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Effectiveness of Spiritual Emotional Freedom Technique in Reducing Social Isolation among Older Adults

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ABSTRACT

Social isolation is increasing among older adults and is correlated with negative impacts on the physical and mental health of individuals. Interventions that focus on helping the emotional and spiritual health of older adults may decrease the perception of loneliness. The aim of this study is to assess the impact of Spiritual Emotional Freedom Technique (SEFT) on social isolation in older adults. The study utilized a randomized controlled trial design in residential aged-care facilities in Punjab, Pakistan. Forty participants aged ≥60 with high psychological distress were randomized in a 1:1 ratio to the study (SEFT group) or control (waitlist control) group to receive a four week SEFT that involved 8 group sessions (n = 20) and (n = 20) waitlist control. Perceived loneliness was measured using the UCLA Loneliness Scale (version 3) pre- and post- intervention. The study maintained intervention fidelity, participant attendance, and blinded outcome assessment. A repeated measure ANOVA was used to assess Time, Group, and Time x Group interaction effects. SEFT demonstrated a much higher effect than control in the improvement of perceived social isolation. There was a statistically significant Time x Group interaction effect for social isolation ($F = 4.31$, $p < .05$, $\eta^2_p = .657$). Analyses showed that participants in the SEFT group experienced a greater social isolation reduction from baseline to post-tests as dose of SEFT increased. SEFT is a successful supplement to social isolation reduction and interventions focusing on the improvement of emotional well-being among older adults. SEFT in community and clinical settings for older adults is highly recommended.

Introduction

In the past ten years, the public health consequences of social loneliness in the elderly have continued to worsen, especially as elderly people begin to experience community loss due to retirement, mobility constraints, or the death of a spouse, the odds of experiencing cognitive decline as a result of sleep disturbance, recurring depression, and anxiety is significantly higher (Courtin & Knapp, 2017; Santini et al.2020). People over 65 years of age will represent approximately 20% of the global population by 2030, and it's predicted that 25% of that age group will experience chronic social isolation (National Academies of Sciences, Engineering, and Medicine, 2020). Both social isolation and loneliness are significant public health issues in the elderly and are characterized by the absence of social relationships and the feeling of loneliness, respectively. Both social isolation and loneliness have been linked with adverse health outcomes such as depression, cognitive decline, morbidity, and increased risk of mortality (Li, 2024). Social isolation refers to a lack of social communication, social activities, and community participation (Cacioppo & Patrick, 2008; Hawkley & Cacioppo, 2010). Social isolation is a growing concern for older adults. Feeling lonely is a subjective experience emotional phenomenon that consists of feeling socially disconnected; Whereas social isolation is not a subjective experience, social isolation is merely the lack of social relationships, social contacts, social interactions, and social networks (de Jong Gierveld et al., 2018). Depending on the geographical area, the social isolation of older people is widespread, and this phenomenon is located between 10%-43%. This problem is particularly severe for the older population, those living alone, those with low economic status, and those with chronic and functional disabilities (Ong et al., 2016; Shankar et al., 2011). Social isolation has multiple adverse consequences. The most prominent include risk, chronic conditions, deterioration of cognitive functioning, dementia, depression, anxiety, and increased risk of death (Holt-Lunstad et al., 2015; Penninkilampi et al., 2018; Valtorta et al., 2016).

Social isolation negatively impacts the mental health of older adults. As social networks dwindle, and peers are lost, older adults become more lonely, and may not have the ability to move freely to develop their social networks, which contributes to psychological distress associated with isolation (Li, 2024). Studies have shown small to moderate impacts on group cognitive behvioral therapy, socialization, exercise, and technology engagement programs to reduce the feelings of loneliness in older adults. These studies have shown a large degree of variation in effect sizes. (Barker et al., 2021). As such, there is a need for new, holistic, and accessible approaches to tackle the emotional and spiritual parts of loneliness beyond the social and behavioral aspects. One new approach is called Spiritual Emotional Freedom Technqiue (SEFT). Several components comprise the theoretical foundation of SEFT. In energy psychology, emotional distress stems from disruptions in or blockages of the energy system of the body (Feinstein, 2012). Specific acupressure point tapping is assumed to restore and re-balance the energy system, which calms emotional distress and arousal (Church, 2022). In addition, some studies in the neurobiological field have indicated that the stimulation of acupressure points can reduce stress by shutting down the amygdala (the nucleus of fear and threat detection in the brain) (Fang et al., 2017). The cognitive portion of SEFT resembles CB therapy cognitive restructuring techniques that aim to change dysfunctional thought (Church et al., 2018). In addition, SEFT also has the spiritual aspect of invoking God, practicing gratitude, and promoting acceptance and surrender, which is consistent with the body of literature that empirically demonstrates the link between the psychological benefits of spirituality and religious coping and heightened resilience, improved emotional regulation, meaning-making, and the regulation of emotions (Koenig, 2012; Pargament et al., 2013).

Literature Review

The phenomena of social isolation and loneliness are extremely problematic for society and even more so for the aging population, as a result of evolving demographics and social patterns. While social isolation refers to the absence of social interactions, loneliness pertains to the subjective experience of disconnection (Holt-Lunstad et al., 2015). While these two constructs are closely related, both are common in the later stages of life due to factors such as retirement, bereavement, declining health, and reduced mobility. Studies have repeatedly shown social isolation negatively impacts the physical and psychological well-being. According to a study conducted by Shamlou et al. (2021), older adults who experience social isolation and loneliness have a low self-care ability which means that socially isolated older adults participate in even fewer health promoting activities. Also, there are studies that show socially isolated older adults show an increase in loneliness and depressive symptoms over time (Li et al., 2024).

The COVID-19 pandemic has worsened the already significant problem of loneliness in the aging population.Numerous studies and meta analyses have shown various degrees of success across different interventions that attempt to target loneliness. However, the problem is still prevalent and complex (Masi et al., 2022). This highlights the necessity of innovative and multidimensional approaches to target both the emotional and social facets of the problem. Emotional and social aspects of loneliness and social isolation can be assessed using several standardized methods and one of the most commonly used ways is the UCLA Loneliness Scale. Furthermore, the UCLA Loneliness Scale is one of the most reliable and valid measures of loneliness that has been used across various studies and diverse populations. In fact, there are studies that provide evidence of its effectiveness in measuring subjective aspects of loneliness, thus, making it one of the most preferred scales in gerontological studies (Russell, 1996; recents studies confirm its psychometric durability).

Numerous strategies have been formulated to combat mental and social isolation in elderly people using techniques that include cognitive-behavioral therapy (CBT), social skills practice, physical activity, and approaches involving technology and social media. Increasing emotionally positive social contacts (fostering social and cognitive interactions) appears to be more efficacious in decreasing isolation than approaches that focus on simple increasing social contacts. For example, motivational and mindfulness interventions have been shown to have a positive impact on mental well-being and decrease feelings of isolation. One of these types of interventions was recently identified as increasing social support, decreasing depression, and increasing life satisfaction in older adults. These results lead to the conclusion that isolation can be decreased by engaging the mental and emotional faculties of the individual. Nevertheless, the above interventions involve mental, emotional, and social isolation and include a holistic approach to the cognitive and emotional structure and processes. This has resulted in interest in complementary partners in addition to the above approaches, including energy psychology techniques, including its spiritual variant Emotional Freedom Techniques (EFT) and SEFT.

Hypothesis

H1. In an RCT, the pre-test level, the experimental and control groups will be comparable regarding social isolation among older adults.

H2.In the experimental group, SEFT will lower social isolation from pre-test to post-test, relative to the control group.

Method

Participants

The research study consisted of 40 older adults aged 60 years and above, recruited from community centers. Participants were randomly assigned to the experimental group (n=20) who received SEFT, and to the control group (n= 20) who received routine care. Baseline equivalence between groups was confirmed through independent t-tests, ensuring comparability. Participants were selected using purposive sampling based on the following criteria

Inclusion Criteria:

- Age ≥ 60 years.
- Ability to communicate and comprehend instructions in the local dialect.
- Participants should be willing to take part in weekly SEFT sessions for a period of 4 weeks.

Exclusion Criteria

- Presence of acute psychiatric conditions (e.g. severe depression, psychosis).
- Involvement in other structured emotional or spiritual interventions during the study period.

Measurement

UCLA Loneliness Scale Version 3

Social isolation was the primary outcome, using the UCLA Loneliness Scale Version 3 (Russell, 1996). This 20-item scale measures subjective feelings of loneliness and social isolation. The scale has a range of 20 to 80, where higher scores mean greater loneliness. The scale has exhibited high reliability (Cronbach's $\alpha = 0.89–0.94$) and high validity with the older adult population.

Procedure

The deputy director's office of Social Welfare and Bait-ul-Mal, Multan, Ref No. 2985, has granted ethical permission to conduct this study. The study complied with the guidelines of Helsinki. To assess informed consent capacity, we adopted a two-step approach.The participants' comprehension was evaluated through the Teach-back method. Participants verbalized their understanding of the consent and participated freely. Consent was documented in writing, and the information sheets were read in the Urdu language.

Intervention

Spiritual Emotional Freedom Therapy (SEFT) Protocol

Stage	Week	Session	Aim & Objectives
Rapport & Assessment	1	1	Rapport building, problem identification
Preparation	2	2	Instructions: say "Bismillah," drink water, remove metals, and identify complaints
Set-Up	3	3	Recite a prayer while tapping the sore spot on the chest
Tune-In	3	3	Focus on the primary issue causing discomfort
Tapping	4	4	Tap nine meridian points (crown, eyebrow, side of eye, under

	eye, under nose, chin, collarbone, under arm, below nipple); conclude with "Alhamdulillah."

Statistical Analysis

Statistical analysis was done using IBM SPSS Statistics version 27 at an alpha value of 0.05. The confirmed accuracy of the analysis stem from a double-entry verification as well as verification of no missing values, no outliers, and normality of distribution. Chi-square calculations, t-test calculations for randomization of control and experimental group, and repeated measures ANOVA calculations for SEFT social isolation were the focus of the analysis along with group x time interaction which identifies different change patterns, and is presented with line graphs. Partial eta-squared was used to determine the ANOVA effects.

Results

Table 1

Distribution of Data in pre, Mid, and Post-tests (N = 40)

Variable	Min	Max	M	SD	Skewness (SE)	Kurtosis (SE)
Social Isolation						
Pre-test	44	65	57.17	4.39	−0.75 (0.37)	0.95 (0.73)
Mid-test	41	67	52.25	5.59	0.20 (0.37)	−0.13 (0.73)
Post-test	35	65	46.95	8.11	0.64 (0.37)	−0.69 (0.73)

Table 1 shows the distributional properties tests for the primary outcome variables across three time points (pretest, midtest, and posttest). To determine if each measure for every assessment occasion was approximately normal, skewness and kurtosis statistics were used. Most variables presented skewness and kurtosis statistics that were close to 0, or were within the range that would still allow for the use of parametric analyses. However, social isolation data showed a shift from a modest negative skew at pretest to a slight positive skew at posttest, demonstrating greater variability and a longer positive right tail at posttest. Most variables showed that skewness and kurtosis were indices of univariate normality for parametric testing, except for slight memory pretest skewness and a few negative kurtosis values at posttest. Because of this, it was determined that parametric repeated measures ANOVA, t-test, and one way ANOVA analyses would be appropriate for assessing the effect of the intervention.

Table 2

Independent Samples t-Test Results for Pre-Test Measures Between Experimental and Control Groups

Variable	Experimental (n = 20)	Control (n = 20)	t	df	p	Cohen's d	95% CI
	M (SD)	M (SD)					[LL, UL]
Social Isolation	56.75 (5.31)	57.60 (3.32)	-.61	38	.547	-0.19	[-0.81, 0.43]

Note. CI = confidence interval; LL = lower limit; UL = upper limit.

As H1 predicted the experimental and control groups would be similar at pretest across the primary outcomes. The outcomes of the independent samples t-test in Table 11, have shown that the experimental and control groups at baseline, for social isolation did not differ significant (t(38) = −0.61, p = .547, d = −0.19 moderation, non-significant baseline difference with the experimental

group scoring lower (better) on average than controls). All of the variables fell within confidence limits, and this provided more evidence of no systematic differences at the baseline. Overall, results show the two groups were statistically similar at the pre-test. Thus, any difference in the post-intervention study can be attributed to the intervention and not pre-intervention variation. This randomization produced comparable groups at baseline, and H1 was supported.

Table 3

Repeated Measures ANOVA Results of Social Isolation Across Time Points Between Experimental and Control Groups

Outcome Variables	Experimental Group			Control Group			ANOVA Results			
	Pre *M* (*SD*)	Mid *M* (*SD*)	Post *M* (*SD*)	Pre *M* (*SD*)	Mid *M* (*SD*)	Post *M* (*SD*)	Time (T)	Group (G)	T × G	η^2_p
Social Isolation	56.75 (5.31)	49.90 (4.27)	41.15 (3.35)	57.60 (3.32)	54.60 (5.86)	52.75 (7.28)	72.84**	19.90**	20.66**	.657

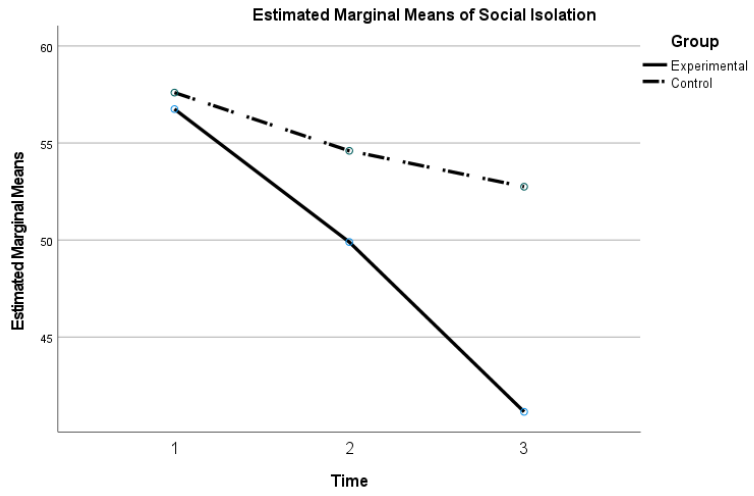
Note. F-values presented for ANOVA results. Degrees of freedom: Time = 2, 76 (sphericity assumed); Group = 1, 38; Time × Group = 2, 76. η^2_p = partial eta squared represents effect size for Time main effect.

*p < .05. **p < .01.

H3 hypothesized that the SEFT group would have more decreased social isolation than the control group. As seen in Table 13 the repeated measures ANOVA noted a time main effect, F(2, 76) = 72.84, p < .01, a main effect of group, F(1, 38) = 19.90, p < .01, and a significant Time × Group interaction, F(2, 76) = 20.66, p < .01 (η^2_p = .657 for time). From the time assessments of social isolation, the SEFT group showed the most significant decline in tracer measurements with social isolation (pre, M = 56.75, SD = 5.31, mid, M = 49.90, SD = 4.27, post, M = 41.15, SD = 3.35) than the control group which showed (pre, M = 57.60, SD = 3.32, mid, M = 54.60, SD = 5.86, post, M = 52.75, SD = 7.28) smaller declines in social isolation. The significant interaction showed the SEFT group's decline in perceived social loneliness was greater than the control group's. This supported H3, that there was a significant decrease in social isolation with SEFT (Figure 1).

Figure 1

Line Graph for Change in Estimated Marginal Means of Social Isolation in Pre, Mid, and Post-Test



Discussion

This study examined the effectiveness of the Spiritual Emotional Freedom Technique (SEFT) in reducing social isolation among the elderly. Results show that SEFT is extremely effective for chronic social isolation. The experimental group's social isolation scores show consistent, progressive improvement (pre-test social isolation score mean = 57.17, SD = 4.39; mid-test score mean = 52.25, SD = 5.59; post-test score mean = 46.95, SD = 8.11). This pattern suggests that the intervention was effective, producing long-lasting change. The increase in variability in post-test scores could indicate individual differences in response to the intervention. Individual differences could be due to baseline emotional resilience, spirituality, or compliance with the sessions. SEFT is effective in alleviating social isolation, and the intervention is useful. Skewness and kurtosis also support the conclusion that all results are statistically valid.

Baseline comparisons assessing social isolation showed no significant difference between the experimental and control groups before the intervention, $t(38) = -0.61$, $p = .547$, Cohen's $d = -0.19$. This shows that the two groups had comparable levels of social isolation; therefore, any changes after the intervention could be attributed to the SEFT intervention rather than to other factors. The use of a randomized control design is also a strength that justifies the study's internal validity and supports the cause-and-effect relationship of the findings. The effectiveness of the intervention is also demonstrated by a repeated measures ANOVA that shows significant main effects of time ($F = 72.84$, $\eta^2_p = .657$), group ($F = 19.90$, $\eta^2_p = .657$) and time x group interaction ($F = 20.66$, $\eta^2_p = .657$) that indicates the SEFT group showed a significant decrease in social isolation and that this decrease was significantly more than any changes that were observed in the control group. The SG sample's mean of 41.15 is significantly lower than the CG sample's mean of 52.75, therefore, the case of perceived social isolation after the SEFT intervention is statistically significant. These findings corroborate earlier studies done on the emotional and social advantages of SEFT. Fauzan et al.

Significant improvements in loneliness in prison inmates after participating in SEFT were reported by (2021). In contrast, Novitriani and Hidayati (2017) reported an increase in self-acceptance and emotional well-being, both of which are closely associated with feelings of social connectedness. The findings are consistent with the integration of theories that combine elements of Cognitive Behavioral Theory (CBT) with the Mind-Body-Spirit model. In their view, negative social isolation and feelings can be alleviated by restructuring negative social cognitions and fostering spiritually positive social connections (Beck, 2020; Sulmasy, 2002). Cognitive and emotional aspects of loneliness appear to be addressed by SEFT, which also appears to contribute to alleviating social isolation among the elderly in a twofold manner.

There are several possible explanations for the intervention's efficacy. First, tapping along with positive affirmations may help manage negative feelings and cognitive distortions associated with loneliness. Furthermore, spiritual affirmations allow participants to experience a sense of purpose, sustain hope, and receive inner emotional support, while also relieving some of the existential burdens associated with social isolation. Additionally, the well-defined, organised structure of the group sessions motivates participants to engage in interpersonal and social interactions, thereby indirectly promoting social connectedness. It can be inferred that these mechanisms acted in concert to achieve the remarkable reduction in social isolation among participants in the experimental group.

Strengths & Limitations

The randomized controlled design enhances causal inference, while the use of a validated measure of loneliness (UCLA Loneliness Scale Version 3) ensures reliable assessment of the primary outcome. Mid-test measurements allowed for monitoring of progressive change, and effect sizes indicate strong practical significance. However, certain limitations should be noted. The moderate sample size (N = 40 per group) may limit generalizability, and the absence of long-term follow-up precludes conclusions about sustained effects. Additionally, individual differences in spiritual orientation or prior exposure to energy-based interventions may have influenced responsiveness. Finally, reliance on self-report measures introduces the possibility of social desirability bias.

Implications for Practice

SEFT can be incorporated into community, residential, and clinical settings to address social isolation in older adults, offering a holistic approach that includes emotional, behavioral, and spiritual aspects. Future studies can focus on longer-term effects, factors that mediate SEFT's effects, such as emotional regulation or spiritual connectedness, and comparisons with other psychosocial interventions, such as mindfulness or CBT-based approaches.

Conclusion

This study provides strong empirical evidence that SEFT is indeed effective in addressing social isolation in older adults. The significant progressive reductions found between pre- and post-test, supported by strong statistical evidence, clearly show the practical and real-world importance of SEFT. SEFT is a promising intervention that takes a holistic approach, addressing emotional, cognitive, and spiritual aspects to promote psychosocial well-being in older adults.

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