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Effectiveness of Self-Healing Training on Death Anxiety, Hope, and Loneliness in Older Adults

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ABSTRACT

The purpose of the present study was to determine the effectiveness of self-healing training on death anxiety, hope, and feelings of loneliness in older adults. The research method was quasi-experimental with a pretest–posttest control group design. The statistical population consisted of adults aged over 70 years residing in a nursing home in Khorramabad City in 2024. Using convenience sampling, 50 participants were selected and randomly assigned to two groups of 25 (25 in the experimental group and 25 in the control group). Participants in the experimental group received self-healing training in eight sessions, each lasting 90 minutes, while the control group did not receive the intervention. Research data were collected using the Death Anxiety Scale (DAS; Templer, 1970), the Hope Questionnaire (HQ; Snyder et al., 1991), and the UCLA Loneliness Scale (Russell et al., 1980), and were analyzed using multivariate analysis of covariance. The findings indicated that, after controlling for pretest effects, there were significant differences between the posttest means of death anxiety, hope, and loneliness in older adults at the 0.01 level. Based on the results of the present study, it can be concluded that empowering older adults through self-healing training is an effective educational approach for reducing death anxiety and loneliness and for enhancing hope in this population.

Keywords: *self-healing training, loneliness, death anxiety, hope, older adults*

1. Introduction

Population aging is one of the most profound demographic transformations of the twenty-first century, with significant psychological, social, and health-related implications for individuals and societies. As life expectancy increases, a growing proportion of older adults face complex psychological challenges associated with aging, including heightened vulnerability to death anxiety, loneliness, and fluctuations in hopefulness. These constructs are not merely transient emotional states but are deeply intertwined with existential concerns, perceived social support, psychological well-being, and adaptive functioning in late life (Özer et al., 2025; Xie & Liu, 2022). Understanding and addressing these interrelated psychological dimensions is therefore a central priority in contemporary gerontological psychology.

Death anxiety represents a core existential concern in older adulthood, reflecting apprehension, fear, or distress associated with the anticipation of death and dying. Empirical evidence consistently indicates that death anxiety intensifies with advancing age, particularly among elderly

individuals experiencing declining physical health, reduced autonomy, or limited social engagement (Alzaben et al., 2023; Zarabi et al., 2021). Studies conducted in diverse cultural contexts have demonstrated that death anxiety is closely linked to loneliness, reduced psychological well-being, and diminished life satisfaction among older adults, especially those residing in nursing homes or living alone (Ergin et al., 2022; Guner et al., 2023). These findings underscore death anxiety as a multidimensional phenomenon shaped by biological aging, psychosocial stressors, and existential meaning-making processes.

Loneliness is another critical psychological challenge in later life, often arising from bereavement, retirement, declining social roles, and physical limitations. Unlike objective social isolation, loneliness reflects a subjective perception of insufficient or unsatisfactory social relationships and has been identified as a powerful predictor of mental health problems in the elderly (Aghajani et al., 2025; Zhou, 2024). Empirical research has demonstrated robust associations between loneliness and elevated death anxiety, suggesting that unmet relational needs may amplify existential fears by undermining individuals' sense of belonging and continuity (Ergin et al., 2022; Guner et al., 2023). During periods of heightened uncertainty, such as the COVID-19 pandemic, loneliness has been shown to exacerbate death-related concerns and psychological distress among older populations (Hamidi et al., 2024; Shirmohammadi et al., 2023).

Hope, by contrast, is conceptualized as a protective psychological resource that facilitates adaptive coping, goal-directed behavior, and emotional regulation in the face of adversity. In later life, hope plays a crucial role in sustaining meaning, resilience, and engagement with life despite physical decline or existential uncertainty (Budescu & Feldman, 2023; Howell et al., 2024). Empirical studies indicate that higher levels of hope are associated with lower death anxiety and improved psychological well-being among elderly individuals, suggesting that hope may function as a buffer against existential distress (Kafi et al., 2024; Shirmohammadi et al., 2023). However, hope is not uniformly distributed in older populations and may be diminished by chronic stress, loneliness, and reduced perceived control over life circumstances (Hashemi et al., 2023; Xie & Liu, 2022).

Recent gerontological research has increasingly emphasized the importance of psychosocial interventions aimed at enhancing internal psychological resources rather than solely reducing symptoms. Within this framework, self-healing approaches have gained attention as integrative interventions that combine cognitive, emotional, behavioral, and spiritual components to promote psychological balance and inner resilience. Although the concept of self-healing has been applied in biomedical contexts—such as regenerative medicine and wound care—it has also evolved into a psychologically grounded approach emphasizing self-awareness, emotional processing, forgiveness, meaning-making, and adaptive coping (Omidian, 2024). In psychological interventions, self-healing is conceptualized as an active, learned process through which individuals mobilize internal capacities to restore emotional equilibrium and psychological well-being.

Empirical evidence supports the effectiveness of self-healing-based interventions across various populations and psychological outcomes. Studies conducted with women experiencing psychological distress, betrayal trauma, or eating-related problems have shown that self-healing training can significantly reduce anxiety, cognitive distortions, and emotional dysregulation while enhancing self-esteem, forgiveness, and self-efficacy (Fathi & Latifi, 2022; Heydari et al., 2022; Nasresfahani et al., 2022). Comparative studies have further demonstrated that self-healing interventions can be as effective as, or complementary to, established therapeutic approaches such as cognitive-behavioral therapy in improving distress tolerance and emotional regulation (Zarabi et al., 2021). These findings suggest that self-healing frameworks offer a flexible and culturally adaptable modality for psychological intervention.

Importantly, self-healing approaches have also been applied in contexts directly relevant to death anxiety and existential distress. Research involving patients with chronic illnesses, such as breast cancer, has shown that self-healing training can significantly reduce death anxiety, stress, and depressive symptoms while promoting psychological adjustment (Zamani Gharaghoosh et al., 2021). Similarly, interventions grounded in positive psychology, emotion-focused therapy, and spiritual well-being have demonstrated efficacy in reducing death anxiety and enhancing resilience among elderly populations (Kafi et al., 2024; Özer et al., 2025; Zarei & Esmailzadeh, 2024). These findings collectively highlight the potential of integrative, meaning-oriented interventions in addressing existential concerns in later life.

Despite the growing body of literature on death anxiety, loneliness, and hope among older adults, several gaps remain evident. First, much of the existing research has focused on

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single outcomes or isolated interventions, limiting understanding of how multifaceted psychological programs simultaneously influence interconnected constructs such as death anxiety, hope, and loneliness. Second, although self-healing approaches have demonstrated effectiveness in younger or clinical populations, empirical studies examining their application among institutionalized elderly individuals remain scarce. Third, cultural context plays a critical role in shaping existential beliefs, coping strategies, and receptivity to psychologically and spiritually oriented interventions, underscoring the need for context-sensitive research in non-Western settings (Arab & Mohammadi, 2023; Hashemi et al., 2023).

Moreover, contemporary models of aging emphasize the interaction between individual psychological resources and social-environmental factors. Perceived social support, psychological well-being, self-acceptance, and self-compassion have all been identified as key mediators in the relationship between aging-related stressors and mental health outcomes in the elderly (Aghajani et al., 2025; Hamidi et al., 2024; Kia et al., 2025). Interventions that strengthen internal coping mechanisms while indirectly enhancing social and emotional functioning may therefore yield more sustainable benefits. In this regard, self-healing training—by integrating emotional awareness, cognitive restructuring, forgiveness, spiritual reflection, and lifestyle modification—may be particularly well-suited to address the complex psychological needs of older adults.

Finally, emerging interdisciplinary research highlights the importance of fostering hope and meaning as central components of healthy aging. Studies in gerontology, health psychology, and even biomedical aging research increasingly recognize hope as a vital contributor to resilience, treatment adherence, and quality of life in older populations (Budescu & Feldman, 2023; Liu & Zuo, 2025). Psychological interventions that explicitly cultivate hope, alongside reducing distress and loneliness, may therefore play a pivotal role in promoting adaptive aging and psychological longevity.

Given the high prevalence of death anxiety and loneliness among elderly individuals residing in nursing homes, and the promising yet underexplored role of self-healing approaches in gerontological psychology, systematic investigation of such interventions is both timely and necessary.

The aim of the present study was to determine the effectiveness of self-healing training on death anxiety, hope, and feelings of loneliness among elderly individuals residing in nursing homes.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental method with a pretest–posttest control group design. The statistical population consisted of older adults aged over 70 years residing in a nursing home in Khorramabad City in 2024. Using convenience sampling, 50 individuals were selected from the statistical population based on the sample size determination table of Cohen et al. (2000) and were randomly assigned to two groups of 25 (25 participants in the experimental group and 25 participants in the control group). The self-healing educational intervention was administered to the experimental group in eight sessions, each lasting 90 minutes, once per week, while the control group did not receive any intervention. Inclusion criteria included age over 70 years, at least a fifth-grade elementary education level, interest and willingness to participate in the study, and completion of an informed consent form. Exclusion criteria included the death of a participant, failure to complete the research questionnaires, and unwillingness to continue participation in the research process. To comply with ethical principles, this study was conducted with full respect for participants' privacy and confidentiality, and informed consent was obtained from all individuals prior to participation. All stages of the research were conducted under the supervision of the university ethics committee, and every effort was made to avoid any physical or psychological harm to participants. The results were reported solely for scientific purposes without disclosure of participants' identities.

2.2. Measures

Death Anxiety Scale (DAS): This questionnaire was developed by Templer (1970) and consists of 15 items. Scoring is based on a dichotomous format of yes (score 1) and no (score 0). The score range of this scale is from 0 to 15, with higher scores (above the mean score of 8) indicating a higher level of death anxiety. Thus, total scores on this scale range from 0 to 15. The reliability of this questionnaire was reported as 0.83 using Cronbach's alpha, and its convergent validity with the Beck Anxiety Inventory (BAI) was reported as 0.40 (Templer, 1970). In Iran, this questionnaire was examined by Soleimani et al. (2022), who reported a Cronbach's alpha coefficient of 0.73 and a convergent validity of 0.35 with the Beck Anxiety Inventory. Its reliability and validity were also examined in the study

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by Rajabi and Bahrani (2001). Construct validity was assessed through factor analysis, and criterion validity was examined using the Death Worry Scale and the Manifest Anxiety Questionnaire; correlations between death anxiety and the Death Worry Scale (r = 0.40) and the Manifest Anxiety Questionnaire (r = 0.43) were reported. To assess reliability, the internal consistency method was used by calculating the correlation between odd and even items completed by 10 participants using the Kuder–Richardson formula, yielding a reliability coefficient of 0.73. In the present study, the Kuder–Richardson coefficient was 0.71.

Hope Questionnaire (HQ): This questionnaire was developed by Snyder et al. (1991) and consists of 12 items. Scoring is based on a five-point Likert scale ranging from strongly disagree (0) to strongly agree (4), with items 3, 7, and 11 scored in reverse. The score range is from 0 to 48, with higher scores indicating greater hope. Snyder et al. (1991) reported a test–retest reliability coefficient of 0.85 over a three-week interval. Concurrent validity with measures of optimism, goal expectancy, and self-esteem ranged from 0.50 to 0.60. The correlation of this questionnaire with the Beck Hopelessness Scale was −0.51 and with the Beck Depression Inventory was −0.43, indicating adequate validity. In the study by Kermani et al. (2010), the reliability coefficient of this scale was reported as 0.86 using Cronbach's alpha and 0.81 through a 10-day test–retest method. The results also showed correlations between the Hope Scale and suicidal ideation (r = −0.53), perceived social support (r = 0.40), and meaning in life (r = 0.57), indicating convergent and divergent validity of the Hope Scale. In the present study, the reliability of this questionnaire was calculated as 0.73 using Cronbach's alpha.

UCLA Loneliness Scale: The Loneliness Questionnaire was developed by Russell et al. (1980) and consists of 20 items, including 10 negatively worded and 10 positively worded statements, rated on a four-point scale. Scoring is based on a four-point Likert scale ranging from never (1) to always (4), with items 1, 5, 6, 9, 10, 15, 16, 19, and 20 scored in reverse. Scores range from 20 (minimum) to 80 (maximum), with a mean score of 50; scores above the mean indicate greater severity of loneliness. The reliability of this questionnaire using the test–retest method over a two-month interval was reported as 0.89, and content validity as 0.79. Reliability in the revised version was also reported as 0.78. This scale was translated by Shokrkon and Mirdrikvand and, after a pilot administration and revisions, was utilized in research. In the present study, the reliability of this questionnaire was calculated as 0.74 using Cronbach's alpha.

2.3. Intervention

In the present study, a self-healing training protocol adapted from Lloyd and Johnson (2005) was implemented for the experimental group in eight weekly sessions, each lasting 90 minutes. The intervention began with establishing a therapeutic alliance, clarifying session goals and rules, introducing situational stressors, and teaching stress management skills, alongside education on the immune system and the effects of physiological and hidden stress linked to destructive cellular memories; participants practiced relaxation and correct breathing exercises at home. Subsequent sessions focused on distinguishing real versus false problems, realistic and problem-oriented thinking, memory retrieval related to life failures and conflicts, identification and root analysis of destructive cellular memories (e.g., resentment, irrational beliefs, and maladaptive behaviors), and mindfulness-based practices. Trauma-focused techniques such as the "glass elevator" and empty-chair technique were introduced, along with guided meditations to process impactful life events. Later sessions emphasized emotional awareness, forgiveness skills, shifting focus from past to future, identifying maladaptive beliefs and the "poor me" syndrome, effective emotional expression, willpower enhancement, problem-solving, and modification of harmful habits using structured behavioral programs. Core self-healing codes—including love, joy, calmness, patience, kindness, goodness, trust, humility, and self-control—were systematically cultivated through cognitive, behavioral, relational, and spiritual exercises aimed at improving self-esteem, resilience, emotional regulation, and interpersonal relationships. Additional components included spiritual practices such as prayer, gratitude, creative visualization, value clarification, and mindfulness, as well as lifestyle modification covering sleep, nutrition, physical activity, hygiene, social engagement, and quality of life across health, relationships, and personal growth domains. The final session focused on consolidating skills, correcting negative self-talk, reinforcing self-care, stress reappraisal, emotional and relational management, spiritual transcendence, trust and surrender, life purpose, and long-term planning, with an emphasis on continued practice of self-healing techniques beyond the intervention period.

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2.4. Data analysis

The data of the present study were analyzed using multivariate analysis of covariance (MANCOVA) with SPSS software, version 26.

3. Findings and Results

The mean age of participants in the experimental group was 74.16 years (SD = 2.28), and in the control group the mean age was 77.84 years (SD = 5.10). In the experimental group, 16 participants were women (64%) and 9 were men (36%). In the control group, 16 participants were women (64%) and 9 were men (36%). Regarding educational level in the control group, 4 participants had elementary education (16%), 8 had lower secondary education (32%), 6 had upper secondary education (24%), 5 had a high school diploma (20%), 1 had an associate degree (4%), and 1 had a bachelor's degree (4%). Regarding educational level in the experimental group, 3 participants had elementary education (12%), 11 had lower secondary education (44%), 8 had upper secondary education (32%), and 3 had a high school diploma (12%).

Table 1

Descriptive Statistics of Participants' Scores on Death Anxiety, Hope, and Loneliness

Variable	Group	Pretest Mean	Pretest SD	Posttest Mean	Posttest SD
Death anxiety	Experimental	8.96	2.03	1.56	0.86
	Control	10.01	1.80	9.28	2.73
Hope	Experimental	22.80	3.71	34.72	6.23
	Control	22.04	2.92	23.24	4.11
Loneliness	Experimental	52.28	4.65	32.84	4.32
	Control	52.72	4.83	52.60	4.70

Based on the results presented in Table 1, the mean scores of the experimental group showed changes at the posttest stage compared with the control group. Participants' scores in the experimental group increased on the hope variable at posttest compared with pretest, while the mean scores of death anxiety and loneliness decreased at posttest compared with pretest.

To examine these changes, multivariate analysis of covariance (MANCOVA) was used. One assumption of this test is the homogeneity of variances, which was examined using Levene's test. The results indicated that the variances of death anxiety, hope, and loneliness were not significant in Levene's test; therefore, it can be concluded that before the intervention the two groups were homogeneous in terms of variances for the research variables ($p > .05$). Another assumption of covariance analysis is the normality of data distribution. To examine this assumption, the Kolmogorov–Smirnov test was used. The results showed that death anxiety, hope, and loneliness met the normality assumption ($p > .05$). In addition, for the third assumption of covariance analysis, namely the equality of variance–covariance matrices, the results of Box's M test (Box's M = 0.25, p = .15) indicated that the variance–covariance matrices were equal. Furthermore, to determine the effect of self-healing training on death anxiety, hope, and loneliness, the assumption of homogeneity of regression slopes was examined. The results showed that the interaction between group condition and pretest was not significant (F = 2.68, p = .29), indicating support for the homogeneity of regression slopes assumption. Therefore, based on the findings, self-healing training increased hope and reduced death anxiety and loneliness in the experimental group.

Given the confirmation of the assumptions of covariance analysis, multivariate analysis of covariance was conducted. The results of this analysis are presented in Table 2.

Table 2

Results of Multivariate Analysis of Covariance on Posttest Means of the Research Variables Controlling for Pretest

Test	Value	F	Hypothesis df	Error df	Significance level	Statistical power
Pillai's Trace	0.35	7.34	3	41	.001	0.35
Wilks' Lambda	0.65	7.34	3	41	.001	0.35
Hotelling's Trace	0.53	7.34	3	41	.001	0.35
Roy's Largest Root	0.53	7.34	3	41	.001	0.35

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The results in Table 2 indicate that there is a significant difference between the experimental and control groups in the posttest outcomes of the dependent variables, controlling for pretest scores. Therefore, it can be concluded that significant differences were observed in the dependent variables of the study (death anxiety, hope, and loneliness) at the $p < .05$ level. Accordingly, the results indicate the effect of the experimental intervention on the groups. To analyze differences in the variables, analysis of covariance was used, the results of which are presented in Table 3.

Table 3

Results of Multivariate Analysis of Covariance

Source	Component	Sum of Squares	df	Mean Square	F	Significance level	Effect size
Pretest	Death anxiety	30.58	1	30.58	8.65	.005	0.16
	Hope	0.29	1	0.29	0.01	.92	0.001
	Loneliness	138.78	1	138.78	7.81	.008	0.14
Group	Death anxiety	604.27	1	604.27	171.09	.001	0.79
	Hope	1593.06	1	1593.06	54.48	.001	0.54
	Loneliness	4650.45	1	4650.45	261.70	.001	0.85
Error	Death anxiety	158.93	45	3.53			
	Hope	1315.86	45	29.24			
	Loneliness	799.65	45	17.77			

According to Table 3, the F values for the posttest of death anxiety ($F = 171.09$, $p < .05$), hope ($F = 54.48$, $p < .05$), and loneliness ($F = 261.70$, $p < .05$) and their significance levels, which are smaller than $p < .05$, indicate that the main hypothesis is confirmed. Older adults who received self-healing training (experimental group) showed significant differences in death anxiety, hope, and loneliness compared with older adults who did not receive this intervention (control group) ($p < .0001$). In other words, the intervention administered to the experimental group had a positive and statistically significant effect on the research variables.

4. Discussion

The present study aimed to examine the effectiveness of self-healing training on death anxiety, hope, and feelings of loneliness among elderly individuals residing in nursing homes. The findings demonstrated that, after controlling for pretest scores, the experimental group showed a significant reduction in death anxiety and loneliness and a significant increase in hope compared with the control group. These results indicate that self-healing training constitutes an effective psychological intervention for improving key existential and emotional outcomes in later life. The observed pattern of change is particularly noteworthy given the interrelated nature of death anxiety, loneliness, and hope in older adulthood and supports the conceptualization of self-healing as a multidimensional intervention that simultaneously targets cognitive, emotional, behavioral, and existential processes.

The significant reduction in death anxiety among participants who received self-healing training is consistent with prior empirical findings highlighting the malleability of death-related fears through structured psychological interventions. Previous studies have shown that death anxiety in the elderly is strongly influenced by psychological resources such as self-acceptance, meaning in life, emotional regulation, and perceived control (Alzaben et al., 2023; Kia et al., 2025). The self-healing protocol used in the present study emphasized awareness of maladaptive beliefs, processing of unresolved emotional experiences, forgiveness, and spiritual reflection, all of which are mechanisms known to mitigate existential fear. Similar reductions in death anxiety have been reported following interventions grounded in positive psychology, emotion-focused therapy, and cognitive-behavioral frameworks, suggesting that addressing internal psychological conflicts and enhancing adaptive meaning-making can effectively alleviate death-related distress (Arab & Mohammadi, 2023; Kafi et al., 2024; Zarei & Esmailzadeh, 2024).

The present findings are also in line with research demonstrating the effectiveness of self-healing-based interventions in reducing death anxiety in populations facing heightened mortality salience, such as patients with chronic illnesses. Zamani Gharaghoosh et al. reported significant reductions in death anxiety among breast cancer patients following self-healing training, attributing these effects to increased emotional awareness, stress regulation, and spiritual coping (Zamani Gharaghoosh et al., 2021). Although the participants in the current study were not

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diagnosed with life-threatening illnesses, advanced age and institutionalization may similarly intensify mortality awareness. The successful application of self-healing training in this context suggests that the intervention addresses core existential concerns that transcend diagnostic categories and are highly relevant in later life.

In addition to reducing death anxiety, self-healing training significantly decreased feelings of loneliness among the elderly participants. Loneliness is a pervasive problem in nursing home settings and has been consistently linked to psychological distress, reduced well-being, and increased death anxiety (Ergin et al., 2022; Guner et al., 2023). The reduction in loneliness observed in the experimental group may be explained by several components of the self-healing protocol, including group interaction, emotional expression, improved self-relationship, and enhanced sense of connectedness with others, nature, and transcendental values. These elements align with evidence indicating that loneliness in older adults is not solely a function of social isolation but is strongly influenced by subjective perceptions of meaning, belonging, and emotional fulfillment (Aghajani et al., 2025; Zhou, 2024).

The present results corroborate prior findings demonstrating that interventions which enhance internal psychological resources can indirectly reduce loneliness. For instance, studies have shown that increased psychological well-being and perceived social support mediate the relationship between loneliness and death anxiety in elderly populations (Hamidi et al., 2024). By strengthening emotional regulation, forgiveness, and self-compassion, self-healing training may reduce negative self-schemas and interpersonal withdrawal, thereby alleviating loneliness even in environments with limited social change. This interpretation is supported by evidence indicating that loneliness is exacerbated by maladaptive cognitive patterns and unresolved emotional conflicts rather than by objective social conditions alone (Hashemi et al., 2023; Xie & Liu, 2022).

A central contribution of the present study is the significant increase in hope observed among participants who received self-healing training. Hope has been identified as a crucial protective factor in older adulthood, associated with greater resilience, psychological well-being, and lower death anxiety (Budescu & Feldman, 2023; Shirmohammadi et al., 2023). The self-healing protocol explicitly targeted hope-enhancing processes, including goal clarification, positive future orientation, emotional acceptance, spiritual trust, and strengthening of personal agency. These components align with theoretical models that conceptualize hope as a dynamic cognitive–motivational system involving pathways thinking and agency thinking, both of which can be cultivated through structured psychological interventions.

The increase in hope observed in this study is consistent with findings from previous interventions emphasizing meaning, spirituality, and positive psychological resources in aging populations. Howell et al. reported that hope-based educational programs can enhance adaptive attitudes toward aging and foster a sense of purpose and engagement among older adults (Howell et al., 2024). Similarly, Shirmohammadi et al. demonstrated that higher levels of hope are associated with lower death anxiety in elderly women, particularly when psychological hardiness and emotional resilience are strengthened (Shirmohammadi et al., 2023). The present findings extend this literature by demonstrating that self-healing training can simultaneously increase hope while reducing existential distress and loneliness.

Importantly, the combined pattern of reduced death anxiety and loneliness alongside increased hope supports integrative models of psychological aging that emphasize the interplay between vulnerability and resilience factors. Rather than addressing symptoms in isolation, self-healing training appears to operate through a synergistic mechanism in which enhanced hope buffers existential fear, reduced loneliness diminishes emotional distress, and decreased death anxiety further reinforces adaptive engagement with life. This holistic effect is consistent with contemporary perspectives in gerontological psychology that advocate for interventions targeting multiple domains of functioning to promote healthy aging (Batı et al., 2024; Özer et al., 2025).

The findings of the present study also align with comparative research demonstrating that self-healing interventions can be as effective as established therapeutic approaches in improving psychological outcomes. Zarabi et al. found that self-healing therapy produced outcomes comparable to cognitive-behavioral therapy in enhancing distress tolerance, suggesting that self-healing may offer a flexible and culturally adaptable alternative for populations with diverse needs (Zarabi et al., 2021). Similarly, studies examining self-healing training in women with psychological distress have reported significant improvements in anxiety, self-esteem, and forgiveness, further supporting the robustness of this approach across populations (Heydari et al., 2022; Nasresfahani et al., 2022).

From a broader theoretical perspective, the effectiveness of self-healing training observed in this study may be

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understood within existential and positive psychology frameworks. By facilitating acceptance of mortality, fostering meaning-making, and strengthening inner resources, self-healing training helps older adults reframe aging-related challenges as opportunities for growth rather than decline. This reframing is particularly important in institutional settings, where loss of autonomy and social roles may otherwise reinforce feelings of helplessness and despair. The present findings thus contribute to a growing body of evidence supporting integrative, meaning-oriented interventions as essential components of mental health care for the elderly (Alzaben et al., 2023; Zhou, 2024).

5. Conclusion

Taken together, the results of this study provide strong empirical support for the use of self-healing training as an effective intervention for reducing death anxiety and loneliness and enhancing hope among elderly individuals. These findings not only replicate and extend previous research but also highlight the value of addressing existential concerns through holistic psychological approaches that integrate emotional, cognitive, social, and spiritual dimensions of well-being.

Regarding limitations, the present study has several constraints that should be acknowledged. First, the sample size was relatively small and limited to elderly individuals residing in a single nursing home, which may restrict the generalizability of the findings to other elderly populations, such as community-dwelling older adults or those from different cultural or socioeconomic backgrounds. Second, the quasi-experimental design, while methodologically appropriate, does not allow for full control over all potential confounding variables. Third, the reliance on self-report measures may have introduced response biases related to social desirability or cognitive limitations associated with advanced age. Finally, the absence of a follow-up assessment prevents conclusions regarding the long-term stability of the observed effects.

In terms of suggestions for future research, subsequent studies should employ larger and more diverse samples across multiple settings to enhance external validity. Longitudinal designs with follow-up assessments are recommended to evaluate the durability of intervention effects over time. Future research may also compare self-healing training with other evidence-based interventions to determine relative efficacy and identify specific mechanisms of change. Additionally, qualitative approaches could be used to explore elderly participants' subjective experiences of self-healing training, thereby enriching understanding of how and why the intervention is effective.

With respect to practical implications, the findings suggest that self-healing training can be incorporated into mental health and psychosocial programs in nursing homes and elderly care centers. Training mental health professionals and caregivers in self-healing principles may enhance the accessibility and sustainability of such interventions. Moreover, integrating self-healing practices into routine care may help promote emotional well-being, reduce existential distress, and support a more meaningful and hopeful experience of aging among older adults.

Authors' Contributions

H.R.A. designed the study, formulated the research objectives, and supervised the implementation of the self-healing training program. F.B.T. contributed to the research methodology, participant recruitment, data collection, and administration of the intervention sessions. M.M. conducted the statistical analyses, interpreted the findings, and contributed to the results and discussion sections. All authors collaborated in drafting and revising the manuscript, approved the final version for publication, and accept full responsibility for the scientific integrity of the study.

Declaration

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

Transparency Statement

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

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Declaration of Interest

The authors report no conflict of interest.

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Ethical 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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