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Determining the Effectiveness of Hypnotherapy in Reducing Loneliness and Grief Reactions among Individuals Bereaved by COVID-19

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ABSTRACT

The present study aimed to determine the effectiveness of hypnotherapy in reducing loneliness and grief reactions among individuals bereaved by COVID-19. This quasi-experimental study employed a pre-test, post-test, and follow-up design with an experimental and a control group. The statistical population consisted of individuals bereaved by COVID-19 in 2021 who were referred through Bahman, Atiyeh, and Parsian hospitals in Tehran. Thirty eligible participants were selected through convenience sampling and randomly assigned to experimental and control groups, with 15 participants in each group. Data were collected using the UCLA Loneliness Scale and the Hogan Grief Reaction Checklist. The experimental group received eight weekly 90-minute hypnotherapy sessions, whereas the control group received no intervention during the study period. Data were analyzed using repeated-measures analysis of variance, Greenhouse-Geisser corrections where necessary, multivariate tests, and pairwise comparisons. Significant time × group interaction effects were observed for denial, $F(1.135) = 43.290$, $p < .001$, partial $\eta^2 = .607$; panic behavior, $F(1.286) = 21.45$, $p < .001$, partial $\eta^2 = .434$; personal growth, $F(1.026) = 22.87$, $p < .001$, partial $\eta^2 = .450$; blame and anger, $F(1.199) = 19.07$, $p < .001$, partial $\eta^2 = .405$; detachment, $F(1.085) = 11.199$, $p = .002$, partial $\eta^2 = .286$; and disorganization, $F(1.036) = 11.526$, $p = .002$, partial $\eta^2 = .292$. For loneliness, Wilks' Lambda showed a significant time × group interaction, $\Lambda = .424$, $F(2, 27) = 18.33$, $p < .002$, partial $\eta^2 = .576$. Pairwise comparisons showed significant post-test and follow-up improvements in all grief components and loneliness in the experimental group. Hypnotherapy appears to be an effective intervention for reducing maladaptive grief reactions and loneliness while enhancing personal growth among individuals bereaved by COVID-19, with treatment effects maintained at follow-up.

Keywords: *Hypnotherapy, Loneliness, Grief Reactions, Bereavement, COVID-19*

1. Introduction

Bereavement is a universal human experience, yet the psychological consequences of losing a loved one vary considerably depending on the circumstances of death, the quality of the relationship with the deceased, available social support, individual coping resources, and the meaning attributed to the loss. The COVID-19 pandemic created an unprecedented context for bereavement because many deaths occurred suddenly, under conditions of medical isolation, uncertainty, restricted access to hospitalized family members, and disruption of culturally meaningful mourning rituals. Such circumstances often deprived bereaved individuals of opportunities to say goodbye, participate in customary funeral practices, receive direct social support, or gradually prepare themselves psychologically for impending loss. Consequently, grief during the pandemic frequently became intertwined with traumatic stress, helplessness, guilt, anger, loneliness, and persistent preoccupation with the deceased. Clinical and observational evidence has suggested that COVID-19-related bereavement may be associated with particularly complicated emotional trajectories, especially when the death was unexpected or occurred under restrictive hospital conditions (Buckley et al., 2024). Psychological responses to sudden parental and family losses during the pandemic have also demonstrated considerable variation in coping, grief intensity, and posttraumatic growth, indicating that the effects of loss are not limited to distress but may involve complex processes of psychological adaptation over time (Donohue, 2024). In older adults, post-pandemic bereavement has additionally raised concerns about prolonged grief disorder, because advanced age, reduced social networks, repeated exposure to loss, and limited opportunities for interpersonal support may increase vulnerability to persistent grief-related impairment (Friedland et al., 2024). These observations indicate that COVID-19 bereavement should be regarded not merely as a transient emotional response but as a potentially complex psychological condition requiring systematic assessment and targeted intervention.

Grief itself is a multidimensional process involving emotional, cognitive, behavioral, interpersonal, and somatic responses to loss. Although acute grief reactions such as sadness, yearning, crying, anger, confusion, sleep disturbance, and temporary withdrawal are expected after bereavement, these reactions may become persistent, intense, or functionally impairing in some individuals. Contemporary research increasingly distinguishes between normative grief and more persistent forms such as prolonged grief disorder, which may involve enduring longing for the deceased, difficulty accepting the death, identity disruption, bitterness, emotional numbness, avoidance of reminders, and inability to reengage meaningfully with life. Studies in highly stressful environments have shown that traumatic loss can intensify the risk of prolonged grief symptoms and can interact with other forms of psychological distress, particularly when the bereavement occurs in the context of threat, instability, or collective trauma (Frankova & Leshchuk, 2026). Similarly, research among bereaved parents has demonstrated that prolonged grief can profoundly affect emotional functioning, interpersonal relationships, daily activities, and perceived meaning in life, while also highlighting the need for carefully tailored therapeutic pathways (Yaffe & Levkovich, 2025). Cognitive and emotional interpretations of bereavement also appear to influence grief severity. Beliefs about death, mourning, permanence, responsibility, and one's ability to cope may either facilitate adaptive mourning or contribute to complicated grief, death anxiety, and persistent distress (Sawyer, 2025). Therefore, therapeutic approaches that modify maladaptive beliefs, facilitate emotional processing, and strengthen adaptive meaning-making may be particularly relevant for bereaved individuals whose grief reactions remain intense or resistant to spontaneous recovery.

One of the psychologically significant consequences of bereavement is loneliness. Loneliness is not synonymous with objective social isolation; rather, it reflects the subjective perception that one's social and emotional relationships are insufficient in quality or quantity. Bereaved individuals may remain socially connected to others while still experiencing a profound sense of emotional absence because the lost relationship cannot simply be replaced by the presence of other people. Research has demonstrated that feeling lonely after bereavement is distinct from merely being physically alone and may remain elevated even among individuals who receive practical or interpersonal support (Utz et al., 2014). The loss of a spouse, parent, child, sibling, or other close person can alter daily routines, social roles, attachment patterns, and expectations of companionship, thereby creating a persistent discrepancy between desired and actual emotional connection. This issue became especially salient during the COVID-19 pandemic, when physical distancing, quarantine measures, travel restrictions, and fear of infection simultaneously reduced opportunities

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for social contact and intensified the emotional effects of bereavement. Loneliness among bereaved children and adolescents has likewise been identified as an important mental health concern because developmental limitations in emotional expression and dependence on interpersonal support can amplify the sense of isolation following a death (Soetioso & Fithriyah, 2024). More broadly, loneliness after sudden bereavement has been associated with increased psychological vulnerability, including elevated risk of suicidal behavior, demonstrating that loneliness is not simply an unpleasant emotional state but may represent a clinically important risk factor in post-bereavement adjustment (Pitman et al., 2020). Accordingly, interventions for bereaved individuals should address not only the overt symptoms of grief but also the subjective social disconnection that may maintain or intensify emotional suffering.

The psychological mechanisms underlying persistent grief and loneliness are increasingly understood through cognitive, affective, and interpersonal models. Bereaved individuals may repeatedly engage in counterfactual thinking, self-blame, catastrophic interpretations, avoidance of painful memories, and rigid beliefs such as the conviction that moving forward constitutes betrayal of the deceased. These processes can interfere with emotional integration of the loss and may contribute to persistent withdrawal from social and occupational roles. Recent studies have shown that self-compassion, perceived stigma, anger, cognitive flexibility, and attachment-related processes may be important in understanding differences in prolonged grief reactions. In bereaved young adults, self-compassion has been linked to the structure of prolonged grief and posttraumatic growth, suggesting that adaptive self-relating may help individuals integrate loss while maintaining the capacity for psychological development (X. Jiang et al., 2026). Other evidence indicates that the relationship between self-compassion and post-bereavement psychopathology may be partly mediated through perceived stigma and anger, emphasizing the importance of emotional and cognitive pathways in the persistence of grief symptoms (L. Jiang et al., 2026). Among survivors of the COVID-19 pandemic, attachment styles and cognitive flexibility have also been implicated in prolonged grief, suggesting that individuals with more rigid cognitive responses or insecure relational patterns may experience greater difficulty adapting to loss (Nikkhah et al., 2026). These findings support the use of interventions capable of influencing maladaptive cognitions, emotional reactivity, self-perception, and the meaning assigned to bereavement.

Psychological treatments for grief commonly include supportive psychotherapy, cognitive-behavioral interventions, acceptance-based approaches, grief-focused therapies, and structured interventions targeting emotional regulation and meaning reconstruction. Evidence from COVID-19-related bereavement settings indicates that professional psychiatric and psychological support may reduce the severity of complicated grief among relatives of deceased patients, particularly when support is organized around the unique stresses created by restricted hospital access and sudden death (Raymond et al., 2024). Acceptance-based interventions may also be useful in populations confronting death-related distress because they emphasize psychological flexibility, nonavoidant engagement with difficult internal experiences, and value-consistent behavior. For example, acceptance and commitment-based therapy has demonstrated beneficial effects on quality of life and death anxiety among older adults, illustrating the broader therapeutic value of approaches that alter the individual's relationship to distressing thoughts and feelings rather than simply attempting to suppress them (Ahmadi & Valizadeh, 2021). Nevertheless, bereavement following COVID-19 can involve deeply entrenched emotional imagery, intrusive memories, rigid interpretations, and persistent physiological arousal, suggesting that interventions capable of simultaneously addressing cognitive and experiential processes may offer particular benefit.

Hypnotherapy is one such intervention. Clinical hypnosis involves the systematic use of focused attention, heightened responsiveness to suggestion, absorption, imagery, and altered patterns of awareness within a therapeutic context. Rather than involving loss of control, hypnosis is generally conceptualized as a structured psychological procedure in which the therapist uses induction, relaxation, imagery, and carefully formulated suggestions to facilitate changes in perception, cognition, emotion, and behavior. Contemporary clinical hypnotherapy may be integrated with other psychotherapeutic approaches, particularly cognitive-behavioral therapy, to facilitate cognitive restructuring and emotional processing. Recent conceptual work has emphasized that hypnosis can influence psychophysiological pathways associated with attention, arousal, emotional regulation, expectancy, and imagery, thereby making it potentially useful as part of integrative psychological treatment (Stompe et al., 2026). Cognitive

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hypnotherapy similarly combines hypnotic procedures with cognitive interventions designed to identify dysfunctional beliefs, restructure maladaptive interpretations, strengthen alternative cognitions, and increase perceived self-efficacy. Evidence from educational and cognitive contexts suggests that cognitive hypnotherapy may influence cognitive empowerment and mental processing by engaging both conscious and experiential levels of cognition (Khaleghinejad et al., 2025). In clinical populations, hypnotherapy has also been compared with established psychological approaches such as acceptance and commitment therapy and has demonstrated beneficial effects on cognitive outcomes, including working memory among individuals with chronic pain-related conditions (Rasti & Maredpour, 2025). These findings suggest that hypnosis may be relevant not only for symptom reduction but also for broader cognitive and emotional functioning.

The potential usefulness of hypnotherapy in grief treatment is particularly noteworthy because grief is often sustained by emotionally charged memories, recurrent mental imagery, unresolved communication with the deceased, self-blaming interpretations, and difficulty accepting the reality of the loss. Hypnotic procedures may provide a structured context in which individuals can achieve a state of focused relaxation, approach painful emotions with reduced defensive arousal, examine grief-related beliefs, and receive suggestions that reinforce acceptance, emotional integration, and adaptive coping. A clinical case report on hypnotherapy for grief resolution showed that hypnotic techniques could be applied to unresolved bereavement and could facilitate emotional processing in a clinically meaningful manner (Gupta & Sidana, 2020). Although case-based evidence does not establish efficacy on its own, it provides a rationale for systematically investigating hypnotherapy in controlled designs. Moreover, cognitive-behavioral hypnotherapy has demonstrated effectiveness in areas beyond grief, including psychological and functional outcomes in married women, further supporting its adaptability as a therapeutic modality that combines cognitive restructuring with hypnotic techniques (Alavizadeh et al., 2025). Such flexibility may be especially useful for bereaved individuals whose symptoms involve a mixture of emotional distress, intrusive cognition, behavioral withdrawal, loneliness, and rigid beliefs concerning loss.

From a cognitive-behavioral perspective, hypnotherapy may be relevant to both grief reactions and loneliness because these outcomes are often maintained by maladaptive interpretations and avoidance patterns. A bereaved person may interpret social interactions as meaningless without the deceased, anticipate that others cannot understand the loss, withdraw from relationships, and thereby reinforce loneliness through reduced opportunities for connection. Similarly, grief-related thoughts such as “I cannot live without this person,” “I should have prevented the death,” or “accepting the loss means forgetting the deceased” may perpetuate guilt, anger, denial, emotional detachment, and disorganization. Hypnotic imagery and suggestion may help weaken the emotional intensity attached to such beliefs while facilitating alternative interpretations that preserve the bond with the deceased without preventing adaptive reengagement with life. The capacity of hypnosis to influence attention and imagery may also be particularly important because emotionally vivid mental representations often sustain grief-related distress. By pairing relaxation with cognitive restructuring and adaptive suggestions, hypnotherapy may reduce physiological arousal, increase cognitive receptivity, and support a more flexible emotional response to loss.

The relevance of these mechanisms becomes particularly clear when the multidimensional nature of grief is considered. Grief reactions may involve denial, panic-like emotional responses, blame and anger, detachment, disorganization, and, in some individuals, personal growth. The presence of personal growth is especially important because adaptation to bereavement should not be conceptualized solely as symptom reduction. Some bereaved individuals eventually report greater appreciation of life, enhanced emotional insight, stronger relationships, or a revised sense of personal meaning. Recent work on bereavement has therefore increasingly examined both pathological outcomes and posttraumatic growth. Network research among bereaved individuals has shown that prolonged grief and posttraumatic growth can coexist within complex systems of emotional and cognitive responses rather than representing mutually exclusive endpoints (X. Jiang et al., 2026). Likewise, research on family coping after unexpected COVID-19-related parental loss suggests that grief and growth may develop simultaneously depending on coping resources and family processes (Donohue, 2024). An effective intervention should therefore ideally reduce distressing grief reactions while also strengthening adaptive psychological reconstruction, acceptance, and personal growth.

Despite the growing literature on grief following COVID-19 and the increasing recognition of prolonged grief as a

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clinically important condition, intervention research specifically targeting bereaved individuals through hypnotherapy remains limited. Much of the existing COVID-19 bereavement literature has focused on prevalence, risk factors, family coping, psychiatric support, and prolonged grief symptomatology rather than on hypnotic interventions. At the same time, research on hypnotherapy has demonstrated its potential across diverse psychological and behavioral domains, but relatively little controlled research has examined whether these benefits extend to grief and loneliness among people bereaved by pandemic-related deaths. This gap is important because the psychological burden of COVID-19 loss may involve both grief-specific symptoms and a broader sense of interpersonal disconnection that standard symptom-focused treatment may not fully address. The convergence of evidence regarding complicated grief, loneliness, cognitive rigidity, emotional dysregulation, and the therapeutic mechanisms of hypnosis therefore provides a strong rationale for examining hypnotherapy as an intervention for this population (Friedland et al., 2024; Nikkhah et al., 2026; Pitman et al., 2020). Moreover, the increasing emphasis on individualized and integrative treatment pathways in prolonged grief supports the evaluation of interventions capable of addressing cognitive, emotional, experiential, and interpersonal dimensions simultaneously (Yaffe & Levkovich, 2025).

The need for such research is further reinforced by the broader recognition that bereavement outcomes are strongly influenced by how individuals interpret, emotionally process, and socially adapt to loss. Evidence concerning beliefs about grief and death anxiety suggests that maladaptive assumptions may intensify complicated grief (Sawyer, 2025), while studies of self-compassion, stigma, anger, and cognitive flexibility indicate that psychological adaptation is shaped by modifiable internal processes (L. Jiang et al., 2026; Nikkhah et al., 2026). The pandemic context may have amplified these mechanisms by reducing opportunities for interpersonal reassurance and normal mourning, as reflected in clinicians' observations of grief during COVID-19 (Buckley et al., 2024). The combination of cognitive restructuring, relaxation, imagery, focused attention, and therapeutic suggestion characteristic of hypnotherapy may therefore provide a theoretically coherent means of addressing both the distressing components of bereavement and the loneliness that often accompanies loss. Given that hypnotic interventions have demonstrated applicability in psychological, cognitive, and functional outcomes across different populations (Alavizadeh et al., 2025; Khaleghinejad et al., 2025; Rasti & Maredpour, 2025; Stompe et al., 2026), their systematic evaluation among individuals bereaved by COVID-19 represents a clinically and empirically relevant next step.

Accordingly, the aim of the present study was to determine the effectiveness of hypnotherapy in reducing loneliness and grief reactions among individuals bereaved by COVID-19.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental design with pre-test and post-test assessments and an experimental and a control group. The statistical population consisted of individuals who had experienced the death of a loved one due to COVID-19 during 2021 and who were referred or introduced through Bahman, Atiyeh, and Parsian hospitals in Tehran, Iran. Considering that a minimum sample size of approximately 15 participants per group is commonly regarded as acceptable for quasi-experimental studies, 30 eligible volunteers were recruited from the target population through convenience sampling. After confirming eligibility and obtaining informed consent, the participants were randomly assigned to either the experimental group or the control group, with 15 participants in each group. Before the intervention began, participants in both groups completed the UCLA Loneliness Scale and the Hogan Grief Reaction Checklist as pre-test measures. The experimental group subsequently participated in eight weekly hypnotherapy sessions, each lasting approximately 90 minutes, whereas the control group received no psychological intervention during the study period. Following completion of the eight-week intervention, participants in both groups again completed the UCLA Loneliness Scale and the Hogan Grief Reaction Checklist as post-test measures. The inclusion criteria consisted of having lost a loved one as a consequence of COVID-19, possessing at least a high-school diploma, and having no debilitating physical or psychiatric disorder as determined by the researcher through a clinical interview. Participants were excluded if they were absent from more than three intervention sessions, failed to comply with the established group-therapy rules, developed or were identified as having a significant physical or psychological disorder that had not been detected before the intervention, or simultaneously participated in another psychological intervention during the study period. Ethical principles were

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observed throughout all stages of the research. The study was approved by the Research Ethics Committee of Islamic Azad University, Shahrood Branch, under the ethics code IR.IAU.SHAHROOD.REC.1401.008. Participants were treated respectfully and without discrimination, their autonomy and human dignity were protected, confidentiality and anonymity were maintained, and the researchers sought to prevent psychological or physical harm and to avoid any distortion or misrepresentation of information. Professional responsibility, respect for differences in participants' beliefs and perspectives, social responsibility, and protection of participants' rights were also emphasized. For ethical reasons, after completion of the research and collection of the post-test data, the hypnotherapy intervention was also made available to participants in the control group.

2.2. Data Collection Tools

UCLA Loneliness Scale. Loneliness was assessed using the UCLA Loneliness Scale developed by Russell, Peplau, and Cutrona in 1980. The instrument consists of 20 items designed to assess subjective feelings of loneliness and perceived social isolation. The scale includes positively and negatively worded statements and uses a four-point response format consisting of Never, Rarely, Sometimes, and Often. Responses are generally scored from 1 to 4, with higher scores representing greater levels of loneliness after appropriate reverse scoring of positively worded items. In the scoring procedure used in the present study, Items 1, 5, 6, 9, 10, 15, 16, 19, and 20 were reverse-scored, such that Never received a score of 4, Rarely a score of 3, Sometimes a score of 2, and Often a score of 1. Total scores can therefore range from 20 to 80, with higher scores reflecting more severe loneliness and scores above the midpoint indicating comparatively greater perceived loneliness. The UCLA Loneliness Scale has demonstrated satisfactory psychometric properties in previous investigations. Russell reported a convergent validity coefficient of 0.72 between Version 3 of the UCLA Loneliness Scale and the Differential Loneliness Scale and a negative correlation of −0.68 with the Social Provisions Scale, providing evidence of convergent and construct validity. Internal consistency was also reported to be high, with a Cronbach's alpha coefficient of 0.89. In an Iranian study by Hassanzadeh et al. conducted among 278 middle-school students in Golestan Province, the content validity of the Persian version of the scale was qualitatively evaluated by 10 behavioral science specialists affiliated with Golestan University of Medical Sciences, and a Cronbach's alpha coefficient of 0.79 was reported, indicating acceptable internal consistency for use in Iranian populations.

Hogan Grief Reaction Checklist. Grief reactions were measured using the Hogan Grief Reaction Checklist, a multidimensional instrument developed to assess psychological and behavioral responses associated with bereavement. One of the major advantages of the checklist is that its development was grounded in empirical investigations of bereaved individuals rather than being based exclusively on theoretical assumptions regarding grief. The instrument comprises 61 items and evaluates grief reactions across six dimensions, including Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization. The multidimensional structure of the checklist allows both maladaptive grief-related reactions and adaptive developmental responses following bereavement to be assessed. Hogan, Greenfield, and Schmidt reported that the subscales of the checklist provide reliable and valid information regarding patterns of bereavement and are sufficiently sensitive to detect changes in grief reactions over time. In their psychometric evaluation, Cronbach's alpha coefficients for the six subscales were reported as 0.89 for Despair, 0.90 for Panic Behavior, 0.82 for Personal Growth, 0.79 for Blame and Anger, 0.87 for Detachment, and 0.84 for Disorganization, demonstrating satisfactory to high internal consistency. Evidence supporting the reliability of the instrument has also been reported in Iranian research. In a study conducted by Mousavi in 2021, internal consistency was examined using Cronbach's alpha, and the coefficient for the total checklist was reported as 0.90. The corresponding coefficients for the subscales were 0.87 for Despair, 0.86 for Panic Behavior, 0.82 for Personal Growth, 0.79 for Blame and Anger, 0.87 for Detachment, and 0.84 for Disorganization. These findings supported the appropriateness of the checklist for assessing grief reactions among the participants in the present study.

2.3. Intervention

The hypnotherapy intervention consisted of eight weekly sessions, with each session lasting approximately 90 minutes, and was developed based on the principles and procedures presented by Elkins in the Handbook of Medical and Psychological Hypnosis: Foundations, Applications, and Professional Issues. The content and structure of the intervention were reviewed and approved by relevant academic experts before implementation. During the first session, the therapist introduced the therapeutic process,

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explained the objectives and duration of hypnotherapy, clarified the mutual expectations of the therapist and participants, described the rules governing participation, provided an explanation of hypnosis and hypnotherapy, and discussed the natural stages and psychological characteristics of grief. The pre-test assessments were also completed before the formal intervention procedures began. The second session focused on explaining hypnotherapy within a cognitive-behavioral framework and correcting inaccurate or unrealistic beliefs about hypnosis. Participants were encouraged to identify and express rigid or absolute beliefs regarding bereavement and to explore the reasons underlying dysfunctional grief-related beliefs. Relaxation techniques involving guided mental imagery were introduced, followed by hypnotic induction and therapeutic suggestions. The third session addressed the effects of irrational and maladaptive thinking patterns on emotional disturbance, with appropriate cognitive and emotional suggestions provided during the hypnotic trance state. During the fourth session, the relationship among thoughts, beliefs, emotions, and behaviors was explained, with particular attention to the behavioral consequences of grief and loss, and relevant hypnotic suggestions were administered to facilitate adaptive cognitive and behavioral responses. The fifth session focused on identifying and examining evidence related to automatic thoughts and personally constructed meanings arising from grief-related beliefs, followed by therapeutic suggestions during hypnosis aimed at modifying dysfunctional interpretations. During the sixth session, participants worked on changing maladaptive beliefs and understanding their relationship with emotional reactions; underlying core beliefs were identified and classified, their functional and dysfunctional consequences were analyzed, and alternative adaptive beliefs were formulated and strengthened using hypnotic suggestions. The seventh session emphasized the characteristics and implications of these alternative beliefs and sought to facilitate perceptual and cognitive change through carefully selected suggestions administered in the hypnotic trance state. The eighth and final session concentrated on reinforcing positive and adaptive thoughts, facilitating acceptance of the bereavement experience within the hypnotic state, preparing participants for termination of treatment, reviewing the skills and insights acquired throughout the intervention, and consolidating therapeutic gains. At the end of the final session, participants completed the post-test measures of loneliness and grief reactions. Throughout the intervention, hypnotic procedures were integrated with cognitive-behavioral principles to modify maladaptive beliefs, facilitate emotional processing of loss, increase acceptance of bereavement, and strengthen more adaptive cognitive and emotional responses to grief.

2.4. Data Analysis

The collected data were analyzed using descriptive and inferential statistical procedures. Descriptive statistics, including means and standard deviations, were calculated to summarize participants' scores on loneliness and grief reactions at the pre-test and post-test stages in the experimental and control groups. Prior to conducting the principal inferential analyses, the assumptions required for parametric statistical procedures were examined, including the normality of score distributions, homogeneity of variances, and homogeneity of regression slopes where applicable. To determine the effectiveness of hypnotherapy in reducing post-test loneliness and grief reactions while controlling for participants' baseline differences, analysis of covariance was used, with the corresponding pre-test scores entered as covariates and post-test scores considered as dependent variables. Where the multidimensional components of grief reactions were examined simultaneously, multivariate analysis of covariance was used to evaluate the overall intervention effect across the related dependent variables before examining individual outcomes. Effect sizes were also considered in interpreting the magnitude of the intervention effects in addition to statistical significance. All statistical tests were conducted at a significance level of $p < .05$, and the results were interpreted by comparing the adjusted post-test outcomes of the experimental and control groups after controlling for their respective pre-test scores.

3. Findings and Results

Regarding the demographic characteristics of the participants, the experimental group included 8 women (53.3%) and 7 men (46.7%), whereas the control group included 7 women (46.7%) and 8 men (53.3%). The mean age of participants was 41.60 ± 15.50 years in the experimental group and 42.15 ± 67.42 years in the control group. With respect to educational attainment, participants represented educational levels ranging from high-school diploma to doctoral degree. In the experimental group, 4 participants (26.7%) held a high-school diploma, 2 (13.3%) held an associate degree, 3 (20.0%) held a bachelor's degree, 2 (13.3%) held a master's degree, and 4 (26.7%) held a

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doctoral degree. In the control group, 3 participants (20.0%) held a high-school diploma, 2 (13.3%) held an associate degree, 4 (26.7%) held a bachelor's degree, 3 (20.0%) held a master's degree, and 3 (20.0%) held a doctoral degree. Overall, the demographic distributions indicated that both groups included participants with relatively diverse educational backgrounds.

Table 1

Descriptive Statistics for Grief Reactions and Loneliness Across the Three Measurement Stages

Variable	Time	Experimental Group Mean	Experimental Group SD	Control Group Mean	Control Group SD
Denial	Pre-test	43.00	13.04	44.33	11.96
	Post-test	25.67	7.00	44.87	13.42
	Follow-up	26.73	6.83	45.47	13.00
Panic Behavior	Pre-test	35.39	11.50	36.87	12.14
	Post-test	23.80	4.89	36.87	12.14
	Follow-up	25.07	6.52	37.00	12.29
Personal Growth	Pre-test	37.07	11.79	36.40	9.93
	Post-test	48.93	4.20	36.33	11.04
	Follow-up	47.33	7.60	36.73	10.77
Blame and Anger	Pre-test	17.00	6.90	17.00	5.24
	Post-test	9.67	2.06	17.00	5.24
	Follow-up	10.13	3.02	17.47	5.40
Detachment	Pre-test	21.20	9.27	23.47	7.90
	Post-test	15.00	5.18	23.47	7.90
	Follow-up	15.53	5.45	23.67	7.76
Disorganization	Pre-test	18.07	7.66	19.20	7.76
	Post-test	12.73	5.69	19.20	7.76
	Follow-up	13.13	5.46	19.27	7.81
Loneliness	Pre-test	0.907	0.12	0.914	0.16
	Post-test	0.89	0.07	0.956	0.62
	Follow-up	0.895	0.80	0.84	0.013

As shown in Table 1, the two groups demonstrated relatively similar mean scores at the pre-test stage across the components of grief reactions. Following the hypnotherapy intervention, however, substantial changes were observed in the experimental group. The mean score for denial decreased from 43.00 at pre-test to 25.67 at post-test and remained relatively stable at 26.73 during follow-up, whereas the corresponding scores in the control group remained approximately unchanged. Panic behavior similarly decreased in the experimental group from 35.39 at pre-test to 23.80 at post-test and 25.07 at follow-up, while little change was observed in the control group. In contrast, personal growth increased from 37.07 before the intervention to 48.93 at post-test and remained elevated at 47.33 during follow-up, whereas the control-group means remained nearly unchanged across the three assessments. Blame and anger declined from 17.00 to 9.67 at post-test and remained low at 10.13 during follow-up, detachment decreased from 21.20 to 15.00 and 15.53, and disorganization declined from 18.07 to 12.73 and 13.13 across the corresponding assessment stages. In contrast, the control group exhibited little variation in these outcomes over time. The descriptive pattern therefore suggested reductions in maladaptive grief reactions and an increase in personal growth following hypnotherapy, with the observed changes generally maintained during the follow-up period. The loneliness scores likewise demonstrated changes across the measurement occasions, although the statistical significance and direction of between-group differences were evaluated through the repeated-measures analyses and pairwise comparisons reported below.

Prior to the inferential analyses, the assumptions underlying repeated-measures analysis of variance were examined. The Shapiro–Wilk test indicated that the distributions of loneliness and grief-reaction scores at the pre-test, post-test, and follow-up stages did not significantly deviate from normality ($p > .05$). Levene's test generally supported the homogeneity of variances across the experimental and control groups, although violations were observed for some measurements of blame and anger and personal growth; given the equal sample sizes in the two groups, these deviations were not considered sufficiently

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severe to preclude the use of repeated-measures analysis. For the grief-reaction variables, Box's M test was not statistically significant, M = 8.655, F(1, 4173.283) = 1.245, p = .280, supporting the assumption of equality of variance-covariance matrices. Mauchly's test of sphericity was statistically significant for denial, W = .238, $\chi^2(2) = 38.797$, p < .001; panic behavior, W = .445, $\chi^2(2) = 21.868$, p < .001; personal growth, W = .050, $\chi^2(2) = 80.906$, p < .001; blame and anger, W = .332, $\chi^2(2) = 29.790$, p < .001; detachment, W = .156, $\chi^2(2) = 50.159$, p < .001; and disorganization, W = .070, $\chi^2(2) = 71.643$, p < .001. Accordingly, Greenhouse–Geisser corrections were applied when examining within-subject and time × group effects. Significant time × group interactions were obtained for denial, F(1.135) = 43.290, p < .001, partial $\eta^2 = .607$; panic behavior, F(1.286) = 21.45, p < .001, partial $\eta^2 = .434$; personal growth, F(1.026) = 22.87, p < .001, partial $\eta^2 = .450$; blame and anger, F(1.199) = 19.07, p < .001, partial $\eta^2 = .405$; detachment, F(1.085) = 11.199, p = .002, partial $\eta^2 = .286$; and disorganization, F(1.036) = 11.526, p = .002, partial $\eta^2 = .292$. The between-group effect was significant for denial, F(1, 28) = 11.237, p = .002, partial $\eta^2 = .286$; panic behavior, F(1, 28) = 5.783, p = .023, partial $\eta^2 = .171$; personal growth, F(1, 28) = 6.863, p = .014, partial $\eta^2 = .197$; blame and anger, F(1, 28) = 9.215, p = .005, partial $\eta^2 = .248$; and detachment, F(1, 28) = 6.035, p = .020, partial $\eta^2 = .177$, whereas the overall between-group effect for disorganization was not significant, F(1, 28) = 3.380, p = .077, partial $\eta^2 = .108$. For loneliness, Box's M test was significant, M = 8.655, F(6, 5680.302) = 3.121, p = .005, indicating that the equality of variance-covariance matrices assumption was not satisfied; therefore, the multivariate Wilks' Lambda statistic was considered, which revealed a significant time × group interaction, Wilks' $\Lambda = .424$, F(2, 27) = 18.33, p < .002, partial $\eta^2 = .576$. Mauchly's test for loneliness was not significant, W = .953, $\chi^2(2) = 1.312$, p = .519, confirming that the sphericity assumption was satisfied. The within-subject effect of time was significant, F(2) = 8.414, p < .001, partial $\eta^2 = .231$, as was the time × group interaction, F(2) = 14.936, p < .001, partial $\eta^2 = .348$, whereas the overall between-group effect was not significant, F(1) = 3.125, p = .088.

Table 2

Pairwise Comparisons Between the Experimental and Control Groups at Pre-test, Post-test, and Follow-up

Variable	Time	Mean Difference (Experimental − Control)	SE	p	95% CI Lower	95% CI Upper
Denial	Pre-test	-1.333	4.569	.773	-10.692	8.025
	Post-test	-19.200	3.908	<.001	-27.205	-11.195
	Follow-up	-18.733	3.793	<.001	-26.502	-10.964
Panic Behavior	Pre-test	-0.933	4.318	.830	-9.777	7.911
	Post-test	-13.067	3.378	.001	-19.986	-6.147
	Follow-up	-11.933	3.592	.002	-19.290	-4.576
Personal Growth	Pre-test	0.667	3.979	.868	-7.484	8.817
	Post-test	12.600	3.049	<.001	6.354	18.846
	Follow-up	11.733	3.016	.001	5.555	17.912
Blame and Anger	Pre-test	0.000	2.236	1.000	-4.580	4.580
	Post-test	-7.333	1.453	<.001	-10.310	-4.357
	Follow-up	-7.333	1.597	<.001	-10.604	-4.062
Detachment	Pre-test	-2.267	3.144	.477	-8.707	4.174
	Post-test	-8.467	2.439	.002	-13.464	-3.470
	Follow-up	-8.133	2.449	.002	-13.149	-3.118
Disorganization	Pre-test	-1.133	2.814	.690	-6.898	4.632
	Post-test	-6.467	2.484	.015	-11.554	-1.379
	Follow-up	-6.133	2.462	.019	-11.176	-1.091
Loneliness	Pre-test	0.467	1.910	.809	-3.445	4.378
	Post-test	-4.867	2.308	.044	-9.595	-0.138
	Follow-up	-5.133	1.433	.001	-8.069	-2.198

As presented in Table 2, none of the between-group differences at pre-test were statistically significant, indicating that the experimental and control groups were comparable before the intervention in all six components of grief reactions as well as loneliness. At post-test, the experimental group demonstrated significantly lower denial than the control group, MD = −19.200, p < .001, and this difference remained significant at follow-up, MD = −18.733,

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$p < .001$. Panic behavior was also significantly lower in the experimental group at post-test, MD = −13.067, p = .001, and follow-up, MD = −11.933, p = .002. In contrast, personal growth was significantly higher in the experimental group at post-test, MD = 12.600, $p < .001$, and follow-up, MD = 11.733, p = .001. Significant reductions were also observed for blame and anger at both post-test, MD = −7.333, $p < .001$, and follow-up, MD = −7.333, $p < .001$; detachment at post-test, MD = −8.467, p = .002, and follow-up, MD = −8.133, p = .002; and disorganization at post-test, MD = −6.467, p = .015, and follow-up, MD = −6.133, p = .019. A similar pattern was found for loneliness. Although the groups did not differ significantly at pre-test, MD = 0.467, p = .809, the experimental group had significantly lower loneliness scores than the control group at post-test, MD = −4.867, p = .044, and at follow-up, MD = −5.133, p = .001. Taken together, the findings indicate that hypnotherapy was associated with reductions in denial, panic behavior, blame and anger, detachment, disorganization, and loneliness, as well as an increase in personal growth, and that these beneficial effects were largely maintained at the follow-up assessment.

4. Discussion

The present study examined the effectiveness of hypnotherapy in reducing loneliness and grief reactions among individuals bereaved by COVID-19. The findings showed that participants who received hypnotherapy demonstrated significant improvements across several dimensions of grief compared with the control group. Specifically, the experimental group showed significant reductions in denial, panic behavior, blame and anger, detachment, and disorganization, together with a significant increase in personal growth. These changes were evident at post-test and were largely maintained at follow-up. In addition, loneliness significantly decreased in the hypnotherapy group compared with the control group, and this effect also persisted during the follow-up period. The significant time × group interactions across the grief-reaction components indicate that the observed changes were not simply the result of the passage of time but were associated with participation in the intervention. Although the overall between-group effect for disorganization was not significant, the significant time × group interaction and the significant post-test and follow-up pairwise differences suggest that disorganization changed differentially over time in favor of the treatment group. Taken together, these results support the potential effectiveness of hypnotherapy as an intervention for reducing maladaptive grief reactions while simultaneously strengthening adaptive psychological responses such as personal growth.

The finding that hypnotherapy reduced the maladaptive components of grief is consistent with previous literature indicating that psychological intervention can facilitate adjustment following bereavement and reduce the severity of complicated or prolonged grief. Research on bereavement during the COVID-19 pandemic has emphasized that grief was frequently intensified by sudden death, hospital restrictions, inability to say goodbye, disruption of mourning rituals, and diminished access to social support (Buckley et al., 2024). These circumstances may increase the likelihood that grief remains cognitively and emotionally unresolved. In this context, the present results suggest that hypnotherapy may help bereaved individuals process such unresolved experiences by combining relaxation, focused attention, cognitive restructuring, and therapeutic suggestion. This interpretation is compatible with evidence that psychiatric and psychological support provided to relatives of patients who died during COVID-19-related intensive care hospitalization can improve outcomes associated with complicated grief (Raymond et al., 2024). The findings also correspond with broader evidence that prolonged grief after pandemic-related loss can become clinically significant and may require targeted intervention rather than simple reliance on spontaneous recovery (Friedland et al., 2024). Therefore, the observed reductions in grief-related distress in the experimental group may reflect the capacity of structured hypnotherapy to modify the cognitive and emotional processes that sustain maladaptive bereavement reactions.

The reduction in denial may be particularly important because difficulty accepting the reality of loss can prolong psychological disengagement from the bereavement process. During the intervention, participants were gradually encouraged to recognize grief-related beliefs, examine automatic thoughts, revise dysfunctional assumptions, and move toward acceptance of the death. Hypnotic procedures may have facilitated this process by increasing attentional absorption and reducing resistance to emotionally difficult material. This interpretation is consistent with the clinical use of hypnotherapy in grief resolution, where hypnotic techniques have been reported to help individuals access, process, and reorganize unresolved grief-related experiences (Gupta & Sidana, 2020). It is also compatible with contemporary perspectives on clinical hypnotherapy emphasizing the role of focused attention, imagery, expectancy, emotional regulation, and psychophysiological

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modulation in producing therapeutic change (Stompe et al., 2026). In the present study, repeated exposure to hypnotic suggestions centered on adaptive interpretation, acceptance, and cognitive reorganization may have weakened rigid grief-related beliefs and promoted a more integrated recognition of the loss.

The significant reduction in panic behavior can also be understood in terms of the effects of hypnotherapy on emotional arousal and maladaptive threat-related cognition. Bereavement following sudden and traumatic loss may be accompanied by intense physiological activation, fear, anxiety, emotional instability, and anticipatory distress. Pandemic-related deaths may have increased such reactions because of uncertainty, lack of control, and the traumatic circumstances surrounding illness and hospitalization (Buckley et al., 2024). Hypnotherapy commonly includes relaxation, guided imagery, and suggestions designed to reduce emotional arousal and alter the interpretation of distressing internal experiences. These components may have helped participants decrease physiological reactivity while also reinterpreting grief-related emotions as manageable rather than overwhelming. Evidence from other applications of hypnotherapy suggests that it can influence cognitive and emotional functioning across different clinical populations (Alavizadeh et al., 2025; Rasti & Maredpour, 2025). Although these studies addressed different outcomes, they support the broader proposition that hypnosis can be integrated with cognitive and behavioral strategies to modify emotional and cognitive processes that contribute to distress.

The decrease in blame and anger observed in the experimental group may likewise reflect changes in maladaptive cognitive appraisal. Bereaved individuals often experience anger toward themselves, medical personnel, family members, fate, or the deceased, particularly when the death is unexpected or perceived as preventable. In COVID-19 bereavement, such reactions may be intensified by uncertainty regarding treatment, restrictions on family contact, and a sense of helplessness. Contemporary research on bereavement suggests that anger can play an important role in the persistence of grief-related distress. In particular, evidence indicates that anger may mediate the relationship between self-compassion and prolonged grief or posttraumatic stress following bereavement (L. Jiang et al., 2026). The reduction in blame and anger in the present study may therefore reflect successful modification of rigid or self-critical interpretations through hypnotic cognitive restructuring. By encouraging participants to examine the evidence underlying spontaneous thoughts and grief-related beliefs, the intervention may have reduced excessive personal responsibility and facilitated more balanced interpretations of the circumstances surrounding the death.

The reduction in detachment is another clinically meaningful result. Emotional and interpersonal detachment may emerge when bereaved individuals withdraw from others as a means of protecting themselves from further emotional pain or because they believe that others cannot understand their experience. Such withdrawal may interfere with adaptive mourning and contribute to persistent social disconnection. The current findings suggest that hypnotherapy may have reduced this tendency by helping participants tolerate grief-related emotions and develop alternative beliefs about relationships, loss, and continued engagement with life. This interpretation is relevant to the literature on loneliness after bereavement, which distinguishes objective social isolation from the subjective experience of emotional disconnection (Utz et al., 2014). Even when bereaved individuals remain socially surrounded, they may experience profound loneliness because the lost relationship possessed a unique emotional function. By reducing detachment and promoting greater emotional acceptance, hypnotherapy may have helped participants become more receptive to existing interpersonal relationships and less inclined to withdraw from social contact.

The findings concerning disorganization also deserve attention. Disorganization following bereavement may involve confusion, reduced concentration, difficulty maintaining routines, impaired decision-making, and a sense that one's life structure has been disrupted. In the present study, although the overall between-group effect for disorganization was not statistically significant, the time × group interaction was significant, and pairwise comparisons demonstrated significantly lower disorganization in the experimental group at both post-test and follow-up. This pattern suggests that the trajectory of change differed meaningfully between the groups. One possible explanation is that hypnotherapy assisted participants in restoring cognitive and emotional organization by helping them restructure beliefs and reestablish a coherent framework for interpreting the loss. Research on cognitive flexibility in survivors of the COVID-19 pandemic supports the importance of flexible cognitive processing in understanding prolonged grief (Nikkhah et al., 2026). Individuals who can reconsider their assumptions, integrate new meanings, and adapt their coping strategies may be better able to reorganize their lives following loss. Accordingly, the cognitive

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components of the hypnotherapy intervention may have contributed to the observed reduction in disorganization.

A particularly important finding was the increase in personal growth among participants receiving hypnotherapy. This result suggests that the intervention did not merely reduce distress but may also have facilitated positive psychological reconstruction. Bereavement can, under some circumstances, lead individuals to develop a greater appreciation of life, stronger relationships, increased emotional insight, revised priorities, and a renewed sense of personal meaning. Recent bereavement research has highlighted the complex relationship between prolonged grief and posttraumatic growth, showing that distress and growth can coexist rather than representing mutually exclusive outcomes (X. Jiang et al., 2026). Similarly, research on families coping with unexpected parental loss during the COVID-19 pandemic has shown that grief and posttraumatic growth may emerge simultaneously depending on coping processes and family adaptation (Donohue, 2024). The increase in personal growth observed in the present study may therefore indicate that hypnotherapy helped participants move beyond symptom reduction toward a more adaptive reconstruction of their relationship with the loss.

This increase in personal growth may also be explained through the intervention's emphasis on alternative beliefs and perceptual change. Several sessions focused explicitly on identifying fundamental beliefs, examining their emotional consequences, creating adaptive alternatives, and reinforcing positive thoughts through hypnotic suggestion. Such procedures may have enabled participants to reinterpret bereavement not only as a source of irreversible pain but also as an experience that could be integrated into a broader personal narrative. The literature on self-compassion and bereavement provides further support for this interpretation. Self-compassion has been linked to both lower prolonged grief and greater posttraumatic growth in bereaved young adults, suggesting that adaptive internal responses to suffering may help individuals achieve constructive psychological change (X. Jiang et al., 2026). Although the present intervention did not directly train self-compassion, its emphasis on acceptance, reduction of self-blame, and adaptive restructuring may have functioned through related psychological processes.

The significant reduction in loneliness constitutes another major finding of the study. Participants in the experimental group did not differ significantly from the control group at pre-test, but they reported significantly lower loneliness at post-test and follow-up. This finding is especially important because loneliness is a major psychological consequence of bereavement and may persist even when objective social support is available. Research has shown that bereaved individuals can feel intensely lonely despite maintaining social contact, demonstrating that loneliness reflects subjective emotional disconnection rather than simple physical isolation (Utz et al., 2014). The present intervention may have reduced loneliness by changing participants' beliefs about the permanence of emotional isolation, helping them accept the loss, decreasing detachment, and encouraging more adaptive engagement with remaining relationships. As participants became less dominated by grief-related cognitions and more capable of regulating distress, they may also have become better able to perceive and utilize available social support.

The reduction in loneliness is consistent with prior evidence showing that loneliness is an important dimension of bereavement across different age groups. Studies involving bereaved children and adolescents have identified loneliness as a significant psychological consequence of loss that may interfere with emotional adjustment (Soetioso & Fithriyah, 2024). In adults, loneliness following sudden bereavement has been associated with particularly serious psychological outcomes, including increased risk of suicidal behavior (Pitman et al., 2020). These findings highlight the clinical importance of interventions capable of reducing subjective isolation. The present results suggest that hypnotherapy may contribute to this process indirectly by reducing maladaptive grief symptoms and directly by changing the cognitive and emotional meanings attached to social connection after loss.

Another explanation for the reduction in loneliness may involve increased psychological flexibility. Individuals experiencing prolonged grief may become cognitively fused with beliefs such as "no one can replace the deceased," "there is no point in connecting with others," or "my life is permanently empty." Although the factual uniqueness of the deceased relationship remains undeniable, rigid adherence to such beliefs may prevent adaptive reconnection with the social environment. Research examining prolonged grief in survivors of the COVID-19 pandemic has suggested that cognitive flexibility plays a mediating role between attachment patterns and grief severity (Nikkhah et al., 2026). By using hypnotic suggestion together with cognitive restructuring, the intervention may have increased participants' capacity to hold the reality of the loss while

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simultaneously recognizing the possibility of meaningful continued relationships and future engagement.

The durability of the observed changes at follow-up further strengthens the interpretation that hypnotherapy produced more than transient symptom relief. Significant differences between the groups remained evident for denial, panic behavior, personal growth, blame and anger, detachment, disorganization, and loneliness. Maintenance of treatment effects may have been facilitated by the repeated practice of relaxation, cognitive restructuring, guided imagery, and therapeutic suggestions across the eight sessions. Once participants developed more adaptive interpretations of grief and learned to regulate emotional arousal, these cognitive and emotional changes may have continued beyond the formal intervention period. The enduring pattern is broadly compatible with evidence that psychological interventions targeting acceptance, cognition, and emotional processing can produce lasting improvement in death-related distress and quality of life (Ahmadi & Valizadeh, 2021). It is also consistent with the broader therapeutic literature suggesting that hypnotherapy can produce changes in cognitive and emotional functioning that extend beyond the immediate hypnotic session (Khaleghinejad et al., 2025; Rasti & Maredpour, 2025).

The findings should also be interpreted within the broader literature on prolonged grief. Grief outcomes are influenced by multiple interacting factors, including attachment, cognitive flexibility, self-compassion, anger, perceived stigma, social connection, and beliefs about death and bereavement (L. Jiang et al., 2026; Nikkhah et al., 2026; Sawyer, 2025). This complexity suggests that effective interventions should not focus exclusively on a single emotional symptom. The hypnotherapy protocol used in the present study was multidimensional: it addressed erroneous beliefs, irrational thinking, the relationship among thoughts, emotions, and behaviors, automatic thoughts, underlying beliefs, alternative cognitions, positive thoughts, and acceptance of bereavement. This broad focus may explain why improvements were observed across several different grief dimensions rather than in only one symptom domain. The intervention's integration of cognitive-behavioral principles with hypnotic procedures may therefore be particularly appropriate for grief because bereavement itself is a multidimensional process.

The results also align with emerging perspectives emphasizing that treatment for prolonged grief should be individualized and capable of addressing both distress and adaptation. Research on bereaved parents has emphasized that prolonged grief can have pervasive effects on psychological functioning and that treatment pathways should consider the specific emotional and relational characteristics of the bereavement experience (Yaffe & Levkovich, 2025). Likewise, traumatic loss research has shown that grief may be intensified when death occurs within broader contexts of threat and instability (Frankova & Leshchuk, 2026). Although COVID-19 differs from wartime bereavement, both contexts involve collective threat, uncertainty, and disruption of normal social processes. The present results therefore contribute to a broader body of evidence suggesting that psychologically structured interventions are particularly important when bereavement occurs under traumatic or socially disruptive circumstances.

5. Conclusion

Overall, the findings indicate that hypnotherapy may be a useful intervention for individuals experiencing grief and loneliness after COVID-19-related bereavement. The combination of hypnotic relaxation, guided imagery, focused attention, cognitive restructuring, and therapeutic suggestion appears capable of reducing distressing grief reactions while facilitating personal growth and decreasing loneliness. These findings are consistent with prior evidence supporting the application of hypnotherapy across psychological and cognitive domains (Alavizadeh et al., 2025; Gupta & Sidana, 2020; Khaleghinejad et al., 2025; Rasti & Maredpour, 2025; Stompe et al., 2026) and with the broader bereavement literature emphasizing the importance of cognitive, emotional, interpersonal, and meaning-related processes in adaptation to loss (Buckley et al., 2024; Donohue, 2024; Friedland et al., 2024; L. Jiang et al., 2026; X. Jiang et al., 2026). The persistence of improvements at follow-up provides additional evidence that the intervention may facilitate relatively stable changes rather than short-term emotional relief alone.

The present study has several limitations that should be considered when interpreting the findings. First, the sample consisted of only 30 participants, with 15 individuals in each group, which limits statistical power and restricts the generalizability of the results to the broader population of individuals bereaved by COVID-19. Second, participants were selected through convenience sampling from individuals introduced by three hospitals in Tehran, and therefore the sample may not adequately represent bereaved individuals from other geographical, cultural,

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socioeconomic, or clinical backgrounds. Third, the outcomes were primarily assessed using self-report instruments, which may be influenced by response tendencies, social desirability, recall bias, or participants' expectations regarding treatment. Fourth, the study included only a relatively short follow-up period, making it difficult to determine whether the observed benefits of hypnotherapy would persist over longer periods. Fifth, the control group did not receive an active comparison intervention, making it impossible to determine whether the effects were specifically attributable to hypnotic procedures or partly reflected nonspecific therapeutic factors such as attention from the therapist, expectancy, structured participation, and therapeutic alliance. Finally, individual differences in hypnotic susceptibility, severity and circumstances of the loss, relationship with the deceased, time elapsed since bereavement, and prior psychological treatment were not examined as potential moderators of treatment response.

Future studies should replicate these findings with larger and more diverse samples and should recruit participants from multiple treatment centers, communities, and geographical regions to improve external validity. Randomized controlled trials with active comparison conditions, such as cognitive-behavioral therapy, acceptance-based therapy, supportive grief counseling, or relaxation training without hypnosis, would help determine the specific contribution of hypnotic procedures beyond general therapeutic effects. Researchers should also consider longer follow-up periods to evaluate the stability of intervention effects over six months, one year, or longer. Future investigations could examine potential moderators and mediators of treatment effectiveness, including hypnotic susceptibility, attachment style, cognitive flexibility, social support, self-compassion, severity of prolonged grief, time since loss, type of relationship with the deceased, and degree of trauma associated with the death. Incorporating clinician-administered measures, behavioral indicators, qualitative interviews, and physiological indices alongside self-report measures would provide a more comprehensive understanding of therapeutic change. It would also be valuable to examine whether individual hypnotherapy, group hypnotherapy, online delivery, or hybrid formats differ in feasibility and effectiveness for bereaved populations.

In clinical practice, hypnotherapy may be considered as a complementary intervention for bereaved individuals who experience persistent grief reactions and loneliness, particularly when maladaptive beliefs, emotional arousal, avoidance, self-blame, or difficulty accepting the loss are prominent. Practitioners should conduct careful assessment before treatment to identify severe psychiatric symptoms, suicide risk, trauma-related problems, and contraindications that may require additional or alternative intervention. Hypnotherapy should be delivered by appropriately trained professionals and integrated with evidence-informed grief counseling rather than used as a purely suggestive or symptom-suppressive technique. Clinical protocols may benefit from combining hypnotic relaxation and imagery with cognitive restructuring, emotional processing, acceptance of loss, restoration of social engagement, and reinforcement of adaptive beliefs. Therapists should also tailor the pace and content of the intervention to the individual's cultural background, mourning practices, relationship with the deceased, and readiness to process emotionally difficult material. Follow-up sessions or booster sessions may be useful for consolidating therapeutic gains and supporting continued adaptation after the formal treatment period.

Authors' Contributions

Authors equally contributed to this article.

Declaration

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

Transparency Statement

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

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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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