

Spiritual Emotional Freedom Therapy (SEFT) Enhances Memory and Daily Function in Older Adults: A Randomized Controlled Trial



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Abstract: *The age of older is one whereby a person will undergo numerous decline in their capacities. Overall, this aging process may present a number of issues, like physically, biologically, mentally, socially and economically. The aging process usually contributes to cognitive impairment, which, in turn, affects the functioning of the elderly. Thus, the purpose of the given study was to research the effectiveness of spiritual emotional therapy on the cognitive status of the elderly. This was experimental randomized controlled trial study consisting experimental and control groups of 20 elderly with Purposive sampling was used. The Subjective Cognitive Decline Questionnaire (SCD-Q9) was used for measurement of cognitive functioning. There were eight therapy sessions (45-60 minutes) were conducted twice in a week. Data were collected and analyses were performed with SPSS v27 and Jamovi v2.6.6. The findings suggested that Spiritual Emotional Freedom Therapy (SEFT) is an effective non-pharmacological intervention for enhancing memory, improving daily functioning, and reducing subjective cognitive decline in older adults. Implementing SEFT within community and clinical settings could provide a culturally appropriate strategy for promoting cognitive health among aging populations in Pakistan.*

Keywords: Spiritual Emotional Freedom Therapy, Subjective Cognitive Decline, Daily Functioning

Introduction

Aging is a global phenomenon that is considered one of the most significant demographic changes in the 21st century. As per the World Health Organization (WHO, 2021), the population of individuals 60 and older is growing at a higher rate than any other group, with this figure projected to be 2.1 billion in 2050. A rise in the aged population is reported globally. It is stated that there are twelve million elderly individuals in Pakistan, and the figure would increase to eighteen million by the year 2050.

One aspect of the results of this demographic change is the growing number of age-related cognitive declines (Pais et al., 2020). With age, there are progressive deteriorations in various cognitive areas (Armstrong et al., 2020; Bopp et al., 2020; Bugaiska et al., 2015), which have an immense influence on the life of the elderly individual, such as self-conception and social interactions (Jia et al., 2023; Parikh et al., 2016).

It can be an example of an increase in the number of elderly people with the rise in morbidity and mortality, as well as a specific increase in the deterioration of cognitive functions. Cognitive functions refer to various higher-order mental skills, including memory, attention, language, and executive control, which allow people to perceive, process, and act upon information (Lezak et al., 2012). This deterioration can be manifested in older adults through their subjective reports of forgetfulness or slowed cognition and may be predictive of objective degradation on standardized cognitive measures (Jessen et al., 2014; Murman, 2015).

Cognitive decline impacts an individual's ability to learn, remember, and complete daily activities, and it increases their risk of developing dementia later in life. One of the ways it may present is Subjective Cognitive Decline (SCD), which involves the individual's self-reporting of issues with memory, attention, and other cognitive processes in daily life (Jessen et al., 2014; Mitchell, 2008).

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SCD is characterized by the perceived loss of memory (other things may be included in the memory, but loss is the most noticeable and usually the reason for concern), but this individual's memory differs from the objectives measured in the memory, or the individual doesn't show loss of memory in other domains according to standardized memory tests (Jessen et al., 2020). Approximately 1 in 9 people aged 45 years or older experience this condition (Taylor et al., 2018). Studies show that 27-43 % of the elderly population living in the community self-reports memory loss (Zuniga et al., 2015). Literature has used a variety of terms that have been used interchangeably to describe a concept of a self-perceived decline in cognition, including subjective cognitive complaints, subjective memory decline, and self-reported cognitive impairment. Nevertheless, such application of multiple interchangeable terms contributed to the challenge of comparing and combining the outcomes of research studies (Jessen et al., 2014). SCD can also be treated with the help of the biopsychosocial model (Rabin et al., 2017). Etiologically relevant determinants may be identified to inform the creation of specific treatment and prevention interventions that will facilitate cognitive and psychological functioning among people with SCD (Rabin et al., 2017). As an example, psychological health interventions can be useful in interventions at an earlier stage of life in individuals where SCD is motivated by mood, personality, and physical health factors. Conversely, cognitive-enhancing interventions would perhaps be beneficial to prevent the development of cognitive impairment in people with SCD that is linked to biomedical risk factors (Smart et al., 2017).

Longitudinal community-based studies converging on the same evidence have made the following findings: depressive and anxiety symptoms and personality traits (e.g., less mastery, less perceived self-efficacy, high neuroticism) have explained the support of subjective memory complaints, when they were controlled by objective memory performance (Comijs et al., 2002), and to a larger extent than cognitive factors (Slavin et al., 2010).

The studies suggested that in the case when an individual has some physical, mental, and psychological issues, spirituality becomes significant in providing comfort and purpose in life (Ilali et al., 2016). Spiritual beliefs also gain relevance in the elderly with increasing age (Lee & Lifan, 2014). Spiritual therapy is a form of psychotherapy that enables individuals to perceive the issues more clearly with the help of certain techniques and principles. This is a type of treatment that involves the use of the brain to enhance empathy, decrease cognitive impairment, and promote internal relaxation among people. It is also less painful for patients (Ramazani & Bakhtiari, 2019; Okhli et al., 2019). One such therapeutic technique is the Spiritual Emotional Freedom Technique (SEFT). The non-pharmacological treatment can solve physical and emotional issues like anxiety, depression, mood problems, and confidence associated with chronic diseases, and is a therapeutic method called Spiritual Emotional Freedom Technique (SEFT), which involves the use of spiritual elements that help reduce psychological and physical issues (Safitri & Sadif, 2013). SEFT was based on Emotional Freedom Technique (EFT), which involves the integration of the science of acupuncture with behavioral interventions within the field of psychology (Zainuddin, 2012). SEFT is one of the less risky methods of energy psychology, where only a light tap using a fingertip (tapping) is applied on a specific region of the body (Bougea et al., 2013). As Swingle et al. (2004) explain, tapping leads to the reduction of brain stress waves or relaxation-related strengthening, and the creation of other desirable physiological activities (Church et al., 2012). SEFT therapy is a readily accessible treatment method that involves a mild tapping of the 18 critical points on the 12 circuits of energy in the body, and the patient will experience instant healing (one-minute wonder). It is a physical and mental healing therapy to recover, in addition to being able to achieve more and find inner peace (Ghamsari et al., 2015; Zainuddin, 2012).

Hypotheses of the Study

H1: Participants receiving SEFT will demonstrate a significant improvement in memory and daily functions and a reduction in subjective cognitive decline scores during intervention as compared to the control group.

H2: Participants receiving SEFT will demonstrate a significant improvement in memory and daily functions and a reduction in subjective cognitive decline scores from pretest to posttest compared to the control group.

Method

Participants

Twenty elderly people (N = 20) aged over 60 years took part in this research. Purposive sampling was used to recruit participants who were found in the community centers and aged care homes according to inclusion criteria. The participants were randomly allocated to two groups through online permuted block randomization: the Experimental group (n = 10) received the SEFT intervention, and the Control group (n = 10) did not receive the intervention at any point during the study period.

Inclusion Criteria & Exclusion Criteria

The selection criteria included being aged 60 years and above, willing to participate in the research and able to speak and comprehend the Urdu language. Participants were dropped from the study when they failed to attend two sessions of SEFT. Also, patients diagnosed with other psychotic disorders during the screening were excluded. The members of other health programs were also not allowed to participate in the current study.

Randomization

After the initial training of recruited groups, one of the researchers, through masking, randomly assigned consenting participants to either Group 1 or Group 2 in a 1:1 ratio according to a randomization process, and online using an online program called Clinical trial randomizer (www.randomization.com) has randomly assigned (Suresh, 2011).

Instrument

Subjective cognitive decline (SCD)

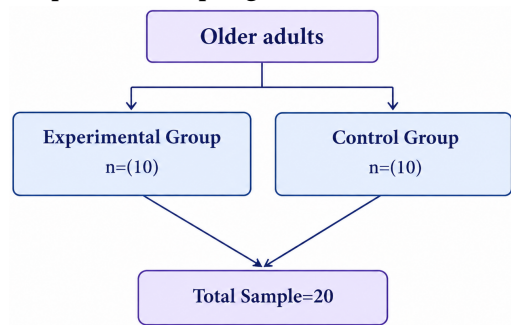
Cognitive functioning and decline were measured from a 9-item subjective cognitive decline questionnaire (SCD-Q9). SCD-Q9 is a rapid assessment scale to detect the victims of MCI among general populations (Hao et al., 2019; Gifford et al., 2015). SCD-Q9 is a scale that includes 2 dimensions and 9 items, such as the overall memory function and time comparison (4 items) as well as daily activity ability (5 items), each of which has a possible score of 0, 0.5 or 1. SCD-Q9 total score ranges between 0 and 9, and the higher the score, the worse SCD symptoms (Hao et al., 2019).

Procedure

Ethical approval was obtained from the Institutional Review Board (IRB) of the Islamia University Bahawalpur. The trial was registered in the Thai Clinical Registry with trial number (TCTR20260630004). After providing informed consent, participants completed baseline assessment (SCD-9). The intervention group attended eight SEFT sessions over four weeks, while the control group received equal sessions but no intervention and continued their usual daily activities. Post-intervention assessments were conducted for both groups one week after the final session. To ensure data integrity, all assessments were performed by trained research assistants who were blind to group allocation.

Figure 1

Sample and Sampling Procedure



Ethical Considerations

The research met the ethical principles of the Declaration of Helsinki (2013) and followed the APA ethics code and conduct. Participation was voluntary, and the participants were reminded of confidentiality and anonymity as well as the right to withdraw at any stage. Data were coded and kept in a safe place.

Intervention

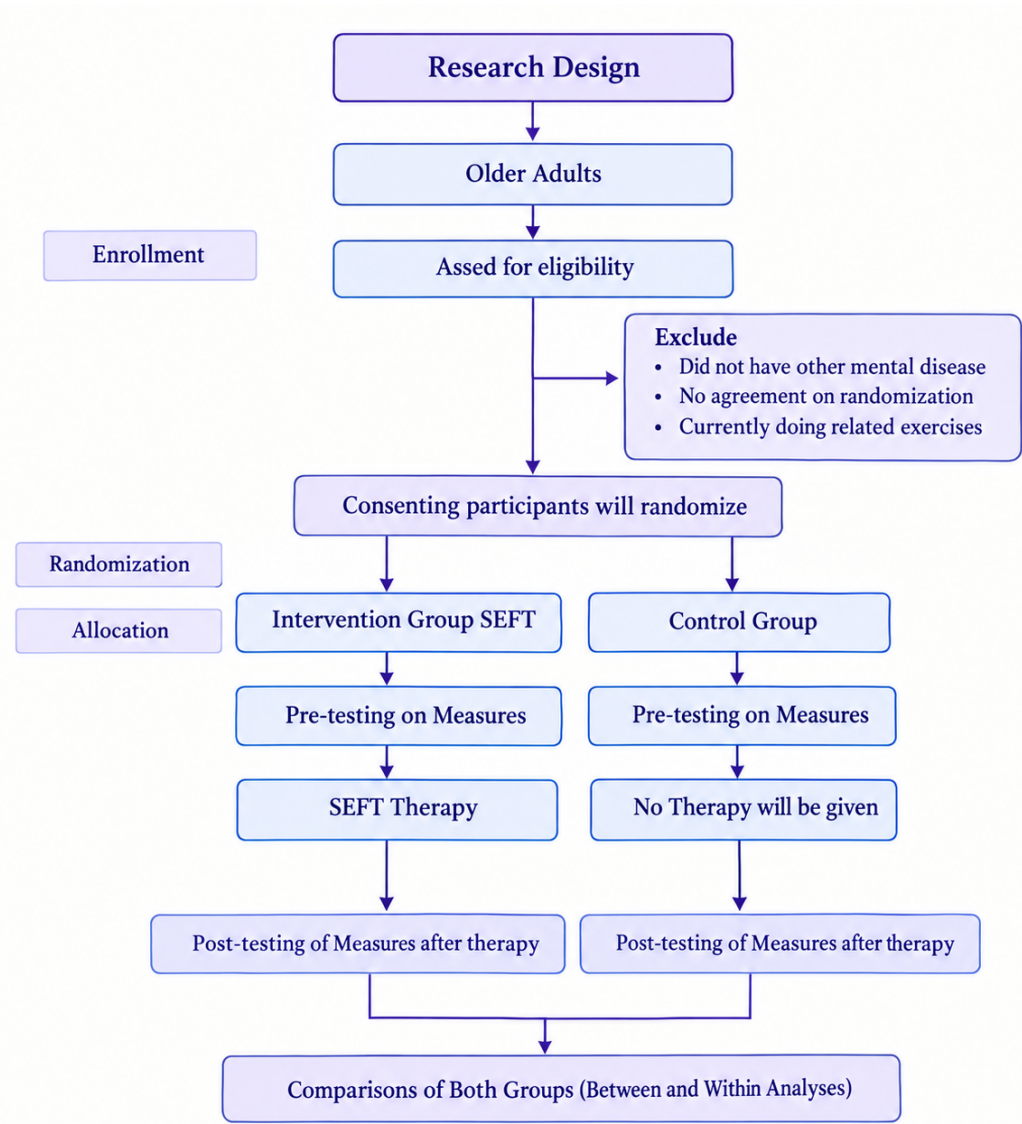
At this stage, the experimental group underwent SEFT intervention, and the control group did not undergo any form of treatment but was engaged in discussion and treated as a waitlist group. The experiment took a period of four weeks with eight sessions of SEFT training, twice a week, for the experimental group. The sessions took about 45-60 minutes and were led by a trained SEFT practitioner in a conducive and distraction-free setting (Zainuddin, 2005).

Table 1

Spiritual Emotional Freedom Therapy (SEFT) Protocol

Sr.No	Steps	Weeks	Sessions	Aims and Objectives of the session
1	Preparation stage	Week-1	1,2	1. Rapport building 2. Assessment & problem Identification: In the Preparation stage, respondents are instructed to say "Bismillah" (for Muslims), drink enough water, remove any metal objects attached to the body such as jewelry or watches, and clearly identify their complaints, such as feelings of anger, irritation, or discomfort.
2	The Set-Up stage	Week-2	3,4	respondents recite a specific prayer sincerely while tapping the sore spot (an area on the upper center of the right or left chest that feels slightly tender when pressed).
3	The Tune-In stage	Week-3	5,6	Tune-In, which involves focusing the mind on the issue or feeling causing the most discomfort or annoyance.
4	The Tapping stage	Week-4	7,8	The final step is The Tapping, where respondents are instructed to continue tuning in while tapping on nine meridian points on the body (crown, eyebrow, side of the eye, under the eye, under the nose, chin, collarbone, under the arm, and below the nipple). This activity concludes with reciting "Alhamdulillah"

Consort Diagram
Figure 2



Statistical Analysis

Data were prepared, coded and screened in SPSS v27 (checks for missing data, entry errors, assumptions, and outliers). Descriptive statistics (means, SDs, and frequencies) summarized sample and baseline characteristics. Hypotheses were tested in Jamovi v2.6.6 using separate linear mixed-effects models for each outcome (Memory & Time Comparison, Daily Activity Ability, Subjective Cognitive Decline). Models included Group (Experimental vs. Control) and Time (Before, During, After) as fixed effects and Participant as a random intercept; parameters were estimated by REML with Satterthwaite-adjusted degrees of freedom. Omnibus tests and, where appropriate, pairwise contrasts were reported. Model fit was summarized using marginal and conditional R^2 . Statistical significance was set at two-tailed $p < .05$.

Results

The sample consisted of 20 older adults (valid $N = 20$) with a mean age of 73.70 years ($SD = 7.17$, range 64–92). Age frequencies show most participants clustered in their early to mid-70s (e.g., 72 years, $n = 3$, 15.0%) with smaller numbers at ages from 64 to 92. Females comprised 60.0% ($n = 12$) and males 40.0% ($n = 8$). Most participants were literate ($n = 13$, 65.0%), though 35.0% ($n = 7$) had no formal literacy; when broken down by highest attainment, 35.0% had no formal education, 20.0% had primary, and 15.0%

each had middle, matric, or intermediate levels. Regarding marital status, 60.0% were married ($n = 12$), 25.0% divorced ($n = 5$), 10.0% single ($n = 2$), and 5.0% widowed ($n = 1$). Family type was evenly split between joint and nuclear households (each 50.0%, $n = 10$). Number of children varied: 20.0% had no children, 25.0% had four children (the largest single category), and the remainder had between one and six children. Participants were evenly randomized into Experimental and Control groups ($n = 10$ each), and all 20 participants (100.0%) were classified as having worse subjective cognitive decline symptoms. Furthermore, the visual representations of the survey data in Figures 1 and 2 highlighted changes in participants' cognitive and functional performance across assessment periods and between groups

Figure 3

Survey Plots of Changes in Memory, Daily Activity Ability, and Subjective Cognitive Decline Across Three Assessment Time Points (Before, During, and After Intervention)

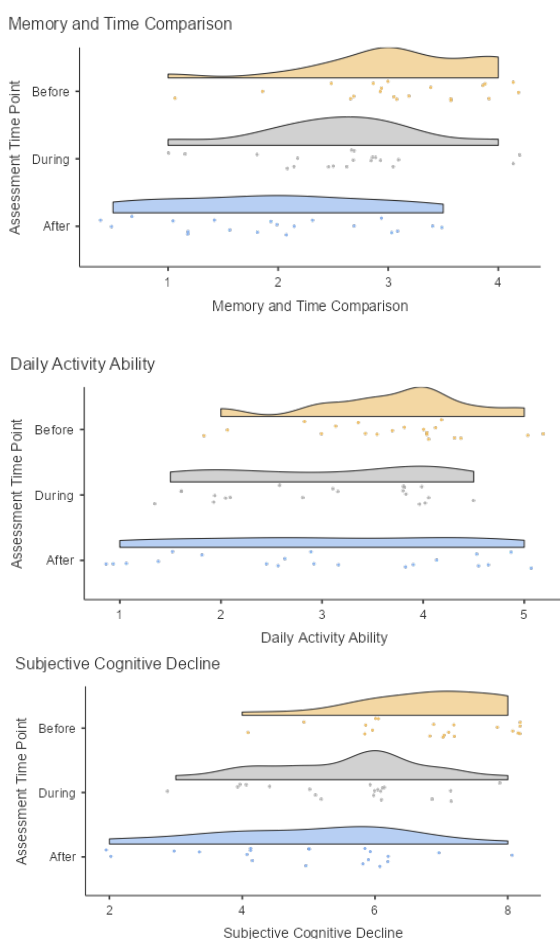
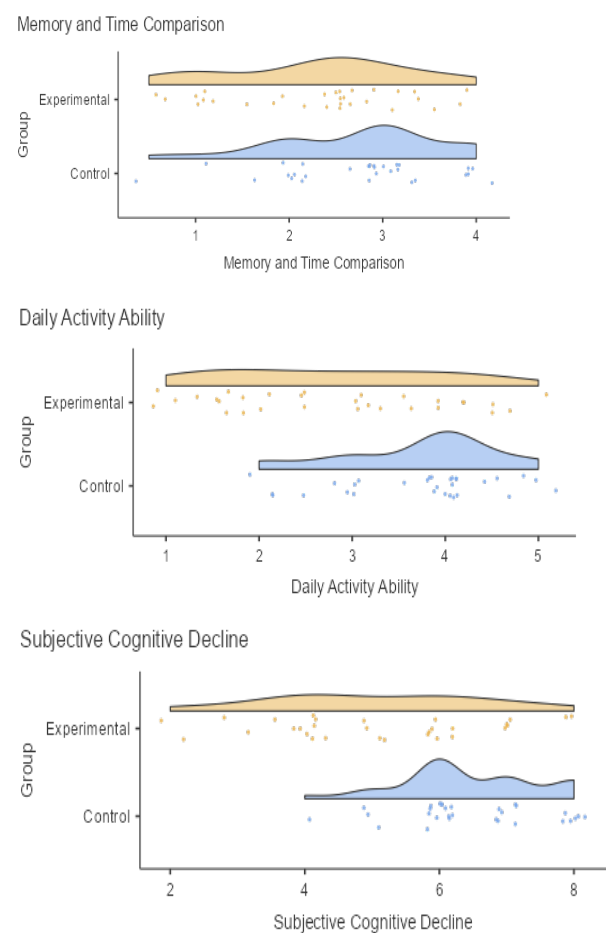


Figure 4

Group Comparisons of Memory, Daily Activity Ability and Subjective Cognitive Decline Between Experimental and Control Groups



As indicated by Figures 3 and 4, the participants showed a strong trend of improvement in time comparison and memory, daily activity ability, and self-rated subjective cognitive decline from pre- to post-intervention periods. Importantly, greater scores before intervention gradually reduced during and after intervention, showing a reduction of cognitive complaints and enhancement of functional ability. Upon comparison of the two groups, experimental group participants consistently scored better than the control group, and these exhibited augmented memory, enhanced performance of activities of daily living, and reduced subjective cognitive decline after the therapeutic intervention.

Table 2

Mixed Model Analysis of all Three Outcome Measures Across Groups and Assessment Time Points

Fixed Effect	Memory and Time Comparison			Daily Activity Ability			Subjective Cognitive Decline		
	<i>B</i>	<i>SE</i>	<i>p</i>	<i>B</i>	<i>SE</i>	<i>p</i>	<i>B</i>	<i>SE</i>	<i>p</i>
Omnibus Tests (<i>F</i>)									
Group	2.67		.120	11.06		.004	15.30		.001
Assessment Time Point	14.54		< .001	5.26		.010	30.20		< .001
Group × Time Point	0.24		.791	10.65		< .001	12.80		< .001
Parameter Estimates									
Intercept	2.53	0.14	< .001	3.24	0.14	< .001	5.77	0.18	< .001
Group (C - E)	0.45	0.28	.120	0.95	0.29	.004	1.40	0.36	.001
During - Before	−0.55	0.22	.016	−0.68	0.25	.009	−1.23	0.25	< .001
After - Before	−1.18	0.22	< .001	−0.70	0.25	.007	−1.88	0.25	< .001
Group × (During - Before)	0.30	0.44	.496	1.55	0.49	.003	1.85	0.49	< .001
Group × (After - Before)	0.15	0.44	.733	2.20	0.49	< .001	2.35	0.49	< .001
Model Fit									
<i>R</i> ² marginal	.294			.406			.569		
<i>R</i> ² conditional	.518			.559			.752		
ICC	.318			.258			.424		

Note. All models fit by REML with Satterthwaite df (*N* = 60, 20 participants). C = Control; E = Experimental. Omnibus test df: Group (1, 18), Time Point (2, 36), Group × Time Point (2, 36). Parameter estimate df: Intercept and Group (18.0), all others (36.0).

Three linear mixed model analyses were conducted to examine the effects of group (Control vs. Experimental) and assessment time point (Before, During, After) on Memory and Time Comparison, Daily Activity Ability, and Subjective Cognitive Decline (Table 2). All models were fit using restricted maximum likelihood estimation with participants as random effects.

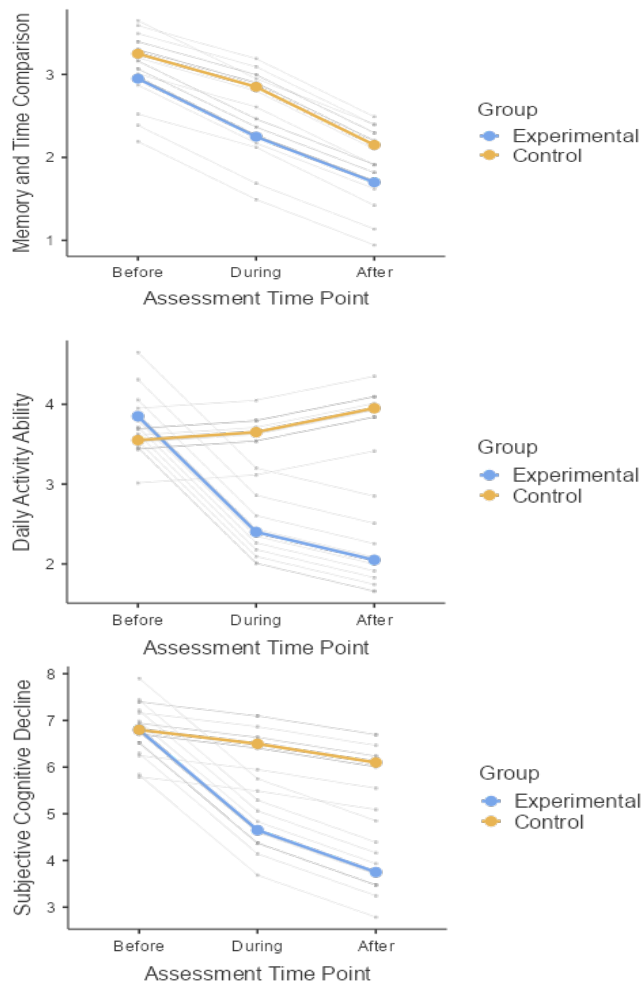
For Memory and Time Comparison, the omnibus tests revealed a significant main effect of assessment time point, $F(2, 36) = 14.54, p < .001$, but no significant main effect of group, $F(1, 18) = 2.67, p = .120$, or group by time point interaction, $F(2, 36) = 0.24, p = .791$. Parameter estimates indicated significant decreases from before to during ($B = -0.55, SE = 0.22, p = .016$) and from before to after ($B = -1.18, SE = 0.22, p < .001$), suggesting overall improvement in memory and time comparison across both groups over time. The model explained 29.4% of the variance in fixed effects and 51.8% when including random effects.

For Daily Activity Ability, all omnibus tests were significant: group, $F(1, 18) = 11.06, p = .004$; assessment time point, $F(2, 36) = 5.26, p = .010$; and the group by time point interaction, $F(2, 36) = 10.65, p < .001$. The significant interaction indicated that the experimental group showed greater improvement over time compared to the control group. Specifically, while both groups showed declines from baseline (during: $B = -0.68, p = .009$; after: $B = -0.70, p = .007$), the interaction terms were positive and significant (during: $B = 1.55, p = .003$; after: $B = 2.20, p < .001$), indicating that the control group experienced less decline or greater improvement relative to the experimental group. The model explained 40.6% of fixed effects variance and 55.9% of total variance.

For Subjective Cognitive Decline, all omnibus tests were highly significant: group, $F(1, 18) = 15.30, p = .001$; assessment time point, $F(2, 36) = 30.20, p < .001$; and the group by time point interaction, $F(2, 36) = 12.80, p < .001$. Figure 3 also showed the same trend: participants who received SEFT showed a significant reduction in subjective cognitive decline (SCD) scores compared to the control group. The experimental group experienced a sharp decline during the intervention phase, with further improvement sustained afterward, indicating that SEFT effectively alleviated SCD in older adults, contributing to improved cognitive self-perception and mental well-being.

Figure 3

Changes in Subjective Cognitive Decline Across Assessment Time Points in Experimental and Control Groups



Note. Random effects are plotted by Participants' ID.

Thus, it has been identified that the participants who received *Spiritual Emotional Freedom Therapy (SEFT)* demonstrated greater reductions in subjective cognitive decline from pre- to post-intervention compared to the control group, reflecting the therapy's effectiveness in improving cognitive well-being.

Discussion

Currently, RCT findings indicate spiritual emotional freedom therapy (SEFT) profoundly impacts subjective cognitive decline and the ability to engage and perform daily activities, even more so in older adults. The findings of the current study yield bidirectional evidence supporting the hypotheses of the study. Hypothesis 1 (within-treatment improvement) and Hypothesis 2 (pre-to post-test improvement) were fully supported by activities of daily living (ADL) scores. In contrast, no memory and time evaluation scores provided such

support. The current trend of findings not only provides evidence for the effectiveness of SEFT but also begins to inform on cognitive aging and the psychological profile concerning the interconnection of cognitive worries and functional deterioration, and the extent to which SEFT can interrupt this vicious cycle.

The outcome of the first hypothesis was further explained by the significant group-by-time interaction on the variable subjective cognitive decline ($F(2, 36) = 12.80, p < .001$), which provided the strongest evidence and support for this hypothesis. This was shown by the experimental participants having an acute decline during the intervention and after that. This outcome was differentiated from the general patterns which the literature on cognitive training documents, which usually have an immediate increase, but after a short time rapidly decline due to a lack of sufficient transfer. On the contrary, the outcomes show a sustained increase, which suggests that SEFT creates a set of psychological or behavioral changes that will endure after the treatment has officially ended. The discovery is especially enlightening when it is viewed in light of modern metacognitive theories that assume two-way interactions between processes of the object level and the functions of the meta-level monitoring and control (Hertzog & Dunlosky, 2012). This improvement trend suggests that SEFT can essentially reset the monitoring role, where individuals form more realistic and less disastrous evaluations of their cognitive abilities and, in so doing, lessen hypervigilance caused by anxiety, which itself ironically deteriorates actual memory performance despite an absence of significant effect of the interventions on actual memory performance upon direct assessment.

In addition, some studies have positioned mind-body interventions at the forefront of effective non-pharmacological approaches for subjective cognitive decline. Chen et al. (2024) demonstrated that mind-body exercises showed the highest probability of being the most effective measures for improving memory (SUCRA value: 90.4) and executive function (SUCRA value: 91.8) in individuals with SCD, substantially outperforming conventional aerobic exercise and cognitive training alone (Mohanty & Kumar, 2023). The coming together of the data suggests that it would be the interventions that include the body, emotions, and existential crisis that would be able to tap the therapeutic mechanisms that are not available through cognitive and/or physical interventions to address cognitive aging.

Memory outcomes compared to daily activity function need significant theoretical contemplation. Both groups had improvements in memory and time difference (main effect of time, $F(2, 36) = 14.54, p < 0.001$), but not to any statistically significant degree, due to a group-by-time interaction ($F(2, 36) = 0.24, p = 0.791$) showing SEFT effects did not provide extra memory benefits obtained under the control condition. Therefore, the following hypotheses of the study pertaining to memory were not corroborated. However, the experimental group was the only one showing significant improvements in daily activity function, interaction effects ($B = 2.20, SE = 0.49, p < 0.001$), showing SEFT effects to be mediated by functional empowerment rather than memory improvement directly. Such outcomes converge to describe SCD in a new light as a complex biopsychosocial phenomenon rather than merely a prodromal indicator of dementia (Munro et al., 2023; Pike et al., 2022). Pike et al. (2022) noted that SCD is associated with a significantly (twice) increased rate of conversion to dementia, which was also shown to be highly moderated by different variable domains, particularly affective symptoms and personality traits, as well as available coping resources based on a comprehensive meta-analysis.

The implications are extensive. SCD is a complex clinical entity. Some participants have concurrent neuropathology, while others have solely psychosomatic-mediated cognitive symptoms, which are amenable to interventions targeting metacognitive beliefs, emotional regulation, and cognitive reappraisal.

The apparent separation of outcomes is best understood with some of the more nuanced interdisciplinary approaches to SEFT. In the tune-in stage of SEFT, metacognitive awareness is activated intentionally by directing attention to thoughts that cause distress and are related to cognitive decline. It is similar to cognitive therapy approaches that include meta-worry and rumination (Wells, 2008), with the exception that SEFT is combined with somatic and spiritual practices that represent what some might term as embodied

metacognitive restructuring. The tapping component is what other cognitive practices would omit and is likely a way of ensuring that participants are activated in a present-moment bodily experience that interrupts the temporal dislocation so common in worries related to future cognitive decline. Defining the practice in those terms resonates with cognitive theories of embodiment that argue that thinking is always situated within a bodily context and that abstract thoughts are constrained by the body (Barsalou, 2020). In that sense, the grounding physical act of tapping may have changed the way some participants think about their cognitive worries and how they experience them in their bodies.

SEFT presents another theoretical complexity that the modern psychological paradigm finds difficult to deal with because of the spiritual aspect of this concept. Recent longitudinal studies have found that spiritual and religious coping can also induce cognitive paths in community-dwelling older adults, and positive spiritual-religious coping is projected to positively affect cognitive outcomes and slower cognitive decline rates in four-year intervals (Vitorino et al., 2023). The repetition of the expression, Bismillah (in God's name) at the start and Alhamdulillah (praise be to God) at the end forms a ritual container that allows explicitly relating the experience of cognitive limitation vulnerability to a greater spiritual story of trust, thankfulness, and divine protection. Such framing can essentially deprioritize cognitive concerns by framing changes in terms of the emotional valence of a disaster as a challenge to normative life that can be met with resources of faith. Khalsa and Newberg (2021)

Theorized the notion of "spiritual fitness" to play an important role in the prevention of Alzheimer's disease, stating that meditation techniques that enable psychological and spiritual well-being could minimize various risk factors of experiencing cognitive decline. The existing evidence offers an empirical foundation for this new paradigm, where the spiritually-fundamental interventions are shown to have a unanimous positive impact on functional outcomes within older adults with cognitive issues.

These psychological mechanisms have neurobiological plausibility based on the new studies in terms of the neural correlates of spiritual practices and effects on the physiology of stress. There is a consistent effect of chronic stress and high levels of cortisol on subjective cognitive complaints as well as objective cognitive deterioration in older adults, forming a self-perpetuating loop in which concern about cognitive decline triggers stress mechanisms, stress compromises the performance of the hippocampus, a memory failure is actually occurring, aiding in the subsequent validation of anxieties and increasing distress (Coelho-Júnior et al., 2022). The therapeutic effect of SEFT can break this vicious cycle at several levels concurrently with the help of the soothing effect of ritualized tapping, the comfort of spiritual affirmation, and the cognitive restructuring of negative perceptions of the decline. Current studies on the topic of emotional freedom methods have shown considerable changes in stress biomarkers and anxiety symptoms in a broad range of populations, and EFT, compared to wait-list comparisons, has shown large effect sizes in meta-analyses (Dincer & Inangil, 2021; Stapleton et al., 2023).

The magnitude of the effect and pattern were closely compared with recent meta-analytical results about interventions involving subjective cognitive factors. Sheng et al. (2020) conducted a systematic review that revealed that psychological interventions had medium-sized effects on objective memory function, whereas cognitive training had only positive margins of benefits. The conditional R^2 of subjective cognitive decline in the current study of .752 is far larger than what is generally reported when using brief psychological interventions on such a population, implying that combining the SEFT approach can represent therapeutic changes not inherent in on-modality interventions. Such superiority can be the intrinsic difference between interventions aimed at cognitive skills and interventions aimed at the metacognitive and emotional situation in which cognitive functioning spreads.

Clinical and Practical Implications

Current findings have implications on a variety of levels of healthcare delivery. To begin with, SEFT is a low-cost and scalable intervention that may be applied in groups with a minimum level of required training; thus,

it is especially applicable to implement in the community, in senior centers, and in healthcare systems with limited resources. Bearing in mind that 152.8 million people will be affected by dementia by 2050 across the world (Nichols et al., 2022), easily accessible interventions to improve cognitive health are of utmost significance as health priorities. Second, SEFT is culturally congruent through the incorporation of spiritual factors in populations in which spirituality is the most important to health and wellbeing, fulfilling the recommendations of recent systematic reviews that have called upon suitably culturally-adapted therapeutic interventions that do not violate various healing traditions and beliefs (Britt et al., 2023); Can (Oz et al., 2022). Third, the test of impact on the ability of day-to-day activities has a specific importance considering that the ability to function is the most vital result in attaining successful aging. Instrumental activities of daily living are directly affected by the preservation of older adults to age in place, maintain autonomy, and avoid institutionalization outcomes with severe individual and social consequences.

The provision of SEFT is relevant and should be included in the training of personnel as integrated care models in the healthcare system relating to aging. SEFT could be provided by primary care providers, occupational therapists, geriatric nurses and/or community health workers with the right training. The peer support and the shared experience in group-based delivery are other advantages that require protective factors of mental health among the elderly. The intensive format of the intervention (eight sessions in four weeks) will increase feasibility, whereas the long-term consequences of using the technique indicate that participants will be inclined to maintain techniques in the future, which will have a long-lasting effect that is not limited to formal treatments.

The implications of these findings are not limited to the immediate issue of SEFT effectiveness but are instead used to shed more light on the nature of subjective cognitive decline itself. The strong treatment effects are indicative of SCD, at least in its earlier forms, being more psychologically malleable than biomedical accounts would have it. Although SCD is a vulnerable period with the risk of developing dementia conversion, the existing evidence is in favor of biopsychosocial reconceptualization that considers neurobiological as well as psychological factors (Rabin et al., 2015). This carries significant ramifications for the manner in which we provide counseling to older adults presenting with cognitive issues, implying that psychological practice ought to be provided at an early stage and in a strong manner, not meant to be used at the palliative stage after the diagnosis of dementia. It is an emergent paradigm shift of SCD in the field where it is no longer seen as a prodromal symptom but as a heterogeneous condition that needs differentiated intervention strategies based on underlying etiologies.

Strengths

There is strong Methodological credibility to this research that fostered confidence in the results. Randomized controlled design with systematic allocation allows for the determination of cause-and-effect relationships about the efficacy of SEFT. Use of multiple timings of assessments in the study showcases the ability to study and fill in gaps about the short-term and long-term effects of the intervention, which is often a challenge in intervention research due to the nonexistence of follow-up data. The use of the statistical method of linear amalgam models is appropriate in working with the data about measures that are repeated and the issue of within-individual correlation to provide valid estimations of the impact of an intervention.

Limitations

There are some limitations to the study. For one, the sample size (N=20) and specific Islamic cultural context are likely too small for any conclusions to be made across populations. There is also no active control, which makes it difficult to determine the specific effects of SEFT outside of general therapeutic factors, if any. There is no way to check SEFT against self-reported measures, and without some active evaluation of cognitive performance through objective measures, there is no way for us to determine whether SEFT improved cognitive performance or just subjective appraisal. The study also lacked the process measures one might

expect to find in a formal evaluation, and the short-term follow-up does not help us determine the sustainability of the intervention in the long term. All of this shows us the need for larger, cross-cultural studies to provide definitive answers on the effectiveness of SEFT, the action mechanisms, and the use of active control and standardized objective measures over prolonged follow-up.

Future Directions

This study leads to several potential directions of future research. In the first place, the analysis of dose-response relationships would help to understand the best intensity of interventions and the time they should last. The protocol now being used involved eight sessions in four weeks; a study that compares shorter and more intensive formats would guide implementation. Second, the moderators of the treatment response should be identified to ascertain whom SEFT would work best for. The potential moderators are baseline SCD severity, comorbid depression or anxiety, spiritual or religious involvement level, education level, and demographic factors. Interventions that are optimized with precision medicine practices that are sensitive to individual characteristics would be ideal. Third, it would be interesting to explore the applicability of SEFT in older adults with objective mild cognitive or early dementia. Provided that SEFT enhances quality of life and functional capacity in these groups, it may become an element of multimodal therapy for neurodegenerative disorders. Fourth, with a deconstruction of studies, it may be clarified what active ingredients lie in the study through a comparison of studies that comprise certain components (tapping, spiritual elements, cognitive focusing), which would make it clear what components are key and which ones are supplementary. Fifth, dissemination and scaling would be supported by implementation research on actual feasibility, acceptability and sustainability of SEFT programs in community and healthcare environments. It is important to understand impediments and facilitators to implementation in order to convert efficacy into effectiveness.

Conclusion

This RCT offers considerable evidence that Spiritual Emotional Freedom Therapy is an effective, culturally-congruent scalable intervention to reduce subjective cognitive decline and enhance daily functional capacity among older adults. The combination of somatic procedures, metacognitive focusing and spiritual sense-making targets various aspects of the aging cognitive experience at the same time, with an effect which seems to surpass that of single-modality interventions. With the world ageing and the prevalence of dementia increasing, the available interventions that may enhance people's cognitive wellbeing are becoming crucially important issues in the realm of public health. SEFT has a prospective outlook on assisting healthy aging in cognitive function and must be included in the toolkits to be used in the framework of geriatric care approaches. The observed benefits indicate that SEFT can trigger changes that can be long-lasting in terms of the way older adults perceive, experience, and react to age-related cognitive changes and interfere with the developmental progression of functional decline and psychological suffering. Further studies that utilize bigger samples, active control conditions, objective cognitive outcomes, mechanistic studies, and long-term follow-up will help determine the role of SEFT in the spectrum of care of cognitive health at later age. These findings are being added to an emerging paradigm that sees spirituality, embodiment, and meaning-making as no longer being peripheral to cognitive health but rather central resources, which, when purposefully developed, could be used to increase resilience, functional capacity, and wellbeing in the face of age-related cognitive challenges.

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