors such as "tug-of-war with a monster," empathy practices, serenity reflection exercises, event recording, and emotional exposure tasks designed to promote movement toward valued life directions. The fourth session targeted cognitive defusion by helping participants recognize excessive attachment to evaluative thoughts and beliefs through exercises such as "watching the mind's train," marching soldiers metaphor, and perspective-taking practices distinguishing self from mental content. The fifth session promoted present-moment awareness using mindfulness exercises, focused attention practices, and experiential activities such as the "leaves on a stream" exercise to reduce rumination about past and future events. The sixth session addressed self-as-context and values clarification, employing metaphors such as the observer self, chessboard metaphor, tombstone and funeral exercises, and structured brainstorming to identify core personal values, with participants tasked to articulate meaningful life priorities. The seventh session focused on committed action by translating identified values into concrete behavioral goals, strengthening flexible coping responses, reinforcing adaptive behavioral patterns, and encouraging implementation of value-consistent actions despite emotional discomfort. The final session reviewed therapeutic content, addressed remaining questions, consolidated learning outcomes, and administered posttest assessments, thereby completing the intervention process.

2.4. Data Analysis

In the present study, descriptive statistical methods, including mean and standard deviation, were used to examine demographic variables. One-way analysis of variance (ANOVA) was employed to compare groups regarding demographic characteristics. To analyze data, test hypotheses, and compare dependent variables across pretest, posttest, and follow-up stages, repeated-measures analysis of variance was conducted along with Fisher's statistic and Bonferroni post hoc tests, provided that statistical assumptions were satisfied. These assumptions included normality of data distribution assessed using the Shapiro–Wilk test, homogeneity of error variances examined through Levene's test, equality of covariance matrices of dependent variables assessed using Box's M test, and sphericity of error covariance matrices examined via Mauchly's test of sphericity. Significance levels of .05 and .01 were considered, and statistical analyses were performed using SPSS version 23.

3. Findings and Results

In the present study, both the intervention and control groups included 10 women (66.67%) and 5 men (33.33%). In the Acceptance and Commitment Therapy group, 5 participants (33.33%) were aged 30–35 years, 5 participants (33.33%) were aged 36–40 years, 3 participants (20%) were aged 41–45 years, and 2 participants (13.33%) were aged 46–50 years. In the control group, 4 participants (26.67%) were aged 30–35 years, 6 participants (40%) were aged 36–40 years, 2 participants (13.33%) were aged 41–45 years, and 3 participants (20%) were aged 46–50 years.

Table 1

Means and Standard Deviations of Rejection Sensitivity and Self-Acceptance in the Acceptance and Commitment Therapy Group and Control Group Across Pretest, Posttest, and Follow-Up

Variable	Group	Pretest Mean	Pretest SD	Posttest Mean	Posttest SD	Follow-Up Mean	Follow-Up SD
Self-Acceptance	Acceptance and Commitment Therapy	40.13	4.71	46.06	4.52	42.46	4.47
	Control	39.26	4.33	37.40	4.59	37.40	4.17
Rejection Sensitivity	Acceptance and Commitment Therapy	41.00	4.24	34.66	4.23	37.60	4.32
	Control	40.33	3.77	42.06	3.80	42.06	4.02

Table 1 indicates that the mean scores of rejection sensitivity and self-acceptance in the intervention group changed at the posttest and follow-up stages.

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Table 2

Results of Repeated-Measures Analysis of Variance Examining the Effect of Acceptance and Commitment Therapy on Rejection Sensitivity

Variable	Source of Effect	Sum of Squares	Mean Square	F	p	Eta Squared
Rejection Sensitivity	Group (Between-Subjects)	396.93	198.46	4.43	.018	.174
	Time (Within-Subjects)	324.84	218.50	124.33	.001	.747
	Time × Group (Interaction)	347.42	116.84	66.48	.001	.760

Table 2 shows that Acceptance and Commitment Therapy significantly reduced rejection sensitivity in the intervention group compared with the control group (p = .018). The main effect of time indicates that mean rejection sensitivity significantly differed across the three measurement stages (pretest, posttest, and follow-up) (p = .001). The interaction effect demonstrates a significant difference between the Acceptance and Commitment Therapy group and the control group over time (p = .001).

Table 3

Results of Repeated-Measures Analysis of Variance Examining the Effect of Acceptance and Commitment Therapy on Self-Acceptance

Variable	Source of Effect	Sum of Squares	Mean Square	F	p	Eta Squared
Self-Acceptance	Group (Between-Subjects)	712.77	356.38	6.06	.005	.224
	Time (Within-Subjects)	209.17	104.58	98.63	.001	.701
	Time × Group (Interaction)	378.43	94.60	89.22	.001	.809

Table 3 indicates that Acceptance and Commitment Therapy significantly increased self-acceptance in the intervention group compared with the control group (p = .005). The main effect of time shows that mean self-acceptance significantly changed across the three measurement stages (pretest, posttest, and follow-up) (p = .001). The interaction effect also indicates a significant difference between the Acceptance and Commitment Therapy group and the control group across time (p = .001).

4. Discussion

The present study aimed to examine the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing rejection sensitivity and enhancing self-acceptance among individuals with visual impairment. The findings demonstrated that participants who received ACT showed a significant reduction in rejection sensitivity compared with the control group across posttest and follow-up measurements. Additionally, the intervention significantly increased levels of self-acceptance in the experimental group, and these effects were maintained over time. The significant interaction effects of time and group indicated that psychological changes were not merely attributable to the passage of time but resulted specifically from participation in the ACT intervention. These findings provide empirical support for the application of acceptance-based psychological interventions within rehabilitation and mental health services for individuals with visual impairment.

The reduction in rejection sensitivity observed in the intervention group can be understood within the framework of psychological flexibility theory. Individuals with visual impairment often encounter repeated experiences of social misunderstanding, dependency expectations, or implicit stigma, which may lead to anticipatory anxiety about rejection and heightened emotional reactivity in interpersonal situations. Research indicates that social exclusion and reduced participation opportunities can intensify psychological distress and reinforce avoidance-based coping patterns (Chandola & Conibere, 2015; Huisman & van Tilburg, 2021). ACT directly targets these processes by encouraging individuals to alter their relationship with internal experiences rather than attempting to eliminate negative thoughts or emotions. Through acceptance and cognitive defusion processes, participants learn to observe fears of rejection without automatically responding through avoidance or withdrawal, thereby reducing rejection-related anxiety.

The significant decrease in rejection sensitivity aligns with theoretical models suggesting that experiential avoidance maintains emotional vulnerability. ACT interventions weaken maladaptive control strategies by promoting openness toward uncomfortable experiences and

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increasing engagement in value-consistent behavior (Hayes & Smith, 2005). Within the cognitive behavioral tradition, ACT represents a contextual evolution emphasizing functional change rather than cognitive correction, allowing individuals to disengage from rigid interpretations of social interactions (Chin & Hayes, 2017). As psychological flexibility increases, individuals become less dominated by self-protective behaviors driven by fear of rejection. The present findings therefore support the proposition that acceptance-based processes modify underlying cognitive–affective responses to perceived interpersonal threat.

Previous empirical research provides convergent evidence supporting these results. Studies examining ACT among youths with visual impairment have shown reductions in perceived stress and improvements in social adjustment following participation in acceptance-based interventions (Mirzaie Varzaneh et al., 2020). Improved social adjustment may naturally correspond with reduced rejection sensitivity, as individuals become more willing to participate in interpersonal environments despite uncertainty or vulnerability. Similarly, research on emotional maturity among adolescents with visual impairment has demonstrated that ACT facilitates adaptive emotional regulation and psychological resilience (Mirmohammadi & Pourmohammadreza-Tajrishi, 2024). The present findings extend these outcomes by specifically identifying rejection sensitivity as a modifiable psychological construct responsive to ACT.

The increase in self-acceptance represents another central outcome of the study. Self-acceptance has been conceptualized as a foundational component of mental health, enabling individuals to maintain self-worth independent of external evaluation or performance outcomes (Chamberlain & Haaga, 2001). For individuals living with visual impairment, self-acceptance may be challenged by societal attitudes, functional limitations, and internalized stigma. Evidence indicates that visually impaired individuals often report lower self-acceptance and heightened fear of negative evaluation compared with sighted populations (Javaheri Moghanlou et al., 2024). Consequently, interventions capable of strengthening unconditional self-acceptance may play a critical role in psychological rehabilitation.

ACT promotes self-acceptance primarily through mindfulness and self-as-context processes. Rather than defining identity through perceived deficits or socially constructed standards, individuals learn to experience the self as an observing perspective capable of containing both strengths and limitations. This process reduces self-criticism and fosters emotional integration, consistent with theoretical descriptions of self-acceptance as an adaptive psychological state promoting well-being and emotional balance (Bowins, 2021). The present results are therefore theoretically coherent with ACT's emphasis on transforming self-related cognition rather than altering external circumstances.

Empirical findings from earlier ACT studies further support the observed increase in self-acceptance. Group-based ACT interventions have been shown to enhance self-esteem among visually impaired students, indicating that acceptance processes positively influence self-evaluative dimensions of psychological functioning (Mirmohammadi et al., 2021). Moreover, research examining loneliness among visually impaired college students identified self-acceptance as a mediating factor between self-stigma and psychological distress, emphasizing its protective function in social adaptation (Kong et al., 2021). The improvement in self-acceptance observed in the present study suggests that ACT may indirectly reduce loneliness and social withdrawal by strengthening internal self-validation mechanisms.

The sustained effects observed during the follow-up stage provide additional support for the durability of ACT outcomes. Unlike symptom-focused interventions that may produce short-term changes, ACT aims to cultivate enduring psychological skills such as mindfulness, acceptance, and value-based action. These skills enable individuals to continue applying therapeutic principles after formal treatment ends, thereby maintaining psychological gains over time (Flaxman et al., 2014). The persistence of reduced rejection sensitivity and enhanced self-acceptance suggests that participants internalized ACT processes and incorporated them into daily coping strategies.

From a broader clinical perspective, the findings are consistent with literature describing ACT as an effective third-wave behavioral therapy applicable across diverse psychological and health-related contexts (Gould & Wetherell, 2022). Acceptance-based interventions have demonstrated efficacy in addressing emotional distress associated with chronic conditions and long-term life challenges. Given that blindness often represents a stable life condition rather than a transient problem, interventions emphasizing acceptance and psychological flexibility are particularly appropriate. ACT does not attempt to eliminate disability-related challenges but instead facilitates adaptive living despite them, an approach aligned with contemporary rehabilitation psychology models.

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The mechanisms underlying these outcomes may also be interpreted through the concept of self-as-context emphasized in ACT theory. By learning to observe thoughts and emotions without fusion, individuals reduce identification with narratives of inadequacy or social rejection (Zettle, 2016). Mindfulness practices incorporated into ACT allow participants to anchor attention in present-moment experience, decreasing rumination about past negative interactions or future rejection expectations. Such processes have previously demonstrated effectiveness in clinical populations experiencing severe psychological distress, further supporting the generalizability of ACT mechanisms (Morris et al., 2017).

Furthermore, psychological adjustment to visual impairment involves ongoing identity reconstruction and adaptation to changing life roles. Research on adjustment to vision loss highlights the importance of psychological coping resources in facilitating successful adaptation (Nakade et al., 2017). ACT may support this adaptive process by encouraging individuals to redefine identity beyond disability-related limitations and to pursue meaningful life goals guided by personal values. The improvement in both rejection sensitivity and self-acceptance observed in the present study indicates that ACT simultaneously addresses interpersonal vulnerability and intrapersonal self-concept, two domains crucial for psychological well-being.

The results also contribute to expanding the cultural and clinical evidence base of ACT. Studies conducted in diverse populations demonstrate that acceptance-based approaches remain effective across cultural contexts because they focus on universal psychological processes rather than culturally specific symptom expressions (Klimczak & Levin, 2023). The consistency between the present findings and prior research supports the robustness of ACT as a contextually adaptable therapeutic model. Moreover, growing global attention to blindness and visual impairment as public health priorities underscores the importance of integrating psychological interventions into rehabilitation services (Chagas Ferreira et al., 2025). The findings therefore hold practical implications for interdisciplinary care models combining medical, social, and psychological support.

5. Conclusion

Overall, the study demonstrates that Acceptance and Commitment Therapy constitutes an effective intervention for improving psychological functioning among individuals with visual impairment. By reducing rejection sensitivity and strengthening self-acceptance, ACT appears to enhance emotional regulation, interpersonal confidence, and adaptive coping capacities. These outcomes support theoretical assumptions underlying acceptance-based therapy and extend existing evidence by highlighting the simultaneous modification of interpersonal and self-related psychological processes.

One limitation of the present study concerns the relatively small sample size, which may restrict the generalizability of the findings to broader populations of individuals with visual impairment. The use of convenience sampling may also introduce selection bias, as participants who volunteered for psychological intervention may have been more motivated for change than the general population. Additionally, reliance on self-report questionnaires may increase susceptibility to response bias or social desirability effects. Another limitation relates to the duration of follow-up, which was limited to one month; therefore, long-term maintenance of treatment effects remains uncertain. Finally, individual differences such as severity of visual impairment, duration of disability, and comorbid psychological conditions were not controlled, which may have influenced treatment outcomes.

Future studies are encouraged to employ larger and more diverse samples using randomized controlled trial designs to strengthen external validity. Longitudinal investigations with extended follow-up periods would provide valuable insight into the long-term sustainability of ACT outcomes. Researchers may also examine mediating mechanisms such as psychological flexibility, mindfulness, or self-compassion to better understand how ACT produces change in visually impaired populations. Comparative studies evaluating ACT against other therapeutic approaches could clarify relative effectiveness. Furthermore, qualitative investigations exploring participants' lived experiences during therapy may enrich understanding of psychological adaptation processes in individuals with visual impairment.

Mental health professionals working in rehabilitation centers and disability support services may consider incorporating Acceptance and Commitment Therapy into psychological care programs for individuals with visual impairment. Group-based ACT interventions can provide cost-effective opportunities for emotional support, social engagement, and skill development. Training rehabilitation specialists, counselors, and clinical psychologists in acceptance-based approaches may enhance multidisciplinary service delivery. Integrating ACT

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principles into community programs, educational settings, and family counseling may also promote psychological resilience, improve self-acceptance, and reduce interpersonal anxiety among visually impaired individuals, ultimately contributing to improved mental health and quality of life.

Authors' Contributions

Authors equally contributed to this article.

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 would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

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

Ethics Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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