THE COMBINATION BETWEEN SPIRITUAL THERAPY AND EMOTIONAL FREEDOM TECHNIQUE TO CONTROL THE DEPRESSION LEVEL IN PEOPLE WITH HIV AND AIDS AT SAMARINDA CITY

M. Ardan
Postgraduate Program, Faculty of Public Health, Hasanuddin University, **INDONESIA**

Andi Zulkifli
Department Epidemiology, Faculty of Public Health, Hasanuddin University, **INDONESIA**

Nurhaedar Jafar
Science Nutrition Program, Faculty of Public Health, Hasanuddin University, **INDONESIA**

ABSTRACT

The cases of infectious diseases in Indonesia increase, one of them is HIV and AIDS, which is quite alarming among the society, coupled with the stigma and discrimination felt by People Living With HIV/AIDS (PLWHA), resulting the higher incidence of depression. This study aims to assess Spiritual and Emotional Freedom Technique (SEFT) combination therapy effects on controlling depression level of PLWHA in Samarinda City. The research design used a quasi-experimental method with a randomized control group design pretest posttest design. Samples taken by simple random sampling were 32 PLWHA. Data collection using a questionnaire that runs from March to May 2019 with a Beck Depression Inventory measuring instrument. Data were analyzed by independent t test. The results showed that respondents' characteristics of two research groups with male sex were 62.5%, female 37.5%, average age was 26-35 years old 50.0% and average education level of high school graduates was 50.0 %. There was no effect of SEFT intervention on depression levels to PLWHA with 1 intervention, p value of 0.264> 0.05, there was an effect of SEFT intervention on depression levels to PLWHA after 3 interventions, p value of 0.000 <0.05. Peer Assistant groups are expected to provide support, motivation and assistance as well as being able to actively provide SEFT therapy to be able to control the level of depression in PLWHA as a non-pharmacological therapy effort.

Keywords: PLWHA, Depression, SEFT Therapy.

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is one of the most frightening diseases in the world. This infectious disease is caused by a viral infection called the Human Immunodeficiency Virus (HIV). This virus causes the patient's body to have an increasingly weakened immune system. If this virus enters the body, it continues to develop with various processes. This disease not only threatens the lives of sufferers, but also other people from the potential for very large transmission (Lestari, 2016).

The Ministry of Health of the Republic of Indonesia states that HIV infections reported in January to June 2018 numbered 21,336 HIV infections while the number of AIDS occurrences in January to June 2018 was 6,162 cases. Until now, the data has not been indicated in stopping the rate of spread of HIV and AIDS (Ministry of Health, 2018). Based on data from the AIDS Commission (KPA) that Samarinda City is the city with the highest cumulative HIV and AIDS cases in East Kalimantan province. Every year the number of HIV and AIDS cases tends to

increase. Since 2013, the reported incidence of HIV and AIDS in Samarinda City per 100,000 population has a number of cases (238) 2.38%, in 2015 as many as 3.51%, and in 2017 as many as 3.8% cases, this happened an increase of 0.3% or as many as 29 cases from 2015 to 2017 new cases (AIDS Commission, Kota Samarinda, 2018).

The stigma of HIV and AIDS is a psychosocial problem that affects many aspects of the lives of sufferers. The higher the stigma received, the lower the quality of life (Said et al., 2016). Related to discrimination from the public, from the survey it was also known that this was caused by the bad stigma of people towards HIV and AIDS, that HIV and AIDS as a contagious disease, could lead to death in those who were infected, also caused by negative behaviors such as sex free. Stigma from the community can lead to shame in People Living With HIV/AIDS (PLWHA) associated with depression or in other words, the lack of support from the community can increase the likelihood of depression in PLWHA (Li, et al., 2009; Paryati, 2012). It can be stated that the more lack of individual welfare felt by PLWHA and individuals is able to influence the reduced welfare of the individual.

According to WHO, the prevalence of depression increased by around 18% from 2005-2017, and globally depressed people were around 35 million (11.67%), 60 million (20%) were bipolar, 21 million (7%) were affected by schizophrenia and 47.5 people affected by dementia (13.83%) (Bustan, 2007; Ministry of Health, 2016). In Indonesia in 2013 showed that the prevalence of mental emotional disorders that showed symptoms of depression and anxiety for ages 15 and over reached 6% or around 14 million people and 1.7 per 1,000 people or reached around 400,000 people who experienced severe mental disorders such as schizophrenia (Indonesian Basic Health Research, 2013). Whereas in 2018 the prevalence of depression in the population aged 15 years and over increased by 0.1% from 2013 to 6.1% and in the province of East Kalimantan the prevalence of the population experiencing depression was around 6.2% with people with mental disorders weighing 1.4 million people (Indonesian Basic Health Research, 2018).

SEFT is the development of Emotional Freedom Technique (EFT). EFT intervention is a technique to overcome emotions that is done by lightly tapping the fingertips by stimulating certain meridian points in the body of an individual while feeling the problem at hand. EFT's intervention was later developed into SEFT (Zainuddin, 2009). SEFT intervention is a technique that connects spirituality in the form of prayer, sincerity and submission with psychology energy in the form of a set of principles and techniques utilizing the body's energy system to improve the state of mind, emotions and behavior through three a simple technique that is set-up, tune-in and staying (Zainuddin, 2014) .Therefore, the purpose of this study was to determine whether there is an influence of Spiritual and Emotional Freedom Technique on controlling depression levels in people living with HIV in Samarinda City.

METODOLOGY

The design of this study used a quasi experiment with a randomized control group design pretest posttest design. The research is located in Samarinda City, East Kalimantan Province, Indonesia. The population in this study were all PLWHA in the city of Samarinda. A sample of 32 PLHIV who were divided into intervention groups and control groups were selected by simple random sampling that had met the inclusion criteria, namely PLHIV who were of productive age (18-45 years), diagnosed HIV positive <5 years old, were taking antiretroviral drugs (ARV), were able to communicate well, do not experience visual disturbances and hearing loss, register in the city of Samarinda, are depressed, and are willing to sign an

informed consent issued by the Ethics Committee of the Hasanuddin University Faculty of Public Health.

Sample screening is carried out by trained field officers and using a pre-tested questionnaire. Data on host factors (age, sex, education, alcohol consumption habits, drug consumption habits), agent factor data (CD4 count), psychosocial factor data (loss of social role in the community, loss of friends or relatives), psychological factor data (family environment , place of residence), data on psychodynamic factors (guilt), physical factor data (deterioration in health), depression level data measured by the Beck Depression Inventory (BDI) questionnaire. Spiritual and Emotional Freedom Technique interventions are carried out 3 (three) times with a span of 5-7 days then the first posttest after 1 (one) intervention, the second posttest after 3 (three) interventions and 1 (one) follow-up follow-up week after the third intervention. To assess the effect of SEFT interventions on controlling depression levels in PLWHA using paired t test.

RESULTS AND DISCUSSION

Sample Characteristics

Table 1. Average Differences in Depression of PLWHA Before and After in the SEFT Intervention Group and Control in Samarinda City PLWHA

Characteristics of Respondents	Depression Level (n=16)			Total n (%)
	Light Mood Disorders	Borderline Depression Limits	Moderate Depression	
	n (%)	n (%)	n (%)	
Age (years)				
17 – 25	1 (6,3%)	1 (6,3%)	1 (6,3%)	3 (18,8%)
26 – 35	1 (6,3%)	3 (18,8%)	4 (25%)	8 (50%)
36 – 45	2 (12,5%)	2 (12,5%)	1 (6,3%)	5 (31,2%)
Gender				
Male	2 (12,5%)	3 (18,8%)	5 (31,3%)	10 (62,5%)
Female	2 (12,5%)	3 (18,8%)	1 (6,3%)	6 (37,5%)
Length of time diagnosed with HIV				
≤ 35 Month	2 (12,5%)	3 (18,8%)	4 (25%)	8 (56,3%)
36 – 60 Month	2 (12,5%)	3 (18,8%)	2(12,5%)	7 (43,8%)
CD4 value				
≥ 600 Sel/MCL	2 (12,5%)	2 (12,5%)	3 (18,8%)	7 (43,8%)
350 – 599 Sel/MCL	1 (6,3%)	2 (12,5%)	0 (0%)	3 (18,8%)
200 – 349 Sel/MCL	0 (0%)	0 (0%)	2 (12,5%)	2 (12,4%)
< 200 Sel/MCL	1 (6,3%)	2 (12,5%)	1 (6,3%)	4 (25%)
Level of education				
Junior high school	0 (0%)	3 (18,8%)	1 (6,3%)	4 (25%)
High school	4 (25%)	2 (12,5%)	2 (12,5%)	8 (50%)
Diploma / Bachelor	0 (0%)	1 (6,3%)	3 (18,8%)	4 (25%)
Marital status				
Not married	2 (12,5%)	2 (12,5%)	4 (25%)	8 (50%)
Marriage	2 (12,5%)	4 (25%)	2 (12,5%)	8 (50%)
Status of residence				
Family	4 (25%)	5 (31,3%)	3 (18,8%)	12 (75%)
Alone or others	0 (0%)	1 (6,3%)	3 (18,8%)	3 (25%)

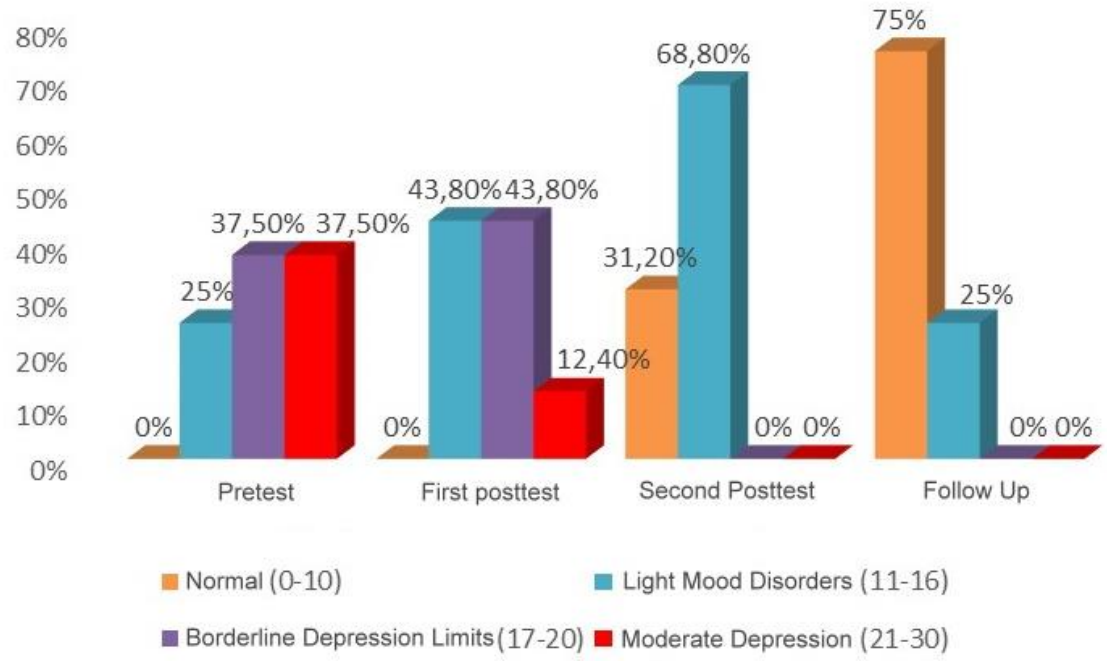
Source: Primary Data, March - May 2019

Table 1. shows the correlation with the characteristics of the respondents of this study. Most PLHIV are between the ages of 26-35 years (50%) which are the productive age group or early adults and 25% of them experience moderate depression. The sex of the respondents was dominated by men (62.5%) with moderate depression as much as 31.3% while women (37.5%) with borderline depression limits as much as 18.8%. The length of time diagnosed with HIV is 56.3% is <35 months including moderate depression as much as 25%. The number of CD4 cells in PLWHA in this study was mostly> 600 Cells / MCL (43.8%) which meant that the respondent's immune system was still good but there were 25% of respondents who had CD4 cells <200 cells / MCL which indicated that they had acquired immunodeficiency syndrome high risk of developing opportunistic infections.

Based on the socio-cultural aspects assessed based on education level, marital status and residence status, it shows that most PLWHA graduated from high school above (75%), while marital status of married PLWHA tend to experience borderline depression levels and unmarried PLWHA tend to experience depression each is 25%. About 75% of PLWHA live with family but have a tendency for depression ranging from mild mood disorders to moderate depression.

Level of Depression of PLWHA

Figure 1. Characteristics of Respondents Based on Depression Levels of PLWHA



Source: Primary Data, March - May 2019.

Figure 1. shows that the level of depression of the respondents at the pretest was divided into 3 categories, namely mild mood disorders (25%), borderline depression and moderate depression limits (37.5%). After SEFT intervention 1 (one) time in the moderate depression category decreased to 12.4% while the borderline border category and mild mood disorders increased to 43.8%). Then after 3 (three) interventions, it was found that there were no people living with HIV who had depression in the category of moderate borderline and depression, but PLWHA who experienced mild mood disorders increased to 68.8% and the normal category increased to 31.2%. One week after the third (three) intervention was carried out

posttest follow-up, it was found that PLWHA who experienced mood disorders were as much as 25% and normal as much as 75%.

Figure 2. Characteristics of Respondents Based on Percentage of Change in Scores of Depression of PLWHA

Source: Primary Data, March - May 2019.

Figure 2. shows that at the first posttest, the second posttest and follow-up posttest were not found by respondents who experienced an increase in depression scores, but the tendency to experience depression scores decreased from 78.75% to 100% which changed while at the first posttest obtained by respondents who did not have a change in the value of the depression score by 31.25%.

Bivariate Analysis

Table 2 Effect of SEFT Interventions on the Average Score of Depression of PLWHA

Statistical Results	Pretest	Post 1	Post 2	Post 3
Intervention *Mean ± SD*	19,5 ± 3,5	17,7 ± 3,8	11,3 ± 2,7	9,4 ± 2,6
Control *Mean ± SD*	19,7 ± 4,2	19,2 ± 3,9	19,1 ± 4,2	19,0 ± 3,8
Δ Mean ± SD *p value*	0,18 ± 0,7 0,893	1,7 ± 3,9 0,264	7,7 ± 1,4 0,000	9,6 ± 1,2 0,000

Source: Primary Data, March - May 2019.

Table 2. shows that the value of the first pretest and posttest after 1 (one) therapy with each value (p = 0.893, p = 0.264) which shows that there is no difference and the effect of SEFT intervention on the level of depression of PLWHA, while after therapy 3 (times) and follow-up results obtained results of each value (p = 0,000) which showed that there was an effect of SEFT intervention on depression levels of PLWHA, from these results it can be concluded that before SEFT therapy and after 1 (one) therapy did not have influence. But after 3 (three) times the SEFT therapy intervention and follow-up had an effect on reducing the level of depression of PLWHA.

The results of this study indicate that there is an influence of spiritual and emotional freedom therapy techniques on controlling the level of depression in people with HIV and AIDS. The results of the study showed that when productive age or early adulthood to adulthood end the tendency to experience depression when living with the HIV virus, this shows that stigma and discrimination are felt to be higher and people's views about free behavior, in men, are also the cause of high level of depression in respondents. Low education and lack of information received result in a high level of depression because basically knowledge can be a pillar in everyday life. Low knowledge about HIV makes someone feel guilty higher and get incorrect information about how to deal with it. The results of the statistical test study in the intervention group showed that there was a decrease in the average score of depression before and after the SEFT intervention, where the mean + SD pre-test was 19.5 + 3.5 to 17.7 + 3.8 at post- first test, 11.3 + 2.7 at the time of the second post-test and 9.5 + 2.6 at the time of follow-up. Whereas the control group showed that there was a decrease in the average depression score before and after the posttest, where the mean + SD pre-test was 19.7 + 4.2 to 19.2 + 3.9 at the first post-test, 19, 1 + 4.2 at the second post-test and 19.0 + 3.8 at the time of follow-up. With the value of p value after the intervention as much as 1 time obtained p = 0.264> 0.05, which means there is no effect of the SEFT intervention on the control of the level of depression of PLWHA, while after intervention three times the value of p value (0,000) means that there is a significant effect a combination of spiritual and emotional freedom therapy intervention techniques to control the level of depression in PLWHA.

The results of this study in accordance with the study of Astuti et al. (2015) stated that there were significant differences in the rate of depression of housewives with HIV, after SEFT intervention was carried out. This is also reinforced by research conducted by Kasih et al. (2017) that there is an effect of SEFT therapy on changes in depression scores in PLWHA at Sungai Bangkong Mental Hospital. So that SEFT Therapy can be recommended as one of the complementary therapies in providing nursing care to PLWHA who are depressed. Besides that Bakara et al., (2013) stated that cognitive behavior of religious behavior had an effect on reducing anxiety about death in people with HIV / AIDS. While Halm (2009) stated that there were significant differences between the levels of depression, anxiety, and stress before and after SEFT interventions between the intervention group and the control group. So it can be concluded that Combination of Spiritual and Emotional Freedom Technique (SEFT) therapy can be done in an effort to control the level of depression in people living with HIV and other diseases that can cause depression in their occupants.

Spiritual therapy creates a relaxation and health response, can lead to confidence in self-care, and is beneficial to anxiety and panic in terminal patients that can lead to calmness. The results of other studies mention there are differences in the decrease in the level of depression in heart failure patients who get spiritual guidance, where spiritual guidance can increase social motivation, physical symptoms and improvement in health status associated with depression (Bakara et al., 2013). Spiritual belief has a strong effect on psychological function in research conducted on cancer patients. Desperation rates, suicidal desires and deaths were lower in cancer patients who received spiritual therapy. Spiritual therapy affects the activity of the sympathetic nervous system, the effects of relaxation are breathing slows more slowly, slow pulse, blood pressure drops, decreases heart muscle oxygen consumption and muscle tension. Relaxation responses also affect mental states and reduce muscle tension, so that creating a comfortable atmosphere, reducing stress also affects the psychoneuroendocrine interactions (Halm, 2009).

Religion has a role in shaping one's concept of health and illness. This concept is strongly influenced by his belief in God's role in determining one's destiny, including in terms of health and illness. The role of religion in all aspects of human life has been around for centuries. Compliance with the religious values of health workers and religious leaders has a role in preventing and reducing HIV transmission. The results of research conducted by Diaz state the role of religion in shaping the concepts of health and sickness and related to the existence of stigma against people with HIV and AIDS (Varas-Díaz, 2010).

SEFT is a therapy that combines spiritual energy and psychological power by putting forward or utilizing the forces that have existed in the human body which will cause multiple strengths and can cure all problems faced by humans by empowering themselves with energy and strength. This SEFT combination therapy process effectively stimulates PLWHA to be relaxed and self-reliant to control themselves so that based on the posttest results to follow-up there is a significant decrease in the level of depression for PLWHA.

SEFT therapy is useful to help someone become more relaxed and be able to deal with a severe situation or situation in his life, because the existence of a positive energy system flow and a positive form of affirmation is what makes SEFT therapy effective (Afriyanti & Wenni, 2018). The nature of relaxation in SEFT can also reduce tension and anxiety where the parasympathetic nervous system is more dominant working than the sympathetic nervous system then in the tune-in phase in SEFT also supports the relaxation process where the phase is done by saying prayer, submission and sincerity to God the Most As well as affirmative sentences that continue to be spoken several times so as to increase self-confidence (Anwar & Niagara, 2011).

CONCLUSION

In this study, it can be concluded that spiritual therapy and emotional freedom technique can control the level of depression in PLWHA, accompanied by that, continuous and consistent administration of SEFT therapy can reduce depression levels which are getting better. Efforts to control depression due to stigma and discrimination, health workers and facilitators of HIV and AIDS are advised not only to focus on providing pharmacological drugs, provide motivation, support and assistance, but also can implement SEFT therapy in an effort to increase the confidence and enthusiasm of PLWHA with non-pharmacological therapy.

REFERENCES

Afriyanti, E., & Wenni, B. P. (2018). The Effect of Spiritual Emotional Freedom Technique (SEFT) on the Self Concept of Breast Cancer Patients with Mastectomy. *Jurnal Keperawatan Padjadjaran*, *6*(3).

Anwar, Z., & Niagara, S. T. (2011). Model terapi SEFT (Spiritual Emotional Freedom Technique) untuk mengatasi gangguan fobia spesifik. *Naskah Publikasi Penelitian Pengembangan IPTEKS. Malang: Universitas Muhammadiyah*.

Astuti, R., Yosep, I., & Susanti, R. D. (2015). Pengaruh intervensi SEFT (Spiritual Emotional Freedom Technique) terhadap penurunan tingkat depresi ibu rumah tangga dengan HIV. *Jurnal Keperawatan Padjadjaran*, *3*(1).

Bakara, D. M., Ibrahim, K., & Sriati, A. (2013). Efek Spiritual Emotional Freedom Techniqueterhadap Cemas dan Depresi, Sindrom Koroner Akut. *Jurnal Keperawatan Padjadjaran*, *1*(1).

Bustan M.N. (2007). *Epidemiologi Penyakit Tidak Menular*. Jakarta: Rineka Cipta.

Halm, M. A. (2009). Relaxation: A self-care healing modality reduces harmful effects of anxiety. *American Journal of Critical Care, 18*(2), 169-172.

Indonesian Basic Health Research, (2013). *Health Research and Development Agency*: Jakarta.

Indonesian Basic Health Research, (2018). *Main Results of 2018 Basic Health Research*, Health Research and Development Agency: Jakarta.

Kasih, C. D. P., (2015). Pengaruh Terapi Spiritual Emotional Freedom Technique Terhadap Perubahan Skor Depresi Pada Orang Dengan HIV dan AIDS Di Rumah Sakit Jiwa Sungai Bangkong. *Jurnal ProNers, 3(1).*

Lestari, Y. (2016). Strategi Komunikasi Sosialisasi Pengetahuan Dasar Komprehensif HIV/AIDS. *Jurnal Komunikasi, 10*(1), 13-28.

Li, L., Lee, S. J., Thammawijaya, P., Jiraphongsa, C., & Rotheram-Borus, M. J. (2009). Stigma, social support, and depression among people living with HIV in Thailand. *AIDS care, 21*(8), 1007-1013.

Ministry of Health, (2016). *The Role of Families Supports Community Mental Health*. Jakarta: Ministry of Health of the Republic of Indonesia.

Ministry of Health, (2018). *Progress Report on HIV-AIDS & Sexually Transmitted Infections (STIs) in Quarter II of 2018,* Jakarta: Ministry of Health of the Republic of Indonesia.

Paryati, T., Raksanagara, A. S., & Afriandi, I. (2012). *Faktor-faktor yang Mempengaruhi Stigma dan Diskriminasi kepada ODHA (Orang dengan HIV/AIDS) oleh petugas kesehatan*. Retrieved from http://pustaka.unpad.ac.id

Said, S., Hakimi, M., and Kusnanto, H. (2016). *Stigma HIV dan AIDS dan Kualitas Hidup Orang Dengan HIV dan AIDS di Yogyakarta,* K.I. XIII, Makassar.

Samarinda City AIDS Commission, (2018). *Samarinda City HIV and AIDS Data in 2018*, Samarinda.

Varas-Díaz, N., Neilands, T. B., Malavé Rivera, S., & Betancourt, E. (2010). Religion and HIV/AIDS stigma: Implications for health professionals in Puerto Rico. *Global Public Health, 5*(3), 295-312.

Zainuddin, A.F. (2009). *SEFT For Healing + Succes + Happiness + Greatness*. Jakarta: Afzan Publising.

Zainuddin, A.F. (2014). *SEFT Total Soution Healing, Happiness, Success, Greatness : SEFTer Handbook*, ed: SEFT Corporation.