The effectiveness of group reality therapy on social adjustment and quality of life of the participants in conference of viewing (Didan) of the Living Word Institute.

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Resumen: El propósito de este estudio fue determinar la eficacia de la terapia de grupo en la calidad de vida de los participantes que asistieron a la Conferencia de visualización (Didan) del Instituto de la Palabra Viva. El método de investigación fue semi-experimental y pretest-post test con el grupo de control. La comunidad estadística de todos los participantes estuvo en la conferencia de referencia en 1394. Los voluntarios fueron seleccionados por muestreo aleatorio y asignados aleatoriamente a grupos experimentales y de control (n1 = n2 = 15). La calidad de vida de todos los participantes se midió mediante el cuestionario de calidad de vida de la OMS (1996). Las intervenciones basadas en la terapia de la realidad se realizaron en 9 sesiones de grupo durante dos semanas para el grupo experimental y no se realizó ningún programa para el grupo de control. Al final de las intervenciones, la calidad de vida de todos los participantes fue re-medida (post-test) y analizada mediante análisis de covarianza multivariante. Los resultados mostraron que las intervenciones terapéuticas tuvieron un efecto significativo en la calidad de vida de los participantes (P <0,01). Con base en los resultados del estudio, se puede concluir que la realidad de la terapia es un método educativo-terapéutico apropiado para mejorar la calidad de vida de los individuos.

Palabras clave: Terapia de Realidad, Calidad de Vida, Conferencias de visión (Didan)

Abstract: The purpose of this study was to determine the effectiveness of group therapy on the quality of life of participants attending the Conference of viewing (Didan) of the Living Word Institute.

The research method was semi-experimental and pretest-posttest design with control group. The statistical community of all participants was at the referral conference in 1394. The volunteers were selected by random sampling and were randomly assigned to experimental and control groups (n1 = n2 = 15). The quality of life of all participants was measured by the WHO Quality of Life Questionnaire (1996). Interventions based on reality therapy were performed in 9 group sessions for two weeks for the experimental group and no program was performed for the control group. At the end of the interventions, the quality of life of all participants was re-measured (post-test) and analyzed using multivariate covariance analysis. The results showed that therapeutic-based interventions had a significant effect on the quality of life of participants (P <0.01). Based on the results of the study, it can be concluded that the reality of therapy is an appropriate educational-therapeutic method for improving the quality of life of individuals.

**Keywords:** Reality Therapy, Quality of Life, Conferences of viewing (Didan)

1. **INTRODUCTION**

Every person at the stages of life decides according to his beliefs, attitudes, values and beliefs, and his actions and behaviors are inspired by thoughts that come from family and school, society, culture and social values, from the characteristics. The main man is his extraordinary ability to think; especially his ability to think about his thinking is perhaps his most unique and humane characteristic, as one with anxiety and anxiety with thoughts and thoughts, it can also rid itself of its own disturbances by way of proper thinking. When human thinking and behavior is wise, it will be joyful, lively and capable; then, it can be said that every human being creates and directs his thoughts and thoughts (Shafi'abadi and Naseri, 1393).

Today, most researchers believe that quality of life has physical, psychological, social and spiritual dimensions, and is related to factors such as age, culture, sex, education, class status, disease and the social environment (King and Hindes, 2003).

Quality of Life is a health concept that has many characteristics, including multidimensionality, dynamism, and subjectivity, which includes a variety of dimensions, such as physical, psychological, and social dimensions. In the physical aspect, it refers to receiving the patient from his or her abilities in performing daily activities and tasks that require energy, or psychological dimension, psychological aspects of health, such as depression, fear, anger, happiness, and relaxation. As well as social dimension relates to the individual's ability to communicate with family members, neighbors and associates (Amiri Majd, Hosseini, Jafari).

The quality of universal life is conceptually more than a health condition. Quality of life is a complex relationship between objectivity and subjectivity, and it requires fundamental and valid facts, and the WHO has social, medical and personal values. In older people, the physical effects on quality of life are reduced and psychological and social factors become more important (Paut, Keith and Warrington, 2011).

Some researchers consider the quality of life to be an objective approach, and the obvious and relevant criteria of life such as physical health, personal circumstances (wealth, living conditions, etc.), social relationships, occupational or other social and economic factors of quality life is considered equivalent. In contrast to this view, there is another approach called the mental approach that has the quality of life synonymous with happiness or satisfaction.

And focuses on the cognitive factors of quality of life (Doocel, Carazipulse, Mazur and Chamara, 2007).

Individuals with their own compromised behaviors can provide an area for improving their quality of life. Social compatibility of individuals as the most important sign of mental health is one of the issues that has attracted many attention in recent decades. Social growth is perhaps the most important sign of health. One of the reasons for the incompatibility of people in social situations is the lack or lack of life skills that can greatly disturb the life of a person (Bick Verdi, 1395).

Zareb (2007; Translating Khodaiai Fard and Abedini, 2012) believes that reality is a form of therapy that can be applied to all people who are in trouble. Not denying reality, responsibility and planning to achieve goals is
one of the main human needs in the process of life, which is given importance in the real-therapeutic approach. The reality of therapy is based on choice theory. In this theory, it is believed that all the actions we do are behavior and that almost all our behaviors are chosen. Glaser treats behavior consisting of four components of performance, thinking, emotion, and physiology, which people indirectly control on both the components of performance and thinking directly and on emotion and physiology. The basic emphasis of choice theory is on the two components of performance and thinking. Glaser believes that in every connection of any kind and form, one can change himself and this means internal control. Therefore, one needs to take control of the outside to succeed and, instead, take behavior based on the doctrine of choice theory.

Because the reality of therapy discusses concepts such as accountability, internal control, successful identity and failure, and these concepts are closely related to the compromise behaviors and the dimensions of mental health of individuals, it seems that interventions based on a reality approach → Therapy will have an impact on increasing the dimensions of quality of life and adolescent adaptive behaviors.

Some researchers define the quality of life with an objective approach. The objective approach regards quality of life as clear and relevant to living standards, such as physical health, personal circumstances, social relationships, or other social and economic factors. In contrast to the mental approach, the quality of life is synonymous with the person's happiness or satisfaction. This perspective emphasizes the cognitive factors in assessing the quality of life (Liu and Shin, 2007).

Between the two objective and subjective approaches, there is a new approach called a holistic approach that its theorists believe that quality of life, like life itself, is a complex and multidimensional concept. The holistic view considers quality of life a multidimensional phenomenon, considering both the objective and the mental components. In this approach, physical health, health Psychological, social relations and quality of life environment are components of quality construct (Leto et al. 2005).

The definition of quality of life in a general sense of well-being is that in this definition, the satisfaction and satisfaction of the life of the city, satisfaction with the life of the work life and the satisfaction of the family life create the components of the overall satisfaction of life and, consequently, the well-being. Indeed, in many studies in this area, researchers have used two concepts of quality of life and well-being. Quality of life includes all living conditions. Several studies have argued that quality of life is a multi-dimensional concept that establishes beliefs and concepts. Researchers, under the influence of their theoretical perspective, offer different definitions of quality of life, for example, sociologically oriented scholars, take into account the structure and content of groups and communities, but researchers have a psychological orientation of individual characteristics such as Welfare, mental health, and so forth (Galway et al., 2005).

1.1. Features of quality of life

Knowing the quality of life features can help us identify its scales. These features include: multi-dimensionality, mentality, and dynamism.

A) Multi-dimensionality: The World Health Organization's Quality of Life Scale, used in this study, includes four dimensions related to physical health, mental health, social relationships, and the environment that are referred to here:

1. Psychological dimension of quality of life: In the psychological dimension, individual growth is important, individual growth is usually cognitively, socially and practically considered. Also, the individual's performance and the success rate in achieving the goals set along with the efficiency level are the determining factors of this variable (Skalak, 2004).
2. Physical dimension of quality of life: Galway et al. (2005) sees quality of life in 5 parts, including natural life, happiness, success in achieving personal goals, benefiting the community and natural capacity. The first part, that is, natural life refers to physical health. Natural life can be a life without disease, as well as adaptation to new success and fresh experiences in life despite chronic illness. Generally speaking, physical health involves concepts such as energy, strength, ability to perform daily activities and self-care.
3. The social dimension of quality of life: One of the factors contributing to the social dimension of the dignity of individuals in the community, which is examined using the theory of base features. According to this theory, any attribute that
distinguishes individuals in groups based on task performance can be used as a factor in the separation of the base and the status of the role of individuals. Based on the theory of base features, people who have a high base, they often experience positive emotions such as: sense of satisfaction, pride and happiness, and those who have a low base have to experience negative feelings such as humiliation, anger and failure. In other words, group interaction in the members of the high base creates positive, solidarity-based feelings, and in the members of the base, there are negative and conflict-based emotions. Therefore, the base is usually happier and more satisfying than other members. Therefore, the status of a person's role can be largely determined by the characteristics of their base in task-based groups. Indeed, individuals in the social ordering hierarchy display a set of expected behaviors that are based on a set of norms, a characteristic of a social role (Smith, 2000).

4. Environmental quality of life: a healthy society high quality to protect the health of citizens are created, but equally as citizens who actively work, your life run, easily and safely move up, (Hosseini, 1392)

B) Being objective: some researchers define the quality of life with an objective approach, and the obvious and relevant criteria of life such as physical health, personal circumstances (wealth, living conditions, etc.) of social communication, occupational activities Or other social and economic factors as equivalent to quality of life (Liu, 2006).

C) Mentality: In contrast to the objective approach, there is another approach called the mental approach that considers quality of life synonymous with the person's happiness or satisfaction and emphasizes the cognitive factors in assessing the quality of life (Liu, 2006). Abilities The subjective and mental experiences of quality of life relate to individual ability to the environment in which they live, which implies the interference of factors such as the degree of independence, a sense of goodness, and personal values (Pyot, Kit and Barrington, 2011)

D) Being dynamic: Quality of life is dynamic, for example, old-fashioned maple only reduces physical effects and cares more about psychosocial factors. The dynamism of quality of life is thus changing with changing time and depends on changes in the individual and environment (Paut, Kate and Barrington, 2011).

Reality Therapy: "One of the therapeutic approaches in psychology that the instigator is Glaser, and includes principles such as life in the present, accountability, control, and choice." The reality of therapy is a "cure" based on the therapist's Along with the authorities, they will create a feasible and well-established program that will initially satisfy him "(Prochaska and Norkras, 2002; Translation of Seyyed Mohammadi, 1392 p. 241).

Quality of Life: "One of the most fundamental concepts in positive psychology is the multidimensional concept that the World Health Organization defines to each individual of the status of life, values, goals, standards and individual interests." Colleagues, 2008 p. 56).

Quality of Life: The purpose of quality of life in this study was the total score that the subject gained in the World Health Organization Quality of Life questionnaire and included dimensions of physical health, mental health, social relations and environmental health.

1.2. Research method

The research method was semi-experimental and the research design was pre-test and post-test with control group. At first, social adjustment and quality of life questionnaires were tested and verified by the subjects of both groups (pre-test). At the end of the sessions, the social adjustment and quality of life questionnaires were returned to the subjects and the data were collected (post-test).

<table>
<thead>
<tr>
<th>Experimentation group</th>
<th>T1</th>
<th>X</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence group</td>
<td>T1</td>
<td>---</td>
<td>T2</td>
</tr>
</tbody>
</table>

1.3.1. Statistical

The statistical population of the study was all participants of the conference, which was held in February 2012.

1.3.2. Sampling method and sample size

The sampling method was voluntary. In the first instance, the names of the participants were presented at the meeting in February 2012, and then their names were sucked in a sack. Thirty people were randomly selected.
and divided into two groups of 15, who were randomly assigned to experimental and control groups.

1.4. Research variables

Independent variable: interventions based on a reality therapy approach
Dependent variable: social adjustment and quality of life
Criteria for entering and leaving people in research

Entry Criteria
- Be sure to attend the conference.
- Have normal physical and mental health.
- B will be for future adult status.

Exit criteria
If more than one session is absent in the reality therapy sessions, it will be excluded from the research.
- If it fails to perform rehearsal exercises, it is excluded from the research.

1.5. Research tool

In this research, social adjustment and quality of life questionnaires were used to collect data. The following was explained.

Social Compliance Scale for Pique Kelly and Wisman:
To measure social adjustment, the questionnaire of questionnaire 52 and Pearson and Wisman (1999) were used. The social adjustment scale has been designed as a rescue scale for assessing drug therapy and psychotherapy in depressed patients. Currently, this scale is widely used to measure the adaptability of patients and healthy people. Theoretical basis and the content of the phrases used in the test are taken from the constructed and scored Grölland interview. This scale evaluates interpersonal relationships in different roles, including emotions, satisfaction, difference, and performance. The structure of the test shows two distinct dimensions: 6 role domains and 5 after compatibility that were selected for each role domain (proportional to the role). The social adjustment scale was originally prepared as an interview program and then turned into a self-assessment test; the self-evaluation version is useful for the implementer in terms of cost-effectiveness, as well as the bias of the interviewer. The self-report version is completed by the respondent, but his relatives can complete it.

Both interviews and self-report versions include 42 questions that describe how to play a role in 6 areas of work: employee, housewife or student, questions 1-18; social activities; leisure time questions 19-29; extended family relationships; questions 30 -37; the role of marriage questions; questions 38-46; the parents of questions 47-50 and the member of the family unit questions 51-54. In this questionnaire, there are separate questions for the working relationships of housewives and hired students, so the scale includes 54 final questions that respondents respond to, according to their own circumstances, 42 questions. Two scales have been used to scale this scale:

1. Calculation of the mean score: To obtain the mean score for each section (such as: work, leisure ...), scroll all the phrases associated with the subscale and divide the total number of related phrases into subscales.
2. Calculation of total score: To get the total score of the test score, put all the questions together and divide the number of questions that the subject is responding to.

A high score in each subscale represents the low level of social adjustment in the subject area. Overall, the overall score also indicates that the subject has an unfavorable social adjustment.

Validity and Validity
Bick Verdi (1395), in a research conducted on students, obtained the coefficient of reliability of the social adjustment questionnaire by using the two-way method for various domains from 0.61 to 0.78. Also, for the overall validity of this scale, its correlation with Social Welfare Adjustment Questionnaire (1993) was 0.73.

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1. Calculating the average score: To obtain the mean score for each section (such as: work, leisure, etc.), the score will sum up all the terms related to the subscale and subtract the total number of phrases associated with that sub-scale Divide

World Health Organization Quality of Life Questionnaire Quality of Life Questionnaire 36 questions (SF-36) are the most popular and most used tool for measuring quality of life. Health organization To create coherence in research and to measure quality of life, the world commissioned a team to build a questionnaire. The result of this group was a questionnaire of quality of life of 100 questions (WHOQOL-100). A few years later, a short form was prepared for easier use of this questionnaire. World Health Organization Quality of Life Questionnaire (WHOQOL-BREF) is a 26-item questionnaire that measures the quality of overall and general life of a person. This scale was developed by a group of experts from the World Health Organization in 1996 and adjusted by the form of questionnaires in the form of 100 questionnaires. The questionnaire consists of four sub-scales that assess the four domains of life: physical health (7 items), mental health (6 items), social relationships (2 items), life environment (8 items), and a general score.

To verify the validity and reliability of this questionnaire, Gholamian (1394) conducted a research on the staff of the university. The reliability of this questionnaire was tested by the method of subtest for the following: physical health 0.77, mental health 0.77, social relations 0.75, the environment was 0.84.

1.6. Research methodology

Theoretical information was gathered through the library through this research. The researches and researches in this field were compiled from the school, research papers and theses and formulated as theoretical and scientific bases of the research. It was also used to obtain better and more useful information than Internet articles. Each member of the experimental group received 9 treatment sessions (60 minutes each session) in a two-week course of treatment-based treatment interventions, while control group members received no treatment. Table 1. Descriptive indicators "Quality of life dimensions" for the experimental group in two stages

| The pre-test- post-test (n1=n2=15) |
The data in the mean table and the standard deviation of "dimensions of quality of life" in the pre-test and post-test stages for test groups are shown. As it is visible in all "dimensions of quality of life" there is a difference between the grades in the pre-test and post-test stages.

Table 2. Descriptive indicators "Quality of life dimensions" for the control group in two stages

The pre-test- post-test (n1=n2=15)

<table>
<thead>
<tr>
<th>Maximum score</th>
<th>Minimum score</th>
<th>Standard deviation</th>
<th>average</th>
<th>Level</th>
<th>Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>14</td>
<td>4.43</td>
<td>22.5</td>
<td>pre-test</td>
<td>physical</td>
</tr>
<tr>
<td>40</td>
<td>24</td>
<td>4.97</td>
<td>33.5</td>
<td>post-test</td>
<td>psychological</td>
</tr>
<tr>
<td>23</td>
<td>9</td>
<td>3.54</td>
<td>17.8</td>
<td>pre-test</td>
<td>social</td>
</tr>
<tr>
<td>41</td>
<td>13</td>
<td>3.14</td>
<td>31.6</td>
<td>post-test</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>2.77</td>
<td>9.1</td>
<td>pre-test</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>10</td>
<td>3.94</td>
<td>21.1</td>
<td>post-test</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>10</td>
<td>4.29</td>
<td>22.3</td>
<td>pre-test</td>
<td>living of Environment</td>
</tr>
<tr>
<td>39</td>
<td>27</td>
<td>4.98</td>
<td>32.4</td>
<td>post-test</td>
<td></td>
</tr>
</tbody>
</table>

Information contained in the mean score and standard deviation of "quality of life dimensions" in the pre-test and post-test stages for the control group are shown. As it is visible in all "dimensions of quality of life" there is a difference between the scores in the pre-test and post-test stages is minor.

2. INFERENTIAL FINDINGS AND EXTRACTING RESULTS

In this section, the research hypotheses were examined and tested.

The main hypothesis: The reality of group therapy increases the quality of life of participants attending the meeting.

To test this hypothesis using multivariate covariance analysis, the effect of group therapy on the quality of life dimensions of participants was analyzed. At first, the assumptions of this test were examined.

2.3. Normalization of data

In reviewing the distribution of data, it is necessary to check the normality of the data and scatter dispersion. Due to the low sample size, data distribution was investigated using Shapiro-Wilk's test. Data from the implementation of this test are presented in the Table 3.

Table 3. Summary of Shapiro-Wilk test results for data distribution

<table>
<thead>
<tr>
<th>Significance Level</th>
<th>Shapiro-Wilk</th>
<th>Change resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.714</td>
<td>0.65</td>
<td>Physical</td>
</tr>
<tr>
<td>0.091</td>
<td>0.912</td>
<td>Psychological</td>
</tr>
<tr>
<td>0.813</td>
<td>0.71</td>
<td>Social</td>
</tr>
<tr>
<td>0.589</td>
<td>0.56</td>
<td>living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environment</td>
</tr>
</tbody>
</table>

The results of Table 3 show that the data related to the variable of quality of life dimensions follow the normal distribution (P <0.05).

The same assumption of variances

To evaluate the variance of dependent variables among the groups, the embox test was used, the results of which are presented in the following table. The Mbox test examines this assumption that the observed covariance matrices of the dependent variables are equal between the groups.
Table 4. Summary of the results of the Mbox test to examine the same assumption of groups variance in terms of quality of life.

<table>
<thead>
<tr>
<th>Box,s M</th>
<th>8.86</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>1.22</td>
</tr>
<tr>
<td>DF1</td>
<td>12</td>
</tr>
<tr>
<td>DF2</td>
<td>5302.05</td>
</tr>
<tr>
<td>Sig</td>
<td>0.91</td>
</tr>
</tbody>
</table>

Considering the F (1.22) and the significant level (0.91), the zero assumption was confirmed and it was concluded that the observed covariance matrices are equal variables among the groups. Therefore, the same presumption has the same variance of groups for the dimensions of quality of life.

In the table below, the result of the four multiple tests is shown for the significance of the effect of the therapeutic reality.

Table 5. Summary of the results of multivariate tests to examine the significance of the effect of medical reality.

<table>
<thead>
<tr>
<th>Squared Eta</th>
<th>Significance level</th>
<th>F</th>
<th>Value</th>
<th>Test</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.76</td>
<td>0.001</td>
<td>44.83</td>
<td>1.73</td>
<td>Pillow effect test</td>
<td></td>
</tr>
<tr>
<td>0.74</td>
<td>0.0001</td>
<td>102.54</td>
<td>0.004</td>
<td>Lambert vickels test</td>
<td></td>
</tr>
<tr>
<td>0.77</td>
<td>0.0001</td>
<td>224.08</td>
<td>70.02</td>
<td>Hoteling effect test</td>
<td></td>
</tr>
<tr>
<td>0.78</td>
<td>0.001</td>
<td>455.64</td>
<td>67</td>
<td>Test the Largest root of zince</td>
<td></td>
</tr>
<tr>
<td>0.54</td>
<td>0.001</td>
<td>7.81</td>
<td>0.54</td>
<td>Pillow effect test</td>
<td></td>
</tr>
<tr>
<td>0.54</td>
<td>0.001</td>
<td>7.81</td>
<td>0.45</td>
<td>Lambert vickels test</td>
<td></td>
</tr>
<tr>
<td>0.54</td>
<td>0.001</td>
<td>7.81</td>
<td>1.18</td>
<td>Hoteling effect test</td>
<td></td>
</tr>
<tr>
<td>0.54</td>
<td>0.001</td>
<td>7.81</td>
<td>1.18</td>
<td>Test the Largest root of zince</td>
<td></td>
</tr>
</tbody>
</table>

Table 6. The results of the Lone test to examine the equality of variance in quality of life dimensions.

<table>
<thead>
<tr>
<th>Squared Eta</th>
<th>Significance level</th>
<th>F</th>
<th>Average of Squares</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.51</td>
<td>0.05</td>
<td>121.97</td>
<td>4878.94</td>
<td>28</td>
<td>1</td>
<td>physical</td>
</tr>
<tr>
<td>0.1</td>
<td>0.001</td>
<td>63.9</td>
<td>2756.29</td>
<td>28</td>
<td>1</td>
<td>psychological</td>
</tr>
<tr>
<td>0.4</td>
<td>0.001</td>
<td>82.97</td>
<td>868.17</td>
<td>28</td>
<td>1</td>
<td>social</td>
</tr>
<tr>
<td>0.1</td>
<td>0.001</td>
<td>148.37</td>
<td>5155.91</td>
<td>28</td>
<td>1</td>
<td>living Environment</td>
</tr>
</tbody>
</table>

Regarding the F level and the significant level, it was found that the variance of the quality of life dimensions error in different stages of testing was not different in individuals.

Table 7. Summary of the results of covariance analysis to determine the effect of therapeutic reality on the quality of life dimensions

<table>
<thead>
<tr>
<th>Squared Eta</th>
<th>Significance level</th>
<th>F</th>
<th>Average of Squares</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Dependent Variable</th>
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<td>2756.29</td>
<td>28</td>
<td>1</td>
<td>psychological</td>
</tr>
<tr>
<td>0.4</td>
<td>0.001</td>
<td>82.97</td>
<td>868.17</td>
<td>28</td>
<td>1</td>
<td>social</td>
</tr>
<tr>
<td>0.1</td>
<td>0.001</td>
<td>148.37</td>
<td>5155.91</td>
<td>28</td>
<td>1</td>
<td>living Environment</td>
</tr>
</tbody>
</table>

Similarly, the results of the table above show that the reality of the treatment has a significant effect on the quality of life dimensions (P <0.01). In other words, the reality-based therapy program has managed to significantly change all aspects of the quality of life.

The first hypothesis: Group-based therapeutic reality increases the quality of life of participants attending the meeting.

The results of Table 4-6 show that group-based treatment based reality interventions can increase the quality of life

At first, the Lone test was used to measure the variance of variable error variables. The dimensions of quality of life (physical, psychological, social, living environment) were used in different stages of the experiment, the results of which were presented in the following table.
of participants in the referral conference at a meaningful level (P < 0.01).

3. DISCUSSION AND CONCLUSION

The theory of therapeutic reality is group-based, which affects the quality of life of the participants in the conference. Based on the findings of the research, it was concluded that the reality of group therapy is effective on the dimensions of the quality of life of participants attending the conference. This result was in line with the results of the researches of Nayort and Baha'i Barri, Bahrain, Azargoon, Ebadi and Aghai (2013). The results of these studies showed that therapeutic-based interventions can reduce the level of anxiety and stress of participants in the research and increase their quality of life.

In explaining the results, it can be said that the dimensions of quality of life in general include the range of physical health, psychological health, environment of life and relationships with others. Which is more precisely in areas like Life satisfaction, positive mood and emotion, self-esteem, social relationships, satisfying relationships and experiences, meaning of life, attention to daily activities of life, appetite and sleep, attention to communicating with others is revealed. Regarding the effect of group therapy, we can say that factors such as the atmosphere of sincere and respectful, free expression of feelings, group solidarity, and empathic understanding in methods used in the form of group therapy, with emphasis on concepts related to reality, right and wrong, and Judging from them and accepting responsibility along with the common characteristics of individuals creates an attitude Differences and behavior was more balanced than in the beginning of the meeting participants. This change in attitudes has improved the relationships between the members of the two groups and increased the hope of improving the path to life and having a sense of satisfaction in most of the participants.

In addition, today anxiety and stress problem is a common and common concern in most people, which has a relatively high and severe anxiety as a dysfunctional phenomenon of people's performance and quality of life, which causes the person to be able to establish It is not a healthy relationship with others and it is not a responsibility to others. In reality, human beings have two basic needs: one is loving and loved, and another has a sense of value for oneself and others. In order to meet these needs, one must behave in a way that is acceptable to others so that others may love him. The criteria for the behavior are desirable, reasonable, diverse, and numerous, and the correctness or inaccuracy of the acts depends on the norms that derive from cultural, social and moral factors and values. If he does not evaluate his behavior and does not seek to correct the misconduct, his basic needs will not be met and, as a result, he will not feel worthy and friendship, and he will be worried and anxious. Also, one needs to "do something to gain and strengthen a range of skills in order to be valued." Glaser (1925) noted that anxiety is referred to as mental illness, in fact, includes hundreds of ways people choose to stay in order to meet their basic genetic needs to behave. Also, the irresponsible behavior of individuals causes anxiety rather than anxiety that causes an individual to be intolerant.

In particular, the therapist’s reality concentrates all his efforts on behavior, he creates a private and active relationship in a responsible way, and has contemplated the present, especially the current behavior of the authorities for success. The therapist does not spend his time on the role of the detective and the searcher, listening to the excuses of the authorities, but by trying to pay attention to the current behavior of the individual and avoiding threatening events, the preconditions for the formation of behavior Responsible and responsible personality in him, and in this way, by strengthening, anxiety and worry, he strengthens the foundation of a healthy personality. According to Glaser, group counseling, by creating a perceptible environment, fulfills the needs of the members and the sense of responsibility and achievement of a successful identity. In addition, this will in turn reduce stress and anxiety of the members and improve their performance. The satisfaction of loving and loving needs in the group is well done and group counseling can be a good environment for achieving identity.

Success and relaxation. On the other hand, according to Seligman, the creation of a sense of control in people, hope for the future, a clear planning and a sense of strength in doing things will reduce anxiety.

Regarding the observance of the provisions mentioned in the group meetings, which take place on the basis of the stages of reality therapy, it is logical to reduce the anxiety and thus increase the quality of life of the participants in the sessions.
In explaining the findings, we can mention the following: As the results of the research show, compatibility in individuals with components such as accountability and internal control is highly correlated. If people have positive and realistic ideas about themselves, they will feel a sense of value.

One of the reasons that increased the test group's grades after intervention is that during these sessions, clients were trained on the basis of the reality-based treatment approach to recognize and correctly meet their basic needs, because satisfying basic needs in a manner Correct, it increases the level of compromised behaviors in individuals. This approach also emphasizes the strengthening of the internal control source. That individuals can attribute success to themselves and believe that the thinking, behavior and emotion they experience are under their control. And if they conclude that their behavior does not lead them to satisfy their needs, they will choose the other behavior and accept the responsibility of the outcome of their choice.

REFERENCES


