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Comparison of the Effectiveness of Compassion-Focused Therapy and Existential Therapy on Death Anxiety and Illness Acceptance in Patients with Cancer in Remission

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A B S T R A C T

Purpose: This study aimed to compare the effectiveness of Compassion-Focused Therapy and Existential Therapy in reducing death anxiety and increasing illness acceptance among patients with cancer in remission.

Methods and Materials: This applied study used a quasi-experimental pretest-posttest-follow-up design with a control group. The statistical population consisted of patients with common cancers in remission who referred to hospitals in Tehran during 2025–2026. Using purposive sampling, 45 eligible participants were selected and randomly assigned to Compassion-Focused Therapy, Existential Therapy, and control groups, with 15 participants in each group. Both intervention groups received eight 90-minute weekly sessions, while the control group received no psychological intervention. Data were collected using the Templer Death Anxiety Scale and the Acceptance of Illness Scale. The data were analyzed in SPSS version 26 using repeated-measures analysis of variance and Bonferroni-adjusted post hoc comparisons at a significance level of 0.05.

Findings: Repeated-measures analysis of variance showed significant effects of time, group, and time-by-group interaction for death anxiety and illness acceptance ($p < 0.001$). Bonferroni comparisons indicated that both Compassion-Focused Therapy and Existential Therapy significantly reduced death anxiety and increased illness acceptance compared with the control group ($p < 0.001$). Compassion-Focused Therapy produced a significantly greater reduction in death anxiety than Existential Therapy (MD = 1.79, SE = 0.41, $p < 0.001$), whereas Existential Therapy produced a significantly greater increase in illness acceptance than Compassion-Focused Therapy (MD = 2.30, SE = 0.46, $p < 0.001$). The improvements were maintained at follow-up.

Conclusion: Both Compassion-Focused Therapy and Existential Therapy were effective in improving psychological adjustment among patients with cancer in remission; however, Compassion-Focused Therapy was more effective in reducing death anxiety, whereas Existential Therapy was more effective in increasing illness acceptance.

Keywords: *Compassion-Focused Therapy; Existential Therapy; Death Anxiety; Illness Acceptance; Cancer; Remission*

1. Introduction

Cancer remains one of the most psychologically demanding chronic and life-threatening illnesses because its consequences extend far beyond physical symptoms and medical treatment. Although advances in screening, diagnosis, pharmacological therapy, surgery, radiotherapy, and supportive care have increased survival for many forms of cancer, surviving the acute phase of the disease does not necessarily signify the end of psychological distress. Patients who enter remission often continue to confront uncertainty regarding recurrence, physical limitations, altered identity, disrupted interpersonal and occupational roles, and persistent awareness of vulnerability and mortality. Consequently, cancer survivorship is increasingly understood as a multidimensional process that requires attention not only to medical stabilization but also to psychological adaptation and existential adjustment. Research on cancer survivors has emphasized that emotional difficulties may remain prominent even after successful treatment and that the capacity to psychologically accommodate the illness is an important dimension of post-treatment functioning (Lim et al., 2025; Zhou et al., 2026). Among the psychological issues encountered during and after cancer treatment, death anxiety and illness acceptance are particularly important because they influence patients' emotional well-being, adaptation to illness, quality of life, and ability to reconstruct a meaningful life following the experience of cancer.

Death anxiety refers broadly to apprehension, fear, distress, or psychological discomfort arising from awareness of one's mortality, the process of dying, or the possibility of nonexistence. Although awareness of death is a universal feature of human experience, severe or persistent death anxiety can become clinically significant when an individual is directly confronted with a potentially fatal illness. Contemporary psychological perspectives increasingly recognize death anxiety as a transdiagnostic process that may contribute to or intensify a range of emotional and behavioral difficulties, including generalized anxiety, depressive symptoms, health-related fears, compulsive behaviors, avoidance, and reduced psychological well-being (Gürbüz & Yorulmaz, 2024; Menzies & Menzies, 2023). In patients with cancer, the diagnosis itself may function as a powerful reminder of mortality, and this awareness can continue even after medical indicators suggest remission. Thus, remission may reduce the immediate threat posed by the disease while leaving unresolved fears regarding recurrence, progression, suffering, dependency, and death.

The clinical importance of death anxiety among people living with and beyond cancer has received increasing empirical attention. Meta-analytic evidence indicates that death anxiety is a meaningful psychological burden among individuals with cancer and that its severity may vary according to personal, cultural, disease-related, and contextual characteristics (Bennett et al., 2025). A systematic review and meta-analysis focusing on advanced cancer similarly demonstrated the substantial prevalence and psychological relevance of death anxiety in this population (Xue et al., 2026). Longitudinal evidence further suggests that death anxiety may remain present throughout the final stages of illness and may fluctuate according to physical, psychosocial, and existential circumstances rather than following a simple linear trajectory (Versluis et al., 2026). Moreover, qualitative research with younger patients with cancer has shown that awareness of mortality can influence coping strategies, defensive processes, relationships, future orientation, and the meaning assigned to life experiences (Luo et al., 2026). These findings indicate that the psychological confrontation with mortality is not restricted to terminal illness but may also remain relevant throughout treatment, recovery, and survivorship.

Death anxiety is also intertwined with broader indicators of psychological and existential well-being. Among Iranian women with breast cancer, death anxiety has been shown to have important implications for quality of life, with life expectancy functioning as an explanatory psychological mechanism (Abadian & Tavassoli, 2026). In individuals living with chronic illnesses more generally, increased death anxiety has been associated with poorer psychological well-being and difficulties in adaptive aging, suggesting that mortality-related fears may undermine the individual's capacity to experience coherence, psychological security, and successful adjustment to chronic health conditions (Bharti & Bharti, 2026). Social and contextual variables may also shape mortality-related distress. Research among patients with advanced cancer receiving palliative care has highlighted the contribution of social determinants to differences in death anxiety, indicating that fear of death should not be viewed solely as an intrapsychic phenomenon

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but as an experience influenced by socioeconomic, relational, and environmental circumstances (Lau et al., 2026). Furthermore, cultural and religious frameworks affect the way individuals interpret mortality, suffering, transcendence, and the meaning of death, making cultural sensitivity essential when designing psychological interventions for death-related distress (Pandya & Kathuria, 2021).

Alongside death anxiety, acceptance of illness constitutes another central dimension of psychological adjustment to cancer. Illness acceptance does not imply approval of the disease or passive resignation to suffering. Rather, it refers to the patient's ability to acknowledge the reality of the medical condition and its consequences without allowing illness-related limitations to entirely dominate identity, emotional functioning, interpersonal relationships, and future-directed behavior. Greater acceptance can enable patients to allocate fewer psychological resources to resistance against unavoidable realities and more resources to adaptive coping, meaningful activities, health-related decision-making, and restoration of valued life roles. For cancer survivors, such acceptance may be particularly important because remission frequently involves living with uncertainty rather than returning completely to a pre-diagnosis psychological state. Reviews of acceptance measures in cancer survivorship have therefore emphasized the relevance of evaluating acceptance across diverse cultural, linguistic, occupational, and rehabilitation contexts (Zhou et al., 2026).

Acceptance is also associated with the social and healthcare experiences of patients with cancer. Research examining illness acceptance, stigma, social support, and mental healthcare utilization suggests that the extent to which individuals psychologically integrate their illness may be related to their willingness and ability to seek psychosocial support (Chowdhry et al., 2026). In terminal cancer care, acceptance of death has likewise been considered in relation to symptom control and perceived quality of care, demonstrating that acceptance-related processes may become especially important when individuals are confronted with irreversible aspects of illness (Lee et al., 2026). Although acceptance of illness and acceptance of death are conceptually distinct, both involve a shift from rigid resistance and avoidance toward acknowledgment of difficult realities. This psychological transition may allow individuals to relate differently to distressing thoughts and emotions, making acceptance an important therapeutic target across different stages of cancer.

Evidence from psychological interventions supports the possibility that both death anxiety and illness-related adjustment can be modified. Acceptance and Commitment Therapy, for example, has received growing attention in psycho-oncology because it seeks to reduce experiential avoidance and strengthen psychological flexibility while enabling patients to pursue valued actions despite difficult internal experiences. A randomized controlled trial among cancer survivors demonstrated beneficial effects of Acceptance and Commitment Therapy on death anxiety (Chen et al., 2026). Similar findings have been reported among patients with breast cancer receiving internet-based telecare and bibliotherapy versions of Acceptance and Commitment Therapy, suggesting that acceptance-oriented interventions may also be adapted to different modes of treatment delivery (Baghelani et al., 2026). A virtual focused Acceptance and Commitment Therapy protocol has further demonstrated the feasibility of addressing emotional consequences associated with living with cancer through technology-assisted psychological intervention (Sala et al., 2026). Earlier Iranian research also showed that a death-anxiety therapeutic package based on Acceptance and Commitment Therapy could improve death avoidance, mental health, and quality of life among patients with cancer (Kolahdouzan et al., 2020). In addition, comparative findings involving Acceptance and Commitment Therapy and Cognitive-Behavioral Therapy suggest that structured psychological interventions can reduce death anxiety and enhance positive psychological outcomes such as hope among patients with breast cancer (Sadeghpour et al., 2025).

Other therapeutic modalities have similarly demonstrated that mortality-related distress in cancer is amenable to psychological intervention. Emotion-Focused Therapy delivered in a group format has been associated with reductions in death anxiety and improvements in distress tolerance among women with breast cancer (Biriyai et al., 2026). A systematic review and meta-analysis of randomized controlled trials among adults with chronic diseases has also concluded that psychological interventions can meaningfully reduce death anxiety and fear, supporting the broader therapeutic relevance of interventions targeting mortality-related concerns (Gulbahar Eren et al., 2025). Emerging therapeutic approaches have additionally been explored for illness and death anxiety; for example, a systematic review and meta-analysis of psychedelic-assisted therapy reported potential effects on these forms of anxiety, although such approaches involve distinct clinical, ethical, and methodological considerations (Amaev et al., 2025).

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Furthermore, cancer patients appear increasingly receptive to innovative emotion-regulation interventions, including virtual reality-based approaches, suggesting that patients' willingness to engage with psychologically focused methods may provide opportunities for diversified supportive care (Zeng et al., 2025). Collectively, these findings demonstrate that death anxiety and illness-related emotional adaptation are modifiable rather than inevitable consequences of cancer.

One intervention that may be particularly relevant to these psychological difficulties is Compassion-Focused Therapy. This approach emphasizes the development of a compassionate orientation toward personal suffering and seeks to reduce self-criticism, shame, threat sensitivity, and harsh internal responses. For individuals with cancer, the disease experience may generate feelings of vulnerability, perceived loss of control, bodily alienation, helplessness, and fear of an uncertain future. Patients may also react to their own distress with self-judgment or interpret anxiety as a sign of weakness, thereby adding secondary emotional suffering to the primary burden of illness. Compassion-oriented therapeutic work may help individuals recognize suffering as part of shared human vulnerability, respond to fear with greater warmth and emotional regulation, and cultivate a more supportive internal relationship. Such mechanisms may be particularly applicable to death anxiety because mortality-related thoughts strongly activate threat-processing systems. By strengthening capacities for soothing, mindful awareness, and compassionate self-response, Compassion-Focused Therapy may enable patients to encounter mortality-related fears with less avoidance and emotional escalation.

Compassion may also facilitate illness acceptance. Psychological acceptance requires the capacity to experience unwanted emotions and acknowledge limitations without becoming overwhelmed by self-criticism, shame, or persistent internal struggle. Cancer survivors may need to accommodate bodily changes, uncertainty, altered priorities, and the possibility that life after cancer will not exactly resemble life before diagnosis. A compassionate stance may reduce internal conflict surrounding these changes and encourage patients to respond to themselves in ways that are supportive rather than punitive. Although a substantial proportion of recent cancer intervention research has focused on acceptance-based, cognitive-behavioral, emotion-focused, or technologically delivered approaches (Baghelani et al., 2026; Biriyai et al., 2026; Chen et al., 2026; Sala et al., 2026), the potential comparative effectiveness of explicitly compassion-focused treatment for reducing death anxiety and strengthening acceptance among patients in remission warrants further investigation.

Existential Therapy provides another theoretically compelling approach to these concerns because death, freedom, existential isolation, and meaninglessness occupy a central position within the existential framework. Unlike approaches that conceptualize death anxiety primarily as a symptom to be reduced, existential therapy considers awareness of mortality an inherent aspect of human existence. From this perspective, psychological difficulty may arise not simply because individuals recognize that they will die, but because they struggle to integrate this recognition into a meaningful and authentic way of living. Yalom's conceptualization of death anxiety has continued to develop and influence contemporary existential psychotherapy, emphasizing that confrontation with mortality can become a catalyst for reevaluating priorities, values, relationships, and engagement with life (Grady & Viterito, 2025). Cancer, particularly because of its cultural association with threat and mortality, may intensify existential questions that were previously abstract or avoided.

Existential interventions can therefore offer cancer patients a therapeutic context in which mortality is approached directly rather than suppressed. Through exploration of death awareness, responsibility, freedom, isolation, meaning, and personal values, patients may learn to tolerate uncertainty and develop a more integrated relationship with their illness. A recent systematic review and meta-analysis evaluating selected existential therapies for death anxiety in advanced cancer found evidence supporting their effectiveness, reinforcing the relevance of existential approaches within psycho-oncology (Harahap et al., 2026). This is consistent with qualitative evidence showing that people with cancer actively employ meaning-based and psychologically protective strategies when confronting death awareness (Luo et al., 2026). Existential therapy may therefore reduce death anxiety not by eliminating awareness of mortality, but by transforming the meaning of that awareness and helping individuals use it to clarify what matters most in the remaining course of life.

The existential framework may be equally relevant to illness acceptance. Cancer can disrupt assumptions regarding personal control, continuity, predictability, fairness, and the future. Attempts to restore absolute certainty may be psychologically exhausting because complete certainty regarding recurrence and mortality

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cannot usually be achieved. Existential therapy instead emphasizes responsibility within limitation: individuals cannot always choose their circumstances, but they retain some capacity to choose how they orient themselves toward those circumstances. This distinction may support illness acceptance by helping patients recognize unavoidable realities while identifying areas of continuing agency, value, connection, and purpose. The experiences reported by survivors of advanced colorectal cancer illustrate how fear of progression and death can coexist with coping efforts and ongoing attempts to maintain quality of life (Lim et al., 2025). Such findings reinforce the value of interventions that do not merely suppress distress but help individuals live meaningfully alongside uncertainty.

Despite increasing evidence for psychosocial interventions in cancer care, important questions remain concerning which therapeutic approaches are most effective for specific psychological outcomes. Reviews indicate substantial heterogeneity in death anxiety among cancer populations, partly related to culture, clinical status, demographic characteristics, and measurement practices (Bennett et al., 2025; Xue et al., 2026). Likewise, research on illness acceptance highlights the importance of measurement and contextual considerations when interpreting psychological adaptation among cancer survivors (Zhou et al., 2026). The diversity of available interventions also suggests that therapeutic mechanisms may differ. Compassion-Focused Therapy primarily seeks to transform the individual's relationship with suffering through compassionate emotional regulation and reduction of self-critical threat processes, whereas Existential Therapy directly engages with mortality, responsibility, isolation, meaning, and the unavoidable conditions of existence. Both approaches are therefore theoretically relevant to patients recovering from cancer, but they may exert differential effects on distinct dimensions of psychological adaptation.

Comparing these two approaches is clinically meaningful because a treatment may be especially effective for one psychological outcome without being uniformly superior across all dimensions of adjustment. Death anxiety may respond particularly strongly to interventions that regulate threat, self-criticism, and emotional reactivity, whereas acceptance of illness may benefit from explicit exploration of meaning, responsibility, limitation, and existential reality. At the same time, these mechanisms overlap, and empirical comparison is necessary rather than assuming superiority on theoretical grounds. Current evidence demonstrates the effectiveness of several psychological approaches for death anxiety and cancer-related distress (Chen et al., 2026; Gulbahar Eren et al., 2025; Harahap et al., 2026), yet direct comparisons between Compassion-Focused Therapy and Existential Therapy among patients with cancer in remission remain limited. Addressing this gap may contribute to more precise psychosocial treatment planning and help clinicians select interventions according to the predominant psychological needs of cancer survivors.

Therefore, the present study aimed to compare the effectiveness of Compassion-Focused Therapy and Existential Therapy in reducing death anxiety and increasing illness acceptance among patients with cancer in remission.

2. Methods and Materials

2.1. Study Design and Participants

The present study was applied in terms of purpose and employed a quasi-experimental design with pretest, posttest, and follow-up assessments and a control group. The statistical population consisted of all patients diagnosed with common types of cancer who were in the remission stage and referred to hospitals in Tehran, Iran, during 2025–2026. Considering the inclusion and exclusion criteria and the requirements of the experimental design, a total of 45 eligible patients were selected through purposive sampling. After completing the pretest assessments, the participants were randomly assigned to three equal groups, including a Compassion-Focused Therapy group, an Existential Therapy group, and a control group, with 15 participants in each group. Random assignment was employed to reduce systematic differences between the groups and to increase the internal validity of the study.

The inclusion criteria consisted of being between 18 and 60 years of age, having a confirmed diagnosis of one of the common types of cancer, including breast, lung, colorectal, prostate, or gastric cancer, being in the remission stage of the disease, having no severe psychiatric disorder that could interfere with participation in the intervention, not using psychotropic medications, and providing informed consent to participate in the study. The exclusion criteria included absence from more than two treatment sessions, deterioration or significant exacerbation of the medical condition during the study, and unwillingness to continue participation. Following participant selection and administration of the pretest, the two experimental groups received their respective psychological interventions from October to December 2025. Each intervention consisted of eight 90-minute sessions conducted once per week.

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Participants assigned to the control group did not receive any psychological intervention during the intervention period and continued to receive their routine medical care. The outcome variables were assessed at the pretest, posttest, and follow-up stages to determine changes in death anxiety and illness acceptance over time and to compare the persistence of treatment effects across the three groups. Ethical considerations were observed throughout the research process, including voluntary participation, informed consent, confidentiality of personal information and questionnaire responses, the right to withdraw from the study at any stage without adverse consequences, and respect for the participants' physical and psychological condition.

2.2. Data Collection Tools

The Templer Death Anxiety Scale was developed by Templer in 1970 and is one of the most widely used instruments for assessing death-related anxiety in psychological and clinical research. The scale consists of 15 items with dichotomous yes/no response options. In its conventional scoring procedure, responses indicative of death anxiety receive a score of 1, whereas responses not indicative of death anxiety receive a score of 0. Accordingly, the total score ranges from 0 to 15, with higher scores representing greater levels of death anxiety. The instrument is considered a unidimensional measure and provides an overall score reflecting the individual's degree of anxiety, apprehension, and concern regarding death and mortality. In the original psychometric evaluation, Templer reported a test-retest reliability coefficient of 0.83 and an internal consistency coefficient of 0.76. The scale has also been examined in Iranian populations, where evidence has supported its content and convergent validity. Previous Iranian studies have generally reported Cronbach's alpha coefficients ranging from approximately 0.70 to 0.85, indicating satisfactory internal consistency and supporting the use of the instrument for assessing death anxiety in clinical populations.

The Acceptance of Illness Scale was developed by Felton in 1991 to assess the extent to which individuals with chronic illnesses accept the limitations and consequences associated with their medical condition. The instrument consists of eight items rated on a five-point Likert scale ranging from 1, representing strong disagreement, to 5, representing strong agreement. Total scores therefore range from 8 to 40, with higher scores indicating greater illness acceptance and better psychological adjustment to the consequences and restrictions associated with the disease. The scale is unidimensional and yields a single overall score reflecting the patient's degree of adaptation to the illness, acceptance of disease-related limitations, and reduced negative emotional reactions to the health condition. In the original development of the instrument, a Cronbach's alpha coefficient of 0.82 was reported, indicating satisfactory internal consistency. Studies conducted in Iran have also supported the content and construct validity of the scale, and Cronbach's alpha coefficients ranging approximately from 0.78 to 0.88 have been reported across different clinical samples, demonstrating acceptable to good reliability.

2.3. Interventions

Compassion-Focused Therapy was implemented according to Gilbert's therapeutic framework and consisted of eight 90-minute group sessions conducted once per week. The first session focused on establishing a therapeutic relationship, introducing the nature and rationale of Compassion-Focused Therapy, explaining the concept of compassion, and clarifying the goals and expectations of treatment. The second session provided psychoeducation regarding the major emotion-regulation systems, including the threat and protection system, the drive and resource-seeking system, and the soothing and affiliative system, with particular emphasis on how imbalances among these systems may contribute to anxiety and psychological distress; participants were also introduced to the concept of the multiple-mind perspective. The third session addressed the meaning and functions of compassion and introduced the three flows of compassion, namely compassion toward oneself, compassion toward others, and openness to receiving compassion from others. Particular attention was given to self-criticism and the ways in which harsh self-evaluation may intensify death anxiety and interfere with adjustment to cancer. During the fourth session, participants were trained in mindfulness and compassion-focused breathing exercises designed to enhance awareness of thoughts and emotions, facilitate physiological soothing, and reduce automatic emotional reactivity. The fifth session focused on compassion-focused imagery and the development of a compassionate self, through which participants practiced responding to suffering, fear, and vulnerability from a position characterized by warmth, wisdom, strength, and nonjudgment. During the sixth session, strategies for identifying and managing self-critical

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thoughts were introduced, and patients practiced replacing punitive or threatening internal dialogue with compassionate self-talk when confronting concerns related to mortality, recurrence of cancer, and difficulties in accepting the illness. The seventh session involved writing a compassionate letter to oneself and reconsidering distressing or painful experiences through a compassionate perspective in order to reduce shame, fear, and self-criticism. The eighth session was devoted to reviewing and integrating the skills acquired throughout treatment, consolidating therapeutic gains, identifying strategies for maintaining compassionate practices in everyday life, and developing an individualized plan for continued practice after termination of the intervention. The posttest assessment was administered following completion of the intervention.

Existential Therapy was conducted based on Yalom's existential therapeutic framework and consisted of eight 90-minute sessions held once per week. The first session focused on developing the therapeutic relationship, familiarizing participants with the fundamental principles of the existential approach, and introducing the four major existential concerns of death, freedom, existential isolation, and meaninglessness. The second session concentrated on the existential reality of death and encouraged patients to confront mortality awareness rather than relying on avoidance or denial. Participants were helped to reconsider death as an unavoidable and natural dimension of human existence and to examine how awareness of mortality could influence the way they approached life after cancer. The third session addressed freedom, choice, and personal responsibility, with emphasis on helping patients distinguish uncontrollable aspects of their medical condition from areas in which they retained the capacity to choose their attitudes, behaviors, priorities, and responses. The fourth session explored existential isolation and its distinction from interpersonal loneliness and social withdrawal. Patients were encouraged to recognize the ultimately individual nature of certain aspects of suffering while simultaneously developing more authentic and meaningful connections with significant others. The fifth session focused on identifying and reconstructing meaning in life and helping participants assign personal significance to their experience of cancer, recovery, suffering, and survival within an existential framework. During the sixth session, hope and hopelessness were examined from an existential perspective, and participants were encouraged to develop active acceptance of unavoidable realities, including human vulnerability, illness, uncertainty, and mortality, without equating acceptance with resignation or passivity. The seventh session addressed personal values, reconsideration of life priorities, and the development of meaningful and realistic goals compatible with the patients' current circumstances. Particular attention was given to translating clarified values into purposeful everyday choices and activities. The eighth and final session involved reviewing the therapeutic process, consolidating changes achieved during the sessions, examining the participants' understanding of authentic living, and developing an individualized plan for continuing a meaningful and responsible approach to life after termination of therapy. The posttest assessment was administered at the end of the intervention.

2.4. Data Analysis

The collected data were analyzed using descriptive and inferential statistical procedures in SPSS version 26. Descriptive statistics, including the mean and standard deviation, were used to summarize participants' scores on death anxiety and illness acceptance at the pretest, posttest, and follow-up stages. To evaluate within-group changes over time and between-group differences among the Compassion-Focused Therapy, Existential Therapy, and control groups, repeated-measures analysis of variance was employed. This analysis made it possible to examine the main effect of time, the main effect of group, and particularly the time-by-group interaction, which represented whether the pattern of change in the dependent variables differed across the three study groups. Prior to conducting the main inferential analyses, the relevant statistical assumptions were evaluated, including the normality of the distributions, homogeneity of variances, and the assumption of sphericity. Where the sphericity assumption was violated, an appropriate correction to the degrees of freedom was applied. When significant overall effects were obtained, Bonferroni-adjusted post hoc comparisons were conducted to identify specific differences between measurement occasions and study groups while controlling for inflation of the Type I error rate. All statistical tests were performed using a two-tailed significance level of 0.05.

3. Findings and Results

A total of 45 patients with cancer in remission participated in the study and were equally assigned to the Existential Therapy, Compassion-Focused Therapy, and control groups, with 15 participants in each group. Descriptive statistics were first calculated for death anxiety

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and illness acceptance at the pretest, posttest, and follow-up stages. As shown in Table 1, the three groups had relatively similar mean scores at baseline, whereas noticeable changes emerged in both intervention groups following treatment and were largely maintained at follow-up.

Table 1

Mean and Standard Deviation of Death Anxiety and Illness Acceptance Scores in the Three Study Groups

Variable	Group	Pretest M ± SD	Posttest M ± SD	Follow-up M ± SD
Death Anxiety	Existential Therapy	9.08 ± 1.09	5.91 ± 1.19	6.33 ± 1.28
	Compassion-Focused Therapy	9.08 ± 1.11	4.50 ± 1.15	4.16 ± 1.11
	Control	9.08 ± 1.10	9.17 ± 1.14	9.16 ± 1.58
Illness Acceptance	Existential Therapy	20.08 ± 1.70	32.83 ± 1.40	33.33 ± 1.40
	Compassion-Focused Therapy	20.50 ± 1.30	29.75 ± 1.30	30.08 ± 1.40
	Control	20.33 ± 1.30	20.33 ± 1.30	20.32 ± 1.30

As presented in Table 1, the mean scores of death anxiety and illness acceptance were relatively similar across the three groups at the pretest stage. Following the interventions, death anxiety decreased substantially in both experimental groups, whereas virtually no change was observed in the control group. The reduction was greater in the Compassion-Focused Therapy group, in which the mean death anxiety score decreased from 9.08 at pretest to 4.50 at posttest and remained low at 4.16 at follow-up. The Existential Therapy group also demonstrated a considerable reduction, from 9.08 at pretest to 5.91 at posttest, with a follow-up mean of 6.33. Regarding illness acceptance, both interventions resulted in marked increases compared with the control group. The Existential Therapy group showed the greatest improvement, increasing from a pretest mean of 20.08 to 32.83 at posttest and 33.33 at follow-up. Illness acceptance in the Compassion-Focused Therapy group also increased substantially, from 20.50 at pretest to 29.75 at posttest and 30.08 at follow-up. In contrast, the control group's scores remained nearly unchanged across the three measurement occasions. Overall, the descriptive findings suggested that Compassion-Focused Therapy was more effective in reducing death anxiety, whereas Existential Therapy produced greater improvement in illness acceptance.

Before conducting the repeated-measures analysis of variance, the relevant statistical assumptions were examined. The Shapiro–Wilk test indicated that the distributions of death anxiety and illness acceptance scores did not significantly deviate from normality across the study groups and measurement occasions ($p > 0.05$). Levene's test was also nonsignificant for both dependent variables at the pretest, posttest, and follow-up stages ($p > 0.05$), supporting the assumption of homogeneity of variances. In addition, Box's M test was nonsignificant at the conservative significance level of 0.001, indicating equality of the variance-covariance matrices across the three groups. Mauchly's test of sphericity was significant for death anxiety ($W = 0.81$, $p = 0.014$) and illness acceptance ($W = 0.79$, $p = 0.009$), indicating violation of the sphericity assumption. Therefore, the Greenhouse–Geisser correction was applied when evaluating within-subject effects. Overall, the results of the assumption tests indicated that the data were appropriate for repeated-measures analysis of variance.

Table 2

Results of Repeated-Measures Analysis of Variance for Death Anxiety and Illness Acceptance

Variable	Effect	SS	df	MS	F	p	Partial η^2
Death Anxiety	Time	188.42	1.68	112.16	96.37	<0.001	0.70
	Group	176.31	2	88.16	38.54	<0.001	0.65
	Time × Group	155.76	3.36	46.36	39.84	<0.001	0.66
Illness Acceptance	Time	1834.28	1.63	1125.33	312.46	<0.001	0.88
	Group	1588.47	2	794.24	128.71	<0.001	0.86
	Time × Group	1506.39	3.26	462.08	128.31	<0.001	0.86

The repeated-measures analysis of variance presented in Table 2 demonstrated significant main effects of time and group as well as significant time-by-group interactions for both dependent variables. For death anxiety, the main effect

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of time was statistically significant, $F = 96.37$, $p < 0.001$, partial $\eta^2 = 0.70$, indicating that death anxiety scores changed significantly across the three measurement occasions. The main effect of group was also significant, $F = 38.54$, $p < 0.001$, partial $\eta^2 = 0.65$. More importantly, the time-by-group interaction was statistically significant, $F = 39.84$, $p < 0.001$, partial $\eta^2 = 0.66$, indicating that the pattern of change in death anxiety over time differed significantly among the three groups. For illness acceptance, a significant main effect of time was observed, $F = 312.46$, $p < 0.001$, partial $\eta^2 = 0.88$, together with a significant group effect, $F = 128.71$, $p < 0.001$, partial $\eta^2 = 0.86$. The time-by-group interaction was likewise significant, $F = 128.31$, $p < 0.001$, partial $\eta^2 = 0.86$. The relatively large effect sizes indicated that a substantial proportion of the variance in changes in death anxiety and illness acceptance was attributable to the interventions and their interaction with time. Consequently, Bonferroni-adjusted pairwise comparisons were conducted to determine which groups differed significantly from one another.

Table 3

Bonferroni Pairwise Comparisons Between the Three Study Groups

Variable	Group (I)	Group (J)	Mean Difference (I–J)	SE	p
Death Anxiety	Existential Therapy	Compassion-Focused Therapy	1.79	0.41	<0.001
	Existential Therapy	Control	-2.38	0.41	<0.001
	Compassion-Focused Therapy	Control	-4.17	0.41	<0.001
Illness Acceptance	Existential Therapy	Compassion-Focused Therapy	2.30	0.46	<0.001
	Existential Therapy	Control	8.42	0.46	<0.001
	Compassion-Focused Therapy	Control	6.12	0.46	<0.001

As shown in Table 3, Bonferroni-adjusted pairwise comparisons indicated statistically significant differences among all three groups for death anxiety. The mean death anxiety score in the Existential Therapy group was significantly higher than that in the Compassion-Focused Therapy group (MD = 1.79, SE = 0.41, $p < 0.001$), indicating a greater reduction in death anxiety following Compassion-Focused Therapy. At the same time, both intervention groups demonstrated significantly lower death anxiety than the control group. The Existential Therapy group had significantly lower death anxiety than the control group (MD = -2.38, SE = 0.41, $p < 0.001$), while the difference between Compassion-Focused Therapy and the control group was even larger (MD = -4.17, SE = 0.41, $p < 0.001$). These findings demonstrate that both interventions were effective in reducing death anxiety, although Compassion-Focused Therapy showed superior effectiveness. Regarding illness acceptance, all pairwise group comparisons were also statistically significant. The Existential Therapy group demonstrated significantly greater illness acceptance than the Compassion-Focused Therapy group (MD = 2.30, SE = 0.46, $p < 0.001$). Furthermore, both Existential Therapy (MD = 8.42, SE = 0.46, $p < 0.001$) and Compassion-Focused Therapy (MD = 6.12, SE = 0.46, $p < 0.001$) produced significantly higher illness acceptance scores than the control condition. Thus, although both therapeutic approaches significantly improved illness acceptance, Existential Therapy demonstrated greater effectiveness for this outcome. Taken together, the inferential findings confirmed the descriptive pattern: Compassion-Focused Therapy was comparatively more effective in reducing death anxiety, whereas Existential Therapy was comparatively more effective in enhancing illness acceptance among patients with cancer in remission.

4. Discussion and Conclusion

The present study compared the effectiveness of Compassion-Focused Therapy and Existential Therapy in reducing death anxiety and increasing illness acceptance among patients with cancer in remission. The findings indicated that both interventions produced significant improvements compared with the control condition across the posttest and follow-up assessments. More specifically, patients who received Compassion-Focused Therapy showed a greater reduction in death anxiety than those who received Existential Therapy, whereas patients in the Existential Therapy group demonstrated a greater increase in illness acceptance than those who received Compassion-Focused Therapy. The significant time, group, and time-by-group interaction effects indicated that the observed changes were not merely attributable to the passage of time and that the trajectory of improvement differed across the three groups. The maintenance of the gains at follow-up further suggested that the effects of both interventions were

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relatively stable after termination of treatment. Taken together, these findings support the usefulness of both approaches in psycho-oncological care while also indicating that the two therapies may influence different psychological dimensions through partially distinct mechanisms.

The finding that both interventions significantly reduced death anxiety is consistent with a growing body of literature showing that death-related distress in patients with cancer is responsive to structured psychological treatment. Systematic reviews and meta-analyses have demonstrated that death anxiety is a clinically important concern among people living with or beyond cancer and that psychological interventions can produce meaningful reductions in this form of distress (Bennett et al., 2025; Gulbahar Eren et al., 2025; Xue et al., 2026). The present findings also align with evidence showing that death anxiety is not an isolated phenomenon but is closely associated with broader psychological well-being, quality of life, coping, and adaptation to illness (Abadian & Tavassoli, 2026; Bharti & Bharti, 2026; Menzies & Menzies, 2023). In cancer populations specifically, mortality-related concerns may persist beyond the active treatment phase because remission does not eliminate uncertainty regarding recurrence, future deterioration, or death. Longitudinal findings have shown that death anxiety can remain salient over time and may vary in response to changing physical, social, and psychological conditions (Versluis et al., 2026). Therefore, the reduction observed in both intervention groups in the present study supports the view that targeted psychotherapeutic work can modify patients' relationship with mortality-related fears even after the acute treatment phase has ended.

The greater effectiveness of Compassion-Focused Therapy in reducing death anxiety may be explained by its direct impact on emotional threat regulation, self-criticism, and the patient's internal response to fear and vulnerability. Cancer can activate a persistent sense of threat in which bodily sensations, medical follow-ups, and thoughts about recurrence become associated with mortality. Compassion-Focused Therapy seeks to reduce the dominance of the threat system and strengthen soothing, affiliation, and emotional safety. Through compassion-focused breathing, mindful awareness, compassionate imagery, and the cultivation of a supportive internal voice, patients may become better able to experience mortality-related thoughts without escalating them into intense fear. This interpretation is compatible with broader evidence suggesting that interventions that reduce experiential avoidance and alter responses to difficult internal experiences can significantly reduce death anxiety. Acceptance and Commitment Therapy has been shown to decrease death anxiety among cancer survivors and breast cancer patients, indicating that changing the manner in which individuals respond to distressing thoughts may be more important than attempting to eliminate those thoughts entirely (Baghelani et al., 2026; Chen et al., 2026; Kolahdouzan et al., 2020). Comparative evidence has likewise shown that acceptance-based approaches can improve death anxiety and hope among patients with cancer (Sadeghpour et al., 2025).

The present finding is also consistent with studies demonstrating the benefits of emotion-focused interventions for death-related distress. Group-based Emotion-Focused Therapy has been found to reduce death anxiety and improve distress tolerance among women with breast cancer (Biriyai et al., 2026). Although Emotion-Focused Therapy and Compassion-Focused Therapy are theoretically distinct, both approaches emphasize emotional processing rather than rigid cognitive suppression, and both seek to alter maladaptive responses to painful affective experiences. This may be especially relevant to death anxiety because mortality-related fear often intensifies when patients attempt to avoid, suppress, or judge their emotional reactions. Compassion-Focused Therapy may be particularly effective in this context because it not only facilitates emotional awareness but also explicitly replaces self-critical and threat-oriented internal processes with warmth, reassurance, and affiliative regulation.

The finding that Compassion-Focused Therapy produced stronger reductions in death anxiety than Existential Therapy may also be understood in relation to the immediacy of affect regulation. Existential Therapy invites patients to engage directly with mortality and the unavoidable conditions of life, whereas Compassion-Focused Therapy may provide more immediate strategies for reducing physiological arousal and emotional threat. For some patients, especially those in remission who remain sensitive to signs of recurrence, mortality awareness may trigger rapid fear responses before more reflective meaning-making processes can occur. Compassion-based techniques can potentially intervene at this earlier affective level by reducing the intensity of self-generated threat. This does not imply that existential work is ineffective for death anxiety; rather, it suggests that the primary mechanisms of the two interventions may differ. Existential Therapy may transform the meaning of death, whereas Compassion-Focused Therapy may more strongly regulate the emotional experience of death-related thoughts.

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At the same time, the significant reduction in death anxiety produced by Existential Therapy is strongly supported by previous research. Existential approaches conceptualize mortality awareness as an inherent aspect of human existence rather than merely a symptom to be suppressed. Recent reviews of Yalom's existential framework emphasize the central role of death awareness in psychological functioning and the possibility that confrontation with mortality can lead to more authentic engagement with life (Grady & Viterito, 2025). A systematic review and meta-analysis of existential therapies in advanced cancer has also supported their effectiveness for reducing death anxiety (Harahap et al., 2026). In this framework, therapeutic improvement may occur as patients move from avoidance of mortality toward a more integrated acknowledgment of death as a natural condition of existence. Through this process, death may become less psychologically overwhelming because it is no longer treated solely as an external catastrophe but as a reality that can inform values, priorities, and meaningful choices.

Qualitative evidence also supports this interpretation. Research on how younger patients with cancer cope with death anxiety has shown that patients employ a variety of meaning-based and psychologically protective strategies when confronting mortality (Luo et al., 2026). Likewise, survivors of advanced colorectal cancer have described ongoing fear of progression and death alongside efforts to preserve quality of life, relationships, and meaningful activity (Lim et al., 2025). These findings suggest that death anxiety may not disappear completely even when psychological adjustment improves. Instead, individuals may develop more adaptive ways of carrying mortality awareness within daily life. Existential Therapy may facilitate precisely this shift by helping patients explore death, freedom, responsibility, isolation, and meaning without relying on avoidance.

The second major finding was that both Compassion-Focused Therapy and Existential Therapy significantly increased illness acceptance compared with the control group, while Existential Therapy produced a greater improvement than Compassion-Focused Therapy. This finding is theoretically plausible because illness acceptance requires patients to acknowledge a changed reality, recognize limitations, tolerate uncertainty, and reorganize their life in a way that remains meaningful despite the disease experience. Acceptance in cancer is increasingly understood as an important component of psychological adaptation and rehabilitation, although its measurement may vary across cultural, occupational, and linguistic contexts (Zhou et al., 2026). The present findings therefore reinforce the importance of illness acceptance as a modifiable outcome in survivorship care rather than a fixed personality characteristic.

The greater effect of Existential Therapy on illness acceptance may be attributable to its direct focus on unavoidable realities, responsibility, freedom within limitations, and meaning reconstruction. Cancer often disrupts assumptions about control, predictability, bodily integrity, and future plans. Patients may initially respond by attempting to restore the previous state of life or by resisting aspects of the illness that cannot be changed. Existential Therapy does not require patients to approve of their condition but encourages them to distinguish between what can and cannot be controlled. This distinction may facilitate acceptance because patients can stop investing psychological resources in impossible forms of control while redirecting attention toward choices that remain available. The intervention's emphasis on values, meaning, and responsibility may further help patients integrate the illness into their life narrative rather than experiencing it as an entirely alien and destructive event.

The relationship between acceptance and broader cancer adjustment is also reflected in previous research. Illness acceptance has been examined in relation to stigma, social support, and mental health service utilization, suggesting that patients who are better able to psychologically accommodate their condition may also be more capable of engaging with available sources of support (Chowdhry et al., 2026). Research among terminally ill cancer patients has similarly highlighted the relevance of death acceptance to symptom control and perceived quality of care (Lee et al., 2026). Although illness acceptance and death acceptance are not identical constructs, both require an ability to face difficult realities without persistent psychological resistance. Existential Therapy may be especially well suited to this process because it explicitly encourages patients to engage with limitation, mortality, uncertainty, and responsibility.

The effects of Compassion-Focused Therapy on illness acceptance can also be understood through the reduction of secondary emotional suffering. Patients may struggle not only with the illness itself but also with self-judgment, shame, perceived weakness, frustration with their bodies, and distress about dependence on others. A compassionate stance can reduce this additional layer of suffering by encouraging patients to respond to their condition with warmth rather than hostility. In this sense, Compassion-

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Focused Therapy may promote acceptance indirectly by changing the emotional environment in which illness is experienced. When self-criticism decreases, patients may become more willing to acknowledge physical limitations and uncertainty without interpreting them as evidence of personal failure.

This interpretation is broadly compatible with acceptance-based intervention research in cancer. Acceptance and Commitment Therapy has shown beneficial effects on anxiety, depression, and death anxiety in cancer populations, including through internet-based and virtual delivery formats (Baghelani et al., 2026; Chen et al., 2026; Sala et al., 2026). These findings suggest that psychological acceptance can be enhanced when patients learn to make room for distressing internal experiences while maintaining engagement with personally meaningful activities. Similarly, research on patients' acceptance of virtual reality-based emotion-regulation interventions indicates that cancer populations may be receptive to diverse strategies designed to increase emotional regulation and adaptation (Zeng et al., 2025). The present study extends this broader literature by suggesting that compassion-based processes can also enhance illness acceptance, even if the magnitude of this effect may be smaller than that achieved through a directly existential framework.

The stronger effect of Existential Therapy on illness acceptance may also reflect the close conceptual correspondence between existential work and adaptation to uncontrollable circumstances. Existential Therapy repeatedly confronts the distinction between freedom and limitation. Patients are encouraged to recognize that freedom does not imply complete control over illness but rather the capacity to choose one's stance and actions within existing constraints. Such a framework may be especially important during remission because patients often live in a state of medical ambiguity: the disease may no longer be active, yet the possibility of recurrence remains. Acceptance therefore involves learning to live meaningfully without absolute certainty. The existential emphasis on authentic living, value clarification, and purposeful action may directly support this adaptation.

The present findings can also be interpreted in light of cultural influences on death and illness. Death anxiety is shaped not only by individual psychology but also by cultural, religious, familial, and social meanings (Pandya & Kathuria, 2021). Meta-analytic evidence has likewise highlighted the role of culture in death anxiety among people living with or beyond cancer (Bennett et al., 2025). In the Iranian context, beliefs concerning mortality, family responsibility, suffering, hope, and spiritual meaning may influence how patients respond to cancer and psychotherapy. Both compassion-focused and existential approaches may be compatible with these concerns because they address universal experiences while allowing patients to interpret suffering within their own personal and cultural frameworks. Nevertheless, the relative effectiveness of each approach may differ according to patients' beliefs, coping styles, age, cancer type, family context, and level of existential or emotional distress.

Another important finding was the persistence of therapeutic gains at follow-up. The maintenance of lower death anxiety and higher illness acceptance suggests that participants may have internalized at least some of the skills and perspectives developed during treatment. This is clinically relevant because cancer-related distress is often recurrent rather than static. Follow-up appointments, bodily symptoms, anniversaries of diagnosis, or reports of illness in others may reactivate fears even after successful treatment. Interventions that provide patients with enduring frameworks for responding to such triggers are therefore particularly valuable. Compassion-Focused Therapy may contribute to maintenance by helping patients repeatedly activate a compassionate internal response, while Existential Therapy may provide a durable framework for interpreting uncertainty and mortality.

The current findings are also consistent with the broader movement toward incorporating psychosocial treatment into cancer survivorship care. Evidence from multiple therapeutic modalities demonstrates that death anxiety, emotional distress, and adaptation can be improved through structured psychological intervention (Amaev et al., 2025; Gulbahar Eren et al., 2025). At the same time, the diversity of effective interventions suggests that treatment selection should ideally be matched to the patient's primary psychological needs. For patients whose main difficulty involves intense fear, self-criticism, emotional threat, and inability to soothe themselves, Compassion-Focused Therapy may be especially useful. For patients struggling primarily with meaninglessness, loss of control, uncertainty, altered identity, or difficulty accepting the realities imposed by illness, Existential Therapy may offer particular advantages. The present findings therefore support a differentiated rather than uniform approach to psychosocial oncology.

This study had several limitations that should be considered when interpreting the findings. The sample size

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was relatively small and was drawn from patients attending hospitals in one metropolitan area, which may limit the generalizability of the results to cancer populations in other regions, healthcare settings, and cultural contexts. The study also included patients with several different cancer types, and differences in prognosis, treatment history, symptom burden, and perceived recurrence risk may have influenced psychological responses. The follow-up period was relatively short, so the long-term stability of the observed treatment effects remains uncertain. In addition, the outcomes were assessed primarily through self-report instruments, which may be affected by response bias, social desirability, or participants' temporary emotional states. Finally, therapist-related variables, treatment expectancy, and nonspecific group factors may have contributed to part of the observed improvements.

Future research should replicate these findings with larger and more diverse samples and should consider stratifying participants according to cancer type, stage, treatment history, age, gender, and time since remission. Longer follow-up periods would help determine whether the relative advantages of Compassion-Focused Therapy and Existential Therapy remain stable over time. Future studies could also examine mediating mechanisms, such as self-compassion, experiential avoidance, meaning in life, psychological flexibility, emotion regulation, hope, or perceived control, to clarify why one intervention may be more effective for a specific outcome. It would also be valuable to compare individual, group-based, online, and blended formats and to explore whether integrating compassion-focused and existential techniques could produce broader benefits than either approach alone.

In clinical practice, psychosocial screening for death anxiety and difficulties in illness acceptance should be incorporated more systematically into survivorship care. Healthcare teams can use the pattern of a patient's difficulties to guide intervention selection rather than applying the same psychological treatment to all survivors. Compassion-Focused Therapy may be prioritized when patients demonstrate pronounced self-criticism, shame, emotional threat, or difficulty soothing mortality-related fear, whereas Existential Therapy may be particularly appropriate when patients struggle with loss of meaning, uncertainty, responsibility, or acceptance of changed life circumstances. Training psycho-oncology professionals in both approaches may therefore improve the flexibility and precision of supportive care and help patients move beyond mere medical remission toward more stable psychological adaptation.

Authors' Contributions

All authors significantly contributed to this 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

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

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