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The Power of Acceptance of Their Disability for Improving Flourishing: Preliminary Insights from Persons with Physical Acquired Disabilities

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Abstract: Following Wright's theory, the process of acceptance of disability helps persons with an acquired disability to change their attitudes toward it. Consequently, a sense of self-satisfaction was developed, a de-emphasis on disability salience was placed, and compensatory behavioral qualities were acquired. Together, these factors promote an individual's adjustment according to disability-related strengths and difficulties. Our cross-sectional study examines how acceptance of disability influences flourishing, characterized by high well-being and low distress. Due to the exploratory nature of the study, two research questions were formulated: *Would each factor of acceptance of disability positively predict each dimension of well-being? (RQ1); Would each factor of acceptance of disability negatively predict distress? (RQ2).* Additionally, we considered gender effects. 107 Italian adults with acquired physical disabilities [M_{year} (SD) = 48.12 (14.87)] filled out an e-survey. Measures of acceptance of disability, well-being, and distress were used. The results indicate that self-satisfaction is a key predictor of flourishing while de-emphasizing disability salience only predicts purpose in life. Compensatory behavioral qualities predicted personal growth, positive relationships, life purposes, and self-acceptance. Gender did not significantly affect outcomes. Despite being preliminary, these initial results support the acceptance of disability as a personal resource for promoting flourishing. They suggest the potential for interventions to help individuals with disabilities process grief and accept their new self-representation.

Keywords: acceptance of disability; acquired physical disability; well-being; distress; flourishing

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1. Introduction

The World Health Organization [1] defined disability as the combination of physical or mental health conditions, environmental factors (e.g., architectural barriers), and personal factors (e.g., negative attitudes toward the disability and lack of social support). In addition, impairment of bodily function or structure, limitation of activity, and restriction in social and community participation result from a disability condition [1]. Congenital and acquired disability are two modes in which disability occurs. The first one includes structural or functional impairments during prenatal life that often are detected during pregnancy, at the time of childbirth, or later in life [2]. The second one, i.e., acquired disability, results from an accident or illness that occurs during the lifespan [3]. Regarding the prevalence rate, the WHO [4] estimated that about 16% of the world's population received a diagnosis of disability (e.g., physical or psychiatric disability) that markedly affects well-being. Therefore, the impact of disability on individuals' experience is a public health issue that is pivotal to be addressed [5–11]. There is controversy on the impact of

disability on the experience of persons with disabilities. On one side, several authors [12,13] discussed pervasive symptoms of anxiety, depression, and negative emotions (e.g., anger) due to a disability. On the other side, positive outcomes have been reached. In particular, these include high levels of self-efficacy [14] and self-esteem [15,16], although participants reported disability-related difficulties. These mixed results paved the way for further studies exploring the role that the acceptance of a disability may play in greater depth. Recently, one study on Italian persons with disability, the study by De Carlo et al. [17], argued that the acceptance of disability can serve as a buffer in reducing emotional exhaustion. Nevertheless, the heterogeneity of the sample (i.e., congenital and acquired disability) led the way to delving into the topic of a specific population. Along the Wright line [18], the current study examined whether the three-factor acceptance of the acquired disability process, that is, self-satisfaction, de-emphasis on disability salience, and compensatory behavioral qualities, would predict the well-being of a person with acquired disability.

1.1. Acceptance of Disability

The process of acceptance of a child's disability has been widely investigated by parents [19–25]. When a multidisciplinary team communicates a child's diagnosis to parents, they are shocked and confused, perceiving themselves as powerless. Afterward, they experience denial toward the diagnosis and negative emotions (e.g., anger, guilt) toward their partner and/or the child. Two conflicting outcomes can result from these steps [24,25]: lack of acceptance vs. acceptance of diagnosis. The lack of acceptance of the diagnosis means the parents may wait for a miracle cure for their child, or they may deny the existence of the diagnosis or its impact on their everyday life [24]. Conversely, the acceptance of diagnosis means the parents may become aware of their child's strengths and limitations and can re-organize their lives accordingly. Therefore, the acceptance of a disability can be conceptualized as acceptance of a loss: parents lose the representation of the "ideal" and healthy child developed since pregnancy and accept the "real" child who has a disability [26].

Similarly to parents, persons with an acquired disability face a process of acceptance of their disability. Based on Wright's conceptualization [18], Kaiser et al. [27] conceived the acceptance of disability as a change in attitudes regarding the (1) development of self-satisfaction, which includes broadening their range of values, refraining from comparing themselves to others; (2) de-emphasizing the disability salience, which includes reducing their emphasis on the limitations imposed by the disability and appearance; and (3) acquired compensatory behavioral qualities, which include focusing attention on the strengths, resources, and abilities. Although no theories have been developed about the process of acceptance of disability of a person with a disability, a person with a disability can accept or not accept their condition. If they do not accept their disability, depression, anxiety symptoms, and a worse quality of life are the main outcomes [13,28]. Conversely, the acceptance of their acquired disability leads individuals to replace the representation of a healthy self with a representation of self with disability [18]. Consequently, a psychosocial adaptation is achieved [29,30]. Among the benefits related to the acceptance of their own acquired disability, Wright [18] highlighted a perception of themselves as non-devaluing individuals, as able to engage in independent and productive activities, e.g., commitment to rehabilitation therapies, time spent in social and recreational activities, and work participation. From the first conceptualization of the acceptance of disability process in persons with acquired disability [18], few studies have been carried out (e.g., [27,31–33]). During the last decade, research on the topic improved hyperbolically [5–11,28,34–42]. This body of research involved different disabilities, for instance, neurological diseases [11,28,40], physical disability [6,8–10,36,37,39,41,42], neurodevelopmental disorders [34], oncological disease [5], and multiple disabilities [7,43]. It is worth noting that these studies analyzed the acceptance of disability in different ways. For instance, several studies [5,9,28,34,39–42] examined the associations between the acceptance of disability and other psychological dimensions, e.g., self-reliance [28], quality of life [28,39,42], social-relational quality [5], and

depression [7,28]. Other studies [35–38] explored the predictive role of the acceptance of disability on life satisfaction [35], hope [37], emotional exhaustion through the mediation of coping with change [17], and well-being through the mediation of meaning in life [36]. In addition, the mediating role of the acceptance of disability was examined in the relationship between self-efficacy and life satisfaction (model 1) and sense of belonging and life satisfaction (model 2) [6]. Finally, as an outcome, the acceptance of disability resulted from social features, such as friendship, family intimacy, and family commitment [5].

Among the demographic features that the abovementioned studies considered, age and gender are the main ones. For age, opposite results were found. One study reported that the older the persons with disability, the higher the degree of acceptance of disability [5]. In contrast, the study by Jankowska-Polańska et al. [42] found that the older the person, the less acceptance. Finally, two studies [35,40] found no association. When gender was considered, most of the studies [7,35,40,41] found no gender differences. Whereas the study by Park et al. [11] showed that acceptance of disability is greater for women than men, the study by Kazimierska-Zaja et al. [8] reported that acceptance of disability is greater for men than women. In addition, another variable that could influence acceptance of the diagnosis is age at diagnosis. To date, few studies have analyzed the role of this demographic variable. Some studies suggested that a younger age at diagnosis is associated with greater adjustment difficulties [44,45] and higher levels of distress [46–48]. Conversely, other research has shown that younger people had more positive attitudes toward disability [49], reported better quality of life [47], and experienced less distress [50].

1.2. Acceptance of Disability and Flourishing

This section will explore the relationship between acceptance of disability and flourishing, in terms of high levels of well-being and low levels of distress, according to the main theoretical frameworks. Following the Complete Mental Health Model by Keyes [51] mental health is reported on a continuum extending from the presence of mental illness (low well-being and presence of mental illness, that is, floundering) to the presence of mental health (high well-being and absence of mental illness, that is, flourishing). For the specific purpose of the current study, we focused on the flourishing state, which is in line with Ryff's theory on psychological well-being [52]. Following Ryff [52], well-being consists of six dimensions, that is, self-acceptance, positive relationships, personal growth, purpose in life, environmental mastery, and autonomy [53]. Thus, flourishing results from the individual's acceptance of themselves (i.e., self-acceptance dimension), having positive relationships (i.e., positive relationships dimension), experiencing personal growth (i.e., personal growth dimension), having life goals (i.e., purpose in life dimension), managing their environment to meet their needs (i.e., environmental mastery dimension), and obtaining a sense of self-determination (i.e., autonomy dimension) [52]. Furthermore, flourishing results from the absence of mental illness which, for the current study, is related to no distress, in terms of zero/few depressive and anxiety traits and stress symptoms [54]. The current study has been also conceived according to the Meaning-Making Model by Park [55]. The author stated that everyone actively attempts to make sense of their experiences, mainly when stressful situations occur, such as an acquired disability. Hence, the process of acceptance of disability consists of two distinct subprocesses, that is, assimilation and accommodation [56]. Assimilation implies that the changes associated with the stressful situation (e.g., disability) are integrated into the self-representation according to the existing global meaning, whereas accommodation implies a reorganization of self-representation based on the stressful situation because it also requires a change in beliefs and thoughts. Both subprocesses help persons redefine new life goals, taking into account their disability-related strengths and limitations, to overcome challenges and adapt to reality [55]. Conversely, persons who do not successfully assimilate or accommodate their disability and related difficulties experience high levels of distress [55]. With this rationale in mind and due to the novelty of our study, two research questions have been formulated:

RQ1: *Would each factor of acceptance of disability (i.e., self-satisfaction, de-emphasis on disability salience, compensatory behavioral qualities) positively predict each dimension of well-being (i.e., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance)?*

RQ2: *Would each factor of acceptance of disability (i.e., self-satisfaction, de-emphasis on disability salience, compensatory behavioral qualities) negatively predict distress?*

2. Materials and Methods

2.1. Procedure

We conducted an exploratory cross-sectional web-based study via an e-questionnaire including demographic features (i.e., chronological age, gender, age at diagnosis) as well as disability-related information (i.e., type of disability and age when the acquired disability occurs). The e-questionnaire was uploaded to the LimeSurvey platform, and the link was spread via the main social media sites (e.g., WhatsApp and Facebook) between March and October 2023. The participants digitally signed an informed e-consent form and were informed about privacy policies.

Three inclusion criteria were used in this study to extract the sub-sample, i.e., (1) having an acquired disability, (2) being aged $\geq$ 18 years, and (3) being independent in filling out the e-questionnaire. The exclusion criteria regard persons with acquired disability with cognitive impairment. The study was approved by the Ethics Committee for Research in Psychology of the Department of Human and Social Sciences of the University of Salento (protocol number: 31665).

2.2. Statistical Plan

No techniques for imputing missing data were computed due to the mandatory responses. The power analysis was calculated via the *jpower* package, and the normality of data distribution was tested via the Kolmogorov–Smirnov test (K-S test). Parametric (i.e., t-test) independent sample tests were computed to investigate differences across gender. Before running the main analyses, correlations between demographic features (i.e., chronological age and age when the acquired disability occurs), the factors of acceptance of disability, and the dimensions of well-being and distress were run. We used all subscales included in the correlations for multiple linear regression models. Descriptive and correlation analyses were computed using the Statistical Package for the Social Sciences [57] Version 25.0, the power analysis was performed using the package *jpower* in Jamovi [58], and the multiple linear regression models were created using the *lm* package in RStudio [59].

2.3. Participants

The e-questionnaire was filled out by 107 (55 males) persons with acquired physical conditions [M (SD) = 48.12 (14.87) years]. Following Szcześniak et al. [36], we used physical condition as an umbrella term that includes various acquired impairments that are mainly a consequence of physical health. The largest group consisted of participants with neurologic disorder (38.3%), followed by motor disability (11.2%) and disability resulting from oncological conditions (11.2%), autoimmune disease (3.7%) and sensory disability (3.7%), genetic disease (1.9%), psychiatric disorder (1.9%), infectious disease (0.9%), multiple disorders (0.9%), and systemic disease (0.9%). Due to the different types of disabilities we recruited for the study, no groups were classified. The mean age of participants when they received a diagnosis was 34.13 (18.57) years. Most participants lived in South Italy (n = 90). Based on the educational levels, participants were divided into three levels: low (up to 11 years of education) for 17.8%, intermediate (up to 13 years of education) for 43%, and high (18 or more years of education) for 39.3%. In addition, 54.21% of participants did not have a partner. Regarding employment status, 54.21% of participants reported being employed, while 45.71% were unemployed. Crossing socio-demographic features (i.e., educational

levels and employment status), 54.2% of participants (1.87% with a low education level, 22.43% with an intermediate level, and 29.91% with a high level of education) are employed, whereas 45.8% (14.02% with a low educational level, 22.43% with an intermediate level, and 9.35% with a high educational level) of participants are not employees.

2.4. Measures

Acceptance of acquired disability. The self-report 9-item Acceptance of Disability Scale [27] was administered to examine the acceptance of their acquired disability. In this scale, three factors are computed. To begin, the (1) self-satisfaction scale evaluates the degree to which persons with disabilities accept themselves and the disability-related difficulties/limitations (example item: "I feel satisfied with my abilities and my disability does not bother me too much"; $\alpha = 0.64$; r = 0.274). In addition, the (2) de-emphasis on disability salience factor examines the degree to which persons with disabilities view their disability as not salient to their identity (example item "My disability, in itself, affects me more than any other characteristic about me"; $\alpha = 0.45$; r = 0.266). Finally, the (3) compensatory behavior quality factor evaluates the degree to which persons with disabilities emphasize positive tributes over which they have some control (example item "How a person conducts himself in life is much more important than physical appearance and ability"; $\alpha = 0.75$; r = 0.426). Response options varied from 1 ("Strongly disagree") to 5 ("Strongly agree"). The total score was calculated as the mean score, and it reflects the high level of each factor.

Well-being. The self-report 42-item Psychological Well-Being questionnaire [52] was used to examine the levels of individuals' well-being in the form of six theoretically motivated dimensions: (1) autonomy, which evaluates the independence and self-determination (example item: "My decisions are not usually influenced by what everyone else is doing"; $\alpha = 0.76$; r = 0.415); (2) the environmental mastery scale, which examines the ability to manage one's life (example item: "In general, I feel I am in charge of the situation in which I live"; $\alpha = 0.52$; r = 0.317); (3) personal growth, which is the tendency of being open to new experiences (example item: "I think it is important to have new experiences that challenge how you think about yourself and the world"; $\alpha = 0.84$x; r = 0.483); (4) positive relations with others in the form of having satisfying, high-quality relationships (example item: "Most people see me as loving and affectionate"; $\alpha = 0.77$; r = 0.400); (5) the purpose in life scale, which reflects the beliefs that one's life is meaningful (example item: "I have a sense of direction and purpose in life"; $\alpha = 0.68$; r = 0.281); and (6) self-acceptance, which is the positive attitude towards oneself and one's past life (example item: "In general, I feel confident and positive about myself"; $\alpha = 0.84$; r = 0.416). Response options varied from 1 ("Strongly disagree") to 5 ("Strongly agree"). The total score was calculated as the mean score, and it reflects the high level of each dimension.

Distress. The self-report 21-item Depression Anxiety Stress Scale [54], evaluates the combined condition of distress ($\alpha = 0.95$; r = 0.373) consisting of three dimensions: depression symptoms (example item: "I couldn't seem to experience any positive feeling at all"; ($\alpha = 0.90$; r = 0.490), anxiety traits (example item: "I felt scared without any good reason"; ($\alpha = 0.89$; r = 0.450), and stress (example item: "I found myself getting agitated"; ($\alpha = 0.88$; r = 0.550). Response options varied from 0 ("Never happened to me") to 3 ("Always happened to me"). The total score was calculated as the mean score, and it reflects the high level of each dimension.

3. Results

3.1. Preliminary Analyses

The power analysis revealed that the sample size ($n = 107$) is adequate for drawing valid conclusions regarding significant effects in collected data, ensuring the robustness of results, and supporting the reliability of the interpretations derived from the data. It can detect effect sizes of $\delta \geq 0.5$ with a probability of at least 0.999.

The K-S tests for the factors (i.e., self-satisfaction, de-emphasis on disability salience, and compensatory behavioral qualities) of the acceptance of disability scale are significant.

The dimensions (i.e., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance) of psychological well-being and the distress scale are not significant.

3.2. Sample Population Description

Table 1 shows the mean scores and standard deviations of the subscales of each measured construct, i.e., acceptance of disability, psychological well-being, and distress.

Table 1. Mean, standard deviations, and theoretical range for each considered subscale.

Factors/Dimensions	M (SD)	Theoretical Score Range
Acceptance of Disability Scale		
Self-satisfaction	3.13 (0.92)	1–5
De-emphasis on disability salience	3.10 (0.63)	1–5
Compensatory behavioral qualities	3.92 (0.83)	1–5
Total score	3.39 (0.59)	1–5
Psychological Well-Being		
Autonomy	3.79 (0.58)	1–5
Environmental mastery	3.45 (0.54)	1–5
Personal growth	3.77 (0.66)	1–5
Positive relations with others	3.74 (0.63)	1–5
Purpose in life	3.55 (0.59)	1–5
Self-acceptance	3.52 (0.73)	1–5
Total score	3.64 (0.54)	1.5
Depression Anxiety Stress Scale		
Depression	1.84 (0.65)	0–3
Anxiety	1.71 (0.63)	0–3
Stress	2.11 (0.58)	0–3
Distress	1.89 (0.57)	0–3

3.3. Gender Comparison

An independent sample t-test revealed a significant difference across gender solely for the compensatory behavior quality factor of acceptance of disability ($t(105) = -1.990$, $p = 0.049$). To be accurate, females reached a higher score [M(SD) = 4.08 (0.85)] compared to their male counterparts [M(DS) = 3.77 (0.78)]. Due to the significant difference being related to the subscale of the compensatory behavior qualities, we included gender as a covariate for the regression model including this factor as a predictor. No significant differences are found in the other subscales of acceptance of disability and in the subscales of the other measures, i.e., psychological well-being and distress.

3.4. Exploring the Correlations between Acceptance of Disability and Well-Being

Before running the multiple linear regression models, correlations between the subscales of acceptance of disability (AOD) and subscales of well-being (WB), as well as distress (DIS), were run.

As shown in Table 2, except for the dimension of well-being named positive relations with others, the self-satisfaction factor correlated positively to all dimensions of psychological well-being and negatively with the depression dimension and distress total score. In other words, the more the person with disabilities accepts themselves and the related difficulties/limitations, the higher the flourishing is in the form of independence (autonomy) and overture to novelty (personal growth), the ability to manage their life (environmental mastery) and experience their life as meaningful (purpose in life), and a positive attitude toward their life. In addition to this high level of well-being, associations showed that the higher the self-satisfaction, the lower the depression and the distress.

Table 2. Correlation coefficients between the main considered constructs.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
(AOD) Self-satisfaction	0.397 ***	0.406 ***	0.351 ***	0.397 ***	0.399 ***	0.392	0.361 ***	0.550 ***	−0.329 ***	0.092	−0.153	−0.211 *	−0.056	−0.13
(AOD) De-emphasis on disability salience (1)		0.099	0.080	0.118	0.146	0.160	0.270 **	0.246 **	−0.145	0.001	−0.058	−0.075	−0.183	−0.152
(AOD) Compensatory behavioral qualities (2)			0.437 ***	0.337 ***	0.491 ***	0.417 ***	0.443 ***	0.446 ***	−0.268 **	−0.147	−0.179	−0.217 **	−0.145	−0.205 *
(WB) Autonomy (3)				0.660 ***	0.725 ***	0.698 ***	0.610	0.700 ***	−0.410 ***	−0.383 ***	−0.285 **	−0.394 ***	0.137	0.044
(WB) Environmental mastery (4)					0.721 ***	0.770 ***	0.700 ***	0.732 ***	−0.429 ***	−0.355 ***	−0.275 **	−0.387 ***	0.149	0.197 *
(WB) Personal growth (5)						0.716 ***	0.763 ***	0.764 ***	−0.490 ***	−0.427 ***	−0.397 ***	−0.479 ***	−0.001	0.010
(WB) Positive relations with others (6)							0.723 ***	0.800 ***	0.508 ***	−0.475 ***	−0.404 ***	−0.506 ***	0.199 *	−117
(WB) Purpose in life (7)								0.698 ***	−0.459 ***	−0.339 ***	−0.292 **	−0.399 ***	−0.037	−0.012
(WB) Self-acceptance (8)									−0.556 ***	−0.400 ***	−0.389 ***	−0.492 ***	0.191	0.131
(DIS) Depression (9)										0.797 ***	0.786 ***	0.942 ***	−0.114	−0.104
(DIS) Anxiety (10)											0.704 ***	0.911 ***	−0.118	−0.118
(DIS) Stress (11)												899 ***	−0.167	−0.166
Distress (12)													−0.142	−0.147
Chronologic age (13)														0.722 ***
Age at diagnosis (14)														

Note: *** $p < 0.001$; ** $p < 0.010$; * $p < 0.050$.

The factor of de-emphasis on disability salience positively correlated to the purpose in life and self-acceptance dimensions of well-being solely. This means that the tendency to de-emphasize disability-related difficulties and limitations is associated with the belief that one's life is meaningful as well as the positive attitude towards oneself and one's past life. For the association between the de-emphasis factor and the distress dimensions, the results showed no significant correlations.

Similarly to the self-satisfaction factor, the compensatory behavioral qualities as a factor of the acceptance of disability are associated with all dimensions of well-being, depression, and distress.

Regarding demographic features, that is, chronological age and the age when the acquired disability occurs, the results highlighted that chronological age is not associated with any dimension of well-being and distress. At the same time, the age when the participants received the diagnosis is negatively correlated with the compensatory behavior quality factor of acceptance of disability. This means that the higher the age when the disability has been acquired, the less the ability to compensate for the disability-related difficulties. Nevertheless, the higher the age when the disability has been acquired, the more ability to manage one's life (environmental mastery dimension).

3.5. Exploring the Interactions between Acceptance of Disability and Well-Being

Next, we delved into the relationships between each factor of the acceptance of disability scale and each dimension of well-being and distress by performing a multiple linear regression analysis (Table 3). Overall, the regression models supported the correlations computed. Regarding the role served by the self-satisfaction resulting from the acceptance of their acquired disability, results showed that this factor acts as a personal resource promoting the flourishing state of the persons with disability, in terms of high well-being and absence of distress. No de-emphasis on disability salience factor acts as a predictor, except for the purposes in the life dimension. This means that the tendency to underestimate disability-related difficulties and limitations leads persons with acquired disability to give

new meaning to their lives. Regarding the role played by the compensatory behavior qualities of the persons with acquired disability, the results did not support the preliminary associations. To be accurate, the results highlighted a significant relationship between the acceptance scale and personal growth, positive relations with others, purpose in life, and self-acceptance. Additionally, based on group comparison, in the regression model using the compensatory ability as a predictor, we included participants' gender as a covariate. The results revealed a non-significant impact of this demographic feature on each well-being and distress dimension.

Table 3. Multiple linear regression model for assessing the relationship between the acceptance of disability and the scores of well-being and distress.

	Autonomy			Environment Mastery			Personal Growth			Positive Relations with Others			Purpose in Life			Self-Acceptance			Distress		
	β	SE	*p*	β	SE	*p*	β	SE	*p*	β	SE	*p*	β	SE	*p*	β	SE	*p*	β	SE	*p*
SS	2.782	0.062	0.172 **	4.082	0.056	0.231 ***	3.066	0.062	0.190 **	3.8805	0.063	0.242 ***	3.141	0.060	0.188 **	5.733	0.066	0.379 ***	−2.061	−062	−0.131 *
DDS	0.033	0.082	0.002	0.557	0.075	0.42	1.212	0.082	0.100	0.419	0.084	0.035	2.471	0.079	0.197 *	1.088	0.087	−095	0.331	0.084	0.027
CBQ	1.508	0.058	0.088	0.678	0.054	0.036	3.573	0.059	0.210 ***	2.325	0.060	0.140	2.144	0.056	0.122 *	2.148	0.062	−134 *	−0.979	0.060	−0.059

Note: SS (self-satisfaction); DDS (de-emphasis on disability salience); CBQ (compensatory behavioral qualities). T: non-standardized coefficient; SE: standard error; β: regression coefficient. *** $p < 0.001$; ** $p < 0.010$; * $p < 0.050$. Model fits = autonomy: F(3, 137) = 5.575, $p = 0.001$, $R^2 = 0.11$; environmental mastery: F(3, 137) = 9.464, $p < 0.001$, $R^2 = 0.18$; personal growth: F(3, 137) = 14.314, $p < 0.001$, $R^2 = 0.24$; positive relations with others: F(3, 137) = 11.17, $p < 0.001$, $R^2 = 0.20$; purpose in life: F(3, 137) = 13.62, $p < 0.001$, $R^2 = 0.23$; self-acceptance: F(3, 137) = 22.92, $p < 0.001$, $R^2 = 0.33$; distress: F(3, 137) = 2.636, $p = 0.052$, $R^2 = 0.054$.

4. Discussion

A diagnosis of acquired physical disability is a challenging event causing high distress and low well-being in the target person [60–63]. In this vulnerable condition, accepting a disability may be a potential buffer in heightening well-being [11,28,36] and decreasing distress [9,64]. According to Wright's [18] theory, acceptance of an acquired disability results in a person broadening their range of values and refraining from comparing themselves to others. Consequently, this process may reduce the individual tendency to emphasize their disability-related limitations, devoting attention to their strengths, resources, and abilities. Following the Complete Mental Health Model [51] assumption, acceptance of disability may be a personal resource that may promote a flourishing state, where high psychological well-being and low distress occur.

Over the past two decades, a large body of literature has investigated the role played by this personal resource concerning self-esteem [38,65], quality of life [31,42], life satisfaction [31,66], social participation [31], and coping [66]. However, only one study [36] took into account well-being. With this rationale in mind, the current study aimed at exploring the protective role served by the acceptance of disability on flourishing. To be accurate, two research questions were addressed in this study. We examined whether the acceptance of disability would positively predict dimensions of well-being (RQ1) and then whether this personal resource would negatively predict distress (RQ2).

For RQ1, the results revealed that the self-satisfaction factor of the acceptance of disability predicted all dimensions of well-being. The de-emphasis on disability salience factor predicted only the purpose in life as a dimension of well-being. Finally, the compensatory behavioral quality factor predicted some dimensions of well-being, including personal growth, positive relationships with others, purpose in life, and self-acceptance. Comprehensively, our results are consistent with previous studies highlighting that those who recognize their competence and abilities—regardless of their disability—are more likely to achieve their goals and succeed in life [34]. Thus, support is provided in considering acceptance of disability as a personal resource as well as leading people with acquired disability to adapt to novel social contexts and environments [39,67]. As found by others [68], the acceptance of a diagnosis may be conceived as a stabilizing or a buffer in contributing to flourishing when environmental conditions heavily affect the family context (e.g., the COVID-19 pandemic).

The ground-breaking contribution of the present study lies in considering the role played by each factor of the acceptance of disability (i.e., self-satisfaction, de-emphasis on disability salience, compensatory behavioral qualities) on each dimension of flourishing (i.e., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance, distress). The main result regards the role of self-satisfaction. Consistent with the literature [69], people with disabilities who create new self-representations that consist of limitations and strengths may re-orient their life goals by leveraging autonomy, positive social connections, personal development, pursuit of life goals, and effective management of environmental demands [53,55,70].

Regarding the second factor of acceptance of disability, namely the de-emphasis on disability salience, it exclusively predicted the dimension of purpose in life of well-being. This means that individuals who do not center their identity around their disability appear to be more inclined to have life purposes. Reducing the salience of disability may allow people to focus on other aspects of their lives, promoting proactive behaviors and a sense of purpose in life.

Lastly, the third factor of acceptance of disability, i.e., the compensatory behavioral qualities, predicted some dimensions of well-being. In particular, those who accept their disability may reconsider their values and priorities, giving new meaning to their lives and highlighting their qualities. The focus on compensatory qualities, in turn, may promote adaptation and the development of new life goals, personal growth, relationships with others, and self-acceptance. Indeed, according to the study by Steger et al. [71], individuals who fail to highlight their qualities experience feelings of dissatisfaction with themselves and perceive a low sense of control and management of their lives.

Regarding our second research question, i.e., exploring whether acceptance of disability would negatively predict distress, the results revealed the relevant role played by self-satisfaction specifically in distress. Consistent with others [7,64,72], individuals who are satisfied with themselves despite their disability experience lower levels of depressive and anxious symptoms and stress. Hence, support for the protective role played by the acceptance of disability as a personal resource in reducing negative psychological symptoms has been provided. This result underscores the importance of coming to terms with disability, as it enables individuals to adapt to their circumstances and effectively cope with challenges [66,73]. Being able to deal with critical and unexpected events may allow persons with disabilities to attribute new meaning to their lives, overcoming experiences of distress [9,10,74,75].

Regarding the impact of sociodemographic features, non-significant associations between acceptance of disability and chronological age and age at diagnosis were found. On chronological age, our results are consistent with previous studies [35,40], whereas, on the age at diagnosis, due to the novelty of the study, further investigations are required to deepen the role of these features. Together, these two demographic features may be called for to boost knowledge on their potential role in the multifactorial process of acceptance of disability. The impact of gender alone has been examined. However, no significant effect of gender on the well-being and distress of people with acquired disabilities was revealed. In general-population-based studies, women often reported lower levels of well-being and higher levels of distress compared to men [76–78]. When vulnerable populations, i.e., persons with disability, were recruited, studies showed mixed results. While some studies confirmed results found in the general population [79,80], others indicated no gender differences [81,82]. Although this result may warrant further investigation, it aligns with studies that analyzed gender differences in the acceptance of disability. Indeed, most studies [8,35,41,83,84] have not found differences in the level of acceptance of disability among genders, suggesting that women and men faced the acceptance of the acquired disability process similarly.

5. Conclusions

Although the results are preliminary, they are promising because they represent the first step toward a more in-depth investigation of the relevant role of acceptance of disability in promoting flourishing among people with acquired physical disabilities. In particular, the strength of the current study is the effort to examine the role played by each factor of acceptance of disability in each dimension of well-being and distress in a vulnerable population. The results revealed that the strongest predictor of well-being and distress is self-satisfaction, which plays a protective role in fostering a state of flourishing, highlighting the importance of self-satisfaction in promoting the development of meaningful social relationships, self-acceptance, autonomy, environmental management, personal growth, and purpose in life. This can be understood in light of Rosenberg's model [85], which suggests that an individual's perception of themselves directly influences their psychological well-being. Specifically, if a person perceives themselves positively, with high self-esteem and a good opinion of themselves, they are more likely to perceive meaning in life [55] and consequently experience psychological well-being. Conversely, if a person has low self-esteem and a negative view of themselves, they are more likely to experience distress, which affects their pursuit of long-term goals [85,86]. Considering our results, self-satisfaction, more than the other two factors, may require adaptation towards the limitations imposed by the disability and positive self-perception. On the non-relevant role served by the other two factors, the results paved the way for a reflection. To be accurate, the de-emphasis of disability salience and compensatory behaviors may be problem-oriented coping strategies [87]. Problem-oriented coping strategies include removing or distancing oneself from the critical situation [88]. These strategies, which require focusing on other aspects of oneself and avoiding disability-related thoughts and emotions, promote individual adaptation. Consequently, self-satisfaction may reduce the risk of experiencing distress more than the other factors.

In conclusion, our study highlights the sophisticated dynamics of the acceptance of disability and its impact on the well-being and distress of people with acquired physical disabilities. The results underscored the importance of self-satisfaction as a critical predictor of flourishing and outlined its role in promoting meaningful social relationships, self-acceptance, autonomy, personal growth, and purpose in life, and in reducing distress.

6. Strengths and Limitations

Although the present study provides preliminary results, it has several strengths.

To begin, the novel aspect of this study is the consideration of the impact of each factor of acceptance of disability individually, in line with Wright's [18] conceptualization. This approach highlights the specific role of self-satisfaction, de-emphasis of disability salience, and acquired compensatory behaviors in the state of flourishing. In addition, this is the second study carried out in Italy, contributing to a better understanding of the topic in this culture. Furthermore, the study extends previous research by delving deeper into the constructs when acquired disabilities are considered, suggesting that acceptance of disability is pivotal in enhancing a flourishing state. Given the novelty of the study, the results should be interpreted considering limitations. The study adopted a cross-sectional web-based design, which limits the ability to observe changes in the variables over time from the time of diagnosis. A longitudinal study would be beneficial in this regard. Convenience sampling introduces a selection bias, as participants may not fully represent the target population. Caution must be taken in generalizing the results to a wider population of people with acquired disabilities. Future studies should aim to involve larger samples and employ random or stratified sampling methods to enhance sample representativeness. Our results show that there is no relationship between chronological age and acceptance of disability. However, the age range in the current study varied from youth to advanced adulthood. Future studies should focus on a narrower age range and analyze the association within a specific developmental stage according to Havighurst's [89] theory. Lastly, the use of self-report questionnaires limits the interpretation of results due to

social desirability effects. Future research could consider incorporating alternative methods to mitigate these limitations and provide a more comprehensive understanding of the topic.

7. Implications and Future Directions

Our results suggest the development of intervention protocols aimed at increasing the acceptance of disability. Interventions can mitigate the negative effects of disability in terms of distress and promote well-being, with potential positive impacts on life domains, including fostering trust in healthcare professionals [90] and encouraging active participation in the treatment process [40].

Specifically, interventions could focus on enhancing self-satisfaction to achieve well-being and reduce distress. Interventions may be directed towards promoting the meaning-making process, in line with Park's model [55], leading to the development of new goals, the enhancement of one's abilities, the creation of pathways to achieve them, and the discovery and development of resources [91].

Our results also suggest that intervention protocols could be extended not only to individuals diagnosed with acquired disabilities but also to other family members, such as parents, siblings, and significant others, given that the literature indicates that a disability diagnosis affects the entire family context [23,43,92–94]. Family intervention programs could aim to increase awareness of the impact of disability on oneself through reflection on personal experiences, thoughts, and positive and negative emotions. Additionally, such interventions could provide emotional support to family members, promoting greater control and management of the impact of disability on their lives. In conclusion, our results provide insights into how to promote flourishing in individuals with physically acquired disabilities by fostering a more positive evaluation of self-evaluation.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data will be available upon reasonable request.

Conflicts of Interest: The authors declare no conflicts of interest.

Notes: Following United Nations suggestions (2022), we used person-first language to refer to persons with disabilities (https://www.un.org/sites/un2.un.org/files/un_disability-inclusive_communication_guidelines.pdf, accessed on 3 February 2024).

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