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Original Article

The Impact of Spiritual Emotional Freedom Technique (SEFT) on Adolescent Nicotine Dependence: A Quasi-Experimental Study

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ABSTRACT

Background: Adolescent smoking remains a major public health concern in Indonesia, with increasing rates of nicotine dependence and limited effectiveness of existing cessation strategies. Culturally relevant, low-cost, and non-pharmacological interventions are needed, particularly for adolescents with strong religious backgrounds. The Spiritual Emotional Freedom Technique (SEFT), which integrates emotional regulation, acupressure tapping, and spiritual affirmation, may offer a holistic approach to smoking cessation. This study aimed to evaluate the effectiveness of SEFT in reducing nicotine dependence among adolescent smokers.
Methods: A quasi-experimental pretest–posttest control group study was conducted in Bengkulu City, Indonesia, involving 60 Muslim adolescent smokers aged 18–25 years who intended to quit smoking. Participants were consecutively recruited and allocated to an intervention group (SEFT; n=30) or a control group (hypnotherapy without tapping; n=30). SEFT was delivered individually for approximately 10 minutes per session over three consecutive days. Nicotine dependence was assessed using the Fagerström Test for Nicotine Dependence (FTND) at baseline and one week post-intervention. Data were analysed using the Wilcoxon signed-rank test and Mann–Whitney U test.
Results: The intervention group showed a significant reduction in FTND scores from pretest to posttest ($p=0.001$), whereas no significant change was observed in the control group ($p=0.177$). Post-intervention FTND scores differed significantly between groups ($p<0.001$), indicating a substantial effect of SEFT in reducing nicotine dependence.
Conclusion: SEFT was effective in reducing nicotine dependence among adolescent smokers and demonstrated greater benefits than hypnotherapy alone. SEFT represents a culturally congruent, low-cost complementary intervention with potential for integration into school- and community-based smoking cessation programs in Indonesia.

INTRODUCTION

Smoking is a public health problem, particularly in low and middle-income countries (Aras & Bayraktar, 2024). Adolescence is a critical period for the initiation of smoking, with many individuals starting between the ages of 13 and 15 years, when health-related behaviours are still forming but can persist into adulthood (World Health Organization, 2021). In several high-income

countries, like the United States and many European nations, the prevalence of smoking behaviors in adolescents has shown a declining trend over the past decade, primarily due to comprehensive tobacco control measures and sustained health promotion programs (WHO, 2019). In contrast, in Southeast Asia, including Indonesia, the prevalence of adolescent smoking continues to increase (Rosilawati, Rafique, & Sudiwijaya, 2024).

Indonesia is among the five countries with the highest number of smokers globally (WHO, 2019). National health survey data show that the prevalence of adolescent smokers rose from 7.2% in 2013 to 9.1% in 2018, indicating a worrying upward trend despite the implementation of numerous policies and regulations to control tobacco (WHO, 2019). At the same time, there has been a rapid increase in the use of electronic nicotine delivery systems (ENDS), which heat liquid to produce inhalable aerosol (World Health Organization (WHO), 2019). Although ENDS do not contain tobacco, they still deliver nicotine and may serve as a gateway to or a substitute for conventional cigarettes among adolescents (World Health Organization (WHO), 2019). The long-term health consequences of nicotine exposure, whether from conventional cigarettes or ENDS, often emerge 10-20 years later (World Health Organization (WHO), 2019). Even so, many young people still underestimate this (Andrade et al., 2017).

A range of smoking cessation methods has been developed, including behavioural counselling, pharmacological therapy (Giulietti et al., 2020), hypnosis, acupuncture (Zhang et al., 2021), meditation, and cognitive behavioral therapy (CBT) (Batra et al., 2024; Celik & Sevi, 2020; Nian et al., 2023) These approaches can be effective in addressing mental and behavioral aspects of nicotine dependence; however, in many real-world settings, their outcomes are often suboptimal and difficult to sustain, especially among adolescents who face strong peer influence and sociocultural pressures (Hastuti, Kulsum, Pustiana, & Ropei, 2022). In addition, access to structured psychological or pharmacological therapy may be limited in school and community settings, and many programs do not explicitly incorporate spiritual dimensions that are important in particular cultural contexts, such as predominantly Muslim populations.

In this context, the Spiritual Emotional Freedom Technique (SEFT) has emerged as a promising complementary approach. SEFT is a psychological healing method that combines spiritual affirmation, simulation of the body's energy meridian points similar to acupressure, and an emotional relaxation approach (Asmawati, Ikhlasia, & Panduragan, 2020; Hastuti et al., 2022; Sulifan, Y., Suroso, & Muhid, 2014; Tania, Mardjan Mardjan, & Elly Trisnawati, 2025). While CBT and hypnosis primarily target cognitive restructuring and behavioral modification, SEFT explicitly integrates a spiritual component with emotional regulation, which may resonate more strongly with Muslim adolescents in Indonesia and enhance their motivation to change. By addressing physical craving, emotional distress, and spiritual meaning simultaneously, SEFT has the potential to provide a more holistic framework for smoking cessation in this population.

However, the empirical evidence base for SEFT in the context of addiction remains very limited. To date, only a small number of empirical studies, fewer than five based on our literature search, have investigated SEFT in relation to addictive behavior, and these have primarily focused on adult populations or non-nicotine-related problems such as anxiety, depression, or general stress (Hastuti et al., 2022). No previous study has specifically examined the effectiveness of SEFT in reducing nicotine dependence among adolescent smokers in Indonesia. This lack of evidence creates a vital research gap, particularly given the rising burden of teenage smoking and the strong cultural and religious relevance of spiritually oriented interventions in this setting.

SEFT is considered a cost-effective, easy-to-implement approach that does not cause side effects, and it has great potential to be developed as a community-based therapy in schools and youth health centres. This study aims to evaluate the effectiveness of the Spiritual Emotional Freedom Technique (SEFT) as a complementary therapy to reduce nicotine addiction in adolescent smokers in Indonesia.

METHODS

This quantitative study used a quasi-experimental pre-post test with a control group design and was conducted in Bengkulu City, Indonesia, in 2024. The study population consisted of active

adolescent smokers. Participants were recruited using consecutive sampling from schools and community settings that agreed to collaborate. Consecutive sampling was chosen for feasibility, given the limited accessibility of adolescent smokers who openly expressed a desire to quit within a defined recruitment period.

The inclusion criteria were: Muslim adolescent active smokers aged 18 to 25, and who had the intention to quit smoking. The Muslim participants' determination was applied because the content of spiritual therapy is based on Islamic teachings. Adolescents with impaired communication and hearing function or who are undergoing other smoking cessation therapies were not included in this study. A total sample of 60 respondents was determined, with 80% statistical power, an estimated effect size (d= 0.50), and an alpha level of 0.05. Eligible participants were alternately assigned, in order of enrolment, to the intervention group (n=30) and the control group (n=30), yielding two groups of comparable size and baseline characteristics.

This study uses primary data sources directly from respondents. The intervention group were given the Spiritual Emotional Freedom Technique (SEFT) in the form of a combination of hypnotherapy and tapping techniques at 18 acupressure points. Hypnotherapy is performed on respondents who are in a state of deep relaxation, to help participants identify emotional or psychological triggers underlying the urge to smoke. While acupressure points include: the crown of the head, Eyebrow, side of the eye, under the eye, under the nose, chin point, collarbone, under arm, ear point, hand, toe point, middle of forehead, side of nose, above lip, side of neck, elbow point, left chest, back of foot. While tapping on a meridian point was used to facilitate emotional release and regulation. The intervention was administered individually by trained and certified therapists following a standardised SEFT protocol. In the control group, only standard hypnotherapy therapy was given without tapping techniques. For both groups, all actions were conducted individually for approximately 10 minutes per session on three consecutive days, according to an agreed schedule. All participants completed the scheduled session and none dropped out.

Research instruments consisted of a demographic data questionnaire and the Fagerstrom Test for Nicotine Dependence (FTND). The FTND comprised six items and was used in its Indonesian translation. The instrument has been tested for validity and reliability among smokers. The FTND was administered as a pretest (baseline) before any intervention and as a posttest one week after completion of the intervention in both the control and intervention groups.

The Independent variable was SEFT, and the dependent variable was cigarette nicotine dependence. All data is processed and analysed quantitatively using SPSS. Categorical data were described using frequencies and percentages, while numerical data were summarised using measures of central tendency and dispersion. The normality of FTND scores was assessed using the Kolmogorov–Smirnov test, which indicated a non-normal distribution ($p<0.05$). Consequently, within-group comparisons of pretest and posttest FTND scores were conducted using the Wilcoxon signed-rank test, and between-group comparisons using the Mann–Whitney U test, with a significance level of $\alpha= 0.05$. Effect sizes (r) were also calculated to quantify the magnitude of SEFT's impact beyond statistical significance

This research has been approved by the Ethics Committee of the Bengkulu Ministry of Health Polytechnic under the number KEPK.BKL/036a/02/2024. Written Informed consent was given to all respondents before the study began. Respondent anonymity was maintained using code numbers instead of personal identifiers, and all data were stored securely. Participants were informed that their participation was voluntary and that they could withdraw from the study at any time without penalty.

RESULTS

This study included a total of 60 adolescent smokers in the analysis, with 30 participants in the intervention group and 30 in the control group. No participants were lost to follow-up, and no FTND data were missing at pretest or posttest.

Table 1. Frequency Distribution of Demographic Characteristics of Active Smoker Adolescents

Characteristics	Intervention Groups		Control Group		Homogeneity Test (p-value)
Age					
Mean		21		21	
Standard deviation		2.084		1.875	0.203
Min-Max		18-25		19-25	
95% CI		20.22-21.78		20.30-21.70	
Long smoking					
Mean		3.70		2.63	
Standard deviation		0.988		0.765	0.251
Min-Max		2-6		1-4	
95% CI		3.33-4.07		2.35-2.92	
Final Education	**n (30)**	**% (100)**	**n (30)**	**% (100)**	
High School Equivalent	20	66.7	23	76.7	0.567
College	10	33.3	7	23.3	
Work					
Non-Permanent Jobs	1	33.3	2	6.7	
Student	6	20	3	10	0.835
Self employed	16	53.3	17	56.6	
Private Employees	5	16.7	6	20	
State Civil Apparatus	2	6.7	2	6.7	
Socioeconomic Status					
Low	15	50	12	40	0.574
Intermediate	10	33.3	14	46.7	
High	5	16.7	4	13.3	
Parent Education					
Elementary school	6	20	5	16.7	
Junior High School	3	10	5	16.7	0.836
High school	11	36.7	12	40	
College	10	33.3	8	26.6	
Parenting Work					
Farmer	6	20	6	20	0.837
Private/Self-Employed	14	46.7	16	53.3	
State Civil Apparatus	10	33.3	8	26.7	
Smoking Status of Parent					
No Smoking	10	33.3	11	36.7	1.001
Smoke	20	66.7	19	63.3	

Table 1 shows the demographic characteristics of respondents in both groups. The mean age of the respondents in the intervention and control groups was the same, 21 years, with standard deviations of 2.08 and 1.88 years, respectively. The mean duration of smoking was lower in the control group of 2.63 years compared to 3.70 years in the intervention group. The majority of respondents were from high school-equivalent education, worked in the informal sector (self-employed), and had a lower-middle socioeconomic status. Parents' Education is primarily at the high school and university levels, and the private/self-employed sector dominates employment. Most of the respondents' parents were also active smokers. The homogeneity of these characteristics strengthens the validity of comparisons between groups in evaluating the effectiveness of the given intervention. Homogeneity tests showed no statistically significant differences between the intervention and control groups across all demographic variables (all $p>0.05$), indicating that the groups were comparable at baseline (Table 1).

Table 2. Frequency Distribution Fagerstrom Test for Nicotine Dependence (FTND)

Variables	Intervention				Control			
	Pretest		Posttest		Pretest		Posttest	
	n (30)	% (100)	n (30)	% (100)	n (30)	% (100)	n (30)	% (100)
How soon after you wake up do you smoke your first cigarette?								
After 60 minutes	1	3.3	8	26.7	0	0	0	0
31 to 60 minutes	4	13.3	6	20.0	0	0	6	20
6 to 30 minutes	4	13.3	8	26.7	8	26.7	4	13.3
Within 5 minutes	21	70	8	26.7	22	73.3	20	66.7
Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., in church, at the library)?								
No	1	3.3	8	26.7	0	0	0	0
Yes	29	96.7	22	73.3	30	100	30	100
Which cigarette would you hate most to give up?								
The first one in the morning	1	3.3	8	26.7	0	0	0	0
Any other	29	96.7	22	73.3	30	100	30	100
How many cigarettes per day do you smoke?								
10 or fewer	1	3.3	8	26.7	0	0	0	0
11 to 20	4	13.3	6	20.0	0	0	6	20
21 to 30	4	13.3	8	26.7	8	26.7	4	13.3
31 or more	21	70	8	26.7	22	73.3	20	66.7
Do you smoke more frequently during the first hours after waking than during the rest of the day?								
No.	1	3.3	8	26.7	0	0	0	0
Yes	29	96.7	22	73.3	30	100	30	100
Do you smoke when you are so ill that you are in bed most of the day?								
No.	1	3.3	8	26.7	0	0	0	0
Yes	29	96.7	22	73.3	30	100	30	100

Table 2 shows changes in the six items of the Fagerstrom Test for Nicotine Dependence (FTND) before and after the action between the intervention and control groups. The results showed that in the intervention group, there was a significant decrease in the answer category that reflected high levels of dependence, such as a reduction in the proportion of respondents who smoked within 5 minutes of waking up from 70% to 26.7% and who continued to smoke despite being seriously ill from 96.7% to 73.3%. Meanwhile, the non-questions showed no significant change, and most respondents remained in the high-dependence category across all question items. This change showed a positive impact of the intervention on the smoking behavior of respondents in the intervention group.

Table 3. Effectiveness of *the* SEFT on the Fagerstrom Test for Nicotine Dependence (FTND)

***Fagerstrom Test for Nicotine Dependence* (FTND)**	**Pretest**	**Posttest**	**p-value Wilcoxon**	**p-value Mann-Whitney**
Intervention Groups				
Mean	4.17	2.52	0.001	0.001
Median	3.70	2.11		
Standard deviation	2.00	2.14		
Min-Max	0.91-9.25	0.23-10		
95% CI	3.43-4.92	1.72-3.32		

Fagerstrom Test for Nicotine Dependence (FTND)	Pretest	Posttest	p-value Wilcoxon	p-value Mann-Whitney
Control Groups				
Mean	4.21	3.80	0.177	
Median	3.93	3.96		
Standard deviation	1.65	1.81		
Min-Max	2.17-8.34	1.14-9.13		
95% CI	3.60-4.83	3.13-4.48		

Table 3 shows the descriptive and inferential statistics for the total FTND. In the intervention group, the mean FTND score decreased from 4.17 (SD= 2.00; 95% CI: 3,43-4,92) at pretest to 2.52 (SD= 2.14; 95% CI: 1,72-3,32) at posttest. Meanwhile, in the control group, FTND scores decreased significantly from 4.21 (SD= 1.65; 95% CI: 3.60-4.83) at pretest to 3.80 (SD = 1.81; 95% CI: 3.13-4.48) at posttest

Bivariate analysis showed that in the intervention group receiving SEFT, the FTND score changed significantly from pretest to posttest (p=0.001). In the control group, there was no difference in pretest and posttest values (p 0.1772). Thus, the Mann-Whitney Test showed a significant difference in posttest scores between the intervention and control groups (p<0.001). These results suggest that SEFT is effective in reducing nicotine dependence in adolescents.

DISCUSSION

Characteristics of Adolescent Smokers

The average age of the overall respondents was 21 years, which was within the age range of 18-25 years. According to the Global Youth Tobacco Survey (GYTS), smoking habits mostly begin at the age of 13-15 years (Friedson, Li, Meckel, Rees, & Sacks, 2024; World Health Organization, 2021). However, the results of this study show that respondents are in a psychosocial developmental phase that is susceptible to exposure to smoking risk behaviors (Jackson, West, & Brown, 2020; Liang, Liao, Lee, & Liu, 2022), Previous studies in Indonesia and other settings have also shown that adolescents and young adults are at high risk of becoming regular smokers, with smoking behavior strongly influenced by environmental and social factors (Defoe, Semon Dubas, Somerville, Lugtig, & van Aken, 2016; Liang et al., 2022; Nurmansyah et al., 2021). This supports the relevance of targeting this age group for smoking cessation interventions.

Most of the participants had a high school education background and low to moderate socioeconomic status. These findings are consistent with evidence that smoking prevalence is higher in individuals with lower educational attainment and socioeconomic status (Andrade et al., 2017; Perski et al., 2022; Wojnar et al., 2024). Many respondents and their parents work in the private or self-employed sectors, where social and workplace norms may be more permissive towards smoking (Le, Pereira Pedrosa, & Murdock, 2024; Vázquez-Otero, Bekalu, Dhawan, & Viswanath, 2023). The behavior of the respondents' parents who smoked was found in both groups. This condition reflects family-level modelling and normalisation of smoking as reported in previous studies (Chen, Nita, Coble, Ortiz, & Leong, 2024; Vázquez-Otero et al., 2023; Wilkinson, Shete, & Prokhorov, 2016). Taken together, these characteristics describe a group embedded in social and familial environments that tend to reinforce tobacco, which is essential when interpreting the impact of SEFT.

Parental smoking was common in both groups. Consistent with previous studies, parental smoking and household exposure to cigarettes are important modelling factors that increase the likelihood of adolescent smoking initiation and maintenance, regardless of parental education level (Chen et al., 2024; Le et al., 2024; Vázquez-Otero et al., 2023; Wilkinson et al., 2016). Taken together, these characteristics depict a group of adolescents embedded in social and familial environments that reinforce smoking, which is important when interpreting the impact of the intervention.

Effectiveness of SEFT against Cigarette Nicotine Addiction

The key finding of this study is that SEFT produced a significant reduction in FTND scores in the intervention group compared with the control group. SEFT comprises three stages—set-up, tune-in, and tapping—designed to address both physical and psychological aspects of problematic behaviors, including smoking (Asmawati et al., 2020). The method combines stimulation of energy meridian points (tapping), positive verbal affirmations, and a spiritual component that engages personal beliefs and emotions (Asmawati et al., 2020; Hastuti et al., 2022; Tania et al., 2025; Winarti, Nurkhastana, & Rohana, 2022). Earlier studies have reported promising effects of SEFT in reducing nicotine addiction and other forms of psychological distress (Asmawati et al., 2020; Tania et al., 2025).

The therapeutic mechanism of SEFT can be understood from psychophysiological and behavioral perspectives. Tapping on specific acupressure points while focusing on cravings or smoking-related thoughts is believed to modulate autonomic arousal and limbic system activation, thereby reducing stress, anxiety, and negative affect that often trigger addictive behaviors (Tania et al., 2025; Winarti et al., 2022) By repeatedly associating smoking-related cues with a state of relaxation rather than tension, SEFT may foster emotional desensitisation and weaken the learned link between stress and smoking. This can help explain the observed reduction in nicotine dependence scores in the intervention group.

In line with previous research, SEFT has been shown to reduce anxiety, emotional distress, and the psychological burden associated with addiction (Ifazatul, 2016; Tania et al., 2025; Winarti et al., 2022). These effects may indirectly lower the urge to smoke by improving emotional regulation. In addition, prior studies have reported that SEFT can significantly decrease the frequency of daily smoking and enhance self-control and spiritual awareness (Asmawati et al., 2020; Tania et al., 2025). SEFT is also relatively simple, cost-effective, and can be delivered by health workers, families, or lay providers, making it a feasible option for smoking cessation interventions in community and school settings (Hastuti et al., 2022; Winarti et al., 2022).

The findings of this study are consistent with broader evidence that psychological support programs and non-pharmacological interventions can be effective in reducing nicotine dependence (Hastuti et al., 2022; Winarti et al., 2022). Integrating SEFT within such frameworks may offer an additional tool, especially in contexts where resources for pharmacological therapy are limited.

Role of spirituality and religiosity

Beyond its emotional and cognitive components, SEFT explicitly incorporates spiritual affirmation and elements of prayer or surrender. A strong religious background generally characterises Indonesian adolescents, and the spiritual affirmations used in SEFT are likely to resonate personally with them (Hastuti et al., 2022; Ifazatul, 2016; Winarti et al., 2022). This spiritual engagement may strengthen relaxation, self-acceptance, and readiness to change—core processes that underpin successful behavioral modification. In this way, SEFT aligns the decision to reduce or quit smoking with adolescents' religious identity and values, potentially increasing internal motivation and adherence to the therapeutic process.

Implications and limitations

The findings suggest that SEFT is a practical, low-cost, and culturally congruent non-pharmacological intervention for adolescent smoking cessation. SEFT could be integrated into school-based health promotion programs, counselling services at Primary Health care, and youth community activities, delivered by trained health workers, school counsellors, or peer educators. In the context of Indonesia's tobacco control efforts, SEFT may serve as a complementary modality alongside more conventional approaches such as brief advice, counselling, and pharmacotherapy, particularly in resource-limited settings where access to specialist services is constrained.

However, several limitations need to be acknowledged. First, the follow-up period was short, with posttest assessment conducted only one week after the intervention. This limits the ability to evaluate long-term abstinence, relapse, or maintenance of behavior change. Second, measurement relied solely on the self-reported FTND instrument, which, despite its validity,

remains vulnerable to recall and social desirability bias. Third, potential moderating factors such as personal motivation to quit smoking or social support from family and peers were not formally measured, although they likely contributed to outcomes and should be considered in future research.

The quasi-experimental design and use of consecutive sampling also limit generalizability. Participants were Muslim adolescents from a single city, which may restrict the applicability of the findings to other regions, age groups, or religious and cultural backgrounds. Furthermore, because the same research team was involved in delivering the intervention, there is a possibility of therapist or expectancy bias.

Recommendations for Future Research

Future research should therefore employ more extended follow-up periods, randomised or multicentre designs, and objective physiological measures to confirm and extend these findings. Comparative studies evaluating SEFT against other evidence-based psychological interventions, such as Cognitive Behavioral Therapy (CBT), and mixed-methods designs that include qualitative exploration of adolescents' experiences of SEFT would further clarify how and for whom this intervention works best.

CONCLUSION

The study demonstrated that the Spiritual Emotional Freedom Technique (SEFT) significantly reduced nicotine dependence among adolescent smokers compared with hypnotherapy alone, indicating that a combination of tapping, emotional processing, and spiritual affirmation can effectively support addiction reduction through enhanced emotion regulation and spiritually anchored behavior change. SEFT thus emerges as a culturally relevant, low-cost, and spiritually integrated complementary intervention that aligns with the religious and social context of Indonesian adolescents and has clear potential for incorporation into school- and community-based smoking cessation programs. Future research should adopt longitudinal designs with larger and more diverse adolescent populations, integrate objective physiological indicators (such as carbon dioxide or cotinine levels), and explore the combination of SEFT with other evidence-based behavioral therapies to clarify its long-term effectiveness, mechanisms of action, and scalability in broader adolescent health and addiction-prevention strategies.

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