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The Emotional Freedom Technique (EFT) as a Spiritual Therapy for Reducing Anxiety Levels in Preoperative Patients

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Abstract

Preoperative anxiety can influence patients' psychological and physiological conditions and may interfere with optimal preparation for surgical procedures. Spiritual Emotional Freedom Technique (SEFT) is a non-pharmacological intervention integrating spiritual elements with tapping techniques to promote relaxation and emotional regulation. This study aimed to evaluate changes in anxiety levels following SEFT among preoperative patients at RSKB Columbia Asia Semarang. An empirical descriptive case-study design with a one-group pretest–posttest approach was conducted involving five preoperative patients who met the inclusion criteria. Anxiety was assessed using the Amsterdam Preoperative Anxiety and Information Scale (APAIS) before and after one SEFT session lasting approximately 10–15 minutes through set-up, tune-in, and tapping stages. Descriptive analysis compared individual and aggregate anxiety scores before and after intervention. All five participants experienced reductions of 6–9 APAIS points. The total score decreased from 109 to 72, while the mean decreased from 21.8 to 14.4. Before intervention, three patients had severe anxiety, one had moderate anxiety, and one had panic anxiety; afterward, four had moderate anxiety and one had mild anxiety. These findings indicate that SEFT was associated with consistently reduced preoperative anxiety and may serve as a complementary nursing intervention for psychological preparation before surgery.

Keywords: Anxiety, Complementary Therapy, Preoperative Patients, SEFT, Spiritual Therapy.



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INTRODUCTION

Surgery is an invasive medical intervention involving direct manipulation of body tissues to establish a diagnosis, treat disease, repair injury, or correct anatomical abnormalities, and its expanding role in contemporary healthcare has increased attention to the quality and safety of perioperative care (Abdurrohman et al., 2023). Global surgical activity has increased substantially, with approximately 165 million surgical procedures estimated to be performed annually, making perioperative outcomes an increasingly important component of modern health-service performance (Ramadhan et al., 2023). In Indonesia, surgical procedures similarly constitute an important component of hospital care, with national health reporting documenting the continuing burden of operative interventions within the healthcare system (Kementerian Kesehatan Republik Indonesia, 2022). Although surgical treatment is directed toward improving physical health, tissue injury and physiological stress associated with invasive procedures can activate inflammatory, metabolic, cardiovascular, and neuroendocrine responses that extend beyond the operative site. These physiological demands occur concurrently with psychological responses to uncertainty, perceived threat, loss of control, and anticipated pain, positioning psychological preparedness as an integral dimension of perioperative care rather than a secondary concern. Contemporary perioperative practice consequently requires a patient-centered framework in which technical surgical safety, physiological stabilization, emotional readiness, and recovery are understood as interacting determinants of clinical outcomes, particularly because optimization before surgery may influence the subsequent recovery trajectory (Gillis et al., 2022).

Among the psychological problems encountered during the perioperative period, preoperative anxiety is particularly important because patients may experience fear of the surgical procedure, anesthesia, postoperative pain, complications, disability, or death before entering the operating room (Almar et al., 2024). Anxiety can manifest cognitively through persistent worry and anticipatory thoughts, emotionally through fear and tension, and physiologically through autonomic activation that

may include increased heart rate, respiratory activity, sweating, and blood pressure. Empirical observations among surgical patients indicate that anxiety may coexist with increased blood pressure before surgery, illustrating the clinically relevant connection between emotional distress and physiological readiness for an operative procedure (Yuliastuti et al., 2023). The intensity of this response is not uniform because age, gender, knowledge, previous experiences, social support, waiting time, and individual coping resources may shape how a patient appraises an impending intervention. First-time surgical experiences are especially capable of generating uncertainty because unfamiliar environments, procedural expectations, and anticipated outcomes may amplify the patient's perception of threat (Tisya et al., 2024). Evidence from other clinical populations also demonstrates that anxiety can interact with sleep and broader psychological functioning, reinforcing the importance of viewing anxiety as a multidimensional health response rather than an isolated emotional symptom (Astuti et al., 2021). Developmental and individual characteristics further shape emotional adaptation to stressful life events, suggesting that preoperative anxiety must be approached through interventions sufficiently flexible to accommodate differences in patient vulnerability and coping capacity (Paputungan, 2023).

Previous studies have examined educational, psychological, complementary, and spiritually oriented strategies for controlling preoperative anxiety, but their findings indicate that information provision alone does not necessarily address the emotional processes underlying surgical fear. Providing anesthesia information can improve patient understanding, yet anxiety may persist when cognitive knowledge does not adequately regulate emotional arousal, uncertainty, or perceived vulnerability (Nur et al., 2022). Spiritual Emotional Freedom Technique (SEFT) has emerged within this context as a complementary mind-body intervention combining focused emotional processing, spiritual orientation, and tapping-based stimulation, with its therapeutic rationale extending beyond conventional informational support. Abdurrohman et al. reported a reduction in mean anxiety scores from 15.39 before SEFT to 10.89 after treatment among 36 preoperative patients, indicating a transition from moderate toward mild anxiety (Abdurrohman et al., 2023). Mardika et al. likewise identified differences in anxiety before and after SEFT administration, strengthening the empirical indication that this intervention may influence the emotional state of patients awaiting surgery (Mardika et al., 2024). Evidence beyond surgical populations is directionally compatible with these findings, as SEFT has been applied to anxiety among patients undergoing pre-percutaneous coronary intervention and to psychological well-being in other vulnerable groups. The broader EFT literature has also matured to the level of systematic synthesis, with recent evidence evaluating its potential for anxiety disorders while simultaneously underscoring the importance of stronger methodological designs and clearer characterization of therapeutic effects (Choi et al., 2025).

Despite these encouraging findings, the existing evidence remains conceptually and empirically fragmented, limiting the extent to which reductions in anxiety can be confidently attributed to a reproducible therapeutic mechanism across perioperative populations. Earlier Indonesian studies reported beneficial effects of SEFT on anxiety, yet differences in populations, settings, intervention procedures, anxiety measurements, and study designs constrain direct comparison and limit generalization across surgical contexts (Kusumasari et al., 2020). A randomized controlled trial conducted among patients awaiting laparoscopic cholecystectomy provides stronger evidence that EFT can reduce surgical fear and anxiety, but procedure-specific findings cannot automatically be generalized to heterogeneous preoperative populations with different clinical and psychological profiles (Menevşe & Yayla, 2024). Recent literature reviewing SEFT for preoperative anxiety continues to suggest therapeutic promise, while the accumulated evidence also reveals a need for context-specific empirical evaluation capable of connecting intervention exposure with measurable changes in anxiety within actual perioperative nursing environments (Umifa, 2026). This limitation becomes more consequential because preoperative anxiety itself is heterogeneous, with demographic factors such as age and gender showing relationships with anxiety levels in surgical populations. The literature also contains numerous studies of anxiety determinants and alternative interventions, but evidence that a risk factor or another non-pharmacological strategy affects anxiety cannot substitute for direct assessment of SEFT in the clinical population for which it is intended. A sharper empirical question consequently concerns whether a structured spiritually integrated intervention can produce measurable anxiety reduction among preoperative patients in a defined surgical-care setting while remaining feasible within routine nursing practice.

Addressing this question is scientifically and clinically important because unmanaged preoperative anxiety can complicate psychological preparation for surgery and may coincide with physiological responses that are undesirable immediately before an invasive procedure. Nurses occupy a strategically important position in this process because repeated patient contact creates opportunities to identify anxiety, provide accurate explanations, strengthen coping behavior, and deliver structured non-pharmacological interventions before surgery (Kawanda & Ambar, 2023). SEFT is particularly relevant to this role because it combines an emotional-regulation procedure with spiritual elements and tapping at defined points, offering a complementary approach that can be incorporated without replacing established medical or anesthetic management (Nurrohmah, 2022). Its spiritual dimension may be clinically meaningful for patients who use faith, surrender, prayer, or transcendent meaning as coping resources when confronting uncertainty, while its emotional component provides a structured focus for distress that simple reassurance may not adequately resolve. The technique has also been described as integrating tapping-based stimulation with spiritual and psychological processes intended to promote emotional regulation and subjective calm (Erika & Kusmawati, 2024). Such an intervention is particularly relevant when anxiety develops during the waiting period before surgery, when pharmacological escalation may neither be necessary nor desirable for every patient but timely nursing support remains possible. The scientific urgency lies in establishing whether this theoretically accessible intervention produces clinically meaningful change under real preoperative conditions rather than assuming effectiveness from its conceptual plausibility or from evidence generated in dissimilar populations.

The present study is positioned within this unresolved area by examining SEFT as a spiritually integrated complementary therapy for preoperative anxiety at RSKB Columbia Asia Semarang, where a preliminary study conducted in March 2026 among five patients awaiting surgery found anxiety characterized by worry, fear, restlessness, difficulty remaining calm, facial tension, increased pulse, and elevated blood pressure. Patients associated these experiences particularly with concerns about the surgical procedure, anesthesia, possible complications, and their postoperative condition, indicating that anxiety in this setting encompasses intertwined cognitive, emotional, and physiological responses. This local clinical pattern provides a direct empirical rationale for evaluating an intervention that targets emotional regulation while accommodating spiritual coping within the period preceding surgery. The study specifically aims to determine the effect of Spiritual Emotional Freedom Technique on anxiety levels among preoperative patients by evaluating measurable changes associated with the intervention in the defined clinical setting. Theoretically, the research contributes to a more integrated understanding of preoperative anxiety by examining spiritual and emotional regulation as components of perioperative adaptation rather than treating anxiety exclusively as an informational deficit or nonspecific stress response. Methodologically, it contributes setting-specific empirical evidence through structured assessment of anxiety in relation to SEFT exposure, creating a clearer basis for judging the intervention's applicability within perioperative nursing care. The findings are expected to inform the development of feasible, patient-centered, non-pharmacological anxiety management while providing a foundation for subsequent studies using broader samples, comparison groups, and more rigorous designs to establish effectiveness and generalizability.

RESEARCH METHODS

This study employed an empirical descriptive case-study design with a one-group pretest–posttest approach to evaluate changes in anxiety levels following Spiritual Emotional Freedom Technique (SEFT) among preoperative patients at RSKB Columbia Asia Semarang. The study involved five preoperative patients who met the inclusion criteria, namely patients scheduled for surgery, experiencing preoperative anxiety, able to communicate and follow the intervention procedures, and willing to participate, while patients with conditions that prevented communication or completion of the SEFT procedure were excluded. Preoperative anxiety represents a clinically relevant response that may vary according to patients' demographic, psychological, and perioperative characteristics, supporting the need for assessment directly within the surgical-care setting (Gumilang et al., 2022). Data were collected through interviews, observation, physical examination, completion of the anxiety questionnaire, and documentation before and after the intervention. Each participant received one SEFT session lasting approximately 10–15 minutes during the preoperative phase through three sequential stages—set-up, tune-in, and tapping—consistent with the application of SEFT as a complementary

intervention for managing anxiety (Kawanda & Ambar, 2023). The use of a pretest–posttest procedure enabled each participant’s anxiety condition before SEFT to serve as the within-participant reference for evaluating the subsequent response to the intervention, an approach consistent with previous clinical applications examining anxiety changes following SEFT (Mardika et al., 2024).

Anxiety was assessed using the Amsterdam Preoperative Anxiety and Information Scale (APAIS) before the SEFT session and reassessed after completion of the intervention to determine changes in anxiety scores and categories. The selection of a structured preoperative anxiety assessment was intended to provide a standardized basis for documenting psychological responses that may otherwise be expressed through heterogeneous emotional and physiological manifestations (Almar et al., 2024). Descriptive analysis was performed by comparing individual and aggregate pre-intervention and post-intervention anxiety levels, including the distribution of participants across the identified anxiety categories, without inferential statistical testing because of the descriptive case-study design and limited sample of five participants. This analytical strategy was restricted to characterizing observed changes after the intervention and did not treat pre–post differences as definitive causal evidence, particularly because the design did not include randomization or a control group. The research procedures followed principles of voluntary participation, confidentiality, respect for participant autonomy, and protection of patients during the preoperative period, consistent with the importance of patient-centered nursing support when managing surgical anxiety (Sumboko et al., 2024). Participants were informed about the study and intervention before participation and provided consent, while SEFT was implemented as a complementary intervention without replacing or interfering with established surgical, anesthetic, or nursing care, consistent with its positioning as a non-pharmacological approach to preoperative anxiety management (Abdurrohman et al., 2023).

RESULTS AND DISCUSSION

Clinical and Demographic Characteristics of Preoperative Patients

The study involved five preoperative patients treated at RSKB Columbia Asia Semarang, comprising four women and one man according to the demographic distribution reported in Table 4.1. Their individually recorded ages were 40, 29, 20, 32, and 38 years, showing that the observed cases were concentrated within adulthood rather than older age groups. The small and clinically specific sample is consistent with the descriptive case-study design, in which individual patterns are examined in depth rather than generalized statistically to the broader surgical population. Demographic characteristics remain relevant because anxiety responses in preoperative settings can vary according to age, gender, previous surgical exposure, and other psychosocial conditions (Gumilang et al., 2022). The predominance of women in this case series should consequently be interpreted as a characteristic of the recruited patients rather than evidence that women generally undergo surgery more frequently. Nevertheless, gender-related differences in emotional expression and anxiety susceptibility have been described in clinical populations, indicating that demographic composition can influence the anxiety profile observed within a small sample (Astuti et al., 2021).

The individual clinical assessments showed that anxiety was accompanied by observable psychological and physiological manifestations before surgery. Patient 1, a 40-year-old woman, obtained an APAIS score of 20 and was classified as having severe anxiety, accompanied by restlessness, nervousness, blood pressure of 140/90 mmHg, pulse of 102 beats/minute, and respiratory rate of 20 breaths/minute. Patient 2, a 29-year-old woman with an APAIS score of 21, similarly presented severe anxiety and expressed fear that she might not regain consciousness after general anesthesia, with blood pressure of 140/90 mmHg and pulse of 110 beats/minute. Concerns about anesthesia, operative procedures, and possible adverse outcomes have been identified as important sources of anxiety among patients awaiting surgery (Hamdani, 2022). Patient 3, aged 20 years, had the highest baseline APAIS score of 27 and was classified in the panic category, with fear, nervousness, difficulty concentrating, pulse of 115 beats/minute, and respiratory rate of 24 breaths/minute. These individual findings illustrate that preoperative anxiety was not confined to subjective worry but was accompanied by measurable autonomic manifestations that may increase the clinical burden of the preoperative period.

Patient 4 was a 32-year-old woman who recorded an APAIS score of 18 and was classified as having moderate anxiety, with restlessness, fear of the surgical procedure, pulse of 105 beats/minute, blood pressure of 120/80 mmHg, and respiratory rate of 20 breaths/minute. Patient 5 was a 38-year-old

man with an APAIS score of 23, corresponding to severe anxiety, and exhibited restlessness, visible tension, nervousness, fear of surgery and anesthesia, sweating, blood pressure of 145/90 mmHg, pulse of 106 beats/minute, and respiratory rate of 22 breaths/minute. Elevated cardiovascular responses accompanying preoperative anxiety have also been observed in clinical studies, supporting the relevance of physiological signs when interpreting psychological distress before surgery (Yuliasuti et al., 2023). The variation in blood pressure and pulse across the five cases indicates that the physiological expression of anxiety was heterogeneous even though every participant had an elevated anxiety category at baseline. Such heterogeneity is clinically plausible because the perceived threat associated with surgery is shaped by individual appraisal, prior experience, information, social support, and coping resources. Surgical nursing therefore requires attention to both standardized anxiety scores and patient-specific manifestations rather than relying on one physiological parameter alone (Silalahi et al., 2024). The case profiles provide a clinically grounded basis for interpreting subsequent changes after SEFT at both the individual and group levels.

Table 1 summarizes the demographic characteristics exactly as reported in the original dataset and is retained without recalculating the source values. The table indicates four female respondents (80%) and one male respondent (20%), while the age classification lists zero respondents aged 40 years and five respondents below 40 years. This age distribution is internally inconsistent with the individual clinical record for Patient 1, who was documented as 40 years old, but the discrepancy is preserved because alteration would modify the original research data. Early adulthood is characterized by substantial occupational, family, and social demands that can shape perceptions of illness and medical procedures, although such developmental considerations should not be treated as deterministic explanations of anxiety (Paputungan, 2023). Previous surgical experience is also reported in the original table as four patients with one previous operation and one patient with more than one operation. Experience with surgery can affect preoperative expectations because familiarity may reduce uncertainty for some patients while previous unpleasant experiences may increase apprehension for others (Tisya et al., 2024).

Table 1. Frequency Distribution of Respondent Characteristics at Columbia Asia Hospital Semarang (n = 5)

Characteristic	Frequency	Percentage
Gender		
Female	4	80%
Male	1	20%
Age		
40 years	0	0%
<40 years	5	100%
Surgical Experience		
Once	4	75%
More than once	1	25%
Total	5	100%

The female predominance reported in Table 1 should be considered descriptively because four of the five cases were women, giving women a numerically dominant presence in the observed anxiety distribution. Some literature has associated female gender with higher self-reported anxiety in clinical settings, potentially reflecting differences in emotional processing, pain anticipation, socialization, and willingness to express fear (Titin, 2021). Reproductive and other gender-specific health conditions also contribute to differences in patterns of healthcare utilization across the life course, although this broader epidemiological context cannot explain the composition of this five-patient sample by itself (Ismawati et al., 2023). Research on reproductive-health determinants further demonstrates that biological and social influences often interact in shaping healthcare exposure among women rather than operating as isolated causal factors (Diana et al., 2024). In the current cases, the more relevant empirical point is that anxiety occurred in both genders represented in the sample, including severe anxiety in the only male participant. Gender should therefore be treated as a contextual characteristic rather than a sufficient

explanation for the observed preoperative anxiety. The results reinforce the importance of individualized screening regardless of patient gender.

Age also warrants cautious interpretation because the individually documented ages ranged from 20 to 40 years, while Table 1 categorizes the entire sample as younger than 40 years despite the recorded 40-year-old participant. Previous research has reported associations between age and preoperative anxiety, suggesting that younger and older adults may appraise surgery differently depending on life responsibilities, illness experience, and psychological adaptation (Rohmawati et al., 2024). The five patients in this study were all within a relatively restricted adult age range, which limits the ability to compare anxiety across broader developmental stages. Educational background, family support, and knowledge are also recognized correlates of preoperative anxiety and may partly explain individual differences that cannot be attributed to age alone (Sumboko et al., 2024). The small case-series design does not permit testing of demographic predictors, and the observed differences should therefore remain descriptive. Clinically, the demographic findings are most useful for contextualizing the pre-intervention anxiety profiles rather than for constructing causal explanations. This interpretation is consistent with the methodological objective of characterizing anxiety changes within five observed cases rather than estimating population-level determinants.

Baseline Preoperative Anxiety and Clinical Manifestations

Baseline APAIS assessment showed that anxiety was clinically prominent before SEFT, with three patients classified as having severe anxiety, one as moderate, and one as panic according to the original categorizations. Patient-level scores were 20, 21, 27, 18, and 23, producing a combined baseline score of 109 across the five participants. The arithmetic mean derived from these available scores was 21.8, while the lowest and highest observed values were 18 and 27, respectively. These values indicate that the sample entered the intervention phase with consistently elevated anxiety rather than with isolated or minimal distress. Preoperative anxiety often reflects uncertainty concerning anesthesia, pain, procedural outcomes, complications, and loss of control, making a high baseline burden clinically plausible in patients awaiting surgery (Almar et al., 2024). The baseline profile therefore establishes a clear within-patient reference against which post-intervention changes can be evaluated.

The most severe baseline response occurred in Patient 3, whose APAIS score of 27 was categorized as panic and accompanied by fear, nervousness, impaired concentration, pulse of 115 beats/minute, and respiratory rate of 24 breaths/minute. Patient 5 recorded the second-highest score of 23 and showed severe anxiety with visible tension, sweating, elevated blood pressure, and fear concerning both surgery and anesthesia. Preoperative anxiety may activate sympathetic responses that manifest through cardiovascular and respiratory changes, although physiological signs are not specific to anxiety and should be interpreted within the broader clinical context (Ramadhan et al., 2023). Patient 2 provided particularly direct qualitative evidence of anesthetic fear by expressing concern that she might not awaken after general anesthesia. Humor-based interventions have also been investigated for anxiety associated with general anesthesia, reflecting the broader clinical recognition that anticipatory fear can be addressed through non-pharmacological strategies (Choerunisa & Hidayati, 2023). The convergence between questionnaire scores, verbal expressions, and observable signs strengthens the clinical interpretation that the baseline anxiety was meaningful rather than merely a numerical artifact.

Waiting for surgery may have further contributed to the observed distress because uncertainty persists during the interval between preparation and entry into the operating room. Research on operative waiting time has identified this period as potentially relevant to the development or escalation of preoperative anxiety (Jumiran, 2020). Patients may repeatedly anticipate pain, anesthetic risk, postoperative functional limitation, or unfavorable outcomes while they have limited control over the timing and sequence of clinical events. The initial assessment in this study was conducted during the preoperative phase, when these concerns were directly salient and could therefore influence APAIS scores and physiological arousal. Cognitive uncertainty can remain substantial even when routine information has already been provided because receiving information does not necessarily eliminate emotionally charged interpretations of surgical risk. Evidence from patients receiving anesthesia information through leaflets suggests that education is valuable but cannot be assumed to resolve anxiety uniformly across individuals (Nur et al., 2022). This distinction supports the use of an intervention such as SEFT that targets emotional regulation in addition to informational needs.

Previous surgical experience represents another clinically relevant contextual factor because Table 4.1 reports that four respondents had undergone surgery once and one had undergone surgery more than once. Limited experience may leave patients without a stable internal reference for anticipating anesthesia, operative sensations, postoperative pain, and the recovery environment. Qualitative evidence from first-time surgical patients has shown that unfamiliarity can intensify fear and uncertainty, particularly when patients construct expectations from incomplete or negative information (Tisya et al., 2024). Prior experience is not invariably protective, however, because a previous difficult recovery or unpleasant anesthetic experience could also heighten anxiety before a later operation. The available data do not specify which individual patients had one versus multiple previous surgical experiences, so no patient-level association can be calculated without introducing unsupported assumptions. Surgical experience is therefore interpreted as a contextual characteristic of the sample rather than a demonstrated determinant of their APAIS scores. This caution is necessary to preserve the descriptive nature of the analysis.

The observed anxiety also needs to be considered in relation to the broader stress response surrounding surgical intervention. Surgical preparation occurs before a procedure that itself induces tissue injury, inflammation, neuroendocrine activation, and metabolic stress, making psychological optimization a relevant component of perioperative care (Gillis et al., 2022). Experimental evidence concerning severe tissue injury illustrates the complex biological pathways involved in systemic stress responses, although such findings should not be directly equated with anxiety in human preoperative patients (Ciftel et al., 2025). In the present cases, increased pulse, respiratory changes, elevated blood pressure, sweating, restlessness, and tension are more appropriately interpreted as clinical correlates observed alongside anxiety than as proof of a specific physiological mechanism. Self-efficacy and perceived coping capability can also influence how individuals respond to stressful performance or health-related situations, supporting the broader role of cognitive appraisal in anxiety (Jayanti et al., 2021). The baseline findings therefore reflect an interaction between anticipated surgical threat, individual coping resources, and observable autonomic activation. This multifaceted presentation provides a rationale for complementary care that addresses emotional experience rather than focusing exclusively on procedural preparation.

At a service level, preoperative anxiety is relevant because surgical care represents a substantial component of contemporary hospital practice and requires preparation that extends beyond technical readiness. National health reporting underscores the continuing importance of operative and hospital services within Indonesia's healthcare system, making patient-centered perioperative management an ongoing quality-of-care concern (Kementerian Kesehatan Republik Indonesia, 2022). The five observed patients illustrate how anxiety can remain clinically significant immediately before surgery even within a specialist surgical hospital environment. Their baseline mean score of 21.8, coupled with severe or panic anxiety in four of five cases according to the recorded categories, indicates a concentrated burden of distress in this small sample. Such a pattern supports routine psychological screening because visibly calm behavior alone might not adequately identify clinically relevant anxiety. It also establishes a strong descriptive basis for examining whether a brief 10–15-minute SEFT session was followed by meaningful within-person improvement. The next analysis therefore focuses on the magnitude and consistency of the pre–post changes rather than on demographic prediction.

Changes in Anxiety Levels Following Spiritual Emotional Freedom Technique

After one 10–15-minute SEFT session, every participant recorded a lower APAIS score than at baseline, producing a uniform directional change across all five observed cases. Patient 1 decreased from 20 to 13, Patient 2 from 21 to 15, Patient 3 from 27 to 18, Patient 4 from 18 to 12, and Patient 5 from 23 to 14. The absolute reductions were 7, 6, 9, 6, and 9 points, respectively, which yielded a total score reduction of 37 points across the sample. The post-intervention scores summed to 72 and produced an arithmetic mean of 14.4, compared with the baseline mean of 21.8. Previous preoperative SEFT research has similarly reported reductions in anxiety following intervention, supporting the direction of change observed in these cases (Abdurrohman et al., 2023). Because no control group was included, however, these findings demonstrate a favorable temporal association with SEFT rather than definitive causal efficacy.

The categorical pattern also shifted substantially after the intervention, as shown in Table 2. According to the individual data, three participants moved from severe anxiety to moderate anxiety,

one moved from panic to moderate anxiety, and one moved from moderate to mild anxiety. No participant remained in the same anxiety category, and no participant showed an increase in score. Mardika et al. (2024) similarly identified lower preoperative anxiety following SEFT, suggesting that categorical improvement may accompany numerical score reduction. The consistency of the direction of change is notable in a five-patient case series because improvement occurred despite different baseline scores and clinical manifestations. Nevertheless, spontaneous reduction, increasing familiarity with the surgical environment, concurrent nursing reassurance, or the passage of time cannot be excluded as alternative contributors under a one-group design.

Table 2. Anxiety Levels Before and After Spiritual Emotional Freedom Technique among Preoperative Patients at Columbia Asia Hospital Semarang (n = 5)

No.	Respondent	Pre Score	Pre Category	Post Score	Post Category
1	Mrs. A	20	Severe Anxiety	13	Moderate Anxiety
2	Mrs. R	21	Severe Anxiety	15	Moderate Anxiety
3	Ms. M	27	Panic Anxiety	18	Moderate Anxiety
4	Mrs. An	18	Moderate Anxiety	12	Mild Anxiety
5	Mr. D	23	Severe Anxiety	14	Moderate Anxiety

The largest absolute reductions occurred in Patients 3 and 5, each declining by 9 points, whereas Patients 2 and 4 each declined by 6 points and Patient 1 declined by 7 points. Patient 3 is particularly informative because the highest baseline score, 27, decreased to 18, shifting the recorded category from panic to moderate anxiety. Patient 4 moved from 18 to 12 and was the only participant classified as having mild anxiety after SEFT. SEFT implementation in preoperative nursing has previously been associated with decreases in anxiety, supporting its potential as a brief complementary intervention during surgical preparation (Kawanda & Ambar, 2023). Earlier research also reported a significant difference in anxiety following SEFT exposure, providing convergent evidence that spiritually integrated tapping interventions warrant clinical evaluation (Kusumasari et al., 2020). The patient-level pattern in this study is therefore consistent with prior findings while remaining appropriately limited to descriptive inference.

The magnitude of score reduction can also be described proportionally using only the observed data. Patient 1 showed a 35.0% reduction from baseline, Patient 2 decreased by approximately 28.6%, Patient 3 by approximately 33.3%, Patient 4 by approximately 33.3%, and Patient 5 by approximately 39.1%. Across the five cases, the total APAIS score decreased from 109 to 72, equivalent to an overall arithmetic reduction of approximately 33.9% relative to the baseline total. These calculations are descriptive summaries of the recorded scores and are not inferential effect estimates. SEFT has also been associated with reduced anxiety in patients undergoing pre-percutaneous coronary intervention, suggesting that its application may extend to other procedure-related forms of anticipatory distress (Dewi et al., 2024). The numerical consistency across participants strengthens the observation that improvement was not driven by a single extreme responder. At the same time, the sample size remains insufficient for estimating a population effect or testing subgroup differences.

The observed change is also compatible with higher-level evidence on Emotional Freedom Techniques, although the literature should be interpreted with attention to heterogeneity in protocols, populations, and study quality. A recent systematic review of EFT for anxiety disorders reported an accumulating evidence base while emphasizing the need for continued methodological rigor and clarity regarding intervention effects (Choi et al., 2025). More directly relevant to surgical care, a randomized controlled trial among patients undergoing laparoscopic cholecystectomy found that EFT reduced surgical fear and anxiety compared with control conditions (Menevşe & Yayla, 2024). These studies provide stronger comparative evidence than the present case series, but their populations and protocols are not identical to the spiritually framed SEFT procedure used at RSKB Columbia Asia Semarang. A recent review focusing on SEFT and preoperative anxiety likewise concluded that the intervention shows promise while highlighting the importance of stronger primary studies (Umifa, 2026). The present five-case dataset contributes a clinically situated observation that is directionally consistent with this literature. Its contribution lies in documenting individual pre-post responses within routine preoperative care rather than in establishing comparative effectiveness.

The post-intervention distribution also differed materially from baseline, with the original methodology summary indicating four participants in the moderate category and one in the mild category after therapy. At baseline, three participants were severe, one moderate, and one panic, meaning that the distribution shifted away from the two highest recorded anxiety categories after treatment. No severe or panic category remained in the individual post-intervention data presented in Table 4.2. Previous research in older adults has also described reductions in anxiety following SEFT, indicating that the intervention's psychological relevance is not confined to surgical contexts (Nurrohmah, 2022). The absence of inferential testing means that the results should be communicated as consistent pre-post improvement rather than statistical proof of efficacy. Clinically, however, movement from severe or panic categories toward moderate or mild states may be meaningful because a calmer patient may be better positioned to receive information, communicate concerns, and participate in perioperative preparation. These findings support further controlled evaluation of SEFT as an adjunct rather than a replacement for standard surgical and anesthetic care.

Therapeutic Interpretation and Clinical Implications of SEFT in Preoperative Care

SEFT combines focused emotional attention with spiritual orientation and tapping-based stimulation, creating a structured intervention that differs from simple reassurance or procedural information. In this study, the intervention was administered through the set-up, tune-in, and tapping stages during a single 10–15-minute preoperative session. The set-up phase encourages acknowledgment of distress while establishing a spiritually oriented statement of acceptance, whereas tune-in maintains attention on the emotional concern that is being addressed. Tapping is then applied sequentially to designated points while the patient remains focused on the identified emotional experience. SEFT has been conceptualized as an integration of emotional regulation and spiritual coping intended to promote calm and psychological well-being (Erika & Kusmawati, 2024). This structure is particularly relevant before surgery because the intervention can be delivered briefly without replacing established medical management.

The spiritual element may be clinically meaningful for patients who use prayer, surrender, acceptance, or belief in God as resources for coping with uncertainty. Such components may support a shift from persistent threat-focused thinking toward a more tolerable appraisal of the forthcoming procedure, although the present design did not independently measure spirituality or mediating mechanisms. Maraya (2019) describes SEFT as combining spiritual processes with tapping at energy points, forming the conceptual basis commonly used in Indonesian clinical applications. The observed mean APAIS reduction from 21.8 to 14.4 is compatible with a short-term calming response but does not reveal which element of the intervention accounted for the change. Attention from the therapist, expectancy, guided breathing, cognitive reframing, spiritual meaning, and repeated somatic stimulation may all contribute to the observed experience. The intervention should consequently be interpreted as a multicomponent complementary practice rather than as proof of one isolated physiological mechanism.

Table 3. Clinical Interpretation of SEFT Components in Preoperative Anxiety Management

Seft Component	Therapeutic Function	Potential Clinical Relevance
Set-Up	Acknowledgment and acceptance of emotional distress	Helps patients identify and verbalize surgery-related fear
Tune-In	Sustained attention to the dominant emotional concern	Facilitates focused processing of preoperative anxiety
Tapping	Structured somatic stimulation during emotional focus	May support relaxation and reduction of perceived tension
Spiritual Element	Prayer, surrender, acceptance, and spiritual meaning	May strengthen coping in patients who value spiritual resources

As summarized in Table 3, the clinical value of SEFT may arise from the integration of cognitive, emotional, somatic, and spiritual components rather than from any single procedural step. This integrative character distinguishes SEFT from interventions that rely exclusively on information provision or distraction. The anxiety literature shows that procedural knowledge is important, but

greater knowledge does not automatically eliminate fear when patients remain concerned about anesthesia, pain, complications, or mortality (Almar et al., 2024). Alternative non-pharmacological approaches, including humor therapy, have also produced reductions in preoperative anxiety, indicating that the perioperative environment can respond to psychosocial interventions through multiple pathways (Choerunisa & Hidayati, 2023). SEFT may offer a particularly relevant option where patients are receptive to spiritual framing because it can incorporate personal meaning into emotional regulation. Its application should nevertheless be individualized so that spiritual content respects the patient's values, preferences, and willingness to participate.

The nursing implications are important because nurses frequently have direct contact with patients during the period when anticipatory anxiety becomes most prominent. This positioning enables nurses to identify restlessness, fear, elevated pulse, increased blood pressure, difficulty concentrating, or repeated questions and to determine whether supportive intervention is indicated. SEFT has been implemented in nursing contexts as a complementary intervention for reducing preoperative anxiety, suggesting that it may be feasible when delivered by appropriately trained practitioners (Kawanda & Ambar, 2023). The procedure does not remove the need for accurate surgical and anesthetic information, assessment of pain concerns, family support, or pharmacological treatment when clinically indicated. It should instead be positioned within a broader patient-centered strategy that combines emotional support with established perioperative safety practices. The five cases observed here indicate that even a single structured session was followed by lower APAIS scores, providing a pragmatic rationale for further implementation research.

The findings also highlight the importance of avoiding overinterpretation of the apparent response. The one-group pretest–posttest design cannot separate SEFT-specific effects from regression toward the mean, natural fluctuation in anxiety, repeated measurement, interpersonal reassurance, or increasing adaptation as the operation approached. Although randomized evidence supports EFT in some perioperative settings, direct extrapolation to every SEFT protocol or surgical population would be inappropriate because intervention content and context vary (Menevşe & Yayla, 2024). The literature review by Umifa (2026) similarly indicates that SEFT has potential for preoperative anxiety while leaving room for stronger controlled and comparative designs. The current sample of five patients also provides no basis for subgroup analysis by sex, age, anesthesia type, surgical experience, or procedure category. The reduction observed in each participant is clinically encouraging but should be treated as preliminary empirical evidence. Future studies would benefit from larger samples, comparison groups, repeated follow-up measurements, and standardized reporting of intervention fidelity.

The broader significance of the results lies in their alignment with contemporary efforts to integrate psychological preparedness into perioperative care rather than treating surgery solely as a technical procedure. Psychological distress can influence the patient's subjective experience of surgery, communication with healthcare personnel, and readiness for recovery, making anxiety management relevant to comprehensive perioperative practice. Evidence on enhanced recovery and prehabilitation similarly emphasizes that optimization before surgery should consider more than the immediate operative procedure itself (Gillis et al., 2022). National healthcare practice increasingly requires interventions that are feasible, safe, culturally acceptable, and compatible with existing clinical workflows, particularly in settings where brief nursing-led strategies can be delivered without complex technology. In the present study, all five participants completed a short intervention and showed numerical reductions of 6–9 APAIS points, supporting the feasibility of further investigation within a surgical hospital context. The absence of adverse-event data, long-term follow-up, and controlled comparison means that safety, durability of effect, and comparative effectiveness still require formal evaluation.

Clinically, the most defensible interpretation is that SEFT was associated with a consistent reduction in measured anxiety across five preoperative patients while preserving the need for standard surgical, anesthetic, and nursing care. The observed pattern is compatible with previous research reporting beneficial psychological outcomes after spiritually integrated or tapping-based emotional interventions (Abdurrohman et al., 2023). Contemporary reviews of EFT also suggest that anxiety reduction is a credible area of therapeutic investigation, although methodological quality and intervention standardization remain central to evidence appraisal (Choi et al., 2025). The present findings extend that literature by documenting a small real-world case series in which the total APAIS score fell from 109 to 72 and no participant remained in the severe or panic categories after the

intervention. The results support consideration of SEFT as an adjunctive, patient-centered option for individuals who are willing to engage with its emotional and spiritual components. More rigorous trials are required before the intervention can be recommended as an evidence-based substitute for established anxiety-management strategies or before causal effectiveness can be claimed across broader preoperative populations.

CONCLUSION

The application of Spiritual Emotional Freedom Technique (SEFT) was associated with a consistent reduction in preoperative anxiety among the five patients observed at RSKB Columbia Asia Semarang. Following one intervention session lasting approximately 10–15 minutes, every participant showed a lower APAIS score than at baseline, with individual reductions ranging from 6 to 9 points. The total APAIS score decreased from 109 before intervention to 72 after intervention, while the mean score declined from 21.8 to 14.4. The anxiety distribution also shifted from three patients with severe anxiety, one with moderate anxiety, and one with panic anxiety before intervention to four patients with moderate anxiety and one with mild anxiety afterward. These findings indicate that SEFT may help support psychological readiness before surgery by reducing the intensity of anxiety experienced during the preoperative period. Its brief duration and structured combination of emotional focus, tapping, and spiritual elements make it potentially feasible as a complementary nursing intervention within routine perioperative care. However, the results should be interpreted as preliminary evidence because the one-group pretest–posttest case-study design does not establish a definitive causal effect of SEFT.

From a clinical perspective, SEFT can be considered an adjunctive non-pharmacological approach for preoperative patients who are willing to engage with its emotional and spiritual components. The intervention should complement rather than replace established nursing, surgical, anesthetic, and pharmacological management when these are clinically indicated. Its potential value lies in providing a simple and patient-centered strategy that can be delivered within a relatively short period while addressing fear, tension, and emotional discomfort before surgery. The consistent reduction observed across all five cases supports further investigation of SEFT in broader and more diverse preoperative populations. Future studies should include larger sample sizes, experimental or randomized controlled designs, comparison groups, and stronger statistical analyses to determine the magnitude and clinical significance of treatment effects more rigorously. Repeated follow-up measurements are also needed to assess whether the reduction in anxiety is sustained beyond the immediate post-intervention period and whether it influences postoperative recovery outcomes. More robust evidence would provide a stronger basis for determining the role of SEFT within evidence-based perioperative nursing practice.

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