



Effect of Spiritual Emotional Freedom Technique (SEFT) on Pain During the COVID-19 Pandemic

Dwi Mulianda,¹ Chandra Bagus Ropyanto²

Abstract

Background/Aim: Effective pain management has become more difficult during the COVID-19 pandemic. The spiritual emotional freedom technique (SEFT) can be one of the efforts to overcome acute and chronic pain because SEFT is an intervention that can overcome physical problems by combining spiritual and psychological energy through sincerity of prayer and surrender. Aim of this study was to analyse the effect of SEFT on pain during the COVID-19 pandemic and the difference in the effect of SEFT on pre- and post-intervention pain.

Methods: The research method was a quasi-experiment with a pre-post-test group design. The study was conducted by assessing the pain scale before and after using the numeric rating scale (NRS). The sample size in the study was 98 respondents. Inclusion criteria were: patients experiencing acute or chronic pain, composed consciousness, being able to communicate well enough and being consistent with the stages of intervention. Exclusion criteria were, unconsciousness, patients diagnosed with COVID-19, shortness of breath, cognitive impairment and hearing loss.

Results: Pain measured by NRS in respondents for the pretest was 2.40 (1.679) and the post-test was 1.39 (0.490) with the interpretation of mild pain. Pretest and post-test on respondents showed significant pain reduction (Wilcoxon test, $p = 0.0001$; Mann Whitney test, $p = 0.013$).

Conclusion: Respondents experienced less pain after SEFT than before the intervention. The impact of the pain scale on respondents was different before and after SEFT.

Key words: Pain; Spiritual therapies; Mental healing; Faith healing; Meditation; Acupressure; Acupuncture treatment; COVID-19.

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Introduction

Effective pain management has become more difficult during the COVID-19 pandemic because patients are afraid they may contract the virus.¹ They tend to avoid hospitals, especially if they are elderly and have comorbidities.² Patients who suffer from acute pain that is not treated are more likely to develop chronic pain.^{3,4} Similarly, patients with untreated chronic pain may experience immunosuppression,⁵ limit their daily activities, which can impair their quality of life,⁶ deteriorate

their cognitive function,⁷ rob them of their functional independence and make it harder for them to participate in social activities.⁸ Anxiety, exhaustion, trouble sleeping,⁹ depression and an increase in suicide risk are all contributing factors. During the COVID-19 pandemic, pain is becoming a more widespread health issue worldwide and may be associated with an increased risk of morbidity and mortality.²

Both pharmacological and non-pharmacological approaches can effectively manage pain. Constipation, nausea and vomiting are side effects of even effective pharmaceutical pain management. Approximately 60 % of people who have no side effects and 40 % of people who have mild nausea prefer analgesics.¹⁰ Additionally, painkillers can weaken the immune system because they cause secondary adrenal insufficiency, which modifies the immune response.¹¹ This is particularly true when using oral or injectable steroids. One of the non-pharmacological methods for managing both acute and persistent pain is the spiritual emotional freedom technique (SEFT).¹²

The combination of spiritual power and energy psychology, or SEFT, is a system of techniques and principles that use the body's energy system to improve conditions of thought, emotion and behavior.¹²⁻¹⁴ The principles of SEFT are similar to those of acupressure and acupuncture, but they go much deeper. Effective, quick, simple, affordable, safe, empowering, universal, compatible, scientific and halal are all qualities of SEFT.¹⁵

Previous research findings demonstrate that SEFT therapy has an impact on reducing postoperative pain intensity in patients, with a p-value of 0.017.¹⁶ Analgesic therapy alone was not as effective at reducing pain in cancer patients as the combination of SEFT intervention and analgesic therapy.¹⁷ Prior studies using SEFT have examined acute or chronic pain in a few different diseases. On the other hand, no research has been done on SEFT on pain with different comorbidities. As a result, scientists wish to examine how SEFT affected pain before and after the COVID-19 pandemic, as well as how different its effects were on pain before and after the intervention.

Aim of this study was to analyse the effect of SEFT on pain during the COVID-19 pandemic and the difference in the effect of SEFT on pre- and post-intervention pain.

Methods

Quantitative and quasi-experimental approach pre-post-test one group design was implemented. The study was conducted by assessing the pre and post-test pain scale of SEFT intervention. The inclusion criteria were: patients with pain, composed consciousness, able to communicate

well enough and consistent with the stages of intervention. Patients with COVID-19, patients not experiencing pain, unconscious patients, with shortness of breath, cognitive impairment and/or hearing loss were not included in the study. The total research sample at the time of the field was 114 people, 16 participants gave incomplete answers, so the final total research sample was 98 respondents. The research location was conducted at STIKES Kesdam IV / Diponegoro Central Java, Indonesia, with respondents spread from Central Java, East Java, West Java, Lampung and South Sumatra.

Data collection was held in December 2022. The numeric rating scale (NRS) was used in data collection. Validity and reliability tests were performed. Instruments used showed validity and reliability tests for pain 0.941 and 0.95.¹⁸

To all subjects who came and met the research inclusion criteria until the required number of subjects was met, pain measurements were taken using the NRS, then SEFT intervention was carried out, 3 stages (set-up, tune-in and tapping), for 20 minutes, 1 time a day. Finally, a post-test was conducted on the respondent.

The first stage of SEFT "the set-up" consisted of 2 activities, saying a prayer sentence with a full sense of *khusyu* and sincerity and surrendering 3 times, while saying it soulfully, then pressing on chest in the Sore Spot (pain point area around the upper chest which if pressed feels a little painful). The second stage "tune-in" consisted of feeling, experiencing the pain, then directing minds to the place of pain, accompanied by hearts and mouths praying. The third stage of "tapping" consisted of tapping lightly with two fingertips on certain key points of the major energy meridians in body while continuing to tune in.

Data analysis used univariate and bivariate analyses. Univariate analysis was conducted to analyse differences of age, gender, occupational factors pre- and post-test pain. Bivariate analysis was used to explore the relationship between variables. Significance was set at $p < 0.05$.

Results

Demographic characteristics of respondents are shown in Figure 1-3.

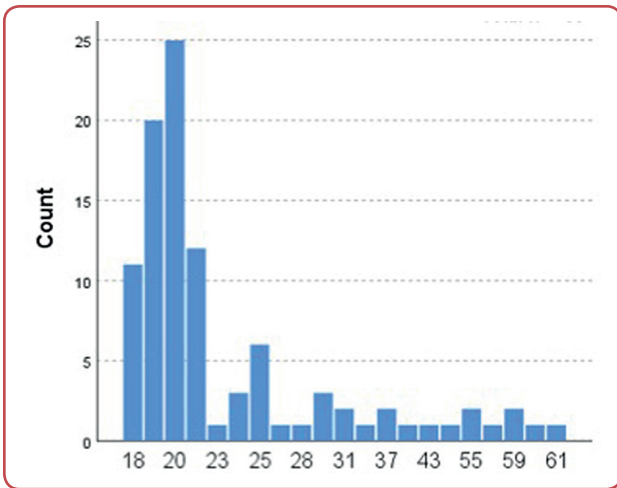


Figure 1: Age distribution of respondents

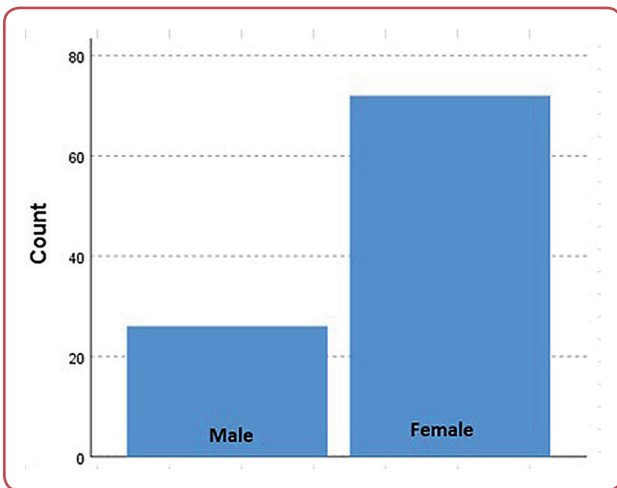


Figure 2: Gender distribution of respondents

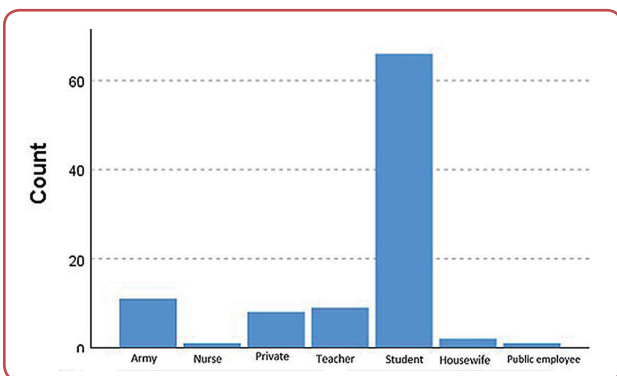


Figure 3: Occupation distribution of respondents

Pain intensity pre- and post-test is shown in Table 1 and 2. The pain experienced by 98 respondents varied from acute pain to chronic pain. Respondents' pain accompanying characteristics consisted of ulcers or gastritis (54 people), hypertension (11 people), hypotension (2 people), migraines (3 people), vertigo (2 people), rheumatism (4 people), asthma (2 people), nephrotic syndrome (1 person), urinary tract infection (1 person), low blood pressure (1 person), typhoid (2 people), muscle pain (2 people), zolpidem use (2 people), dysmenorrhoea (2 people) and diabetes mellitus (1 person).

Bivariate tests in this study used nonparametric tests because some data were not normally distributed. The nonparametric test used in this study was the Wilcoxon test with the results of 83 respondents experiencing a decrease in pain scale, 2 respondents increased pain scale and 13 respondents fixed pain scale. The average value of pain measured by NRS in respondents for the pretest was 2.40 (1.679) and the post-test was 1.39 (0.490) with mild pain interpretation. Pre-test and post-test in respondents the value was $Z = -3.631$. Wilcoxon test results p value = 0.0001 showed significant difference in pain level before and after SEFT.

The results of the Mann-Whitney test U-test showed significant pain reduction after SEFT ($U = 805.500$, $Z = -2.484$, $p = 0.013$) found $p < 0.005$, meaning that there was a difference in the effect of the pain scale before and after SEFT on respondents.

Table 1: Pain intensity before and after spiritual emotional freedom technique (SEFT)

Pain intensity*	N	Mean	SD	Min	Max
Pre-SEFT	98	4.72	1.92	1	10
Post-SEFT	98	2.33	1.49	0	7

*NRS - numeric rating scale 1-10; Wilcoxon test: $Z = -3.631$, $p = 0.0001$.

Table 2: Pain intensity categories before and after spiritual emotional freedom technique (SEFT)

Participants - N (%)	Total	No pain	Mild	Moderate	Severe	Very severe
Pre-SEFT	98 (100.00)	0 (0.00)	30 (30.61)	54 (55.10)	13 (13.26)	1 (1.02)
Post-SEFT	99 (100.00)	10 (10.29)	74 (75.51)	12 (12.24)	2 (2.04)	0 (0.00)

Discussion

Acute pain is an unpleasant physiological, sensory and affective experience linked to tissue damage. It is typically sudden in onset, time-limited and drives behaviour to prevent actual or potential tissue injury. Acute pain is expected in response to noxious stimuli that can become pathological.^{19, 20} Pallor, diaphoresis, elevated blood pressure, dilated pupils, skeletal muscle tension, rapid or shallow breathing and behaviour like sobbing, whimpering, or guarding the painful body part are all indicators of acute pain. Patients are frequently able to pinpoint the location of acute pain, characterise it (eg, as sharp, dull, stabbing or cramping) and identify temporal patterns (eg when it starts and changes over time). Acute pain is frequently brought on by trauma, including surgery. However, acute pain doesn't always go away on its own or not even after treatment. Acute pain is supposed to go away in a few days or weeks, but it can last up to three months or longer before becoming chronic.^{21, 22}

A complex medical condition that lasts longer than three months and persists after the normal healing period is known as chronic pain.²³ Chronic pain falls into seven categories according to the 11th International Classification of Diseases (ICD-11): primary, cancer-related, post-traumatic and post-operative, neuropathic, visceral, musculoskeletal and headache/orofacial.²⁴ Chronic pain patients may have up to 88 % of other comorbid conditions, including diabetes mellitus, cancer, heart and lung conditions and depression.²⁵ An issue with the innervation system is pain. The four main components of nociception—transduction, transmission, interpretation and modulation of pain in the peripheral nervous system (PNS) and central nervous system (CNS) are involved in the complex network of neurophysiological processes that make up pain.²⁶

Pre-SEFT intervention obtained data showed that 54 respondents (55.10 %) experienced moderate pain. Post-SEFT intervention 74 respondents (75.51 %) experienced mild pain. The percentage of respondents' pain characteristics post SEFT intervention was strengthened by the results of the Wilcoxon test after being given SEFT intervention, 83 respondents experienced a decrease in pain scale, 13 respondents had a fixed pain scale and 2 respondents had an increased pain scale. The increased pain characteristics of respondents post-SEFT intervention were influenced by

the type of pain that had long been experienced by 2 respondents, namely rheumatism and diabetes mellitus.

Combining SEFT is a system of techniques and principles that use the body's energy system to improve circumstances related to thought, emotion and behaviour. Its principles are similar to those of acupressure and acupuncture and its clinical outcomes are unusually fast, long-lasting and durable. The goal of the psychological therapy known as the SEFT intervention was initially to supplement pre-existing psychotherapy instruments. The 15 different therapeutic modalities that makeup SEFT, which includes spiritual strength are as follows: 1) neuro-linguistic programming (NLP); 2) systemic desensitisation; 3) psychoanalysis; 4) logotherapy; 5) eye movement desensitisation reprocessing (EMDR); 6) Sedona method; 7) Ericsonian hypnosis; 8) provocative therapy; 9) suggestion and affirmation; 10) creative visualisation; 11) relaxation and meditation; 12) gestalt therapy; 13) energy psychology; 14) powerful prayer; faith, concentration, acceptance, surrender, gratitude, 15) loving-kindness therapy.¹⁵

The three steps of SEFT are set-up, tune-in and tapping. The first phase of the set-up is to neutralise psychological resistance and make sure that the energy flow in our bodies is directed appropriately. The two activities that make up the set-up are saying the prayer sentence three times with complete *khusyu*, sincerity and surrender and pressing our chest precisely in the "Sore Spot" (the area around the upper chest that hurts a little when pressed) while saying it with soul. The second step, called tune-in, involves feeling the pain we are experiencing, focusing our minds there and opening our mouths and hearts to pray. For emotional problems, we tune-in by thinking about something or certain events that can trigger unfavourable feelings that we wish to get rid of. Our mouth and heart pray when a negative emotion occurs, such as anger, sadness, fear, etc. In the third step, tapping, we continue to tune-in while gently tapping specific body points with two fingertips. These are the main points of "the major energy meridians" and tapping on them multiple times can help balance out any pain or emotional disturbance we are experiencing, because the energy flow through the body has returned to balance and normal.

Previous research findings demonstrate that SEFT therapy has an impact on reducing post-operative pain intensity in patients.¹⁶ Analgesic therapy alone was not as effective at reducing pain in cancer patients as the combination of SEFT intervention and analgesic therapy, according to another study.¹⁷

β -nerve fibres sent to the dorsal column nucleus and nerve impulses sent through the medial lemniscus *via* collateral pathways connected to the periaqueductal grey area (PAG) can both be stimulated by SEFT tapping stimulation. To lessen pain, the body produces enkephalin, a form of opium, as a result of stimulating the PAG. The principles of SEFT therapy are similar to those of acupuncture and acupressure. The difference lies in the fact that SEFT prioritises application expertise over the use of needles or other tools, making its techniques safer, easier, faster and simpler even without risk. Additionally, God is involved in the SEFT process.¹⁵

In this condition, the sympathetic nerves that produce tension can be reduced in function and increased in parasympathetic nerves, ending the cycle of pain and muscle tension. Alternatively, SEFT therapy can activate parasympathetic nerves, which are expected to suppress tension and anxiety by reciprocating, resulting in counter-conditioning and pain relief. By applying pressure to a single point on the meridian system, the periaqueductal grey matter can release endorphin, a naturally occurring substance or neurotransmitter that resembles morphine. Muscle tension and pain perception are reduced when endorphin is present at the junction of nerve cells. In the process of lowering the pain scale, this has an impact on the physiological elements of pain stimulation and transmission.^{27, 28} Additionally, both subjects' breathing rhythms will become more regular as a result of SEFT therapy and their hearts will beat more steadily and regularly, facilitating smooth blood circulation throughout their bodies and leaving the client in a highly relaxed state. Using tapping or light tapping as a stimulant on the body's acupoints is known as SEFT therapy. When the body is stimulated by light tapping or tapping, the body responds by mobilising more neurotransmitter signals. This reduces the regulation of the hypothalamic-pituitary-adrenal axis (HPA axis) until the production of stress hormones, in this

case cortisol, is reduced. This can enhance the reduction of pain by the physiological aspects of transduction pain.²⁹ With its foundation in energy psychology and spiritual power, SEFT therapy can help develop brief therapy to address psychological and physical issues in line with the physiological aspects of pain modulation.³⁰

SEFT was significantly applied to patients who had complaints of pain with various kinds of comorbidities. This study has limitations in increasing the frequency of SEFT for respondents who experienced increased pain.

Conclusion

The respondents experienced less pain after SEFT than they did before the intervention. Recommendation is for further research to increase the frequency of SEFT.

Ethics

Ethical approval was obtained from Research and Community Services on 26 August 2022, with number 061/EC/VIII/2022. Data collection was carried out by selecting research subjects, providing informed consent to prospective respondents, providing information about the aims and objectives of the study and asking for respondents' consent by signing.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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Data access

The data that support the findings of this study are available from the corresponding author upon reasonable individual request.

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