European International University, EIU-Paris

Doctoral Thesis

Title: ASSESSING THE EFFECTIVENESS OF EMOTIONAL FREEDOM TECHNIQUE FOR IMPROVING THE WELL-BEING OF CARE HOME RESIDENTS

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In Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy (Ph.D.) in Lifestyle Medicine

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Date:

April 2026



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A Dissertation

Submitted to the Faculty of Lifestyle Prescriptions® University

in partial fulfilment of the requirements

for the degree of Doctor of Philosophy in Lifestyle Medicine

By

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2026

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ABSTRACT

Care home residents experience disproportionately high rates of anxiety, yet for them access to psychological support remains limited. This dissertation examines the use of Emotional Freedom Technique (EFT), a non-pharmacological intervention, to enhance well-being and reduce anxiety when delivered by care assistants through a Train-the-Trainer (TTT) model. A mixed-methods design combined visual Likert scales across ten EFT sessions and a seven-week follow-up with qualitative insights from carer interviews and observations. Findings suggest EFT may likely improve residents' well-being, though reductions in anxiety were less consistent, particularly for those with advanced cognitive impairment.

Carers reported benefits, such as increased calmness and engagement, alongside challenges, including variable resident participation and the need for continued staff support. The study provides early evidence that a TTT model may be a feasible, low-cost approach to embedding EFT in care homes programming, while also identifying areas for refinement, especially in dementia care. More broadly, it points to the potential of empowering frontline staff to deliver accessible, non-pharmacological strategies that address a critical gap in elderly mental health support for this under-researched population.

ACHNOWLEDGEMENTS

This Ph.D. journey has been an incredible chapter of my life, and I am deeply grateful to those who have supported and guided me along the way. First and foremost, I extend my heartfelt thanks to my supervisors, Dr. Catherine Alter and Dr. Nick Deal. Your expertise, guidance, and encouragement have been invaluable throughout this process. A special thanks to Nick for your patient and insightful support with the statistical analysis, I could not have navigated that without you. I am profoundly grateful to Mobina Sayani for opening her care home and allowing me to conduct this research. To Chacha King, the COO, thank you for your unwavering support in organizing the logistics of this research. To the 14 incredible care assistants who graciously gave their time, and the residents who were open to trying a new therapy, I am deeply humbled by your contributions and courage. I extend my heartfelt thanks to Johannes R. Fisslinger, founder of Lifestyle Prescriptions® University, whose visionary work sparked the beginning of this journey and continues to inspire. To my family, my husband Andrew, whose unconditional support has been my anchor, and my children, Tyler and Dakota, thank you for believing in me and cheering me on. This dissertation reflects not only my own efforts, but also the dedication of those who supported me along the way. To all of you, my deepest thanks.

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Chapter 1

INTRODUCTION

The purpose of this dissertation is to evaluate the effectiveness of Emotional Freedom Techniques (EFT) in treating anxiety and improving well-being among care home residents. As explained throughout the dissertation, EFT is a promising stress-relief method that integrates elements of cognitive therapy with somatic stimulation, and is well positioned to enhance the subjective well-being (SWB) of care home residents.

Older adults living in care homes experience significantly higher rates of mental health disorders than their counterparts living in the community, highlighting the scale and urgency of the problem. Evidence indicates that between 40% and 50% of care home residents experience depression, while approximately 30% present with clinically significant anxiety (Seitz et al., 2010). In contrast, prevalence rates among community-dwelling adults are substantially lower, with studies reporting that only around 7% of adults experience depression and approximately 6% suffer from anxiety disorders (NHS, 2022). Even among older adults living independently, the prevalence remains far below that observed in institutional settings, estimated at 10%–15% for depression and 5%–7% for anxiety (Luppa et al., 2012).

Despite this stark disparity, mental health needs in care homes are frequently under-recognised and inadequately addressed, with fewer than 20% of affected residents receiving appropriate interventions (Seitz et al., 2010). Furthermore, evidence-based non-pharmacological approaches remain underutilised, despite their proven effectiveness in improving emotional well-being and quality of life.

As an EFT-certified practitioner with a particular interest in elderly care and future plans to acquire a care home, I am deeply invested in exploring interventions that address these unmet

emotional needs. Endorsed by the U.S. National Centre for Complementary and Integrative Health (NCCIH, n.d.), EFT is supported by over 100 peer-reviewed studies and has demonstrated effectiveness in reducing anxiety and depression in various contexts and across various populations, including among veterans, healthcare workers, pre-surgical patients, and individuals diagnosed with COVID-19 (Church, 2014; Church et al., 2012; Church & Brooks, 2010; Tambunan, 2022).

A further contribution of this study is to consider non-traditional ways of delivering low-cost mental health interventions in these resource constrained settings. Specifically, the research pioneers the application of the Train-the-Trainer (TTT) model to equip care assistants with the knowledge and skills needed to deliver EFT. As the first study to integrate the TTT model with EFT in a care home setting, it explores the intervention's potential as a scalable and sustainable approach to improving residents' mental health. The inherent simplicity and flexibility of EFT make it ideally suited to integrate into daily care routines, enabling carers to provide consistent emotional support. By empowering care assistants to deliver EFT this study offers an innovative, cost-effective solution to enhance residents' well-being. In doing so, it addresses a critical gap in emotional support within residential care environments, contributing to improved quality of life for a frequently overlooked population.

Problem Statement

The UK's rapidly aging population, a trend mirrored globally, where the number of people aged 60 and over is projected to double by 2050 (WHO, 2024), highlights the pressing need for improved elderly care. In 2020, nearly half a million people resided in UK care homes (Berg, 2024), and projections indicate that this figure will rise by 127% by 2040 (Kingston et al., 2018). The growing demand, coupled with an anticipated shortage of 58,000 care home beds by

2035 (Evans, 2022), challenges care providers to meet not only physical but also emotional needs. Historically, mental well-being in older adults has been overlooked in policymaking and resource allocation, despite its crucial role in overall quality of care (Lee, 2006). Although a range of non-pharmacological interventions, such as talking therapies, movement, exercise activities, and other wellness interventions, have shown promising results (Perach et al., 2019), these are often expensive and resource intensive to provide. Moreover, the UK lacks comprehensive evaluations of accessible and cost-effective solutions for individuals aged 65 and over (National Institute for Health and Care Excellence, 2008).

Perhaps understandably, care homes have traditionally focused on maintaining the physical health of their residents and have paid less attention to emotional well-being. This status quo is increasingly recognized as inadequate, as it does not consider the broader aspects of holistic well-being that is essential for a person's quality of life, especially in later years. Moreover, a sense of well-being is essential for both physical and mental health, with greater well-being linked to longer life expectancy and more years of good health without chronic disease or disability (Chida & Steptoe, 2008). Given the strong association between well-being and longevity, prioritizing the emotional wellness of care home residents may also reduce the incidence of chronic disease in this population and reduce costs accordingly (Zaninotto & Steptoe, 2019).

Although the well-being of care home residents is increasingly acknowledged as a critical issue in elderly care, providing effective interventions presents a range of complex challenges. Staffing shortages in many care homes limit the time available for care workers to provide emotional support, often resulting in a focus on physical care over psychological needs. Additionally, elderly residents frequently experience multiple chronic conditions, cognitive

impairments, and physical disabilities, complicating the diagnosis and treatment of mental health issues, as symptoms may overlap with normal aging or other medical conditions. Factors such as ageism, prolonged stress, illness, and isolation further increase the risk of depression and anxiety, making clear diagnosis and timely intervention difficult (Lapane et al., 2022).

The lack of access to mental health professionals and tailored therapeutic services compounds these challenges, as most staff members are primarily trained in physical care and may lack the skills to address mental health concerns effectively. Stigma surrounding mental health treatment further deters residents from seeking help, leaving emotional distress unaddressed. Additionally, care home environments often fail to support key aspects of well-being, such as social connections, autonomy, and meaningful activities. Although psychosocial interventions, like social activities and outings, aim to alleviate loneliness and improve mood, they often fall short of tackling persistent depression and anxiety which affect up to 40% and 30% of residents respectively (Age Concern and the Mental Health Foundation, 2006; Theurer et al., 2015). Among practitioners, there is increasing recognition that enhancing the emotional well-being of care home residents is fundamental to delivering high-quality, holistic care.

Significance and Contribution of the Study

In recognition of the above deficits in current elderly care, this study tests whether EFT may offer a practical, cost-effective method to address the emotional needs of care home residents. Its simplicity is what allows it to be delivered through the Train-the-Trainer model (TTT), enabling care assistants to independently administer the technique after initial training.

Research has demonstrated EFT's effectiveness in reducing anxiety, depression, and mood disturbances (Church & Brooks, 2010; Pandey, 2020; Tambunan, 2022), establishing it as

a promising tool for elderly care (Harbottle, 2019). With mounting evidence indicating that fostering mental well-being can serve as a preventative measure against mental disorders such as anxiety and depression (Schotanus-Dijkstra et al., 2017), a structured EFT intervention can contribute as an innovative, non-pharmacological, low-cost strategy for promoting emotional health, holding promise for elders in care homes. Correlational studies further support this approach, revealing significant links between depression, anxiety, and various aspects of well-being (Malone & Wachholtz, 2018), underscoring EFT's potential to address these mental health challenges. Unlike many well-being interventions that require extensive resources, such as therapists or activity coordinators, EFT only requires initial staff training and refreshers, enabling care assistants to apply the technique throughout the day in just a few minutes, offering immediate improvements in residents' emotional states.

Addressing mental health concerns among care home residents is essential to improving quality of life, satisfaction, and overall health outcomes (National Institute for Health and Care Excellence, 2013). While traditional therapies, such as cognitive and creative therapies, have demonstrated benefits, EFT's unique approach combines simplicity, adaptability, and effectiveness. It offers an immediate solution for residents experiencing distress, anxiety, or agitation (Harbottle, 2019), making it suitable for both individual and group settings. The Train-the-Trainer model further ensures sustainability by equipping care assistants with the skills to administer EFT independently, reducing reliance on external specialists. Unlike traditional approaches which often depend on specialist facilitators to implement interventions, the TTT model embeds expertise within the existing workforce, enabling care staff to act as in-house practitioners. This approach increases the accessibility and continuity of EFT delivery while reducing costs and logistical barriers associated with employing external practitioners. Evidence

from previous TTT applications in areas such as dementia care, nutritional screening, and psychosocial interventions demonstrates that it enhances staff competence, promotes confidence, and supports the long-term integration of new practices into routine care (Fossey et al., 2020; Goodman et al., 2014; Marks et al., 2013). When applied to EFT, this model offers a simple, efficient, and sustainable means of improving residents' emotional well-being as part of everyday care.

This study makes a valuable contribution to the existing literature on Emotional Freedom Techniques (EFT) by examining its application within care home settings through a Train-the-Trainer (TTT) model, an area with no prior research. By pioneering this approach, the dissertation opens new pathways for scalable, cost-effective mental health interventions in geriatric care, setting a foundation for future research on empowering non-clinical staff to deliver evidence-based emotional support. While EFT has been studied primarily in other populations, its use among elderly, particularly care home residents, remains underexplored, especially as a care assistant-led intervention.

Overview of the Research Design and Findings

This dissertation contributes to the evolving field of geriatric mental health by critically examining how EFT can be integrated into residential care settings through a carer-led intervention using the Train-the-Trainer model. A mixed-methods research design, combining repeated quantitative measures with qualitative observations, allowed for a nuanced understanding of both outcomes and implementation processes. While the quantitative findings revealed considerable variability and only limited statistical significance, they nonetheless indicated promising trends in improved emotional engagement, mood regulation, and overall well-being for some residents. These patterns were echoed in carers' qualitative accounts, which

described subtle but meaningful changes in residents' affect and interactions following EFT sessions. Importantly, the study also highlights key barriers including differences in residents' cognitive abilities, variability in response to the intervention, and challenges in maintaining delivery consistency, all of which shape the feasibility of embedding EFT into routine care. By situating these mixed outcomes within the broader context of emotional well-being support, the findings argue that, while EFT is not a universal solution, it offers potential as a complementary, non-pharmacological approach worthy of further investigation. Moreover, it demonstrates the value of empowering frontline care staff as in-house practitioners, suggesting that even modest gains in emotional support can represent meaningful progress in a field where such interventions remain underexplored.

Research Questions

This study investigates the following questions:

1. Does a care assistant-led EFT intervention significantly enhance the well-being of care home residents?
2. Does a care assistant-led EFT intervention significantly reduce anxiety among care home residents?
3. Is the Train-the-Trainer model effective in equipping care assistants to deliver EFT?

Summary

This dissertation is organized into five chapters, each contributing to the overarching thesis that care home residents have been historically overlooked, both socially and in research, resulting in a mental health crisis marked by high rates of anxiety and depression. It argues that EFT offers a promising, though not unproblematic, response to this crisis by enhancing

residents' emotional well-being and demonstrating scalability, cost-effectiveness, and feasibility when delivered by care assistants.

The literature review argues that current elderly mental health approaches insufficiently meet the emotional needs of residents. It positions high rates of anxiety and depression in care homes as the outcome of intertwined societal, institutional, and individual drivers of mental distress. This chapter contends that EFT could intervene across all these levels, and that its foundations in energy psychology and subjective well-being reinforce its credibility as a viable, evidence-informed non-pharmacological intervention in geriatric care.

Chapter 3 develops this thesis further by outlining the research design and methods used to test EFT's effectiveness. It argues that a mixed-methods approach, combining quantitative measures of well-being and anxiety with qualitative insights, provides a richer understanding of EFT's impact. The chapter also advances the argument that the Train-the-Trainer model offers not just a method of delivery, but also a way to embed EFT sustainably and ethically in care home settings.

Chapter 4 presents the results of the study, showing that quantitative analysis, using statistical tests to measure changes in well-being and anxiety levels, demonstrates improvements among residents. In parallel, qualitative thematic analysis of carers' feedback underscores the effectiveness of the Train-the-Trainer (TTT) model, illustrating how it facilitated the integration of EFT into daily routines and supporting its feasibility as a sustainable implementation strategy. This chapter further argues that qualitative observational data provide further evidence that EFT can positively shift residents' emotional states and patterns of engagement.

The final chapter synthesizes the findings, to argue that EFT, when led by care assistants, can be both effective and feasible as a response to the ongoing mental health crisis in care

homes. It demonstrates that, when implemented through care assistants, EFT has implications for geriatric care policy and practice, particularly by enriching daily care provision and reducing reliance on pharmacological interventions. It further establishes that while promising, EFT requires longer-term study to evaluate its sustained impact and wider applicability in care settings. Together, these findings advance the dissertation's central thesis that addressing the historical neglect of residents' emotional needs requires innovative, scalable approaches, of which EFT represents a viable, though partial, solution.

Chapter 2

LITERATURE REVIEW

This thematic review critically examines the existing literature on the effectiveness of EFT delivered by carers through a Train-the-Trainer (TTT) model to enhance the well-being of elderly residents in care home settings. The chapter begins by examining the mental health crisis within care homes, focusing on the prevalence of anxiety and depression, before exploring the societal, institutional, and individual drivers of these issues. The analysis emphasizes the complex interplay of these factors and the need for a holistic approach that goes beyond traditional clinical treatments. The review then considers potential solutions, highlighting the growing exploration of accessible, cost-effective interventions in care home settings. A core contention of this review is that interventions that prioritize improving the overall emotional and psychological health of residents, rather than merely treating symptoms of anxiety and depression, are a potentially valuable component of holistic care. Among these, Emotional Freedom Techniques (EFT) emerge as a promising non-pharmacological option due to their adaptability, ease of use, and evidence base. Finally, the review identifies key research gaps, particularly regarding the long-term efficacy of EFT, its mechanisms of action, and its practical application in care homes.

The primary aim of the literature search was to evaluate the effectiveness of EFT delivered by trained carers in enhancing the well-being of elderly care home residents. Key search terms included “Emotional Freedom Techniques (EFT),” “Train-the-Trainer (TTT) model,” “elderly care,” “anxiety and depression in care homes,” and “care home interventions.” The search was conducted electronically across major academic databases such as PubMed, Google Scholar, ScienceDirect, and the Cochrane Library, as well as reputable websites such as

the World Health Organization (WHO) and national healthcare agencies. The search process was expanded using a snowballing sampling technique, where references from relevant studies generated additional sources.

Inclusion criteria focused on peer-reviewed articles and credible reports published in English or French (the author's native language) that addressed elderly populations in care homes, interventions such as EFT, and the use of the TTT model. Exclusion criteria included articles published in languages other than English or French, and anecdotal testimonies without empirical evidence. From an initial pool of 453 resources, abstracts and full texts were evaluated, resulting in the selection of 306 studies for in-depth analysis, forming the foundation of this literature review.

Definition of Key Terms

Anxiety. A state of heightened worry or fear that can disrupt daily functioning and is common among elderly residents in care homes (Rodda et al., 2011).

Care-assistant/carer. An individual whose job is to help and look after people who are ill or have a disability, either in their own home or in a special home or hospital (Cambridge University Press, n.d.)

Care Home. A facility that offers both personal care services and accommodation, catering to individuals who, due to old age, illness, or disability, are unable to provide this care for themselves (NHS Digital, n.d.)

Depression. A mood disorder characterized by persistent feelings of sadness, loss of interest or pleasure in daily activities, and a range of physical and emotional symptoms that impair functioning (Malone & Wachholtz, 2018).

Elder/elderly. people aged 65 and over.

Emotional Freedom Techniques (EFT). EFT is a therapeutic approach based on a theoretical model of energy psychology that integrates cognitive and somatic methods, using acupressure tapping to alleviate emotional distress by restoring balance in the body's energy system (Church, 2013).

Resident. An individual who lives in a facility that provides personal and medical care.

Subjective Well-Being (SWB). SWB refers to individuals' cognitive and affective evaluations of their lives, including positive emotions, negative emotions, and overall life satisfaction (Diener, 1984).

Train-the-Trainer (TTT) Model. TTT is an educational approach that empowers selected individuals to deliver training to others or lead activities within their organization (Suhrheinrich, 2011).

The Crisis in UK Care Homes

Care homes provide accommodation, personal care, and nursing services, and play a critical role in the health and social care system for elders, supporting them with complex health conditions and age-related challenges, many of whom are in the later stages of life (Gordon et al., 2014). Currently, the UK has 16,700 care facilities accommodating approximately 441,479 senior residents (Berg, 2024). However, as global life expectancy continues to rise, many Western countries will experience a rapid aging of their populations; as birth rates drop and life expectancy increases, the ratio of younger working age people to older dependents is often framed as a creeping demographic crisis in its own right (Erk, 2017).

Perhaps unsurprisingly, aging populations are framed in increasingly alarmist terms as they are viewed as placing additional strains on stretched healthcare and social care systems, increasing the demand for expensive and specialized residential care (Centre for Ageing Better,

2022). In the UK, 19% of the population was aged 65 or older in 2022, a figure projected to reach 22% within the next decade (Storey, 2022). Additionally, shifts in family structures, including the transition from extended to nuclear families and the increased participation of women in the workforce, have reduced traditional family caregiving resources, increasing reliance on institutional care for elderly individuals (Berg, 2024). These sociodemographic shifts have significant implications for long-term care, particularly as the prevalence of age-related conditions, including dementia, mobility impairments, chronic illnesses, and mental health conditions continues to increase (Centre for Ageing Better, 2022).

The etiology of mental health issues in the general population is complex and often poorly understood, as onset is linked to multiple bio-psycho-social causes (Duncan-Jones, 2021). Among care home residents, this complexity is intensified by the unique combination of cognitive decline, social isolation, loss of autonomy, and chronic physical health conditions, all of which contribute to psychological distress (Seitz et al., 2010). The institutional environment further exacerbates mental health problems, as residents frequently experience disengagement, lack of meaningful activities, and limited personal agency over their daily lives (Clarke et al., 2018; Harmer & Orrell, 2008; Palacios-Ceña et al., 2016). Furthermore, approximately 52% of residents enter care homes with pre-existing mental health conditions. Studies indicate that an estimate of 50% of care home residents, particularly those with dementia, experience co-occurring psychiatric disorders, requiring continuous monitoring and intervention (Tsiachristas et al., 2023). The bidirectional relationship between physical and mental health is also critical, as chronic illness and pain frequently worsen psychological distress, creating a cycle that reduces quality of life (Diefenbach et al., 2012; Manandhar et al., 2019).

The mental health challenges faced by older adults in UK care homes are part of a wider, international crisis. Across the world, depression and anxiety remain among the most prevalent mental health conditions in residential care, yet they are consistently underdiagnosed and undertreated. For example, a study in Canada estimated that more than 27.1% of long-term care residents experience depression (Hoben et al., 2019), while research in Australia shows that 62.5% of older adults entering residential aged care exhibit at least mild depressive symptoms, with 16% showing major symptoms (Australian Institute of Health and Welfare, 2024). Similarly, in the United States, up to 35.9% of newly admitted nursing home residents have a documented diagnosis of depression and/or an anxiety disorder, yet the use of psychological therapies remains extremely low, with only 0.9–2.0% receiving such treatments (Ulbricht et al., 2019). The situation in Europe reflects comparable patterns: in Germany, a cluster-randomized study on depression in nursing homes reports that major depression is underdiagnosed, and only about half of those diagnosed receive appropriate therapy (Ulbricht et al., 2019). Evidence from Asia further reinforces this global trend. In China, a meta-analysis of older adults in nursing homes estimated a prevalence of 23.6% for depression (Wang et al., 2021), while in Japan, studies report that approximately 50% of nursing home residents experience depressive symptoms, and about 20% suffer from major depression (Hara et al., 2022). Taken together, these international findings demonstrate that emotional distress among older adults in residential care is a widespread issue, transcending geographical and cultural boundaries.

The mental health crisis in care homes is also a major and growing economic burden in the UK, significantly straining health and social care systems. Overall, mental ill-health costs England an estimated £300 billion annually, including £130 billion in human costs from reduced quality of life and premature mortality (Cardoso, 2024). Crucially, healthcare costs are around

50% higher for older adults experiencing depressive symptoms, underlining the significant financial consequences of untreated mental illness in later life (Katon et al., 2003). Within this broader context, direct public spending on mental health services was estimated at £22.5 billion per year in 2007, accounting for over 12% of the NHS budget, and is projected to rise to £32.6 billion by 2026, or £47.5 billion when workforce costs are considered (McCrone et al., 2008). Dementia alone represents 66% of total mental health spending, increasing from £14.85 billion to nearly £24 billion over the same period. Depression and anxiety add further pressures, with services expected to cost £3 billion by 2026. Nearly half of care home residents experience late-life depression (Stewart et al., 2014), and around 3% of placements are directly linked to depressive disorders (McCrone et al., 2008). Globally, Major Depressive Disorder and Generalised Anxiety Disorder are leading causes of disability and premature death, affecting over 300 million people (Ferrari et al., 2013). Depression is ranked as the largest contributor to global disability (7.5% of all years lived with disability) and anxiety sixth (3.4%) (Ferrari et al., 2013), with depressive disorders responsible for 56.33 million disability-adjusted life years in 2021 (Rong et al., 2025). In summary, the scale and cost of mental ill-health in care homes highlight an urgent need for targeted, integrated interventions, as failing to address these challenges will continue to drive rising healthcare expenditure, deepen social and economic burdens, and compromise the quality of life for older adults.

In summary, the combination of demographic change, rising care needs, pre-existing mental health conditions, and institutional challenges underpins what is widely described as a crisis in UK care homes. These factors highlight the urgent need for holistic care approaches that integrate both physical and emotional well-being.

Challenges in Mental Health Care: Explanations

Mental health issues have become increasingly prevalent among care home residents, and represent a major factor in the deepening crisis in institutional care (Grabowski et al., 2010). An estimated 75% of UK residents in care homes meet the criteria for a significant mental disorder, highlighting an alarmingly high occurrence (Stewart et al., 2014). Research consistently highlights that residents experience elevated levels of mental distress significantly compromising their psychological well-being (Corder R, 2016; Delaney et al., 2011a; Roya et al., 2020; Smalbrugge et al., 2006; Stewart et al., 2014; Thompsell & Burns, 2018). Concerns persist regarding the sector's capacity to meet future demands, particularly in relation to staffing shortages, funding constraints, and the limited provision of mental health care (Berg, 2024).

When I was looking for explanations for the current crisis in care homes, I found that the high rate of mental health problems is related to a complex interplay of individual, institutional, and societal factors. To examine these dynamics in more detail, I organized the literature thematically to explore different answers. As detailed below, explanations of this crisis are often framed in relation to the different levels within which humans exist, individual psychology or biomedical explanations, institutional features that impact the problem, and societal and structural explanations. Separating the literature into these three levels helps explain the complexity of the problem and provides a finer grained analysis of interventions needed.

Mental Health among Individual Residents

The care home crisis can be understood by the combination of residents' current biological, psychological, and social factors that interact to heighten their anxiety and depression. To understand this dynamic, it is necessary to understand how physical health, emotional states, and social environments collectively influence wellbeing in later life (Engel, 1977; Bolton & Gillett, 2019). Research indicates that a substantial proportion of residents enter

care homes with pre-existing mental health conditions, particularly dementia, and they require continuous monitoring and intervention (Tsiachristas et al., 2023) which strains care homes resources.

Abundant research has shown that comorbid physical and psychiatric conditions exacerbate psychological distress such as anxiety and depression, increasing the amount and complexity of care needed (Poss et al., 2021). Cognitive impairments are strongly associated with elevated rates of depression and anxiety, as behavioural and psychological disturbances frequently accompany cognitive decline (Seitz et al., 2010). Additionally, chronic physical conditions such as arthritis and diabetes contribute to physical discomfort, reduced quality of life, and emotional distress (Forjaz et al., 2015; Ní Mhaoláin et al., 2012).

Beyond biological and medical concerns, the transition to institutional care itself can be psychologically distressing, as it often involves a loss of independence, familiar surroundings, and diminishing contact with family. This shift can also mirror a broader experience of aging, where daily life and social worlds gradually narrow, leading to a quieter existence with fewer connections and a reduced sense of purpose. Central to this body of literature are the concepts of identity and social networks, and the ways in which self-efficacy can erode as social ties fade. The shift from community and family to residential living frequently results in a sense of exclusion from previous social networks, intensifying emotional distress and vulnerability to mental health decline (Polacsek & Woolford, 2022). Continuity theory (Atchley, 1989) suggests that individuals adapt to aging by maintaining familiar habits, values, and roles; however, when older adults experience disruptions in their established life patterns, it becomes difficult to maintain habits and norms, and they may suffer identity loss, heightened distress, and increased susceptibility to anxiety and depression.

Social isolation is a critical factor influencing mental health at the individual level. Social Support Theory (Cohen & Wills, 1985) emphasizes the protective role of social networks, yet many residents experience severe loneliness due to the loss of family connections and friendships (Panthi, 2022; Victor, 2012); evidence of this disconnect is particularly poignant following the COVID-19 pandemic (Llorente-Barroso et al., 2021). Beyond social disconnection, the sense of displacement and lack of autonomy in care homes further compounds psychological distress, as residents struggle with feelings of purposelessness and identity loss (Seitz et al., 2010). Furthermore, restricted interactions, limited social activities, and inadequate engagement opportunities can significantly diminish quality of life, creating a cycle of declining mental health (Guarnera et al., 2023).

The high prevalence of depression and anxiety in residents, particularly in settings where meaningful social interactions are limited or absent, can be understood as a process of disengagement that leads to isolation and emotional withdrawal (Cumming & Henry, 1961). Additionally, environmental factors such as nutritional deficiencies, oxidative stress, and prolonged exposure to harmful chemicals, often resulting from past employment in industrial settings or prolonged residence in substandard housing, can exacerbate neurological and psychological distress (Gustafson et al., 2016; The Collaborative on Health and the Environment, 2008). Together, these biological, psychological, and social risks drive the high prevalence of anxiety and depression in care homes and demand a workforce that is both skilled and adequately resourced.

Institutional-Level Dysfunction

A second factor implicated in the crisis is the nature of the institutional environment, namely the care home itself, and how its institutional features may be to blame for residents'

psychological distress (Roya et al., 2020). At the institutional level, care homes face challenges that impact the mental health of residents, including inadequate resources, lack of service integration, and a primary focus on physical health, which often overshadows attention to emotional and psychological well-being. Despite growing awareness of mental health issues, many facilities remain ill-equipped to address these concerns effectively (National Institute for Health and Care Excellence, 2015). The underfunding of psychological support services has led to an overreliance on pharmacological interventions, which often fails to provide comprehensive care (Stewart et al., 2014). The social isolation and loss of autonomy discussed above can be compounded by the experience of entering residential care institutions. Research suggests that care home environments can be experienced as depersonalizing, fostering institutionalization and diminishing residents' autonomy (Boamah et al., 2021; Grabowski et al., 2010; Rodríguez-Martínez et al., 2023a; Šare et al., 2021).

Among the most pressing structural challenges in care homes are understaffing and insufficient carer training. Facilities struggle hiring qualified personnel, resulting in suboptimal care (Shah et al., 2011). Staffing shortages are particularly critical in homes that must care for residents with complex mental health needs, such as dementia (Tsiachristas et al., 2023). This shortfall contributes to carer stress and burnout, which negatively affects the quality of care and, consequently, residents' mental well-being (Mukamel et al., 2023). Overworked and under trained staff lack the capacity to provide individualized emotional support, leading to feelings of neglect and social isolation among residents (Corder R, 2016; Delaney et al., 2011a). Additionally, low staff-to-resident ratios hinder the implementation of holistic mental health interventions (Smalbrugge et al., 2006).

The emotional burden of caregiving further impacts staff mental health, with high levels of stress, anxiety, and depression among carers compromising the quality of resident care (Guillen-Burgos et al., 2022; Honda et al., 2014). Again, the COVID-19 pandemic exacerbated these pressures, intensifying isolation for both residents and staff (Guillen-Burgos et al., 2022; Rojo-Perez et al., 2022). Given the central role of carers, addressing these issues requires comprehensive mental health support not only for residents but also for staff (Kinman et al., 2020).

Disengagement Theory, one of the earliest theories of aging, proposed that older adults naturally withdraw from social roles and activities as part of the aging process, viewing this disengagement as inevitable and beneficial (Cumming & Henry, 1961). However, this perspective has been increasingly challenged. In recent decades, attention has shifted towards the Activity Theory of Aging (Havighurst, 1963), which argues that maintaining social and physical activity is essential for well-being in later life. Research supports this view, showing that physical activity not only mitigates age-related functional decline but also enhances psychological well-being, thereby reducing the risk of mental health deterioration (Cunningham et al., 2020; Kaewsuphan et al., 2023). Activity theory also points towards the need to maintain positive social roles in the later stages in life that can contribute to the maintenance of good psychological health in older age. These findings sit in stark contrast to the disengagement theory of aging that assumes that age is associated with withdrawal from social roles and activities (Douma et al., 2017). Unfortunately, many care home organisations reflect an assumption that residents are naturally withdrawing and implicitly (though likely unintentionally) promote a model that will support social disengagement above social activity. Given current structural, financial, and social pressures on the sector, it is difficult to imagine

how this situation could be effectively remedied, with psychological distress a predictable consequence of the institutional status quo (E. Church, 2025; Rodríguez-Martínez et al., 2023a).

Against this background, it is understandable why efforts to improve social activity and reduce isolation in care homes have often been difficult to implement, and why well-meaning reforms have often been unsuccessful. One example is the promotion of “person-centred care,” introduced in the UK as a best practice to respond to residents’ individual needs. Studies link this approach to greater activity and the maintenance of positive social roles, highlighting the value of tailored support (Shannon et al., 2024).

Despite the recognized benefits of person-centered care, its implementation remains inconsistent due to rigid organizational structures and underfunding (Seah et al., 2022). Coulter & Oldham (2016) note that barriers include cultural resistance, skill gaps among clinicians, poor integration of health and social care, weak coordination among specialists, and shortages of doctors, all of which undermine service delivery. As a result, a one-size-fits-all approach often prevails, ignoring the diverse experiences of older adults, thereby contributing to mental health issues (Moore et al., 2016).

Closely related to the issues raised above, is the reality that many carers feel overburdened and undertrained to deliver meaningful activities, reinforcing a routine-driven model that prioritises physical over emotional care (Costello et al., 2019). Additionally, caring roles in the UK have historically been undervalued, often perceived as "unskilled" work, which can undermine carers’ morale and motivation (Knowles, 2024). This perception hampers recruitment and retention of skilled staff and limits recognition of the emotional aspects of care, reinforcing the focus on physical rather than holistic health.

Unsurprisingly, institutional culture is often blamed for disregarding residents' personal preferences, reducing opportunities for stimulating activities that enhance quality of life (Koren, 2010). Neglect of social and emotional engagement, coupled with prioritisation of medical treatment, contributes to higher rates of anxiety and depression, as residents feel increasingly disengaged, undervalued, and socially isolated (Daley et al., 2022; Luff et al., 2015). Research emphasizes the need for structured programs that foster social and physical activity, as such initiatives have been shown to enhance psychological resilience and improve mental health outcomes (Anandh et al., 2021; Kazeminis et al., 2020).

Finally, a notable gap in care home infrastructure is the limited integration with medical and mental health services. Many facilities lack regular access to mental health professionals, resulting in delayed interventions for residents experiencing anxiety and depression (Davies et al., 2011). Even where provision exists, care is rarely coordinated with medical teams, and many facilities lack comprehensive mental health policies to systematically monitor and support residents' emotional needs (Theurer et al., 2015).

In summary, research on the institutionalisation of seniors in care homes settings identifies routine and normalised suboptimal care, where both staff and residents become accustomed to limited mental health support (MacCourt et al., 2021). Key challenges include inadequate staffing, fragmented systems, and a continuing emphasis on physical over emotional care, alongside environmental barriers and the absence of proactive mental health policies.

Societal Drivers of Anxiety and Depression in Care Homes

The high prevalence of anxiety and depression in care homes can be attributed to various societal factors that shape the experiences of aging individuals. Among these factors are ageism, social disengagement, and inadequacies in social welfare policies that exacerbate mental health

issues. Ageism, broadly defined as the systematic stereotyping and discrimination based on age (Officer & de la Fuente-Núñez, 2018), has long been recognised as a driver of exclusion and /or poor treatment of older people. Ageing is a socially constructed concept, often viewed as a period of decline and dependency, forcing exclusion of older individuals from active participation in society (Gleason, 2017). This perception frequently marginalizes seniors as burdensome, leading to institutionalisation, where they face further social isolation (Corder R, 2016; Delaney et al., 2011a). The lack of meaningful social engagement in such environments exacerbates mental health deterioration, as residents experience heightened feelings of loneliness and identity loss (Roya et al., 2020).

Indeed, for many years, the leading social scientific theory of aging was Cumming and Henry's (1961) Disengagement Theory, which suggested that older people naturally withdraw from society as they age. Though now widely discredited, it reinforced ageist assumptions by normalising marginalisation. By contrast, numerous studies demonstrate that social participation is positively associated with healthy ageing, while disengagement is linked to social isolation and cognitive decline (Ejiri et al., 2022).

Stigma Theory (Goffman, 1963) further explains this exclusion, suggesting that societal perceptions of aging as a period of decline can be internalized by older people, reinforcing their marginalization. When society views older adults primarily through the lens of their physical limitations, it can result in a lack of attention to their emotional and psychological needs. This societal neglect can perpetuate feelings of worthlessness and despair among residents, exacerbating anxiety and depression (Wiersma & Dupuis, 2010). For example, a report from The World Health Organization (WHO, 2021) recently linked the stigma of ageism directly to poorer health outcomes and increased social isolation among older individuals. When internalised, these

attitudes lead to self-directed ageism, as older individuals accept and embody the stereotypes. This creates a self-perpetuating cycle in which negative beliefs about aging contribute to depression, anxiety, and cognitive decline, reinforcing the very stereotypes that caused their exclusion (Henry et al., 2023; Weir, 2023).

A related set of critical theories have linked the social exclusion of older people with wider social fears concerning illness, mortality, and cognitive decline. A key piece of literature in this corpus is the work of Greenberg et al. (1986) called Terror Management Theory, which explains how social fear of aging and discomfort contributes to the institutionalization of older adults and neglect of their well-being and mental health (Greenberg et al., 1986). The "Scrooge Effect," as described in Terror Management Theory, suggests that reminders of mortality trigger existential anxiety, shaping negative social behaviors and attitudes toward both the elderly and the terminally ill. Similarly, Susan Sontag's seminal work, *Illness as Metaphor* (Sontag, 1978), discusses how societal perceptions of illness lead to the stigmatization and isolation of affected individuals.

These psychological theories have also been accompanied by welfarist and social policy explanations that trace the social exclusion of older people to historical limitations in social welfare policies. A common assertion in this literature is that early social security and healthcare systems were not designed to accommodate the increasing longevity of modern populations. Béland and Gran (2008) argue that the original frameworks for social security were established at a time when life expectancy was significantly shorter, leading to a misalignment between the policies and the realities of modern aging populations. Beyond pension provision, the lack of a comprehensive national strategy for long-term elderly care has resulted in fragmented services that fail to meet the holistic needs of institutionalised older adults (Reeves et al., 2023). This

policy gap has meant that welfare policies targeting elder care have often been implemented in a reactive fashion, only emerging when a crisis is already looming (Fraser, 2024). Subsequently, this has left many care institutions ill-equipped to provide adequate emotional and psychological support, further contributing to the prevalence of anxiety and depression.

Additional societal factors contributing to the mental health crisis among care home residents in the UK stem from a complex interplay of inadequate funding, poor hospital-care homes integration, and the challenges posed by a shifting socio-political landscape. Chronic underfunding of care homes has led to insufficient resources for mental health care, resulting in residents being unable to access appropriate treatment (Fuchs et al., 2022; Tsiachristas et al., 2023). This financial constraint is compounded by the fragmented nature of services, where the disconnect between hospital systems and care homes often prevents effective communication and continuity of care (Devi et al., 2020; Wilkinson et al., 2023). Moreover, the UK government's long-standing promises of social care reforms has seen a cycle of "on again" and "off again" initiatives, perpetuating ongoing challenges in the sector and obstructing long-term planning (The King's Fund, 2023). Recent changes to employment legislation have further strained workforce stability in a sector already marked by burnout and high turnover rates (Devi et al., 2020; Wilkinson et al., 2023). As a result, care home residents, many of whom experience significant mental health issues, face a precarious situation that is exacerbated by a system stuck within a perpetual state of reform and inadequate support. These challenges influence the wider framework of elder care and manifest at the institutional level through staff shortages, constrained resources, and operational limitations.

In summary, the prevalence of anxiety and depression in care homes reflects residents' pre-existing vulnerabilities, institutional structures and practices, entrenched societal attitudes,

and inadequacies in welfare policy. Chronic underfunding, fragmented service delivery, and political instability further exacerbate the crisis, leaving homes struggling to provide consistent mental health care. Addressing this requires not only policy reform, but also a cultural shift in how ageing is perceived and valued.

Well-Being Versus Anxiety and Depression

Having explored the background and context of my dissertation, I now turn to the dependent variables: residents' anxiety and well-being. While numerous solutions have been proposed to address the challenges in care homes, most have proven inadequate, impractical, and less than effective. Given the multiple factors contributing to this crisis, there is an urgent need to test interventions capable of offering a more doable and effective response. The remainder of the chapter outlines my dependent variables and argues that EFT represents a promising intervention with potential to mitigate the mental health crisis in care homes.

Traditionally, health has been understood as the absence of disease or injury, a definition that has shaped much of modern curative healthcare. However, this perspective has evolved over time, reflecting growing recognition that physical health alone does not fully encapsulate an individual's overall well-being. The World Health Organization (WHO) articulated this shift in 1948, defining health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). While this definition broadened the concept of health, integrating it into service delivery has proven challenging, and many healthcare systems remain structured around disease management rather than the promotion of holistic care (Ross, 2009).

A potential solution proposed in this study to address the mental health challenges is a shift towards enhancing overall well-being rather than solely focusing on the treatment of

anxiety and depression. Addressing well-being holistically may serve as a more effective intervention, fostering a stronger sense of self among residents and improving their mental health outcomes as a secondary effect. This approach offers a broader and potentially more sustainable framework than traditional clinical models that isolate mental health conditions from their broader psychosocial context (Ryan & Deci, 2001).

The Concept of Well-Being

Defining well-being remains a challenge, as no universally accepted definition currently exists. While research on well-being has evolved over time, from Aristotle to contemporary studies, its meaning remains widely debated. Although key components like happiness and life satisfaction are generally agreed upon, interpretations vary, highlighting the multidimensional and subjective nature of the concept (Angner, 2011; Jarden & Roache, 2023). This complexity is reflected in different theoretical frameworks, including eudaimonism (Besser, 2016), the capability approach (Robeyns & Byskov, n.d.), life satisfaction theory (Maddux, 2017), and objective list theories (Fletcher, 2013), all of which underscore well-being's multifaceted nature and diverse interpretations of human experience (Chappell & Meissner, 2023).

Conceptual frameworks of well-being in the literature are commonly organized around two principal dimensions: hedonic and eudaimonic well-being. Hedonic well-being emphasizes the pursuit of pleasure and happiness, characterized by the presence of positive emotions and the reduction, or absence, of negative affect (Diener et al., 1985). In contrast, eudaimonic well-being centres on meaning and self-realization, highlighting the importance of living in accordance with one's values and achieving personal growth (Ryan & Deci, 2001).

Subjective well-being (SWB), introduced by Ed Diener (1984) as an empirical measure of happiness, incorporates both hedonic and eudaimonic dimensions. It consists of three

components: positive affect (frequency of positive emotions), negative affect (frequency of negative emotions), and life satisfaction. In the literature, the hedonic dimension is often defined as “feeling good” and experiencing low anxiety, with emotional states recognised as central indicators of overall health. This study adopts the hedonic dimension of SWB, as it provides a measurable framework focused on reducing negative emotions and enhancing positive feelings, whereas broader conceptions of well-being are often less precise and more difficult to apply in research.

A well-being-centered approach aligns with research emphasizing the complex and multifaceted nature of mental health in older adults (Jivraj et al., 2014; Reker & Wong, 1984). Many psychological challenges faced by care home residents are not necessarily rooted in clinical psychiatric disorders but often arise from deteriorating physical functions, loss of autonomy, dissatisfaction with their environment, and social isolation from family and friends (Bryant, 2010; Smalbrugge et al., 2006; Stewart et al., 2014). Anxiety in this context is not necessarily comparable to clinical anxiety observed in younger populations, but is better understood as a symptom of diminished well-being. Research suggests that anxiety in care home residents is frequently linked to environmental stressors, such as unfamiliar surroundings, reduced autonomy, noise, lack of privacy, and inadequate individualization of care and uncertainty about the future, rather than to primary anxiety disorder (Creighton et al., 2016; de Oliveira et al., 2021; Nordin et al., 2017). Moreover, traditional diagnostic criteria for anxiety may also fail to capture the unique ways distress manifests in older adults, as symptoms often overlap with cognitive impairment or physical ailments (Wuthrich & Frei, 2015). As such, interventions that enhance overall well-being may concurrently alleviate anxiety and depressive

symptoms, making well-being improvement a viable "backdoor" strategy to support mental health in care homes (Keyes, 2007).

Given that anxiety in care home populations is often linked to environmental dissatisfaction and social disconnection rather than clinical anxiety disorders, a holistic intervention that enhances emotional and social well-being may yield more meaningful improvements than narrowly focused psychiatric treatments (NICE, 2013). Research on aging and mental health suggests that well-being-centered approaches can significantly enhance life satisfaction and reduce distress among older adults (Diener et al., 2017; Hu et al., 2020). By improving well-being, care homes may indirectly address anxiety and depression, providing a sustainable and resident-centered solution to the ongoing mental health crisis in institutional settings.

Research further shows that improving well-being not only enhances quality of life but also contributes to better physical health, increased lifespan, and reduced disease risk. A substantial body of literature links high subjective well-being (SWB) to improved health outcomes, including enhanced survival rates and protection against conditions such as heart disease and arthritis (Diener, 2024; Eid & Larsen, 2008; Steptoe et al., 2015a). SWB also influences immune function and hormonal balance, contributing to reduced inflammation and better insulin regulation (Black & Garbutt, 2002; Penninx et al., 2003; Skaff et al., 2009). Meta-analyses confirm a positive relationship between SWB and lower mortality risk, particularly in older populations (Chida & Steptoe, 2008; Howell, 2009). Research by Steptoe et al. (2008, 2015b) at University College London further demonstrates that higher SWB levels significantly extend lifespan by reducing stress and improving overall health (Zaninotto & Steptoe, 2019). These findings underscore the critical need for structured interventions that

enhance emotional well-being as a means of supporting healthier aging, particularly for dementia patients, who make up over 70% of UK care home residents (Wittenberg et al., 2020).

While most studies support a positive relationship between well-being and health, further research is needed to clarify the underlying mechanisms and assess the effectiveness of non-pharmacological interventions in elderly mental care (DuBois et al., 2015; Diener et al., 2017;). Challenges remain, including the need for effective staff training, cultural shifts in care practices, and cost-effectiveness assessments (Livingston et al., 2014). A collaborative approach that integrates targeted staff training emerges as a key strategy for improving the mental well-being of care home residents (Thompsell & Burns, 2017). Beyond the mere experience of positive emotions, there are abundant findings that show the connection between well-being, health, and longevity, and they underscore the importance of prioritizing the well-being of care home residents.

Despite substantial evidence linking subjective well-being (SWB) to improved health outcomes, research on practical and scalable interventions to enhance well-being in care home settings remains limited. This dissertation explores EFT as a non-pharmacological, cost-effective approach to promoting well-being among care home residents. In addition to its primary focus on well-being, EFT may also yield improvements in health markers as a secondary outcome, though further research is needed to systematically assess this potential effect.

Emotional Freedom Techniques (EFT) to Enhance Residents Well-Being

The EFT intervention tested in this dissertation is focused on enhancing overall well-being rather than specifically targeting anxiety or depression. EFT is designed to promote emotional regulation and psychological resilience, potentially mitigating the underlying causes of distress among care home residents (Harbottle, 2019). This proposed well-being-centered

approach responds to mental health challenges across individual, institutional, and societal levels discussed in the previous section. In this dissertation, well-being is understood primarily as an individual emotional state, encompassing subjective experiences such as mood regulation, anxiety reduction, emotional engagement, and a sense of feeling good. This conceptualisation aligns with Diener's (1984) definition of subjective well-being, which emphasises individuals' evaluations of their emotional states and life satisfaction. This focus reflects the core aim of the study: to explore how Emotional Freedom Techniques (EFT) can enhance residents' day-to-day emotional quality of life within care settings. While the intervention may also have secondary implications for care practices at the institutional level and for broader societal perceptions of ageing, these are considered indirect outcomes rather than central variables of investigation.

Most critically, at the individual level, EFT directly mitigates anxiety and depression, enhancing emotional resilience and quality of life (Warrier, 2018). While EFT cannot resolve institutional structural and process issues like social exclusion, embedding well-being strategies into daily care may foster a transformative cultural shift, reducing psychological distress and redefining mental health support in care homes. Additionally, at the institutional level, it can empower carers with the tools to deliver mental health interventions while also fostering greater awareness of well-being within the care home environment. At the societal level, EFT raises awareness of elderly individuals' right to emotional well-being, challenging ageist assumptions that overlook their psychological needs. Given the high prevalence of mental health difficulties among residents, this study argues that EFT, when delivered by trained carers, is expected to enhance residents' overall sense of well-being.

Implementing EFT to Enhance Residents Well-Being

Implementing EFT interventions may provide a practical and cost-effective approach to address residents' emotional and psychological needs, potentially improving mental health outcomes in care settings. So far, this review has drawn together several related strands of literature, highlighting the limited availability of scalable, non-pharmacological interventions, with medication still the primary treatment option.

EFT may provide a partial remedy to the crisis in care homes. There is a growing evidence base showing that it can be delivered at low cost by trained carers, aligning with the wider shift towards holistic, person-centered care. As this study demonstrates, carers play a crucial role in shaping the emotional environment of care homes, and their ability to deliver simple, effective mental health support can have a profound impact on residents' well-being. Training carers in EFT through the Train-the-Trainer model not only addresses individual symptoms of anxiety and depression but also empowers staff institutionally, shifting care towards a more emotionally responsive framework. By framing EFT as a practical, cost-effective, and easily integrated intervention, this study argues that enhancing well-being can directly mitigate the mental health crisis in care homes while fostering a cultural shift towards more compassionate, holistic care practices.

EFT Protocol

EFT is a therapeutic intervention aimed at enhancing positive emotions, reducing negative affect, and improving subjective well-being. Although initially controversial in the field of mental health primarily due to its unconventional integration of psychological and somatic components, diverging significantly from traditional therapeutic practices, EFT is now recognized by the U.S. National Center for Complementary and Integrative Health (NCCIH, n.d.) and acknowledged as the most prominent form of energy psychology. The technique

integrates elements of exposure therapy, cognitive therapy, and acupressure by tapping on specific points on the face and body while vocalising or imagining specific thoughts or emotions (Bach et al., 2019). Its supposed mechanism of action involves stimulating meridian points during the EFT process, which has been shown to contribute significantly to its effectiveness (D. Church et al., 2020).

Historically, acupuncture meridians were considered purely theoretical, but they are now understood to have a physiological basis in the Bonghan system, discovered by Korean scientist Kim Bong-Han in the 1950s. This vascular network, also known as the Primo Vascular System (PVS), closely aligns with traditional 5,000-year-old meridian charts, providing a tangible connection between ancient practices and modern scientific frameworks (Soh et al., 2013). This integration of historical and contemporary insights offers an understanding of EFT's mechanisms, bridging traditional energy psychology with evidence-based practice (*Dr. Roger Callahan*, n.d.).

The original EFT protocol, initially known as Thought Field Therapy (TFT), was developed by psychiatrist Roger Callahan in 1980. Drawing on principles from Chinese medicine and acupuncture, Callahan incorporated meridian points into his therapeutic approach. His initial protocol was highly individualized, with tapping points tailored to each recipient's specific needs and conditions. Gary Craig, a Stanford engineering graduate and student of Callahan, later refined the technique by standardizing the sequence of tapping points, creating a universally applicable protocol. Craig's streamlined methodology demonstrated comparable efficacy and has become the foundation of modern EFT practice (Craig, 2008).

The standard EFT protocol involves tapping on 8 to 13 acupressure points while using specific phrasing. Patients are guided through the application of EFT by a trained therapist, who

demonstrates how to perform the tapping and where to do it. While the intervention is not practically challenging, there is a degree of training required and EFT can be time-intensive when following clinical protocols. This raises concerns about whether carers can learn and apply the technique consistently with residents. To address this, a simplified version of EFT has been developed that focuses exclusively on hand acupressure points (Figure 1), ensuring the intervention is practical and accessible in care home settings.



Figure 1. *EFT Tapping Points (This figure illustrates the points from the EFT classical protocol (blue & pink) and the hand points (pink) used in this study's adapted protocol.). Note. Figure created by the author.*

My adapted protocol was designed to accommodate the physical and emotional needs of elderly residents, many of whom may have limited mobility, cognitive impairments, or heightened sensitivity to new practices. It draws on various EFT protocols and was developed in consultation with Catie Bertoux (personal communication, July 22, 2022), the only known EFT practitioner with extensive experience applying EFT in care home environments. Bertoux recommended a protocol that is practical and efficient while preserving EFT's core therapeutic benefits. Accordingly, this study employs a version of the "secret tapping" method described by Dawson Church in *The EFT Manual* (Dawson. Church, 2019). In this approach, tapping is

performed discreetly, such as under a table, and focuses exclusively on the hand points, located on the outside edge of the nail on each finger. Although finger-point tapping is included as part of standard EFT practitioner training and is often used in combination with the full nine-point sequence, to date there are no published studies that have examined the effects of using hand points alone as a standalone intervention**.** This adaptation enhances EFT's applicability in care homes, allowing for unobtrusive delivery suited to the practical constraints and sensitivities of the environment.

EFT Efficacy and Benefits

A growing body of research identifies Emotional Freedom Techniques (EFT) as an effective intervention for conditions including PTSD, anxiety, and depression (*Scientific Research on EFT Tapping*, 2025). Supported by over 275 studies, including 51 randomized controlled trials, EFT has demonstrated significant efficacy in addressing stress and mental health challenges, which are common among elderly populations (Church & Brooks, 2010; Tambunan, 2022; Wahyuningsih, 2021). One notable study by Church et al. (2012) highlighted EFT's effectiveness in reducing anxiety and cortisol levels, a key biomarker of stress. The study found a 24.39% reduction in cortisol levels among the EFT group, significantly greater than reductions observed in groups receiving supportive interviews (-14.25%) or no treatment (-14.44%). Replication confirmed that even brief EFT sessions significantly reduce cortisol levels, reinforcing its value as a short-term stress intervention (Stapleton et al., 2020).

Emerging research has also highlighted physiological mechanisms underlying EFT's effectiveness of (Feinstein, 2019). For instance, Swingle et al. (2004) reported immediate improvements in traumatic stress symptoms after two EFT sessions, with brainwave assessments showing increased sensory motor cortex activity and reduced right frontal cortex arousal.

Similarly, Lambrou et al. (2002) reported reductions in anxiety alongside physiological changes such as EMG activity and Theta wave modulation, indicating the role of brain activity in EFT's therapeutic efficacy.

Studies further suggest that EFT's outcomes for anxiety, surpass those of cognitive behavioural therapy (CBT) and medication (Andrade & Feinstein, 2004; Chatwin et al., 2016; Church et al., 2017). A meta-analysis of 20 studies concluded that EFT is highly effective in reducing depressive symptoms, with effect sizes exceeding those typically observed in antidepressant trials (Nelms & Castel, 2016a). In elderly care specifically, EFT has shown promising results in managing hypertension (Cholifah et al., 2020; Wahyuningsih, 2021), improving mood (Harbottle, 2019), alleviating anxiety and depression in elderly with type 2 diabetes (Zhang et al., 2017), and addressing sleep disorders (Souilm et al., 2022). However, its application to residents with psychosocial disorders such as dementia remains unexplored.

Prominent researchers, including Tony Stewart, Liz Boath, Peta Stapleton, and Dawson Church, have extensively studied and advocated for EFT, emphasizing its potential across various domains, including elderly care (Bach et al., 2019; Boath et al., 2014; P. B. Stapleton, 2020). Despite initial scepticism, their findings highlight EFT's value and calls for its wider adoption within healthcare systems such as the NHS (Innes, 2014; NHS, n.d.; NHS Greater Manchester, n.d.; NHS University Hospital Dorset, n.d.). The National Institute for Health and Care Excellence (NICE) has also acknowledged EFT's potential, recommending further research to strengthen its evidence base (Footman, n.d.).

The wider body of research on non-pharmacological interventions also underscores the importance of holistic approaches in care homes. Mindfulness-based practices, music therapy, Pilates, and touch-based therapies like hand massage have been shown to improve mood, reduce

anxiety, and foster social interaction (Perach et al., 2019; Ravari et al., 2021; Sung et al., 2010). These findings suggest that somatic interventions like EFT could provide a similarly effective, non-invasive option for emotional careEFT offers several advantages for elderly residents: it is easy to learn, cost-effective, adaptable to individual needs, and can be used without constant practitioner presence. Care assistants can administer EFT to calm distressed or anxious residents, while residents can also practice it independently or in groups (Harbottle, 2019). Together, these features underscore EFT's potential as a practical, scalable, and impactful intervention for enhancing well-being in care homes.

Mechanisms of Therapeutic Action

Although a growing body of research demonstrates that EFT can alleviate anxiety, depression, and trauma-related symptoms, understanding how these effects occur is essential for establishing its theoretical foundation. EFT integrates cognitive, somatic, and physiological processes to modulate stress responses and emotional regulation. The technique involves focused attention on specific thoughts or memories (a process similar to exposure therapy) while simultaneously stimulating acupoints through gentle tapping. This combination is theorised to reduce hyperactivation of the amygdala and other limbic structures involved in the stress response (Feinstein, 2019), promoting a state of physiological calm that enhances the capacity for positive affect. Empirical studies have documented significant decreases in cortisol following EFT sessions (Church et al., 2012) and shifts in brain activity patterns, including reduced right frontal cortical arousal (Swingle et al., 2001), indicating modulation of autonomic and neuroendocrine systems. Furthermore, increases in salivary immunoglobulin A (IgA) suggest a broader influence on immune functioning and stress resilience (Bach et al., 2019). These physiological changes, combined with cognitive reframing, and the promotion of positive

emotional states, create a plausible causal pathway through which EFT reduces emotional reactivity and enhances well-being.

EFT Limitations

While EFT has shown potential in addressing psychological and physiological concerns such as anxiety, stress, and pain, and despite evidence supporting its efficacy, there are notable limitations and concerns with its application that warrant discussion. Critics have highlighted methodological weaknesses, inconsistencies in application, and the need for more robust empirical validation before EFT can be widely accepted as a standardized therapeutic intervention (Bakker, 2013; McCaslin, 2009; Spielmans et al., 2020).

One significant limitation of EFT is the variability in individual responses. While studies such as those by Jameela & Thapa (2024), Lambert (2020), Taylor et al. (2020), Temple & Mollon (2011), and Warrier (2018) report improvements in anxiety levels among specific populations, other research finds inconsistent outcomes. For example, EFT has shown benefits for patients with chronic disease, but results vary and not all participants experience improvement (Rachman et al., 2023; Sucipto et al., 2023). Furthermore, the anecdotal nature of some of this evidence raises concerns about methodological rigour, particularly in studies lacking controls for placebo effects or other psychological influences.

Another key limitation is the lack of standardized protocols. Variations such as classical EFT and Spiritual Emotional Freedom Techniques (SEFT), and differences in duration and implementation environments complicate comparisons across studies (Ariska & Widaningsih, 2023; Irman & Wijayanti, 2022). Without consistent guidelines for diverse populations, clinical use and generalisability remain uncertain. Moreover, much of the research focuses on short-term

outcomes, limiting insight into long-term efficacy, particularly in addressing chronic conditions and complex mental health challenges (Armstrong, 2019; Baker et al., 2009).

Concerns also centre on EFT's grounding in controversial psychological theories, compared with established therapeutic models, such as Cognitive Behavioral Therapy (CBT). Critics argue that proposed mechanisms like energy flow and meridian tapping lack empirical support (Rancour, 2017). While Stapleton identifies physiological and anatomical mechanisms shared with acupuncture, including electrical conductivity in acupoints, mechanosensory transduction, and meridian theory (P. Stapleton et al., 2023), she, along with other researchers, acknowledges that these concepts remain scientifically unverified, underscoring the need for further empirical investigation (D. Church & Nelms, 2016; Rancour, 2017).

Methodological weaknesses are another recurring issue. Small samples, short interventions, and reliance on self-reports in many studies can lead to inflated claims about EFT's effectiveness and limit methodological robustness (Boness et al., 2024; Gaesser & Karan, 2017; Pfund et al., 2024; Sebastian & Nelms, 2017). Others lack control groups, randomisation, or blinding, undermining internal validity (Bakker, 2013). These concerns raise questions about whether EFT's outcomes surpass placebo effects or compare favourably with established cognitive-behavioural approaches (Baker et al., 2009).

Nonetheless, EFT has demonstrated clinical benefits for conditions such as anxiety, stress, and PTSD (Church, 2013; Church et al., 2016; Kalla & Khalil, 2014; Seok & Kim, 2024). The fact that it produces observable therapeutic benefits suggests that, even with unclear mechanisms, it retains value as an intervention. While these critiques are valid, they do not necessarily invalidate EFT as a therapeutic tool, but rather underscore the need for higher-quality research. Calls for more rigorous randomized controlled trials (RCTs), objective biomarkers

(such as stress biochemistry and neural imaging), and improved study designs (Stapleton et al., 2020) suggests that EFT holds promise; however, its scientific legitimacy depends on addressing these methodological limitations.

In summary, while EFT presents a promising non-pharmacological approach to addressing psychological distress, its widespread implementation is limited by variability in individual response, lack of standardization in application, uncertain theoretical foundations, and insufficient understanding of underlying mechanisms. Although studies such as Harbottle (Harbottle, 2019) suggest benefits in care homes, rigorously designed trials are needed to validate its effectiveness, establish standardized protocols, and determine long-term impact. Continued research is essential to substantiate EFT's therapeutic claims and identify its most effective applications in care home settings.

Train-The-Trainer Model (TTT) to implement EFT in Care Homes

The review of existing literature confirmed the effectiveness of TTT programs in enhancing knowledge and improving care practices within health and social care settings (Marks et al., 2013; Yarber et al., 2015). TTT has also proven effective for implementing well-being interventions and upskilling healthcare professionals working with older adults. For instance, a Connecticut-based study used the TTT model to train 25 professionals from multiple agencies in depression screening for elderly home health care patients, leading to significant improvements in self-efficacy and competence in managing depression (Delaney et al., 2011b). Similarly, a telehealth-based TTT program trained volunteers to support carers of people with dementia, improving both nutritional outcomes and carers' quality of life (Krug et al., 2020). These findings highlight the TTT model's adaptability and effectiveness in equipping individuals with skills and confidence to deliver targeted interventions for older adults

In care homes, the model has been applied across various domains, including nutritional screening with the Malnutrition Universal Screening Tool (MUST) (R. Lee & Scott, 2009), safety practices, and end-of-life care (Goodman et al., 2014). In dementia care specifically, TTT has proven particularly valuable in equipping trainers with skills and resources to implement psychosocial interventions. For example, it has been used to address behavioural issues associated with dementia (Huang et al., 2015), reduce aggressive behaviours during personal care interventions such as "Bathing Without a Battle" (Gozalo et al., 2014), and train staff as well-being coaches for residents (Fossey et al., 2020). Fossey emphasizes the importance of relationship-building, resource use, and positioning trainees as agents of change in dementia care. Marks et al. (2013) further highlight the model's adaptability for populations with disabilities and cognitive impairments. An international program by Chan et al. (2020) also demonstrated success, with dementia training delivered in the UK leading to improved competence and job satisfaction among healthcare professionals from Hong Kong.

Research also identifies enablers and barriers to effective Train-the-Trainer (TTT) model implementation. A simulation-based dementia TTT program reported enablers such as strong management support and trainee motivation, alongside barriers including limited time for training, difficulty releasing staff from duties, and inconsistent management backing (Heward et al., 2021). These challenges mirror those encountered in this study. Orfaly et al. (2005) emphasize the importance of flexibility in revising training plans to overcome such barriers, a principle reflected into this dissertation's methodology.

Overall, the TTT model has demonstrated its effectiveness in sustainably upskilling staff, improving care quality, and reducing reliance on external resources. However, its application for emotional well-being interventions, such as Emotional Freedom Techniques (EFT), remains

underexplored. To date, only study (Lambert et al., 2022) has applied EFT within the TTT framework, reporting significant reductions in anxiety and distress alongside improved engagement and well-being among schoolchildren. Yet variability in trainer competence affected the consistency and quality of EFT delivery, highlighting the need for standardized training protocols.

Gaps in Research

Research into enhancing the quality of life for elderly care home residents, particularly regarding their emotional well-being, reveals several gaps that could inform future studies and initiatives (Martyr et al., 2018). Systematic reviews suggest that non-pharmacological interventions, such as exercise, cognitive training, and group-based activities, can improve well-being in this population (Windle, 2008). While these findings align with the potential benefits of EFT, the evidence base remains limited and inconsistent (Brown Wilson et al., 2019), highlighting the need for further exploration of scalable solutions. In particular, future studies are needed to examine EFT's long-term sustainability, develop standardised protocols, and investigate its impact across diverse cultural groups and elderly populations. With over 200 recognised energy medicine approaches (Leskowitz, 2022), research is also required to isolate the specific therapeutic components driving EFT's effectiveness.

Delivering psychological interventions in care homes presents significant challenges, including unpredictability, inadequate training, resource constraints, and logistical complications (Collins, 2022). While brief therapy sessions, such as Emotional Freedom Techniques (EFT), show promise in overcoming some of these barriers, their effectiveness in care home settings remains under-researched (Harbottle, 2019). Carer-led approaches using the Train-the-Trainer (TTT) model offer a potential solution by empowering staff to provide direct support, yet little

evidence exists on their application in this context. Although TTT is well established in healthcare and education, its real-world use in care homes has received limited attention. Most EFT studies are conducted in controlled environments, giving little insight into how interventions can be adapted to complex settings where staff workload, resident engagement, and institutional pressures shape outcomes. To date, only one study (Lambert, 2020) has examined EFT within a TTT framework, underscoring a major research gap in understanding how EFT can be embedded into routine caregiving rather than delivered solely by external practitioners. This limited evidence highlights the need for further investigation into implementation challenges, long-term effectiveness, and scalability in care home environments.

Research on resident well-being, particularly for individuals with dementia and cognitive impairments, is also limited (Bar-Tur, 2021). Although unmet psychological needs are widely recognised in geriatric literature, there is still a demand for tailored, evidence-based interventions that address these needs in residential care. To bridge this gap, Bar-Tur (2021) advocates applying positive aging theories in care homes, supported by comprehensive assessment tools, longitudinal studies, and training programs for care assistants. Yet despite valuable insights from studies on non-pharmacological approaches, methodological weaknesses such as small sample sizes and lack of longitudinal validation continue to limit generalisability (Brown Wilson et al., 2019; Bar-Tur, 2021).

Another gap concerns the absence of standardized well-being assessment tools, making cross-study comparisons difficult (Rodríguez-Martínez et al., 2023b; Schott et al., 2021). This lack of consistency also contributes to the problem that many interventions, including EFT, are evaluated in isolation rather than within integrated care models, overlooking organisational and cultural factors that shape implementation (Burke & Hutchins, 2007). To overcome these

limitations, future research could focus on large-scale, longitudinal studies with standardized well-being measures, while also examining how EFT and TTT function in real-world care homes. In this context, exploring long-term outcomes, carer experiences, and resident perspectives may offer valuable insights into how evidence-based well-being interventions can be embedded sustainably into elderly care.

Summary and Conclusion

This chapter has provided an in-depth examination of the mental health challenges faced by elderly residents in care homes, with a particular focus on the prevalence of anxiety and depression. These conditions, widespread in care home populations, are exacerbated by cognitive impairments such as dementia, social isolation, and the loss of autonomy associated with institutional care. Depression and anxiety are not just individual health issues but systemic problems shaped by the care home environment, inadequate mental health provision, and broader societal attitudes towards aging.

A key aspect of this chapter is the recognition of EFT as a non-pharmacological approach to emotional well-being. EFT shows promise in alleviating symptoms of anxiety and depression, though research into its application in elderly care homes remains very limited. Despite the potential of EFT, significant gaps remain in understanding its long-term effectiveness, mechanisms, and scalability, underscoring the need for further research through comprehensive, longitudinal studies that assess its sustainability, applicability to diverse elderly populations, and integration within holistic care models that addresses the intersection of physical health, cognitive decline, and emotional well-being.

In conclusion, the high prevalence of mental health challenges in care homes, including anxiety and depression, reflect both individual and systemic shortcomings. The proposed

well-being-focused approach, delivered through carer-led EFT interventions, offers a promising pathway to improve residents' emotional and psychological health. This study seeks to contribute to geriatric care by evaluating the feasibility and impact of implementing Emotional Freedom Technique through trained carers, providing insights into its potential to improve the emotional well-being of care home residents, while also laying the groundwork for future research in this critical domain.

Chapter 3

RESEARCH METHODOLOGY

This study had two aims: first, to evaluate the effectiveness of EFT in improving well-being and reducing anxiety among care home residents, and second to assess the feasibility of delivering these interventions by care home staff in situ. The intervention used the Train-the-Trainer (TTT) model, which involves training other researchers or other individuals within the organisation, to implement interventions and/or collect data. In this study, I trained 14 carers to deliver EFT interventions and collect data each week. As such, the study represents a real-world application of EFT in care settings.

I adopted a within-subject quasi-experimental mixed-methods design to assess the effectiveness of carer-led EFT in reducing anxiety and improving well-being among the residents. Quantitative and qualitative data were collected, employing a non-concurrent multiple baseline design, reflecting the fact that all participants started at different baselines and that the intervention started at slightly different times for each resident (based on the carer's schedule). Each carer conducted 10 EFT sessions with one resident over a flexible time frame, accommodating the unpredictable and dynamic nature of care home environments (Drummond et al., 2024). Scheduling constraints prevented consecutive daily sessions, producing variation in session timing and intervals. This flexibility allowed the intervention to fit with carers' availability, residents' routines, and their physical and emotional states. At each session, carers assessed residents' well-being and anxiety levels immediately before and after the intervention using validated visual analogue scales. This repeated-measures, within-subjects design allowed each resident to serve as their own control, allowing for analysis of intra-individual changes and

the impact of EFT. Follow-up measures conducted seven weeks after the final session provided insights into the intervention's lasting effects and enabled an assessment of its long-term efficacy.

The mixed-methods approach combined quantitative and qualitative strategies. Quantitative data were drawn from pre- and post-intervention assessments using visual Likert scales to evaluate changes in residents' well-being and anxiety levels. Because the data were collected over ten sessions plus a follow-up session seven weeks later, I was able to capture both immediate and lasting effects of EFT.

The quantitative data collection protocols outlined above were complemented by qualitative data gathered through semi-structured interviews with care assistants, providing insights into the practical implementation of the intervention and its challenges. Additionally, observational carer's notes captured residents' emotional states during the intervention. This chapter reflects on the wider methodology of this study, as well as the ethical considerations adhered to throughout the research process to ensure integrity and compliance, and concludes with an examination of the study's limitations and anticipated outcomes.

Research Setting and Participants

The study was conducted at a residential care home in Gloucester, accommodating 32 residents over 65 years old within a single interconnected building comprising three adapted sections. The facility specializes in dementia care, with most residents on the dementia spectrum. The home also provides respite and palliative care, reflecting the typical services offered by similar facilities in the region. Most residents (90%) are council-funded, with the remainder self-funded, representing a socio-economic population with moderate financial means. At the time of the study, the home was at full capacity and supported by a team of 28 staff members representing 10 different nationalities, reflecting both the ethnic diversity of the locality and

residential care provision in contemporary England. The care home, owned and managed by the same individual for over 20 years, fosters a close-knit environment with strong familiarity between the owner, residents, and staff. Its logistical advantages, including proximity within two hours of London, and a sizeable resident population from which to recruit, made it a suitable choice for this study.

Sampling Method and Inclusion Criteria

The study employed a purposive sampling approach, as described by Kelly (2010), wherein the researchers deliberately selected respondents who were most likely to provide appropriate and useful information for the research objectives (Bisht, 2024). The care home manager selected residents with dementia or cognitive impairments at a level that would not hinder their ability to comprehend the intervention or respond to the Visual Likert Scales.

Inclusion criteria required residents to have proficiency in English and sufficient mental capacity to provide informed consent. Exclusion criteria applied to individuals with advanced dementia, severe cognitive impairments, psychiatric disorders, psychosis, substance dependence, bipolar disorder, or suicidal ideation, to ensure both meaningful engagement and participant safety. Based on these criteria, the care home manager initially identified 15 eligible residents. To confirm capacity for informed consent, carers presented the Resident Participant Information Sheet (PIS) (see Appendix A) and the Resident Consent Form with Simplified Information Sheet (see Appendix B), supporting comprehension for those with reduced cognitive ability. Following this assessment, one resident was excluded due to insufficient mental capacity, leaving a final sample of 14 participants.

Care assistants were selected using convenience sampling, based on the home's staffing needs, skills, availability, and their ability to engage in the intervention and training. Selection

criteria included fair level of English comprehension and a minimum work schedule of three days per week. The number of carers was selected to match the number of participating residents, with two additional carers included to mitigate the impact of potential dropouts and illness.

Coordination with care home management was central to the selection process. The first training session introduced pre-selected carers to the study, during which the Carer Participant Information Sheet (PIS) (see Appendix C) and the Carer Consent Form (see Appendix D) were distributed. This session provided detailed information to enable carers to make an informed decision regarding their participation. During the session, I introduced myself as the researcher and provided an overview of the EFT protocol, outlining the research objectives and the commitments required for training and intervention delivery. A group practice was conducted to facilitate understanding, allowing carers to follow the script and experienced EFT themselves. The session also covered an overview of the training content, data collection instruments and ethical considerations. To encourage participation, carers were incentivized with a university-issued certificate, training in a validated stress-relief technique applicable in personal and professional contexts, and opportunities for additional EFT sessions to support their own well-being.

Implementation: Train-The-Trainer Model (TTT)

Grounded in educational theory and organizational psychology, TTT model formed a central component of this study's empirical framework. This approach enabled selected care assistants to receive training from the researcher, a certified and experienced EFT practitioner, so they could deliver the EFT intervention and record residents' well-being and anxiety levels. By preparing a small group of trainees to disseminate knowledge to a broader audience, the TTT

model enhances the scalability and cost-effectiveness of training programs (Dahlem et al., 2020). Widely recognized as a scalable educational approach, the TTT model equips selected individuals to train others within their field, fostering sustainable learning across domains such as healthcare and dementia care (Burke & Hutchins, 2007; Suhrheinrich, 2011). Specifically, the TTT model equipped care staff with the skills to deliver EFT to residents, which represent a sustainable method of delivering these kinds of interventions, negating the need for expensive qualified practitioners. As such, it ensures that psychological interventions remain accessible in resource-constrained environments, directly addressing the emotional needs of residents who often lack access to psychological care (NICE, 2013).

I chose to implement the EFT intervention using the TTT model for several reasons, particularly because it strengthened connections between residents and staff, thereby promoting well-being and reinforcing relationships (Custers et al., 2011). Additionally, Clifton et al. (2018) demonstrated the model's cost-effectiveness, with their study across 28 UK nursing homes showing significant improvements in staff knowledge, confidence, and cost-saving outcomes, particularly in managing falls and urinary tract infections. These findings underscore the TTT model’s potential to address both care quality and resource efficiency in care homes.

However, while TTT approaches hold significant promise for implementing interventions, concerns about consistency, ethical practice, and trainer preparedness persist (Brion & Cordeiro, 2019; Pearce et al., 2012). Pearce et al. (2012) emphasized the importance of ensuring uniform and ethical intervention delivery, while Brion and Cordeiro (2019) highlighted the need for equipping trainees to handle unexpected challenges effectively. In response to these issues, my study integrated structured training materials and procedures to support consistent and ethical delivery of EFT. The training emphasized rehearsal of EFT sessions and focused on three

core principles: consent, neutrality, and consistency. To enhance adaptability, trainees were prepared for various scenarios reflecting residents' diverse conditions. Training materials were carefully designed to be visually and verbally clear, ensuring accessibility and comprehensibility for participants with varied language abilities. The logistical implementation addressed time constraints and staff scheduling challenges. A customized schedule, developed in collaboration with the care home manager, aligned training with staff shifts to minimize disruption to daily responsibilities while also accommodating weekly roster changes and late confirmations, ensuring the effective delivery of training despite these pressures.

Following the initial introductory meeting, three additional one-hour training sessions were conducted over a four-week period, organized into two groups to accommodate carers' shift patterns and ensure full participation. The second training session focused on reviewing EFT protocol, incorporating group practice, and a discussion on addressing potential challenges such as resident fatigue or unwillingness to participate. Emphasis was placed on strict adherence to the protocol to ensure consistency and reliability in data. Care assistants received detailed training on the resident consent process, including clear explanations of the 10 points on the consent form to ensure residents' understanding and recognition of their right to withdraw at any time. Care assistants were encouraged to practice EFT techniques on themselves to build confidence, and an initial version of the individual intervention booklet was distributed for feedback to guide refinement.

The third training session standardized intervention delivery through mock interventions, instrument training on visual scales, and mock data recording, enhancing carers' accuracy and confidence. Ethical and logistical considerations, such as secure document storage, supervision, and communication protocols, were also addressed, with emphasis on minimizing desirability

bias (Bergen & Labonté, 2020). Feedback on the revised intervention booklet was gathered to finalize it before printing. The final training session prepared carers for the intervention phase with additional mock sessions, data collection practice, and a review of ethical considerations. Carers were encouraged to raise questions and share concerns, allowing clarification of uncertainties about the protocol, data recording, and resident engagement.

Monitoring how carers delivered the intervention in practice was an important consideration, although it was not possible to verify this systematically. To gain some insight into how the training translated into practice, I directly observed six sessions delivered by different carers at the start of the intervention. During these observations, carers appeared to follow the structured intervention guide step by step, reading each page in sequence and adhering closely to the scripted instructions, which suggested that they were capable of delivering EFT appropriately. I also attempted to introduce a remote fidelity check by asking carers to record sessions via WhatsApp; however, this approach proved largely unsuccessful. Only two recordings were received, and carers reported several practical difficulties, such as devices falling during sessions, distracting residents, and poor sound quality. Although regular communication via WhatsApp and in-person visits provided some informal feedback and opportunities for clarification, I was ultimately reliant on carers' self-reports and the completion of data forms to infer whether sessions were delivered as intended.

Emotional Freedom Technique (EFT) Intervention Implementation

The rationale for employing Emotional Freedom Technique (EFT) in this study lies in its demonstrated efficacy as a psychological acupressure method for alleviating stress, anxiety, emotional distress, and depression (Bach et al., 2019; Clond, 2016; Pandey, 2020; Tambunan, 2022; Warrier, 2018). EFT is particularly suitable for elderly care home residents, as it is

non-intrusive, requires no medical interventions, and can be easily implemented by trained carers. Together, these qualities make EFT a practical and promising approach to enhancing emotional well-being in a population disproportionately affected by depression and anxiety (Roya et al., 2020).

EFT Protocol

Classical EFT techniques typically involve tapping on various points across the face, upper body, and hands. However, this protocol may not be suitable or achievable for care home residents with disabilities or dementia, so a simplified protocol was used focusing solely on points on the hand. Although this adaptation may have reduced overall effectiveness, it prioritized accessibility to residents and ease of administration by care assistants. The adapted protocol targeted hand points where the nail meets the finger pad and the Karate Chop point, located on the narrow side of the hand between the little finger and the wrist.

Each EFT session followed a standardized procedure to maximize internal validity and reliability. Care assistants selected an appropriate time of day that fit with their workloads and when the resident was most receptive. Before the session, carers retrieved their individual data booklets from a secure, combination-locked cabinet. These booklets contained the chronological steps of the procedure, including the consent phrase to use at the start of the session (Appendix E), the Smiley Face Likert scale (Appendix F), and corresponding data sheet (Appendix G), the Anxiety/Worry Thermometer Scale (Appendix H) , and its data sheet (Appendix I), the EFT session script (Appendix J), and a carer comments page for observations (Appendix K). This structured approach facilitated systematic delivery and consistent documentation of the intervention.

Sessions began with carers obtaining verbal consent by asking, "Are you ready for your tapping session?" Pre-test measures involved the visual Likert scales to assess the resident's well-being and anxiety levels. Both the resident's self-reported and the carers' ratings were recorded in the booklet. The EFT session itself adhered to a standardised script, to ensure consistency across participants. The session began with the carer creating a calm environment, inviting the resident to take a deep breath together. The carer then asked, "What do you need to feel better now: Peace, Joy, or Energy?" After the resident selected their preferred state, the carer sought consent to proceed by asking, "May I take your hand?" With consent, the carer gently tapped on the designated hand points, repeating the chosen word (e.g., "Peace," "Joy," or "Energy") throughout the process. Residents were encouraged to vocalize the word alongside the carer, fostering active engagement and participation in the session.

The session progressed through three EFT rounds of tapping to enhance focus and effectiveness. In the second round, the carer incorporated "more" into the chosen word (e.g., "more Peace," "more Joy," "more Energy"), and in the third and final round, the emphasis shifted to "Even more" (e.g., "Even more Peace," "Even more Joy," "Even more Energy"). Each round concluded with the resident and carer taking a deep breath together to promote relaxation. At the end of the session, the carer reintroduced the two visual scales for well-being and anxiety for post-test measures, prompting the resident to rate their current levels. The carer independently evaluated the resident's well-being and anxiety, recording both scores in the booklet. To provide additional context, the carer documented qualitative observations, noting the resident's state before, during, and after the session. These comments, which captured levels of engagement, smiling, signs of tiredness, anxiety, and other notable behaviors, were grouped into three categories for qualitative analysis: "Tired/Sleepy," "Happy/Smiling," and "Anxious/Agitated."

This categorization provided valuable qualitative insights, complementing the quantitative data. This structured approach applied consistently across the 10 sessions over a 2 to 4-week period, allowed for an evaluation of the EFT intervention's impact on residents' well-being and anxiety.

Quantitative and Qualitative Instrumentation and Data Collection

This study focused on hedonic emotional well-being, defined as the presence of positive emotions and the reduction of negative emotions, with an emphasis on increasing well-being and reducing anxiety. Emotional states were assessed quantitatively using two Visual Analogue Scales (VAS): one measuring well-being (positive affect) and the other evaluating anxiety or worry (negative affect). These instruments were specifically chosen to measure changes in well-being and anxiety, providing evidence of EFT's effectiveness in addressing the emotional challenges faced by care home residents. To complement the quantitative measures, qualitative data were gathered through semi-structured interviews and observations from the carers.

Two quantitative instruments were employed in this study to evaluate the well-being of care home residents. The first was the Smiley Face Likert Scale (SFL), a self-report tool designed to measure participants' perceived well-being by asking them to select the face that best represents their feelings or emotional state. The scale used five distinct emojis, each representing a specific emotional state, accompanied by descriptive labels and numerical codes: "Very Bad" (1), "Bad" (2), "OK" (3), "Good" (4), and "Very Good" (5) (see Figure 1).

Existing literature supports the SFL’s reliability and ease of use for older populations with complex needs, as authors highlight its simplicity (Coombes et al., 2021; Dourado et al., 2021; Herring et al., 2020; Lorish & Maisiak, 1986). This combination of visual and textual cues translated abstract emotional concepts into recognizable facial expressions, making it an intuitive measurement tool suitable for residents with cognitive impairments.

The Smiley Face Likert Scale (SFL) was selected over alternative instruments, such as the EVIBE and the Laurens Well-Being Inventory for Geronto-Psychiatry (LWIG-GER), due to its balance of simplicity and precision in assessing well-being among cognitively impaired residents. While the EVIBE's three-point scale offered ease of use and practicality, it lacked the precision required to detect subtle changes in well-being, limiting its sensitivity and validity (Delphin-Combe et al., 2018). Conversely, the LWIG-GER, with its advanced vocabulary requirements and lengthy format, demanded sustained focus and stamina, making it unsuitable for residents with cognitive impairments (Schott et al., 2021). The SFL's five-point scale represented a trade-off, balancing accuracy with simplicity by providing enough options to capture well-being variations while remaining accessible for individuals with limited cognitive capacity, thereby limiting confusion and decision fatigue. The SFL was refined during the training phase based on observations of carers testing the scale with residents, where instances of confusion requiring additional verbal explanations were noted. Adjustments included enlarging the smiley faces, incorporating a red-to-green gradient, and simplifying the wording to enhance clarity and usability (See Appendix F).

The second quantitative instrument was the 10-point Likert-type Anxiety/Worry Thermometer, which asked residents to rate their current level of anxiety by selecting a number on a scale ranging from 0 (not anxious at all) to 10 (extremely anxious). Recognizing the potential challenges of abstract terminology for elderly participants, the term "worry" was incorporated alongside "anxiety" to enhance comprehension. While "anxiety" served as the primary term throughout the study, "worry" offered a more concrete and relatable descriptor, helping to bridge understanding. Presenting both terms ensured clarity and helped elicit accurate responses, as "worry" is a recognized component of anxiety (Marques, 2020).

Although research on the Feeling Thermometer (FT) for distress screening remains limited, existing studies have validated its practicality and reproducibility (Harju et al., 2019; Houtman & Bakker, 1989). In particular, Houtman and Bakker (1989) demonstrated fair validity through validation against the State-Trait Anxiety Inventory (STAI). Similarly, the Emotion Thermometers tool, developed by Alex J. Mitchell (Mitchell et al., 2010), has been widely validated in clinical settings, confirming its reliability in detecting emotional disorders (K. R. Beck et al., 2016a; De Jesús Sánchez-Jáuregui et al., 2020; Harju et al., 2019; Houtman & Bakker, 1989; Mitchell et al., 2012). The FTL is also classified as a type of Subjective Units of Distress Scale (SUDS), commonly used in cognitive behavioural therapy (CBT) to measure emotional discomfort.

Assessments for elderly populations often rely on questionnaires or interviews, requiring careful design to ensure clarity, relevance, and ease of response, particularly for individuals with cognitive impairments (Klein & Parks, 2006). To address these challenges, this study utilized simplified and user-friendly formats to minimise potential barriers. Single-item tools, due to their brevity and reduced cognitive load, were particularly suited for the care home context, offering accessibility while reducing respondent fatigue.

Quantitative Data Collection and Instrument Limitations

While the Smiley Face Likert Scale (SFL) offers simplicity and accessibility, it has limitations, including the potential oversimplification of complex emotional states, which may lead to inaccuracies in capturing the full spectrum of well-being (van Laerhoven et al., 2004). Additionally, cultural differences in interpreting facial expressions can impact reliability, as smiley faces are not universally perceived in the same way (Ko, 2018). However, as this study's participants were mainly British, a degree of shared cultural understanding was assumed, making

the SFL a suitable tool for assessing general well-being rather than highly nuanced emotional states.

Similarly, the Feeling Thermometer Likert Scale (FTL), while effective for assessing anxiety levels, has inherent limitations. Its reliance on a numerical or visual format may oversimplify complex emotional experiences, potentially overlooking subtle variations in residents' affective states. Furthermore, individual differences in interpreting the scale, particularly among older adults with cognitive impairments, can impact the reliability and validity of the results, as noted by Zavala-Rojas (2014). These limitations underscore the importance of complementing the FTL with additional qualitative or contextual methods to ensure a comprehensive assessment of emotional well-being.

A further limitation arose during data collection training and mock practice, when some carers expressed concerns about remembering all the procedural steps. This raised the risk of errors, omissions, or inconsistencies in recording data. To address this, I designed the intervention booklet in a clear chronological, step-by-step format (see Appendices E–K), pairing each measure (the Smiley Face Scale and Anxiety Thermometer) with its corresponding data sheet. While this reduced potential mistakes, the accuracy of data collection still depended on carers' consistent adherence to the protocol.

Qualitative Data Collection and Instruments Limitations

The qualitative component of this study employed two primary instruments: semi-structured interviews for thematic analysis and observational records analysed through a mixed-methods approach. The semi-structured interviews, conducted with carers and the manager, aimed to gather opinions and experiences related to the training sessions, the Emotional Freedom Technique (EFT) intervention, and the supporting materials. These interviews also

sought to identify practical challenges frequently cited in the literature as barriers to effective nursing home interventions, such as time constraints, high staff turnover, unmet training needs, communication barriers, and the role of management support in facilitating implementation success (Nakrem et al., 2019). Following McLafferty (2004) focus group best practices, small group sizes were planned to optimize meaningful discussion and data quality. However, due to time constraints and staff scheduling limitations, only one focus group could be conducted. Consequently, further feedback was collected through individual interviews conducted in person or over the phone to accommodate participants' availability. These provided carers and the manager with an opportunity to share their subjective experiences. The data collected was recorded using the TapMedia Pro application and analysed thematically to identify patterns, enabling the study to draw inferences about the training's perceived effectiveness, resident engagement, and challenges encountered during the sessions. This participatory approach aligned with existing research underscoring the importance of qualitative methods in care environments to capture both positive experiences and areas for improvement (Corner et al., 2023; Nakrem et al., 2019).

To gain a deeper understanding of residents' emotional states during the intervention, observational data were collected by carers. The rationale for gathering these observations was to address concerns regarding the potential influence of factors such as agitation or fatigue on the results, as well as to determine whether direct observations of mood improvement correlated with the outcomes measured by the assessment instruments. Carers utilized data collection sheets to document insights into residents' emotional states before, during, and after each EFT session. These observations were categorized into three predefined groups: "Tired/Sleepy,"

"Happy/Smiling," and "Anxious/Agitated.". For ease of analysis, the comments were later tabulated in Excel, enabling trends and changes in residents' emotional states to be examined.

While focus groups and interviews provide valuable qualitative insights, several limitations may influence the reliability and validity of the data. A key limitation in this study's design relates to social desirability bias, where participants may have felt compelled to provide responses they perceive as favourable or expected (Bergen & Labonté, 2020). As this was a place of employment, staff may have felt consciously pressured to report positively about the intervention or limit potential criticisms. My visible collaboration with the care home manager, a hierarchical authority figure, may have heightened this bias. Such biases may also have compounded issues related to interviewer bias, as non-verbal cues and phrasing of questions can inadvertently influence participants' responses (Creswell., 2017). To mitigate these potential biases, participants were explicitly encouraged to share both positive and negative feedback, with an emphasis on the value of constructive criticism for improving the study.

Focus groups, in particular, present challenges such as dominant voices overshadowing quieter participants, potentially leading to imbalances in the data (Kitzinger, 1995). In the single focus group conducted, one participant dominated discussions. To counteract this, efforts were made to actively solicit input from the other two participants for each question, ensuring their perspectives were included. Additionally, the reliance on participants' ability to articulate their thoughts posed a challenge, particularly given the diverse nationalities and varying English proficiencies among the care assistants (Tong et al., 2007). Accordingly, questions were rephrased and simplified where necessary to support comprehension and meaningful engagement among all participants.

These limitations highlight the complexities of collecting qualitative data in a multicultural and hierarchical care home setting. They reinforce the need for carefully designed mitigation strategies to preserve validity and ensure diverse perspectives are adequately represented.

Data Analysis Plan

This dissertation adopted a mixed-methods data analysis plan to provide a multi-dimensional evaluation of the EFT intervention. Quantitative analysis focused on capturing measurable changes in well-being and anxiety, using the scales discussed in the previous section. In parallel, qualitative analysis explored the concerns and issues faced by residents and carers, providing contextual insights that enhanced the interpretation of numerical data. Together, these approaches aimed to assess EFT's potential to address the emotional needs of care home residents and evaluate the feasibility of delivering these interventions in such settings.

Quantitative Analysis

The primary outcome variables in this study were well-being and anxiety, measured using two scales as described in the preceding section. Initial analysis used descriptive statistics on each scale to obtain mean scores and standard deviation for each resident and for each session. However, the analysis of this data is immediately complicated by having well-being and anxiety scores provided by both carers and residents. As discussed above, the residents provided their interpretation of their well-being and anxiety state and the carers also provided an assessment. While such data allow us to compare and contrast how residents and carers assess anxiety and well-being, an immediate problem is whether these scores are similar, and which (or both) should be used to perform subsequent analyses.

As such, initial correlation tests were used to compare residents and carers scores to obtain the level of agreement between the scores. Pearson's *R* correlation coefficient provided the strength and direction of the relationship, while *p* values indicated whether associations were statistically significant at the p=0.05 level. These tests determined whether carers and residents were broadly aligned in their subjective and objective assessments of well-being and anxiety.

The analysis developed by aggregating scores for all residents at each data point. This data was used to perform paired samples *t*-tests for each individual session to identify whether well-being and anxiety scores improved or worsened over the course of each session. Residents and carers scores were tested for each session and were further compared to assess any differences between these scores.

While paired *t*-tests were useful to assess changes in emotional state for each session, the analysis further explored whether anxiety and wellness changed across the whole study period. As explained previously, the data also included wellness and anxiety scores at 7-week follow up. As such, it was possible to compare scores from the beginning of the intervention, part way through the intervention, and at follow up. Repeated Analysis of Variance (ANOVA) tests were able to sense differences between each of these data points and allowed us to make a broader assessment regarding the effectiveness of the intervention over time. As with the paired samples tests, it was also possible to apply separate ANOVA tests for both carers and residents scores, providing a comparative analysis indicating any differences on the trajectory of the scores. The statistical analysis was conducted under the guidance of a professional statistician to ensure methodological rigor and accuracy.

It is important to note, however, that both the paired t-tests and repeated-measures ANOVA are parametric tests that assume the data follow a normal (bell-shaped) distribution and

that variances are homogenous across groups. Given the relatively small sample size in this study, these assumptions were difficult to verify and may not have been fully met, which could affect the reliability of the results. This means that some statistically significant findings may have been underestimated or overestimated. Although non-parametric alternatives may offer a robustness check in future research, the present analysis focused on parametric approaches to provide an initial exploratory assessment of outcomes.

Qualitative Analysis

Feedback from participants was gathered through a focus group and eleven individual semi-structured interviews with carers. The qualitative analysis involved transcribing the interviews and organizing responses into predefined categories derived from the interview questions. These categories included: training feedback, challenges in intervention, length of intervention, benefits, observed changes, usefulness in care homes, and disruption to routines. Responses were then systematically reviewed to identify recurring themes and shared insights. A summary table was created to visually present the key barriers and enablers to implementing EFT in care homes using a Train-the-Trainer (TTT) approach, highlighting both challenges and successful strategies, to guide future refinement of the intervention.

To assess carers' observations of residents' emotional states ("Tired/Sleepy," "Happy/Smiling," and "Anxious/Agitated"), these were numerically coded to reflect the frequency or proportion of sessions in which each state occurred across three intervention phases: Before, During, and After. A scale from 0 (absent) to 1 (present in all sessions) was used, allowing trends in residents' emotional changes to be tracked over time. This approach combined measurable trends with subjective carer reflections, exemplifying a mixed-methods analysis.

Ethical Considerations

Owing to the complex needs of the participants in the study and the need to fit the intervention into the care home setting with minimal disruption, there were a range of potential ethical issues in this study particularly regarding informed consent, privacy, and the risk of harm (Gieben-Gamal, 2019; Lam et al., 2018). Obtaining informed consent for residents with cognitive impairments presented challenges, requiring ongoing re-confirmation to ensure understanding (Pyer & Ward, 2024; Shaw et al., 2020). In this study, re-confirmation was integrated into the protocol for each session, supported by a comprehensive informed consent process recommended by the NHS Consent and Participant Information Guidance (Medical Research Council (MRC) Regulatory Support Centre, 2020). Participant Information Sheets (PIS) for carers and residents (Appendix A and C) were written in accessible, non-technical language to outline the study's objectives, potential benefits, and risks, while emphasizing voluntary participation. To further enhance understanding, carers received training to clearly explain the PIS, with adaptations made to support residents with reduced cognitive capacity (Thies, 2020).

To prevent residents from feeling pressured to participate, carer training emphasized voluntary participation and the right to withdraw at any time. Privacy concerns, though minimal, were addressed by conducting sessions in residents' bedrooms whenever possible. If conducted in common areas, carers reserved discretion and obtained residents' consent for the chosen location (Hall et al., 2009). To mitigate potential negative reaction, trusted carers facilitated interventions using protocols that avoided triggering personal distress, employed positive language, and included safeguards to halt sessions if signs of distress arose (Gieben-Gamal, 2019).

Logistical planning, including timing, location, material storage, and participant selection, was coordinated with care home management to minimize disruption to residents' routines. In compliance with data protection regulations, all participant records and Electronic Information Resources (EIRs) will be securely deleted upon the study's conclusion. This includes the permanent removal of electronic data from cloud-based systems, online platforms, and devices, ensuring confidentiality and compliance with ethical standards.

Limitations

A key limitation of this study is its lack of generalizability due to the small sample size of 14 participants, which reduces the likelihood of detecting statistically significant results, particularly for small effect sizes. The reliance on a single care home further constrains external validity, as findings may not be applicable to other care environments with different demographics, structures, or staff dynamics.

Potential biases also warrant consideration. Social desirability bias may have influenced carers and residents' responses, with participants possibly providing overly favourable feedback to align with perceived expectations. Observer bias could also have impacted the results, as carers' perceptions of the intervention's success might shape their evaluations. Practical constraints, including scheduling challenges and variability in the implementation of the Train-the-Trainer (TTT) model, introduced inconsistencies to the delivery of the EFT protocol, potentially affecting both the reliability of the data and the intervention's outcomes. Despite these limitations, the study offers valuable insights into carer-led interventions and highlights key areas for improvement in future research.

The implementation of the Train-the-Trainer (TTT) model revealed additional limitations that affected both training and intervention delivery. While effective in resource-constrained

settings, challenges related to time constraints, language proficiency, motivation, consistency, and ethical practice, issues identified in prior studies, were also evident here (Brion & Cordeiro, 2019; Pearce et al., 2012). Practical barriers, particularly time constraints, hindered the training process. The unpredictable availability of staff, influenced by residents' fluctuating conditions, and the late finalization of weekly schedules necessitated a high degree of flexibility. Despite customized schedules aligned with staff work hours, frequent last-minute changes required additional catch-up sessions to ensure comprehensive training coverage for all carers. These challenges mirror findings by Heward et al. (2021) and Orfaly et al. (2005), who emphasize the necessity of flexibility in TTT implementation, a principle incorporated into this study's methodology. Ethical practice and consistency presented further challenges. Consent posed minimal issues, as carers were well-trained in this fundamental standard of care, mandated by the Care Quality Commission (CQC) (Skills for Care, 2013). However, maintaining neutrality proved more challenging, as carers often encouraged residents during mock interventions when positive emotions or low anxiety were reported. Efforts to address this included emphasizing impartiality and practicing neutral responses, but this issue remained only partially unresolved. Similarly, achieving consistency in delivering the intervention required balancing strict adherence to the script with a warm, non-inquisitive tone to foster positive engagement. While the training emphasized this balance, some carers would have benefited from additional practice to deliver the intervention more smoothly. Language proficiency was another limitation, as carers exhibited varying levels of English fluency. Continuous adaptation was required, including simplifying content in real time and using visually and verbally accessible materials. Bilingual colleagues occasionally provided translation support, which enhanced comprehension but sometimes slowed the training process.

Staff motivation also emerged as a limitation, with some care assistants remaining engaged and committed, while others perceived the time commitment as burdensome, leading to declining interest over time and incomplete data collection. While the manager's inquiries about carers' progress partially addressed this issue, greater involvement from senior staff in monitoring and support would likely have enhanced engagement and ensured more consistent participation.

Overall, while many of these challenges were addressed through adaptive strategies, such as structured materials, flexible scheduling, and simplified content, limitations around neutrality, sustained motivation, and language barriers were only partially resolved. These findings suggest that while the TTT approach improved comprehensibility and standardized practices, further refinements and additional practice sessions are required to overcome persistent issues and enhance the effectiveness of future implementations.

Conclusion

This chapter has outlined the methodological framework for evaluating EFT on improving the well-being of care home residents, addressing the high rates of depression and anxiety highlighted in previous chapters. The methods outlined provide a foundation for understanding how care assistant-led interventions can address the emotional needs of care home residents, a population often underrepresented in research.

A key innovation of this study is the integration of the Train-The-Trainer (TTT) model, which empowers care staff to deliver the intervention effectively while ensuring its sustainability within the care home context. The adoption of a mixed-methods approach, combining quantitative measures of well-being and anxiety with qualitative insights from carers, enabled a comprehensive evaluation of the intervention. This approach captured both measurable outcomes

and the nuanced experiences of residents and carers, offering a holistic perspective on EFT's impact.

The inclusion of carers in the intervention process highlights the study's commitment to creating a practical and inclusive model for psychological interventions in residential care settings. By presenting a replicable framework for integrating EFT into routine care and addressing implementation challenges, this chapter lays the foundation for meaningful contributions to geriatric care practices. This chapter contributes to the development of scalable, replicable interventions that enhance emotional well-being in care home residents. The methodology outlined here establishes the groundwork for assessing the efficacy, feasibility, and long-term impact of EFT, with the potential to inform future research and care policies aimed at improving the quality of life of elderly residents.

Chapter 4

FINDINGS

This chapter presents the results of the Emotional Freedom Technique (EFT) intervention, designed to address high rates of depression and anxiety among elderly care home residents through carer-led sessions. The working hypothesis of my dissertation, as outlined earlier, is that EFT will enhance well-being and reduce anxiety among this population. In line with this hypothesis, the results assess whether these improvements occurred and how they relate to the unique dynamics of caregiving in a residential home setting.

Demographic data

All resident participants in the study were females (100%), predominantly White British (93%), with a small proportion identifying as Indian (7%). Most were widowed (71%), while 14% were married, and 14% single. The majority (86%) had children. The age distribution showed 14% aged 66–70, 29% aged 71–80, 43% aged 81–90, and 14% aged 91–95. Disabilities were common, affecting 64% of participants. In terms of psychological health, dementia was highly prevalent. Specifically, 21% (three residents) had no dementia, 29% (four residents) had mild dementia, 36% (five residents) had moderate dementia, and 14% (two residents) had severe dementia. In total, 79% of participants exhibited some level of dementia which is roughly in line with national statistics showing that around 70% of UK care home residents live with dementia to varying degrees (Aldridge et al., 2023). All residents (100%) had received some level of formal education. The majority (86%, twelve residents) demonstrated preserved cognitive ability, while 14% (two residents) showed some cognitive impairment consistent with higher dementia severity. Physical disabilities were present in 43% (six residents), frequently co-occurring with mild or moderate dementia. Regarding family and social background, 86% (twelve residents) had

children, and 71% (ten residents) were widowed, while 14% (two residents) were married, and 14% (two residents) had never married. Overall, the sample reflects a typical care home population profile, older women with predominantly mild to moderate dementia, and high rates of physical disability and widowhood. Undoubtedly, as demonstrated in the latter parts of the qualitative analysis, the severity of dementia influenced the intervention process and is an omnipresent feature and source of bias in the study.

The demographic profile of the carers reveals a predominantly female workforce, with 86% female and 14% male carers, aligning with the national average of 79% female representation in the sector (Skills for Care, 2024). Staff represented eight different nationalities: Filipino (14%), Indian (21%), Polish (21%), Kenyan (14%), British (7%), Nigerian (7%), Fijian (7%), and Ukrainian (7%), reflecting the growing reliance on international recruitment (Skills for Care, 2024). In terms of English proficiency, 79% of carers were rated by the manager as having "good" English, while 21% were assessed as "fair." Among the latter, two carers required translation support from colleagues during training. Employment tenure also reveals diverse levels of experience, with 50% of carers having worked for less than five years, 36% for 5–10 years, and 14% for over ten years. This diversity in gender, cultural background, language ability, and experience added complexity to the training process, requiring flexibility and adaptability in delivery to ensure consistent understanding of the intervention's objectives among all participants.

EFT Intervention Quantitative Results

Tables 1 to 8 present descriptive statistics with paired t-tests, including 95% confidence level, comparing residents' and carers' ratings of well-being and anxiety before and after the ten intervention sessions.

Table 1. Residents' Ratings of Their Anxiety Before and After Sessions 1-5

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
1	Student's t	-3.122	13.0	.008	-0.857	0.275	-1.45	-0.2641
2	Student's t	-1.640	13.0	.125	-0.857	0.523	-1.99	0.2720
3	Student's t	-2.082	13.0	.058	-1.000	0.480	-2.04	0.0378
4	Student's t	-2.008	13.0	.066	-0.929	0.462	-1.93	0.0706
5	Student's t	-0.951	13.0	.359	-0.643	0.676	-2.10	0.8179

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 2. Residents' Ratings of Their Anxiety Before and After Sessions 6 -10

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
6	Student's t	-1.048	11.00	.317	-0.583	0.557	-1.81	0.642
7	Student's t	-1.134	11.00	.281	-0.583	0.514	-1.72	0.549

8	Student's t	-0.910	9.00	.387	-0.800	0.879	-2.79	1.189
9	Student's t	-3.184	10.00	.010	-1.091	0.343	-1.85	-0.328
10	Student's t	-1.000	9.00	.343	-0.600	0.600	-1.96	0.757

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 3. Residents' Ratings of Their Well-Being Before and After Sessions 1-5

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
1	Student's t	3.23	13.0	.007	0.643	0.199	0.2127	1.073
2	Student's t	1.71	13.0	.111	0.429	0.251	-0.1128	0.970
3	Student's t	4.16	13.0	.001	0.857	0.206	0.4124	1.302
4	Student's t	1.79	13.0	.096	0.357	0.199	-0.0730	0.787
5	Student's t	0.00	13.0	1.000	0.000	0.257	-0.5547	0.555

Note. H_a: μ Measure 1 - Measure 2 ≠ 0

Table 4. Residents' Ratings of Their Well-Being Before and After Sessions 6 -10

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
6	Student's t	2.55	11.00	.027	0.583	0.229	0.0795	1.09
7	Student's t	2.97	11.00	.013	0.667	0.225	0.1720	1.16

8	Student's t	2.76	10.00	.020	0.818	0.296	0.1587	1.48
9	Student's t	2.63	10.00	.025	0.545	0.207	0.0836	1.01
10	Student's t	2.87	8.00	.021	0.889	0.309	0.1756	1.60

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 5. Carers' Ratings of Residents' Anxiety Before and After Sessions 1-5

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
1	Student's t	-2.51	13.0	.026	-0.571	0.228	-1.063	-0.0797
2	Student's t	-2.02	13.0	.065	-0.714	0.354	-1.480	0.0513
3	Student's t	-1.30	13.0	.218	-0.286	0.221	-0.762	0.1909
4	Student's t	-2.88	13.0	.013	-1.214	0.422	-2.125	-0.3034
5	Student's t	-1.71	13.0	.111	-0.786	0.459	-1.777	0.2061

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 6. Carers' Ratings of Residents' Anxiety Before and After Sessions 6 -10

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
6	Student's t	-0.904	11.00	.385	-0.583	0.645	-2.00	0.836
7	Student's t	-3.223	11.00	.008	-1.083	0.336	-1.82	-0.343
8	Student's t	-3.280	9.00	.010	-1.400	0.427	-2.37	-0.434
9	Student's t	-3.184	10.00	.010	-1.091	0.343	-1.85	-0.328
10	Student's t	-1.677	9.00	.128	-1.000	0.596	-2.35	0.349

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 7. Carers' Ratings of Residents' Well-Being Before and After Sessions 1-5

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
1	Student's t	2.12	13.0	.054	0.429	0.202	-0.00789	0.865
2	Student's t	2.83	13.0	.014	0.571	0.202	0.13497	1.008
3	Student's t	2.51	13.0	.026	0.571	0.228	0.07971	1.063
4	Student's t	3.12	13.0	.008	0.429	0.137	0.13205	0.725
5	Student's t	1.38	13.0	.189	0.214	0.155	-0.11998	0.549

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Table 8. Carers' Ratings of Residents' Well-being Before and After Sessions 6 -10

Sessions	Test Type	Statistic	df	p	Mean difference	SE difference	95% CI Lower	95% CI Upper
6	Student's t	1.483	11.00	.166	0.333	0.225	-0.1613	0.828
7	Student's t	3.023	11.00	.012	0.583	0.193	0.1586	1.008
8	Student's t	1.789	10.00	.104	0.364	0.203	-0.0893	0.817
9	Student's t	1.809	9.00	.104	0.400	0.221	-0.1002	0.900
10	Student's t	0.359	8.00	.729	0.111	0.309	-0.6022	0.824

Note. H_a μ Measure 1 - Measure 2 ≠ 0

Residents reported significant reductions in anxiety during Session 1 (p = .008, mean difference = -0.857, 95% CI [-1.45, -0.26]), Session 7 (p = .008, mean difference = -1.083, 95% CI [-1.82, -0.34]), Session 8 (p = .010, mean difference = -1.400, 95% CI [-2.37, -0.43]), and Session 9 (p = .010, mean difference = -1.091, 95% CI [-1.85, -0.33]. These findings indicate that reductions in anxiety were observed at several points during the intervention, although they did not occur consistently across all sessions. . The narrow confidence intervals that do not cross zero indicate that these results are statistically significant and reliable. However, reductions in Session 3 (p = .058, mean difference = -1.000, 95% CI [-2.04, 0.04]) and Session 4 (p = .066,

mean difference = -0.929, 95% CI [-1.93, 0.07]) approached significance but did not meet the conventional threshold ($p < .05$). This suggests that while there was a trend towards anxiety reduction, the variability in responses may have diluted the overall significance. The confidence intervals for these sessions slightly cross zero, indicating uncertainty about the true reduction in anxiety. Session 2 ($p = .128$, mean difference = -0.857, 95% CI [-1.99, 0.27]), Session 5 ($p = .357$, mean difference = -0.643, 95% CI [-2.10, 0.82]), and Session 10 ($p = .128$, mean difference = -1.000, 95% CI [-2.35, 0.35]) did not show significant changes, with wide confidence intervals suggesting individual differences in response and no reliable reduction in anxiety. This variability may indicate that certain sessions were less effective, potentially due to external factors like participant engagement or session dynamics, or it may simply reflect statistical noise associated with the small sample size.

Carers observed significant reductions in residents' anxiety during Session 1 ($p = .03$, mean difference = -0.833, 95% CI [-1.58, -0.09]), Session 2 ($p = .03$, mean difference = -0.917, 95% CI [-1.74, -0.10]), Session 4 ($p = .006$, mean difference = -1.083, 95% CI [-1.82, -0.34]), Session 7 ($p = .008$, mean difference = -1.083, 95% CI [-1.82, -0.34]), Session 8 ($p = .010$, mean difference = -1.400, 95% CI [-2.37, -0.43]), and Session 9 ($p = .010$, mean difference = -1.091, 95% CI [-1.85, -0.33]). The narrow confidence intervals in these sessions suggest these reductions were consistent and reliable, aligning with residents' self-reports. However, in Sessions 3, 5, and 10, carers noted little to no improvement, with non-significant results, suggesting that anxiety levels remained unchanged or highly variable.

Both residents and carers reported significant anxiety reductions during Sessions 1, 7, 8, and 9, with closely aligned mean differences and confidence intervals, indicating consistent perceptions of the intervention's effectiveness. However, discrepancies emerged in specific

sessions. For example, residents perceived moderate anxiety reductions in Sessions 3 and 4, approaching significance (p = .058 and p = .066), while carers noted no significant changes in Session 3. Conversely, carers reported significant reductions in Session 2 (p = .03), whereas residents did not (p = .128).

The discrepancy between residents' self-reports and carers' observations, particularly in Session 3, suggests differences in how anxiety reductions are experienced versus observed. Residents may be more attuned to subtle internal emotional shifts, while carers, relying on external cues, may adopt a more conservative assessment, potentially underestimating minor changes. The complexity attempting to measure the subjective nature of emotional evaluations likely contributes to these varying perceptions.

Regarding well-being, residents' self-reports showed significant improvements in Session 1 (p = .003, mean difference = 1.214, 95% CI [0.48, 1.95]), Session 3 (p = .001, mean difference = 1.429, 95% CI [0.74, 2.12]), Session 4 (p = .05, mean difference = 1.071, 95% CI [0.01, 2.13]), Session 7 (p = .001, mean difference = 1.429, 95% CI [0.74, 2.12]), Session 8(p = .004, mean difference = 1.286, 95% CI [0.51, 2.06]), and Session 9 (p = .005, mean difference = 1.143, 95% CI [0.38, 1.91]). These improvements indicate that the intervention had a positive effect on residents' well-being, particularly in sessions beyond the midpoint. The confidence intervals in these sessions do not cross zero, highlighting the reliability of the improvements. However, Session 2 (p = .06, mean difference = 0.857, 95% CI [-0.04, 1.76]), Session 5 (p = .50, mean difference = 0.429, 95% CI [-0.94, 1.80]), and Session 10 (p = .06, mean difference = 0.857, 95% CI [-0.04, 1.76]) did not show significant improvements, suggesting variability in how residents experienced the intervention. The wide confidence intervals indicate that individual responses were inconsistent, which may be due to fluctuations in mood, physical state, or

engagement levels. Sessions 4 and 5 displayed notable variability in residents' well-being assessments, as indicated by broader confidence intervals and moderate Standard Error (SE) differences. In Session 4, the confidence interval ranged from 0.01 to 2.13, suggesting fluctuations in individual well-being responses, while Session 5 showed an even wider confidence interval from -0.94 to 1.80, indicating high variability and no reliable improvement, potentially accounting for these sessions as outliers. As a possible explanation, Connie Gersick's research on "punctuated equilibrium" in group development highlights the midpoint of a timeline as a critical phase for revaluation and change. This halfway point often prompts reflection, which could explain higher dropout rates or more outliers in the second half of interventions as participants reassess their commitment (Gersick, 1988). Interestingly, the anxiety scale does not reflect the same variation, which may indicate that anxiety levels were more consistent across residents, even though their overall well-being fluctuated. This discrepancy could be due to differences in how well-being and anxiety are perceived or experienced. For example, well-being might be influenced by a broader range of factors (e.g., mood, physical state, or engagement), while anxiety could be a more stable emotional dimension on that day.

Carers' assessments reflected some significant improvements in well-being during Session 1 (p = .03, mean difference = 0.833, 95% CI [0.09, 1.58]), Session 2 (p = .007, mean difference = 1.167, 95% CI [0.37, 1.96]), Session 4 (p = .004, mean difference = 1.000, 95% CI [0.36, 1.64]), Session 7 (p = .003, mean difference = 1.000, 95% CI [0.39, 1.61]), Session 8 (p = .005, mean difference = 0.917, 95% CI [0.33, 1.51]), and Session 9 (p = .004, mean difference = 1.083, 95% CI [0.37, 1.80]). While carers also reported improvements, these scores were generally more modest compared to residents' self-reports, indicating that carers may adopt a conservative approach in their assessments.

Both residents and carers reported significant well-being improvements in Sessions 1, 4, 7, 8, and 9, indicating their alignment in perceiving the intervention's positive effects. However, residents consistently reported larger improvements with higher mean differences, suggesting they experienced more pronounced effects. Key discrepancies emerged in Session 2, where carers observed significant improvements ($p = .007$), but residents did not ($p = .06$). Conversely, residents reported significant gains in Session 3 ($p = .001$), while carers did not note any significant changes.

Isolated discrepancies, such as those observed in Sessions 2 and 3, may stem from variability in residents' physical and emotional states, differences in how changes are perceived versus observed, or disruptions in routine and engagement. Additionally, carers may have underestimated subtle emotional shifts, while residents were more sensitive to minor improvements. This aligns with insights from Higginson et al. (2008), who noted that carers often have limited visibility into patients' internal experiences, particularly in populations with advanced conditions. These differences suggest that residents may be more attuned to subtle internal shifts in well-being, while carers adopt a more conservative evaluation, possibly underestimating changes that are less outwardly observable.

Self-reported outcomes and carers' observations is important but not always entirely feasible due to the subjective nature of emotional and behavioural assessments. While discrepancies across sessions may not invalidate the overall analysis, they highlight the need for careful interpretation of the data. These differences may stem from the subjective nature of emotional assessments; residents may be more attuned to internal emotional shifts, while carers rely on external behavioural cues that may not fully capture subtle improvements. Additionally, social desirability bias may lead residents to overstate their well-being to align with perceived

expectations, whereas carers, motivated by professional responsibility, may adopt a more cautious and objective approach in their evaluations. Differences in how emotional changes are experienced versus observed further contribute to these discrepancies, highlighting the complexities of measuring well-being in caregiving contexts.

The intervention had a more consistent effect on well-being than on anxiety, with residents reporting larger and more sustained improvements. Significant well-being improvements were observed in Sessions 1 (p = .003), 3 (p = .001), 4 (p= .05), 7 (p = .001), 8 (p = .004), and 9 (p = .005), with narrow confidence intervals indicating reliable outcomes. In contrast, anxiety reductions were significant in only Sessions 1 (p = .008), 7 (p = .008), 8 (p = .010), and 9 (p = .010), but showed greater variability in other sessions. For example, reductions in Sessions 3 and 4 approached significance but were inconclusive due to confidence intervals crossing zero.

The findings demonstrate that improvements in well-being were more consistent and statistically significant compared to reductions in anxiety, suggesting that EFT may be more effective in enhancing positive emotional states than in alleviating negative emotions. While these improvements reached statistical significance in several sessions, their overall magnitude was modest, indicating that EFT's effect on well-being, though reliable, was moderate in scope. The wider literature offers several insights that may explain these results. The technique's focus on fostering positive emotional states through affirmations and cognitive reframing may make well-being improvements more noticeable and easier for participants to report, particularly when combined with its physiological calming effects, such as cortisol reduction (D. Church et al., 2012). This may be easier to achieve through cultivating positive emotions like joy, peace or energy, which directly support positive emotional states. Anxiety is a multifaceted construct

involving physical, psychological, and behavioural components, making it harder to address consistently (A. T. Beck & Clark, 1997). Any intervention aimed at reducing anxiety requires patients to focus on and make efforts to dispel negative feelings. In short, EFT may be better suited to building up positive emotions than in dispelling negative ones, and these results provide tentative evidence of that distinction.

Additionally, residents may experience social desirability bias, making them more reluctant to report negative emotions, or may find it easier to engage with positive outcomes due to cognitive limitations. It is also worth considering whether the methodological tools used for the study may invoke different cognitive framings and subjective assessments. For example, the well-being Smiley face scale tends to be simpler and more user-friendly compared to the thermometer anxiety assessments tool. Together, these factors suggest that while EFT effectively enhances positive emotional states, its impact on anxiety may be less consistent due to both the complexity of anxiety and the challenges measuring it. Additionally, assessing anxiety in the elderly, especially those with dementia, is particularly difficult due to several age-related factors: older adults often report fewer negative emotions and are hesitant to discuss such feelings, which may lead to underreporting symptoms (Lawton et al., 1993; Pachana et al., 2007). Cognitive impairments in dementia, such as memory and language issues, further complicate the accurate expression of emotions, challenging the assessment process (Kwak et al., 2017). While the intervention enhanced positive emotional states, its less consistent impact on anxiety highlights individual differences in emotional responses, the complexity of measuring anxiety, or the need for additional strategies to complement the effects of EFT for anxiety management.

Overall, the findings suggest that, when delivered in this manner, EFT is more effective in enhancing positive emotional states than in consistently reducing anxiety, possibly due to the

complexity of anxiety as an emotional construct and variations in how improvements are experienced versus observed. The alignment between residents' and carers' observations in certain sessions underscores the intervention's effectiveness, though discrepancies highlight the subjective nature of emotional assessments.

Follow-up Measure

The persistence of the intervention's effects was assessed through follow-up measures at both 6- and 7-weeks post-intervention (Table 9), designed to confirm the results and mitigate the risk of potential data loss. As complete data were available for all residents at both time points, and results showed consistent patterns between weeks 6 and 7 with no significant differences, the 7-week measure will serve as the primary follow-up for the remainder of this study.

Table 9. T-Test: 6-Week vs 7-Week Follow-Up

Wellness			
6-Week	7-week	t	p
3.64	3.93	0.67	0.26
6-Week	Session 5 After	t	p
3.64	3.71	0.15	0.44
7-week	Session 5 After	t	p
3.93	3.71	0.58	0.28

Anxiety			
6-Week	7-week	t	p
3.93	3.64	-0.43	0.33
6-Week	Session 5 After	t	p

3.93	3.71	-0.36	0.36
7-week	Session 5 After	t	p
3.64	3.71	0.20	0.42

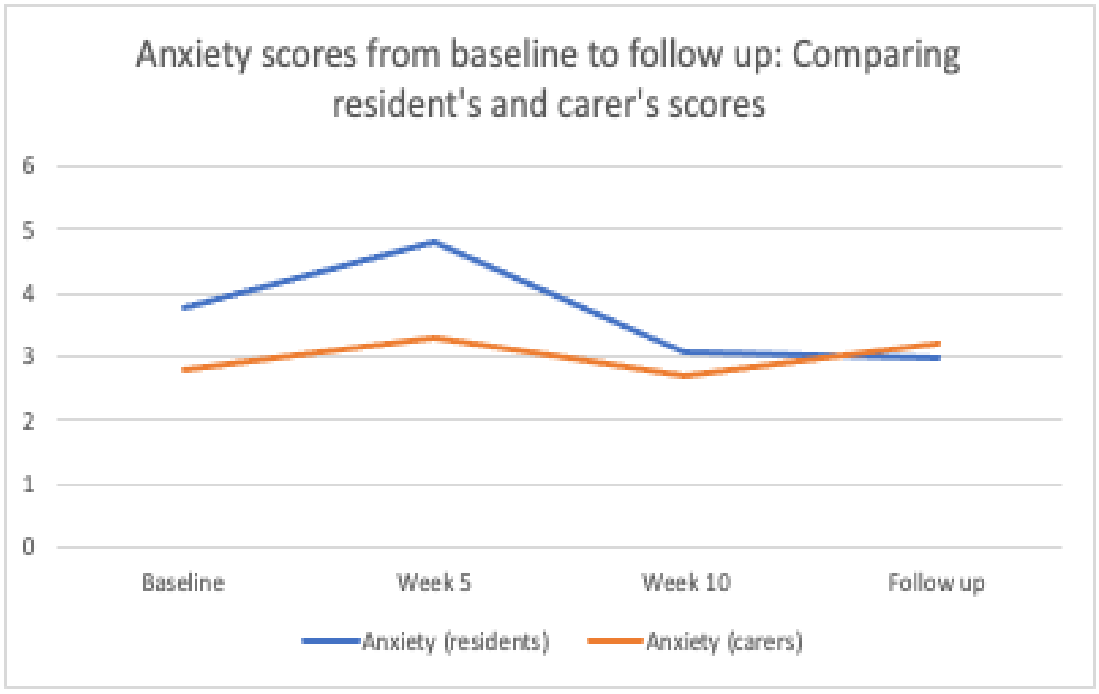
Changes in Residents' and Carers' Ratings over Time - Repeated ANOVA

This analysis allows for a direct comparison of residents' and carers' scores across the entire intervention period, enabling an evaluation of changes over time and a comparative assessment of the intervention's effectiveness. By examining how scores vary between groups and across different time points, the repeated ANOVA identifies patterns or trends that may indicate whether the intervention had a significant impact on participants. The differences in mean scores reported in this table are derived from the use of ANOVA, which calculates "marginal means" rather than simple descriptive means. Marginal means are adjusted to account for missing data, ensuring that the analysis provides a more reliable model by minimizing the impact of data gaps, reflecting its capacity to offer a more refined and statistically robust representation of the data.

Table 10. Anxiety Scores from Baseline to Follow up: Residents vs. Carers' scores

	Anxiety (residents)	Anxiety (carers)
Baseline	3.8	2.8
Week 5	4.8	3.3
Week 10	3.1	2.7
Follow up	3.0	3.2

Figure 2. *Anxiety Scores from Baseline to Follow up: Comparing Resident's and Carer's Scores*



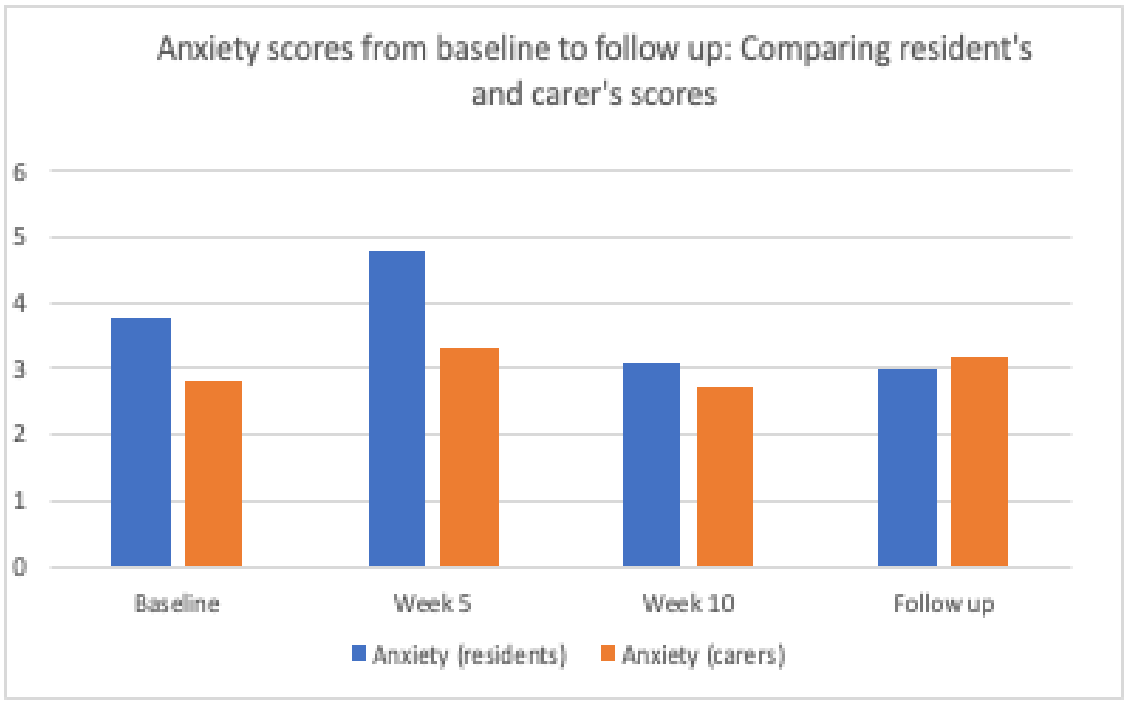
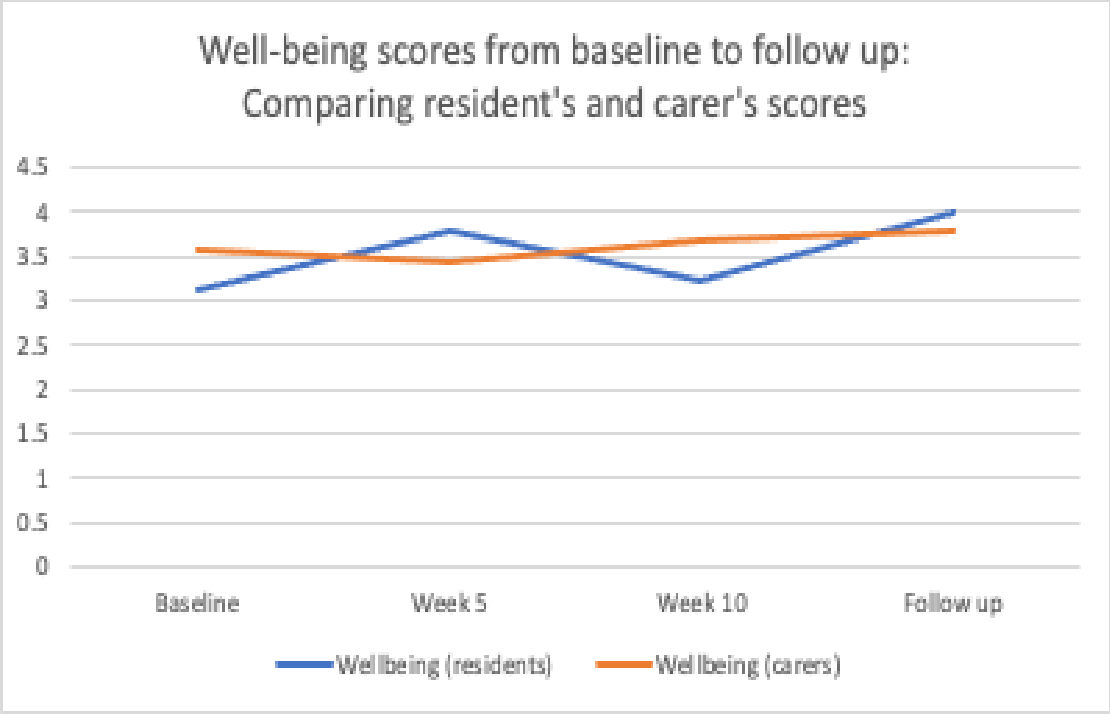


Table 11 . Well-Being Scores from Baseline to Follow up: Residents vs. Carers' Scores

	Wellbeing (residents)	Wellbeing (carers)
Baseline	3.11	3.56
Week 5	3.78	3.44
Week 10	3.22	3.67
Follow up	4.00	3.78

Figure 3. *Well-Being Scores from Baseline to Follow up: Comparing Resident's and Carer's Scores*



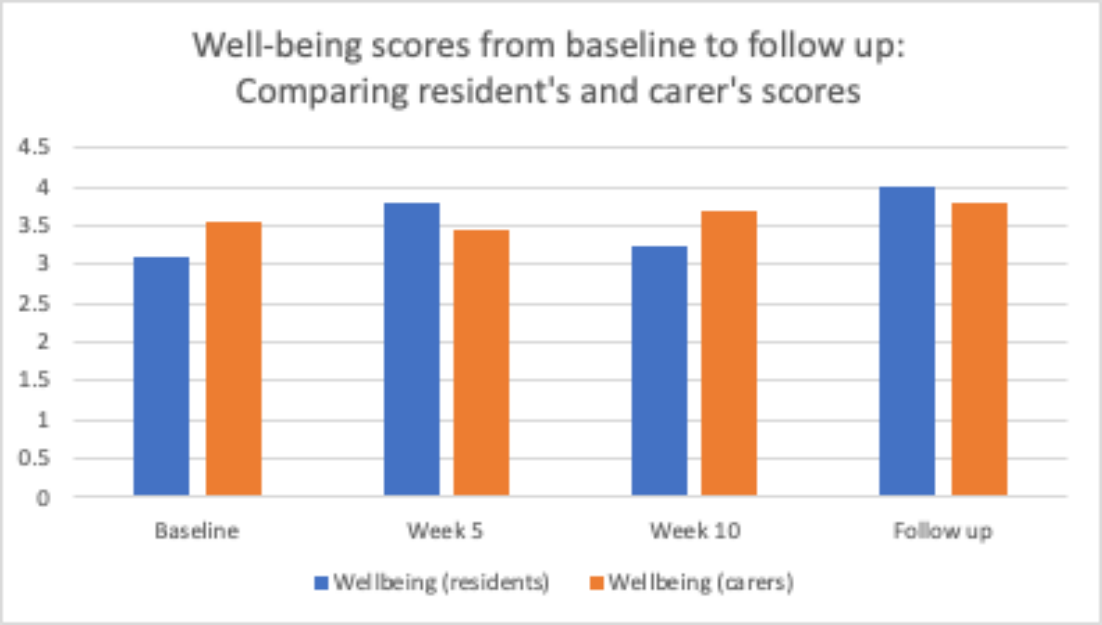


Table 10 and 11 and Figures 2 and 3 summarize residents' and carers' ratings of anxiety and well-being across four time points: baseline, before week 5, before week 10, and follow-up (seven weeks post-intervention).

Residents' self-reported anxiety scores initially peaked at week 5 (4.8) but declined progressively from baseline (3.8) to week 10 (3.1) and further at follow-up (3.0). This trend suggests a potential positive association between the intervention and reduced anxiety over time, even though the changes are small and not statistically significant. It should be noted that even statistically small changes can be clinically meaningful, particularly in studies with small sample sizes. While causation cannot be established, the observed pattern aligns with the possibility of a beneficial relationship. In contrast, carers' ratings of residents' anxiety started lower at baseline (2.8) and remained relatively flat over time with a slight increase at follow-up (3.2) ending slightly higher than at week 10 (2.7).

Residents' well-being scores demonstrated a clear upward trend, increasing from 3.11 at baseline to a peak of 3.78 at week 5, dipping slightly to 3.22 at week 10, and rebounding to 4.0 at

follow-up. While these improvements suggest a positive trajectory for residents' well-being, the lack of statistical significance emphasises the need for cautious interpretation of the findings. Carers rated residents' well-being higher than residents themselves at baseline but lower during the mid-intervention period, aligning closely at follow-up. Well-being scores exhibited a clearer, more consistent upward trajectory compared to anxiety, which showed greater variability, particularly in residents' mid-intervention ratings.

Overall, the data indicate that the intervention had a mixed impact on anxiety and well-being. Residents' self-reports show a general decline in anxiety and a trend toward improved well-being, particularly at the follow-up phase, though these changes were not always statistically significant. Carers' assessments generally aligned with these trends but showed smaller magnitudes of change, particularly in anxiety, where carers consistently rated residents as less anxious than the residents rated themselves. Overall, while the findings suggest that the intervention may have contributed to reductions in anxiety and improvements in well-being, the variability in results and lack of consistent statistical significance highlight the need for cautious interpretation.

Correlation of Residents and Carers Results

Table 12. Correlations Between Carer and Resident Ratings of Anxiety and Well-Being

Scale	Session	Before	C to R Corr	p
Anxiety	1	Before	.713	.001
Anxiety	1	After	.813	.001
Wellness	1	Before	.534	.02
Wellness	1	After	.414	.06
Anxiety	2	Before	.571	.02

Anxiety	2	After	.509	.04
Wellness	2	Before	.676	.004
Wellness	2	After	.634	.008
Anxiety	3	Before	.583	.01
Anxiety	3	After	.258	.17
Wellness	3	Before	.493	.03
Wellness	3	After	.454	.04
Anxiety	4	Before	.607	.01
Anxiety	4	After	.627	.01
Wellness	4	Before	.58	.01
Wellness	4	After	.454	.04
Anxiety	5	Before	.456	.04
Anxiety	5	After	.734	.001
Wellness	5	Before	.778	.001
Wellness	5	After	.331	.1

Table 12 presents the correlation coefficients (C to R Corr) and p-values, examining the agreement between carers and residents' assessments of anxiety and well-being across the first five EFT sessions, pre- and post-intervention. This analysis evaluates the extent to which residents' self-reported anxiety and well-being align with carers' observations. The rationale for comparing carers and residents' scores was to understand the alignment or discrepancies between internal self-reports (residents' experiences) and external observations (carers' perspectives). Residents' self-reported measures may have been influenced by variations in their energy or

mood, potentially affecting the reliability of their responses. Notable changes observed in some residents raised questions about the consistency of these self-reports.

By including carers' assessments, grounded in their familiarity with the residents, their perspective offered an additional layer of verification for the intervention's understanding and outcomes. A more detailed discussion will be explored in Chapter 5.

The results indicate a generally moderate level of agreement between carers and residents' ratings, with a mean correlation of 0.561 across the sessions. While there is variability in the strength of correlations, most (17 out of 20) are statistically significant ($p < .05$), demonstrating alignment between carers' observations and residents' self-reports in most instances. Pre-intervention correlations are consistently stronger, particularly in anxiety ratings, while post-intervention correlations, especially in well-being, show greater variability. The intervention appears to have influenced how emotional states were perceived, with residents internalizing their emotional changes as direct recipients of EFT. This internalization may explain the stronger pre-intervention correlations and greater post-intervention variability, particularly in well-being scores, as these effects were less evident to external observers such as carers. While most correlations were moderate to strong and statistically significant ($r \approx .45–.81$, $p < .05$), a small number of weaker results deviated from this pattern: for example, anxiety ratings in Session 3 After ($r = .258$, $p = .17$), well-being ratings in Session 1 After ($r = .414$, $p = .06$), and well-being ratings in Session 5 After ($r = .331$, $p = .10$) deviated from the overall pattern. These occurrences likely reflect mild outliers in the data points that diverge from expected trends but do not appear severe enough to breach the assumptions of the statistical tests or compromise the validity of the analysis. Their presence may have slightly reduced the strength of some correlations but is unlikely to have altered the overall interpretation of the results.

The lower correlations may indicate differences in how carers and residents assess emotional states, potentially influenced by factors such as residents' fluctuating energy, mood, or cognitive ability, as well as carers' own state of mind or time constraints due to work pressures. Despite these occasional discrepancies, the overall pattern suggests alignment between the two perspectives, especially in pre-intervention anxiety ratings (e.g., Session 1 Before: $r = .713$, $p = .001$) and well-being ratings early in the intervention (e.g., Session 2 Before: $r = .676$, $p = .004$). While the p-values confirm the statistical significance of most correlations, the variability in R values suggests that the strength of agreement is not uniform across sessions or scales. Nevertheless, the consistency of significant correlations across multiple sessions provides confidence in the overall alignment between carers and residents' ratings and supports the value of including both perspectives in assessing the intervention's outcomes.

Qualitative Results

This qualitative analysis explores carers' experiences of delivering EFT through the Train-the-Trainer (TTT) model, with a focus on its feasibility and acceptability within the care home context. The aim is not to establish the clinical effectiveness of EFT, but to highlight practical enablers and barriers that shaped its implementation, including staff training, resident engagement, and integration into daily routines. By examining carers' feedback and observations, this section considers how EFT might be adapted for real-world care home environments and what these insights suggest about the TTT model's potential to sustain non-pharmacological interventions.

Thematic Analysis of Staff Feedback

Feedback from 13 carers (10 individual interviews and one focus group) and the care home manager was analysed thematically, offering insights into the feasibility and acceptability

of EFT when delivered through the Train-the-Trainer model. Carers generally described the training as clear and accessible, though some indicated that additional opportunities to practise EFT prior to delivering it with residents would have enhanced their confidence. As one carer reflected, "*With practice, I was getting better and better, so more time and more practice can be better*."

Regarding implementation, carers reported challenges including residents' fluctuating moods, cognitive impairments, environmental distractions, and staff shortages. Several stressed the importance of timing, observing that sessions were most effective when residents were receptive. One explained, *"You need to know when the resident is ok, to find the right time."* Such factors often determined whether EFT could be carried out successfully on a given day.

Despite these barriers, the intervention was generally regarded as beneficial in supporting residents' relaxation and emotional stability. Carers frequently described residents as calmer or in improved moods following sessions, with one noting, *"It helped in calming down anxious residents."* Another highlighted the value of the interaction itself: *"It was a very nice interaction with the resident, time just to focus and be with her."* Some carers also reported informally using EFT themselves to manage stress, indicating an additional though unintended benefit for staff well-being.

Most carers considered the ten-day duration appropriate and reported minimal disruption to daily routines, though they emphasised the need for flexibility when working with residents with advanced dementia or during times of staff shortage.

Overall, carers' feedback suggests that while EFT was well received and perceived as valuable for both residents and staff, its successful delivery depended on flexibility, sensitivity to

residents' needs, and careful scheduling within the realities of care home life. These insights support the feasibility of care assistant-led EFT while also highlighting its limitations, particularly for residents with severe cognitive impairments.

Observational Results of Residents Emotional States

This section presents carers' observations of residents' emotional states before, during, and after EFT sessions. These data supplement the quantitative findings by offering descriptive insights into patterns of mood, engagement, and variability across different levels of dementia. Rather than establishing effectiveness, the analysis highlights how residents appeared to respond in practice, with particular attention to the feasibility of implementing EFT in a care home setting and the potential need for adaptation for those with more advanced dementia. The figures in Tables 13, 14 and 15 represent the proportion of sessions (ranging from 0 = never observed to 1 = always observed) in which carers recorded residents as displaying a given emotional state. These values were calculated by coding observational comments into categories ('Tired/Sleepy,' 'Happy/Smiling,' 'Anxious/Agitated') and dividing the frequency of occurrence by the total number of sessions per resident.

Table 13. Residents Tired/Sleepy State Before, During, and After the Sessions (n=14)

Residents	Dementia Level	Before Tired/Sleepy	During Tired/Sleepy	After Tired/Sleepy
Su	None	0.2	0	0.2
An	None	0.8	0	0
Ba T	None	0.2	0.2	0
Th	Mild	0.1	0	0.1

Me	Mild	0.5	0	0
Ma	Mild	1	0	0
Va	Mild	1	0	0
Ei	Mild	0.6	0	0.1
Be	Moderate	0.9	0.1	0.2
Pa	Moderate	0.6	0.2	0.5
Li	Moderate	0.11	0	0
Ba L	Moderate	0.43	0	0.1
Ca	High	0.44	0	0.08
Co	High	0.5	0	1

Table 14. Residents Happy/Smiling State Before, During, and After the Sessions

Residents	Dementia Level	Before Happy/Smiling	During Happy/Smiling	After Happy/Smiling
Su	None	0.8	0.4	0.6
An	None	0	1	1
Ba T	None	0	0.8	0
Th	Mild	0.9	0.9	1
Me	Mild	0.5	1	1
Ma	Mild	0	1	1
Va	Mild	0	0.86	1
Ei	Mild	0.4	1	0.9

Be	Moderate	0	0.8	0.8
Pa	Moderate	0	0.4	0.5
Li	Moderate	0.78	1	1
Ba L	Moderate	0.43	1	0.9
Ca	High	0.44	1	0.9
Co	High	0	1	0

Table 15. Resident Anxious/Agitated State Before, During, and After the Sessions

Resident	Dementia Level	Before Anxious/Agitated	During Anxious/Agitated	After Anxious/Agitated
Su	None	0	0.6	0.4
An	None	0.2	0	0
Ba T	None	0.8	0	0.8
Th	Mild	0	0.1	0
Me	Mild	0	0	0
Ma	Mild	0	0	0
Va	Mild	0	0.14	0
Ei	Mild	0.4	0	0
Be	Moderate	0.1	0.1	0
Pa	Moderate	0.4	0.4	0
Li	Moderate	0.11	0	0

Ba L	Moderate	0.14	0	0
Ca	High	0.56	0	0.01
Co	High	0.5	0	0

Overall, the observations suggested a shift toward more positive emotional states during and after the intervention. Several residents showed reduced tiredness and agitation alongside increases in smiling and positive engagement. For example, carers noted that residents who appeared disengaged or anxious beforehand often became calmer or more responsive during sessions. In some cases, carers observed sustained improvements, while in others the effects were short-lived or inconsistent. Patterns also appeared to vary according to dementia severity: residents with mild or no dementia tended to display more consistent increases in positive changes, whereas those with more advanced dementia showed improvements with less stability. This echoes carers' feedback that engagement depended heavily on cognitive ability and residents' readiness to participate. Importantly, while some residents benefited noticeably, others were less responsive, underscoring the need for flexibility in applying the intervention.

These findings suggest that, from carers' perspectives, EFT was associated with moments of increased relaxation, reduced agitation, and enhanced interaction. However, the variability in outcomes highlights both the opportunities and the limitations of implementing EFT in this context. These observational data are best understood as offering practical insights into how residents engaged with the intervention, supporting the broader conclusion that EFT can be feasible in care homes but requires adaptation to individual needs and circumstances.

Significance and Conclusion

This chapter has provided an analysis of the Emotional Freedom Technique (EFT) intervention, integrating quantitative and qualitative data to assess its impact on residents' well-being and anxiety. The study aimed to evaluate the feasibility and effectiveness of EFT as a well-being intervention in care homes, focusing on its potential to address emotional needs and promote relaxation among residents with varying levels of dementia. Quantitative results revealed improvements in well-being across sessions, while reductions in anxiety showed more variability. Qualitative findings complemented these results, highlighting carers' observations of increased engagement and relaxation, alongside challenges such as resident's mood fluctuation, logistical constraints, and staffing limitations.

The significance of this study lies in its unique contribution to the growing field of non-pharmacological interventions for emotional well-being in care settings. By examining EFT, this research addresses a gap in the literature regarding scalable, easy-to-implement techniques that can be integrated into daily care routines. It also bridges the gap between theoretical research on emotional interventions and practical applications within resource-constrained environments, such as care homes. The findings emphasize the importance of tailored approaches, thorough training for carers, and adaptability to residents' individual needs.

Together, these insights underscore EFT's potential as a practical tool for enhancing well-being in care homes, while also identifying areas for refinement to optimize its implementation. These conclusions set the stage for the next chapter, which will discuss the broader implications of the results, explore study limitations, and offer recommendations for future research and practice in improving emotional care for older adults.

Chapter 5

CONCLUSIONS AND RECOMMENTATIONS

This chapter discusses and summarises the findings regarding the effectiveness of Emotional Freedom Techniques (EFT) in reducing anxiety and improving the well-being of care home residents. It summarises the main theoretical and empirical features of the study, highlights implications for practice, and provides recommendations for future research.

My research explored, for the first time, the effectiveness of EFT delivered by carers trained through the Train-the-Trainer (TTT) model to an elderly population living in a residential care home. While EFT has shown significant efficacy in reducing anxiety across various healthcare settings (Boath et al., 2012; D. Church & Brooks, 2010; Pandey, 2020), its application in care homes, particularly through the TTT model, remains underexplored. To date, only one study has combined both approaches, focusing on primary school students (Lambert, 2020). As noted in the introductory sections of this dissertation, care home residents suffer from considerable anxiety and stress (Corder R, 2016), which represent significant unmet psychological needs. This research therefore offers preliminary evidence of a straightforward, low-burden, and cost-effective approach that could be integrated into care routines in such environments. The results also suggest that a TTT model is a broadly acceptable and potentially efficient way of scaling the delivery of such interventions, provided practical barriers are addressed.

Though the study lacked the experimental design and sample size to draw firm statistical inferences, both the quantitative and qualitative findings suggest that Emotional Freedom Technique provided psychological benefits to this population. These benefits, however, were not uniform, with improvement in well-being appearing more consistent than reduction in anxiety.

The study also raises an important methodological issue as carers' and residents' assessments of the intervention's impact were not always aligned. While these scores followed broadly the same trajectory, carers were often more conservative in their assessment than residents, particularly regarding anxiety.

The more consistent improvements in well-being stand in contrast to the greater variability seen in anxiety outcomes. For example, while pre and post-test scores for each session showed a reduction on the anxiety scale, these improvements only met the $p = 0.05$ threshold in five of the ten sessions. This is true in relation to both carers and residents' assessments. In comparison, well-being scores reached the significance threshold on 8 out of 10 sessions, though effect sizes tended to be smaller in later stages of the study period. This pattern suggests that while EFT can initially improve well-being, its long-term effects may require additional sessions to maintain their strength. In terms of anxiety, reductions were observed after each EFT session, but the compound effects appeared modest and variability across sessions indicates that the impact on anxiety was not consistently robust. This finding suggests that while EFT holds potential as an anxiety-reduction tool, the improvements may not be sufficient to ensure long-term benefits without supplementary interventions.

In terms of follow up, from baseline through Session 5, Session 10-, and 7-weeks post-intervention, the study showed a gradual improvement in residents' well-being, with both residents' and carers' ratings reflecting positive changes. Notably, these improvements were sustained at the 7-week follow-up, indicating that the benefits of EFT, though modest, may persist beyond the immediate intervention period. However, the lack of compounded improvements across sessions reinforces earlier indications that while EFT produces initial

positive effects, it may also require additional or continued sessions to sustain and strengthen long-term gains.

Overall, these results convey a promising yet tempered assessment of EFT in this setting, with moderate effects, though some indication that benefits may continue beyond the intervention period. However, the variability in the results between well-being and anxiety indicate other conceptual and methodological factors that warrant further consideration. For example, the variability in anxiety reductions, along with differing perspectives between residents and carers, underscores the mixed effectiveness of the intervention and highlights the challenges of measuring emotional states, particularly anxiety, through both self-reports and external evaluations. Further, disparity in outcomes between well-being and anxiety likely reflect the very different psycho-social dimensions of these emotional states. As indicated in previous chapters, well-being may be easier to enhance through positive affirmations and cognitive reframing as well-being is an emotional state that can be induced or "built up" through the EFT intervention. In contrast, anxiety is a potentially more complex construct and treatment requires dispelling a negative state, rather than building a positive one. As such, it is harder to address uniformly, especially in elderly residents with the added cognitive barriers associated with dementia. In turn, EFT scripts, which focus on fostering positive emotional states such as joy and peace, may be more effective in enhancing well-being than in alleviating anxiety.

For similar reasons, challenges in accurately measuring negative emotions may have impacted the results. A key concern is that the anxiety thermometer used in this study, while practical, is a simplistic tool that reduces precision and depth of anxiety evaluations. Without a more objective measure, residents and carers almost certainly made their assessments based on different, though overlapping criteria. For example, residents likely base their assessments on

internal experiences of anxiety that are not outwardly expressed, whereas carers relied on observable behaviors that may not have reflected residents' internal states.

The above observations may account for some of the variability between the carers's and resident's scores. A particularly interesting feature of the assessments was that concordance tended to be higher at pretest. Stronger pre-intervention correlations highlight consistency in identifying baseline emotional states, while post-intervention variability underscores the personal nature of emotional changes. Nevertheless, both perspectives provide valuable insights with their respective strengths and limitations. Residents' ratings offer a direct account of their subjective experiences, which is crucial for evaluating personal impact but may be influenced by biases such as social desirability or cognitive impairments. Carers' ratings, by contrast, provide more objective assessments based on observable behaviours but risk overlooking subtle internal changes. Taken together, these perspectives provide a more comprehensive understanding of the intervention's effects. These findings align with research by Schat (2017) et al. and Möller (2000), which emphasise the need for nuanced emotional assessments given discrepancies between self-reported and observer-rated measures. While more detailed instruments, such as the Hamilton Rating Scale for Anxiety or the Geriatric Anxiety Inventory (Souilm et al., 2022) could have mitigated some of these challenges, they are not adequately adapted for residents with varying levels of dementia.

In addition to evaluating the EFT intervention, this dissertation has included an exploratory analysis of carers' perceptions of the EFT training and intervention, drawing on qualitative data initially planned to be collected through focus groups. The aim of this exercise was to arrive at a broader assessment of whether the intervention was manageable within the acre home environment, identify challenges encountered, and evaluate the effectiveness of the TTT

model in practice. Due to scheduling difficulties and staffing constraints, data were collected though one focus group and 11 individual semi-structured interviews. The thematic analysis of carers feedback revealed both positive and negative outcomes, practical challenges during implementation, and suggestions for improvement.

Carers found the training clear, straightforward, and effective but suggested incorporating more hands-on practice and additional time to build confidence in delivering EFT. They also noted challenges related to residents' mood variability and reluctance to participate, particularly among those with advanced dementia, suggesting that shorter, simpler interventions might have been more effective. Despite these barriers, carers observed positive emotional changes in certain residents; however, some of these benefits may have been influenced by the undivided attention residents received and the calming effect of the deep-breathing exercises included in the session scripts.

Carers further highlighted EFT's adaptability, stress-reducing potential, and minimal disruption to routines as key advantages, confirming that the intervention was both acceptable and feasible in practice. These findings support the potential value of delivering EFT through the TTT model, while also suggesting that tailoring interventions to residents' cognitive levels may enhance effectiveness warranting further research. Carers additionally recommended extending the training to include emotional self-care and ongoing support throughout the intervention period, which could improve both implementation and staff well-being. The inclusion of emotional self-care support for care assistants was reinforced by the manager's observation of staff informally using EFT on themselves during stressful situations, echoing existing research showing EFT's benefits for healthcare professionals managing stress and burnout (Blacher, 2023; Dincer & Inangil, 2021; Wati et al., 2019). Finally, some carers suggested testing EFT as a group

activity, reflecting its successful use in care settings elsewhere, such as Bertoux's implementation in France (Harbottle, 2019).

An additional set of qualitative data was collected from carers' observational comments on residents' emotional states before, during, and after the intervention. These data were gathered following preliminary testing of the instruments, which revealed significant variability in residents' moods and energy levels. These observations offered insights into residents' emotional experience throughout the intervention, with 11 out of 14 residents showing some degree of mood improvement, particularly after sessions. However, outcomes remained variable, particularly among residents with more advanced dementia who often continued to display anxiety and agitation. This suggests that the intervention may be more effective if adapted to residents' cognitive levels, as proposed by the Allen Cognitive Disabilities Model (Allen, 1992). These observational findings complement the quantitative and qualitative results, underscoring the importance of integrating both subjective experiences and external observations to capture the nuanced impact of EFT in care home settings.

Overall, the findings suggest that EFT, when delivered by carers through the TTT model and with the methodology applied in this study, led to measurable improvements in residents' emotional well-being and some reductions in anxiety. The intervention was generally well received and minimally disruptive to care routines, offering a promising yet cautious demonstration of EFT's potential in this context. However, the effects were uneven and not consistently statistically significant, indicating that while the approach shows potential for enhancing positive emotional states, its impact on anxiety reduction remains less robust. Future programmes could strengthen outcomes by refining the intervention protocol, increasing session frequency, and providing more structured supervision to improve consistency and depth of

delivery. The evidence indicates that the intervention was both acceptable and minimally disruptive to care home routines, offering a promising yet cautious assessment of EFT in this setting. The results indicate moderate effects, with some evidence that benefits may extend beyond the intervention period. However, the variability between well-being and anxiety outcomes point to conceptual and methodological factors that warrant further consideration. For example, the variability in anxiety reductions, coupled with differing perspectives between residents and carers, highlight the mixed effectiveness of the intervention and the inherent challenges of measuring emotional states, particularly anxiety. By contrast, previous studies reporting stronger outcomes in reducing anxiety and depression were typically conducted with younger, cognitively intact populations and delivered by experienced EFT practitioners using the classical protocol. The more robust effects observed in those contexts may therefore reflect both population characteristics and practitioner expertise (Andrade & Feinstein, 2004; D. Church & Feinstein, 2017; Nelms & Castel, 2016b).

Given the limited availability of non-pharmacological interventions for emotional distress in care homes, this dissertation presents a promising contribution as the first study to combine the limited but successful applications of EFT and the Train-the-Trainer (TTT) model within care settings. Beyond its contribution to the EFT and well-being literature, this study offers broader insights into the delivery of psychosocial interventions within residential care environments. Taken together, the findings of this study resonate with and extend existing research on anxiety-related challenges in later life. As highlighted in the literature review, anxiety in older adults often manifests in complex and overlapping ways, not only as persistent worry or agitation but also as sleep disturbances, behavioural withdrawal, and somatic symptoms (Gulpers et al., 2016; Lenze & Wetherell, 2011). The modest but consistent improvements in well-being

observed here, and the qualitative reports of residents appearing calmer and more relaxed following EFT, suggest that similar approaches could possibly benefit related conditions such as insomnia, which is both a symptom and amplifier of late-life anxiety (Brenes et al., 2009). Moreover, the Train-the-Trainer model demonstrated that carers can practically deliver such interventions as part of everyday care routines, indicating that this approach might translate effectively to other emotional or behavioural challenges frequently seen in residential care, such as chronic worry, agitation, or adjustment-related stress. However, the variability and limited statistical robustness of the anxiety outcomes in this study underline key limitations. Transferring this approach to different symptom domains would likely require condition-specific adaptation, highlighting both its potential and its boundaries: while it shows promise as a flexible, scalable model for managing a broader spectrum of emotional challenges in care home settings, its effectiveness will depend on thoughtful modification and further empirical validation.

Limitations

The primary limitations associated with this study revolve around a number of methodological issues related to sampling, missing data, the nature of the population, and features of the care environment. In larger future studies, the small sample issue could be addressed by conducting research in a bigger care home or across multiple sites, which would provide a larger participant pool and a more robust data set. This limitation was compounded by missing data in the later weeks of the study, with 15 sessions unrecorded: two carers missed Session 9, two carers missed all data from Sessions 5 to 10, and one carer missed Sessions 8 to 10. As such, a complete data set could not be obtained. While it is difficult to specify the precise reasons for this, it was likely due to intervention or research fatigue (Ashley, 2021) among both carers and residents. For example, during the qualitative follow up, one care assistant explained

that after missing a week, her resident lost interest when sessions resumed. It is also possible that the infrequent presence of the researcher after the training contributed to a decline in motivation, with the intervention's continuity relying on the manager's occasional oversight. As such, this might be considered a limitation of the TTT model, where closer supervision could have alleviated the issue. Regular check-ins or brief motivational sessions could help sustain participants' motivation and engagement throughout the study, mitigating fatigue over time (Bos et al., 2015).

Another limitation relates to the statistical analysis of a small sample size. Traditional parametric tests, such as t-tests, assume that the underlying data follow a normal (bell-shaped) distribution, and that variance is evenly distributed across groups. In small-sample contexts, these assumptions are difficult to verify and are often violated, which can compromise the reliability of the results presented here. This means that some statistically significant findings may have been missed, while others could be overstated, making it difficult to draw firm conclusions from the data. Future studies should therefore be mindful of these constraints when interpreting findings derived from small samples.

In addition, the treatment of potential outliers in the correlation analysis between carers' and residents' ratings represents another limitation. Although a visual inspection was used to identify unusually high or low values, a reasonable approach given the exploratory nature and small sample size of this study, it does not provide a precise statistical assessment. Mild outliers may therefore have remained in the dataset and could have slightly attenuated or inflated some correlations. Future research could build on this by applying standardised methods, such as *z*-score analysis, to more accurately assess their presence and potential impact.

Another notable limitation was the absence of a comparison group, making it difficult to attribute the observed improvements exclusively to the EFT intervention. It remains unclear whether the observed benefits stemmed from the carer's undivided attention or if EFT was the primary factor. This uncertainty could be considered a form of observation bias, also known as the Hawthorne effect, which refers to inconsistencies in study outcomes due to participants improving simply because they are aware they are being observed. A similar phenomenon was noted in Opie et al. (2002) study on challenging behaviour in nursing homes, where residents showed improvements regardless of the actual intervention being tested, potentially leading to seemingly positive results. Oswald et al. (2014) further suggested that trust in the researcher conducting the intervention is a key factor in limiting this kind of bias. In the context of this study, the use of the TTT model may have helped mitigate its impact, as carers, familiar to residents, already have an established foundation of trust.

Variability in carers' schedules and the fluctuating needs of residents presented additional challenges. The unpredictable nature of both factors required flexibility and active involvement from management. By their nature, care homes are busy and sometimes high stress environments that are subject to unplanned disruption, such as resident illness, staff sickness and absence, or equipment failure. On reflection, greater awareness of these situational constraints might have warranted more proactive planning, such as adjusting rosters to better accommodate the intervention. In addition, smaller and more frequent training sessions, scheduled during available time slots rather than attempting to coordinate larger group sessions, may have been a more appropriate choice, fitting more easily around existing schedules. As such, these considerations indicate a range of planning and logistical issues that could be better managed when considering further research.

Lastly, a notable limitation of this study was the lack of cultural and gender diversity, as all participants were female and predominantly White British. While this reflects the demographic composition of the care home involved, it may limit the extent to which findings can be generalised to more diverse populations. Future research could benefit from including a broader range of participants in terms of gender and ethnicity, when possible, to provide a more nuanced understanding of how EFT may impact individuals from different cultural backgrounds and experiences.

In sum, the limitations present in this study reflect the situational constraints inherent to this kind of environment. Issues such as small sample size, cultural homogeneity, and the lack of comparison group are, in many ways, a set of trade-offs given the single care home context and the small participant pool available. Inevitably, a larger care home or multiple sites study would allow for a broader participant base and more robust data. Variability in carers' schedules and residents' needs also posed challenges, reinforcing the need for greater flexibility in intervention design. Additionally, a more personalized approach to training, with a longer introduction to EFT and shorter, flexible tapping sessions, could improve staff motivation and resident engagement, thereby enhancing the overall effectiveness of the intervention.

Future Research and Recommendation

Future research in the application of Emotional Freedom Technique (EFT) for elderly populations, particularly in care home environments, is crucial to addressing the gaps identified in existing literature. As highlighted in the review, there is a significant lack of research focusing on elderly individuals, especially those residing in care homes or living with dementia (Martyr et al., 2018). Indeed, it is common to see dementia and cognitive decline listed as exclusion criteria in EFT studies, as researchers seek to protect internal validity and limit confounding factors.

Despite a small number of studies examining EFT in elderly populations (Cholifah et al., 2020; Hwan, 2015; Wahyuningsih, 2021; Zhang et al., 2017), its application in care home settings remains scarce, with only one study identified by Harbottle (2019). Additionally, research on well-being within these populations is limited (Bar-Tur, 2021). This study sets a valuable precedent for future investigation into the use of EFT administered by carers to address the high rates of anxiety and depression among care home residents. Although the results were not always statistically significant, they nonetheless indicate a promising trend in reducing anxiety and improving well-being. EFT has shown effectiveness in alleviating emotional distress across a range of healthcare contexts, including dental and hospital environments (Saleh et al., 2017; Temple & Mollon, 2011; Thomas et al., 2017), and has been effective in reducing stress and burnout among healthcare professionals (Dincer & Inangil, 2021; Patterson, 2016; Rostami et al., 2020; Sansuwito et al., 2022; Suzanna et al., 2023; Wati et al., 2019). Given the clear need for non-pharmacological interventions to support the emotional needs of care home residents, EFT's brief and fast-acting nature makes it an ideal candidate for integration into care home practice.

This study highlights the importance of further research into the adaptation and implementation of EFT for elderly residents, particularly those with cognitive impairments. The classical EFT protocol commonly used in research, along with standard anxiety assessment tools, underscores the need for significant adjustments when applied to elderly populations, especially those with dementia. The traditional EFT protocol is often too complex for carers to implement and may even risk triggering emotional distress for residents. For care environment, where time constraints and limited attention spans are common, simplified approaches are essential. Accordingly, a key consideration for future research is how best to streamline EFT protocols so

that carers can easily learn and administer them safely, while ensuring that these adaptations remain effective in addressing residents' emotional needs.

Additionally, EFT simplicity, combined with its demonstrated effectiveness in enhancing emotional well-being (Banerjee, 2015; Jasubhai S, 2020; Kim, 2017; Okyay & Uçar, 2023; P. Stapleton et al., 2017), positions it well for delivery through the Train-the-Trainer (TTT) model. The TTT approach, already shown to be effective in other care home interventions, provides a promising framework for enabling carers to deliver EFT in short, flexible sessions across a variety of contexts (Fossey et al., 2020; Gozalo et al., 2014; Krug et al., 2020; Mayrhofer et al., 2016). However, further research is needed to examine the integration of EFT with the TTT model, as only one study to date has investigated this combined approach (Lambert, 2020). Future studies might explore how EFT can be effectively adapted for care home settings within the TTT framework, taking into account the accessibility, practicality, and sustainability of training for carers, while also accommodating the diverse cognitive levels and emotional needs of residents.

The practical implications of this study suggest that EFT hold potential as a supplementary intervention for enhancing the mental well-being of care home residents. Harbottle's (2019) account of Bertoux's use of EFT in care homes supports its effectiveness in calming anxious, confused, or aggressive residents, thereby assisting carers in managing emotional distress. Even brief five-minute EFT sessions can provide relief, offering a simple, non-invasive tool that can be easily incorporated into daily care routines to improve residents' emotional states. Given the positive evidence, care homes may find value in exploring EFT as a complementary approach to traditional therapies, particularly for managing anxiety and promoting overall emotional well-being. This could involve integrating EFT into routines

practice, providing structured staff training, potentially through the Train-the-Trainer (TTT) model, and offering ongoing support to ensure consistency and fidelity in delivery. Additionally, tailoring EFT sessions to residents' individual needs and cognitive levels, while incorporating regular feedback from both staff and residents, could help optimize outcomes and ensure the approach is embedded effectively within the care environment. Looking ahead, the development of clear, evidence-based guidelines for EFT use in care homes could standardize its implementation, supporting more consistent results and better outcomes. Such work could also encourage EFT's wider acceptance within mainstream psychotherapy and promote its adoption as a recognised mental health intervention in residential care.

Despite the promising findings, challenges remain, including limitations in the available literature and the insufficient sample sizes of existing studies. As noted in chapter two, more systematic research, particularly large-scale groups, is necessary, alongside the integration of biomarkers to better capture EFT's physiological effects. Moreover, the study underscores the lack of recognition of anxiety in older adults, especially those with dementia. Although the relationship between EFT and anxiety was found to be complex and less conclusive in this research, it may still be worthwhile to explore EFT as an accessible, low-cost intervention, particularly since anxiety in this population often goes untreated due to clinicians' difficulties in identifying it.

In addition to increasing sample size, future research could strengthen the analytical robustness of small-sample studies by exploring statistical methods that do not rely on strict distributional assumptions. Permutation-based approaches, for example, calculate significance by repeatedly resampling the existing data rather than assuming a normal distribution, which makes them particularly well suited to small and heterogeneous datasets. Adopting such methods would

help researchers obtain more precise estimates of intervention effects, improve sensitivity to subtle changes, and enhance the reliability and interpretability of findings in future EFT studies conducted in care home settings. Future studies could also benefit from incorporating standardised outlier detection methods, such as *z*-score analysis, to further improve the accuracy and interpretability of correlation findings.

This research, the first to explore the use of Emotional Freedom Technique (EFT) through the Train-the-Trainer (TTT) model in care homes, lays important groundwork for future studies. It demonstrates the feasibility of empowering carers to deliver EFT, offering a potential strategy to alleviate anxiety and depression among care home residents. Given its low cost, ease of implementation, and capacity to improve mental health, EFT could represent a valuable tool within mainstream psychotherapy, particularly for populations with limited access to traditional therapeutic options. The significance of this study lies in addressing the under-researched emotional needs of elderly residents in care homes, a group frequently overlooked in research. Furthermore, it presents EFT as a cost-effective intervention that can be easily integrated into care home daily routines, benefiting both residents by enhancing their emotional well-being, and staff by equipping them with practical strategies to manage stress. Nevertheless, further research is essential to validate EFT's efficacy, establish clear implementation guidelines, and ensure sustainable integration into routine care, ultimately providing a scalable solution for meeting the mental health needs of elderly residents in care homes. Building on the findings of this study, the next phase of my work will involve piloting the integration of Emotional Freedom Techniques into everyday care practices within a residential care home setting. This applied project aims to explore EFT's potential to support residents through common challenges such as grief, adjustment to institutional life, social engagement, and resistance to care. The practical insights

generated from this pilot could also provide the foundation for future empirical research, offering valuable evidence on how EFT may be adapted to address a broader spectrum of emotional and behavioural needs in residential care environments.

* * * * * * *

Appendices

Appendix A. Resident Participant Information Sheet (PIS)

PARTICIPANT INFORMATION SHEET: RESIDENTS

Dear resident,

You are invited to take part in a research study evaluating the effectiveness of a quick and simple intervention called EFT (Emotional Freedom Technique) in improving your well-being.

Study Overview

This study explores the potential benefits of EFT in improving the well-being of care home residents and your involvement is essential to the success of this initiative.

***Emotional Freedom Technique (EFT)** is a very easy-to-learn and effective stress-relief technique that involves gentle tapping on specific points of the body combined with chosen words to promote relaxation and well-being.*

Your Role as a participant resident

- **Questions:** You'll be asked to indicate your emotion level using a drawing of a feeling thermometer and a smiley face.
- **Intervention:** Once a week a care assistant you know will gently tap on your hand and use words to enhance your well-being. It will take 5 to 15 minutes depending on your needs.
- **Recording**: We might record the sessions for the support and supervision of the care assistant.

Key Information

- **Benefits:** Potentially improving your well-being, and make you feel happier.
- **Risk:** No emotional discomfort is anticipated as discussing personal issues is not part of the process.
- **Data Security**: All research data will be securely stored, following data protection regulations. All records of participants will be erased once the research has served its intended purpose.

Voluntary participation

Participation is entirely voluntary, your decision to participate or not won't affect the service you receive, and you can stop the study anytime without any consequence.

Next Steps

If you are interested in participating in this project, please tell a member of staff before the 20th of April. The EFT sessions will be scheduled by the manager, so it does not interfere with your daily routine.

Thank you for considering this exciting opportunity, your decision matters.

Milly Anne Vinogradoff: Researcher - 07855772393 – millyk@mac.con

Lifestyle Prescription University (LPU) contact: Emma Patricio- emma@lifestyleprescriptions.tv

Appendix B. Resident Consent Form & Simplified Information Sheet

RESIDENTS CONSENT FORM & INFORMATION SHEET

PROJECT OBJECTIVE:
Find out if EFT/ Tapping improves the well-being of care home residents.

Emotional Freedom Technique (EFT / Tapping):
Therapy using gentle tapping on the hand with caring words to help relax.

NAME OF RESEARCHER: Milly Anne Vinogradoff
CONTACT: millyk@mac.com / 078 55 77 2393

	If you agree tick the box ✓
A carer I know will gently tap on my hand once a day for 10 day to see if this will make me feel more relax and happy. **I understand that once a day for 10 days a carer I know will gently tap on my hands using caring words**	
I will be asked how I feel before and after each EFT session by pointing on a drawing. **I understand that I will show how I feel on a drawing**	
There should be no risk because I will not discussing personal issues, so there should be no emotional discomfort. **I understand that there should be no risk**	
My information will be kept confidential except if it's required by law or if there's a risk of harm. **I understand that my name will stay secret**	
My decision to participate or not won't affect any current or future services I receive and can stop the project at anytime without any consequences. **I understand that I can stop at any time with no consequences**	
I agree to audio/video recording of the session for supervison purposes. **I understand that the carer will record the sessions**	
I confirm that I understood the information about this study. I had the chance to think about it, ask questions, and got answers. **I understand what was explained to me about the project**	
I agree to take part in this project. **yes I'd like to participate**	

_____ _____ X_____

Name of Participant Date Signature

Lifestyle Prescription University (LPU) contact: Emma Patricio- emma@lifestyleprescriptions.tv

Appendix C. Carer Participant Information Sheet (PIS)

PARTICIPANT INFORMATION SHEET: CARE ASSISTANT TRAINEE

Dear care assistant,

You are invited to take part in a research study evaluating the efficacy of a quick and simple intervention called EFT (Emotional Freedom Technique) in improving the well-being of care home residents.

Study Overview

This research is a part of my doctorate at LPU (Lifestyle Prescription University), where I plan to investigate whether EFT can improve the well-being of care home residents. I intend to teach this simple technique to care assistants, who will play a crucial role in this study.

Emotional Freedom Technique (EFT) *is a very easy-to-learn and effective stress-relief technique that involves gentle tapping on specific points of the body combined with chosen words to promote relaxation and well-being.*

Your Role as a Care Assistant Trainee

- **Training**: As a trainee care assistant, you'll receive a 4-hour training at the care home including EFT easy-to-follow instructions and practice.
- **Intervention**: It will only take 5 to 15 min per day to perform EFT with 1 resident for 10 days.
- **Recording**: We'll record the sessions to help with the study.
  Qualification: You don't need any qualifications, just a good understanding of English

Key Information

- **Benefits:** Potentially improving the well-being of the residents, raising the standard of the care home and learning a stress-help tool for yourself.
- **Risk:** The study anticipates no emotional discomfort as discussing personal issues is not part of the process.
- **Data Security**: All research data will be securely stored, following data protection regulations. All records of participants will be erased once the research has served its intended purpose.

Voluntary participation

Participation is entirely voluntary for both care assistants and residents. Your decision will not impact in any way the service to the residents or your job as a care assistant.

Next Steps

If you are interested in participating in this project, please tell your manager before the 1st of May. The training sessions will be scheduled by the manager so it does not interfere with your daily tasks.

Thank you for considering this exciting opportunity, your decision matters.

Milly Anne Vinogradoff: Researcher - 07855772393 – millyk@mac.con

Lifestyle Prescription University (LPU) contact: Emma Patricio- emma@lifestyleprescriptions.tv

Appendix D. Carer Consent Form

CONSENT FORM FOR CARE ASSISTANTS

STUDY TITLE: Exploring the Impact of Emotional Freedom Technique (EFT) Administered by Care Assistants on the Well-being of Care Home Residents.

NAME OF RESEARCHER: Milly Anne Vinogradoff

CONTACT: millyk@mac.com / 07855772393

	If you agree, please tick the box
I understand that this project looks at how EFT, a quick and simple method using gentle touches on the resident hand, can help improve their wellbeing.	
I understand that I will complete 10 EFT sessions with one or more residents.	
I understand that the benefit of this study might be the improvement of the residents well-being.	
I understand that there is minimal risk because we will not discuss personal issues, so there should be no emotional discomfort for the resident.	
I understand that all personal information will be kept confidential. In rare cases, we might need to share if it's required by law or if there's a risk of harm.	
I understand that my decision to join or not join will have no negative consequences for me.	
I undertsand that I can leave the study anytime without any negative consequences.	
I agree to audio/video recording of the session for supervison purposes.	
I confirm that I read and understood the information sheet about this study. I had the chance to think about it, ask questions, and got satisfying answers.	
I agree to take part in this study.	

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

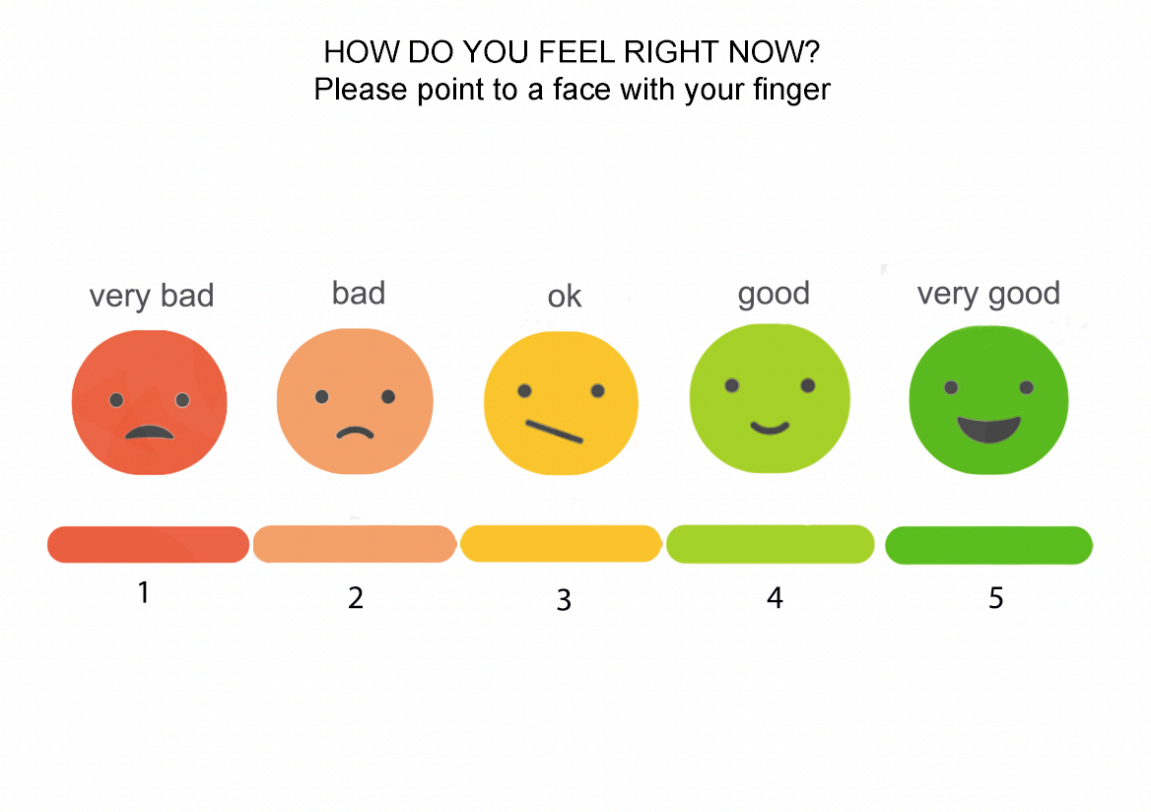
Name of Researcher Date Signature

Appendix E. Consent Phrase

CARER NAME:……..

1. **Start recording**
2. **Are you ready for your tapping session?**
   Not now: try later same day

Appendix F. Smiley Face Likert Scale



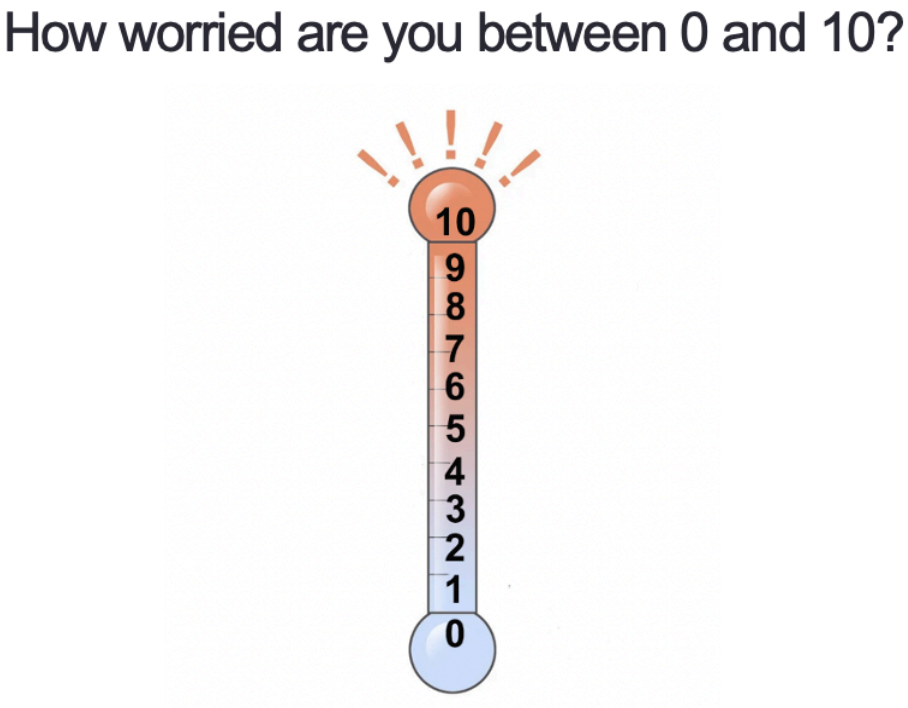
Appendix G. Data Sheet for the Smiley Face Likert scale

Data Resident and Carer



Day	Dates	When		CARER	Day	Dates	When		CARER
1			1 to 5	1 to 5	6			1 to 5	1 to 5
		BEFORE 1					BEFORE 6		
		AFTER 1					AFTER 6		
2					7				
		BEFORE 2					BEFORE 7		
		AFTER 2					AFTER 1		
3					8				
		BEFORE 3					BEFORE 8		
		AFTER 3					AFTER 8		
4					9				
		BEFORE 4					BEFORE 9		
		AFTER 4					AFTER 9		
5					10				
		BEFORE 5					BEFORE 10		
		AFTER 5					AFTER 10		

Appendix H. Anxiety/Worry Thermometer Scale



Appendix I. Data Sheet for the Anxiety/Worry Thermometer Scale

Data Resident and Carer



Day	Dates	Timing		CARER	Day	Dates	Timing		CARER
1			0 to 10	0 to 10	6			0 to 10	0 to 10
		BEFORE 1					BEFORE 6		
		AFTER 1					AFTER 6		
2					7				
		BEFORE 2					BEFORE 7		
		AFTER 2					AFTER 1		
3					8				
		BEFORE 3					BEFORE 8		
		AFTER 3					AFTER 8		
4					9				
		BEFORE 4					BEFORE 9		
		AFTER 4					AFTER 9		
5					10				
		BEFORE 5					BEFORE 10		
		AFTER 5					AFTER 10		

Appendix J. Script of the EFT Sessions

WHAT DO YOU NEED TO FEEL BETTER NOW?

- **Peace?** (calm, relaxed, serenity)
- **Joy?** (happy, fun, love)
- **Energy?** (movement, activities)

MAY I TAKE YOUR HAND?

- TAP + **WORD….** (breath)
- TAP + **MORE …..** (breath)
- TAP + **EVEN MORE …..** (breath)

DATA AGAIN 😐🌡️

Appendix K. Carer Comments

CARER COMMENTS

Example:
Active, relaxed, involved, making jokes, body posture changed, smiling, laughing
sleepy, tired, sick, not interested, agitated, sad, upset, anxious etc…

BEFORE

DURING

AFTER

Appendix L. Carer Feedback by Theme

Training & Improvement

Key Themes: Clear instructions, need for more practice

Summary: "The training was easy to understand." "More practice would help improve confidence."

Sample Carer Comments:

(Note: The numbers correspond to individual carers who provided feedback.)

1: Training is ok

2: Training was good, informative, I learned everything I needed, bit rushed for me because I am always in a hurry to leave (part time). Practice more with staff, but I still understood enough and felt comfortable to use it with the residents.

3 Training was very good, very easy, I felt comfortable.

4: Training was clear and easy

5: experience EFT it first more, not just do it for the sake of the study, more practice first, material is easy

Approach resident with a 'good vibe' is important

6: Training was good

7: Training was very clear

you train us really well, I think it's ok, to Improve: more training for the understanding of some people, yes maybe more training of EFT for the staff, so you do it very well to do it to others

8: The training was clear, training is ok, I understand everything, the material was very easy, very helpful. We discussed with the staff that sometimes we can use tapping for us to relax.

9: The training was ok, easy for the staff to have the knowledge to do EFT to the resident

10: Very good training, clear, understandable.

Nothing to improve I can think about. Maybe yes, Teach EFT to staff first, because now I can see that with the practice I was getting better and better, so more time more practice can be better.

11: Training was ok

12: Training was ok buttoo long: when get to 3rd round 'even ore' they are bored

13: At first during the training, I didn't think EFT would be effective, then practically it was ok.

Nothing to improve, the way you teach was easy.

Challenges & Difficulties

Key Themes: Residents' mood, distractions, staff workload

Summary: "Sometimes the resident is not willing." "Too many distractions in the environment."

Sample Carer Comments:

1: Just time, but no problem except she is often tired

2: not necessarily in the mood or willing

not really present sometimes

3 My resident was not hearing well, she is not repeating with me because she doesn't hear well, otherwise ok.

4: She was in a bad mood the last days; I try a few times but not possible. Her husband in hospital, she is in a bad mood. it was too long for her

5: The problem is their mood, sometimes they're good, ready to go, sometimes not.

I have to speak a bit with her first, not straight to the questions, a little chat first.

6: The resident was getting distracted with everything else around, or telling me about her past, more difficult with dementia resident. Better with people who understand more, low dementia level, what’s going on.

7: When they just not fancy to do it, but luckily my resident did respond well. it depends on their mood, really. No challenge with my resident, nothing really, she just said thank you very much, it depends on their mood, but she is always in a good mood.

8: Depend on the resident, my resident is cooperating, she is really happy with the tapping, she enjoyed the tapping. With her, the challenge is to explain, not to use it. Some residents can't remember, my resident was ok.

9: You need to know when the resident is ok, to find the right time, you need to see the way the resident feels. Sometimes the resident is not willing to do it, most of the time she was ok.

Timing, find time when resident is ok and willing.

10**:** Nothing negative. no challenge, my resident is full minded. Sometimes she is a pessimistic person so it's about her mood. She was cooperative. It's a bit different with a resident with dementia. No problem with full minded people.

11: With my first resident, she was not interested (she dropped out). with the 2nd resident, sometimes she just speaks about going home, so I need to listen and then come back again, then it's getting long. Some days I can't manage, she is crying to go home, looking for family. Sometimes we are too busy

12: I take the resident to the quiet lounge to do the tapping, but she keeps talking about other things, not concentrating on EFT, I was starting 3 times again and again, sometimes I had to stop because she was just talking about personal things, her families. session was too long for my resident, when get to 3rd round 'even more' she was bored.

13: it's a challenge when we are short staff, then we cannot do the session. Session is too long makes her bored. 1 to 3 min they listen, then they are going to something else. Can't predict their mood, we need to start the session and see their mood.

Duration

Key Themes: 10-day length mostly appropriate

Summary: "Perfect length, but a few found it too long."

Sample Carer Comments:

(Note: The numbers correspond to individual carers who provided feedback.)

1: 10 days is perfect

2: fine, good timing

3: ok

4: ok

5: The resident said, oh again! So, I try to do the next day.

6: A bit long with someone like my resident. it was hard when busy

7: I think it is good, it's not too long

8: 10 days is ok

9: ok because it was not like every day, sometimes there was a day no, then next day yes, so was alright

10: 10 days is ok. At the beginning when I was too busy and couldn't come for 1 day, she asked me already about the tapping session

11: 10 days is ok

12: 10 days was ok

13: Every day will be a problem, not every day is fine

Benefits

Key Themes: Relaxation, stress reduction

Summary: "It helped in calming down anxious residents."

Sample Carer Comments:

Manager: That give us an understanding on how to manage stressful residents. I think even not as an activity but just a stress management tool, because many people here suffer from anxiety, physical aggression, some of them are always worried about their family, if you sit with them and do this, saying

everything is ok, it is a de-escalation of stress for the resident, it shouldn't be an activity but for the support of stress and anxiety.

1: the first positive I found is that it's really relaxing

2: Sometimes she seems more relax after, depends how stress she was when we start, my resident is quite an anxious lady. She walks around a lot, if I approach her when she sat down was fine, but if I try to stop her when she walks was not as good. Finding the right time for carer and for the resident

4: difficult to tell

5: she was more positive

7: it was Helpful for the resident I think it made their mind more active, like a type of activity.

8: yes, it was good, I could use it in the future. we used it in the staff lounge area

9: when everything goes well at the end of the session the resident is happy

10: yes, it was good, she was asking about the tapping session when not happening because of busy daily routine.

Also It was a very nice interaction with the resident, time just to focus and be with her.

11: yes, it was good

13: Sometimes, but cut session times and more simple for some residents introduce time management of the session depending on resident response

Observed Changes

Key Themes: Increased relaxation, but short-lived for some

Summary: "Smiles more, but effect fades after a few minutes."

Sample Carer Comments:

Manager: When we're having a stressful day, you see all the staff tapping for themselves. So, it's already a thing for them. they already know that, when my staff are stressing, they are tapping! (Laughter). I

definitely think that even if it's not an activity that we implement, people are already adding it to their day-to-day activity when sometimes when everything gets stressful, they tap

1: when I approach her, she is tired and moody, after EFT, she gets energy and become happy, smiling

2: sometimes I can see she was more relax after; other time I don't think it made any difference.

3 When we start, she is very happy, and very happy when we stop. She is in a happy mood, making jokes.

4: hard to know if she likes it or not

5: yes, especially with this resident, I see changes. During the session she was involved, after she started laughing, making jokes.

6: it was not very useful for my resident

7: She liked it, she feels really relax when you do it, sleepy as well, so seems it's working. She was calmer and sleepier

8: She responded well, notice more relax

I could see a positive difference after tapping, if she forgot her family, she is laughing, she communicates well.

9: Maybe when you start the resident is a bit down, then she is engaged, sometimes she was happy, some other day she is not willing at all. When everything goes well at the end of it, she is happy.

10: sometimes she wants to talk about her things, when do EFT she zones out

11: Big difference from the beginning of tapping to the end. After the session she is happy, but after 5 min they go back to their mood. She is smiling, happy, after a few min she remembers her family and be sad. I could see a positive difference after tapping, if she forgot her family, she is laughing, she communicates well.

Usefulness in Care Homes

Key Themes: EFT helps residents feel better, calm, or sleep; easier to connect with them

Summary: "It calms the residents." "They feel more relaxed or happy after EFT."

Sample Carer Comments:

Manager: I think that most definitely moving forward even after this project is done, some staff will still be doing it, they now see the benefits, even if it's not working for some people, that moment of just tapping, breathing in, breathing out kind of calm them down, so I think like moving forward it's something that people who have taken part in this project will continue doing.

1: yes, very useful. most of them don't get involved in exercise or activities, so it helps them a lot to bring the mood up, you can do it daily and not wait for a scheduled activity. Can do it as an activity twice a week

2: I do think it is beneficial so for some of them, in certain situation to just takes stress down one notch

3: Useful yes, an activity that helping them, and the connection with the carer.

4: yes

5: Useful only to those willing and who can, not for everyone

6: Useful for some residents in care homes., who understand what's going on and take part in it, but some with dementia it's too much for their brain

7: Yes definitely. Because it gives them an activity as well, keep them distracted and in a good mood, and tapping of the hand make them calm, relax as well. Yes, something to do especially when we just do nothing sometimes.

8: Yes

9: It can be good for the residents who are not feeling well all the time, the active residents.

10: yes, first of all, when we are really busy, it gives me a little time to interact with the resident which is very important, it's like an excuse to interact but later on tapping, talking, breathing, I think she likes it. Yes, I think good to implement in care homes.

11: yes, but time can be an issue

12: yes, it can be helpful

13: question about when to do tapping after the study. Most of resident are not in a good mood they don't want to talk to the carers too much and some of them are ok to be touched, most don't. we can do EFT when they are in a good mood.

Disruption in care home

Key Themes: Varied resident engagement; better with alert residents; sensory or trauma reactions in some cases

Summary: "More effective for alert residents." "Sometimes residents do it themselves."

Sample Carer Comments:

Manager: No, it didn’t make any disruption, people found a way, after they finish everything, they go on their break, or just standing around, they take the resident in a quiet area and do it with them, it didn’t make any disruption, because I saw people asking the seniors, is it ok to do EFT now, so usually the do it after they do all their duty, I don’t think there was any disruption at all

1: no disruption

2: Not disruptive

3: No

4: No

5: No

6: No

7: not disruptive

8: It was not disruptive, I try to make it during my free time, evening time when it's calm. My resident is not moving sometimes she stays in her chair, so I tell her we'll do tapping later, and she cooperate.

9: No

10: was ok

11: ok

12: was ok

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