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Reducing Primigravida Anxiety: A Comparison of Audiovisual Spiritual Emotional Freedom Technique Therapy and Educational Video

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ABSTRACT

Introduction: Primigravida pregnant women are vulnerable to anxiety, worry, and fear during pregnancy, childbirth, and postpartum period. If not managed properly, anxiety during pregnancy can negatively affect maternal and fetal outcomes, including pre-eclampsia, premature birth, miscarriage, impaired uteroplacental blood flow, low birth weight, congenital abnormalities, as well as postpartum stress and depression. Complementary therapies such as the Spiritual Emotional Freedom Technique (SEFT), have been suggested as non-pharmacological strategies to alleviate anxiety. This study aimed to compare the effectiveness of audiovisual-based SEFT therapy and antenatal class educational videos in reducing anxiety levels among primigravida pregnant women.
Method: This study used a quasi-experimental nonequivalent control group design conducted in two groups with 27 respondents in each group. Respondents were asked to fill out the Pregnancy Related Anxiety Questionnaire-Revised 2 (PRAQ-R2) before the first day of treatment and after the third day of treatment to determine anxiety scores, then compared and statistically analyzed using Wilcoxon and Mann-Whitney test.
Results: Anxiety scores significantly decreased in the audiovisual-based SEFT group ($p < 0.001$) and were significantly greater than in the antenatal educational video group ($p = 0.046$).
Conclusion: Audiovisual media-based SEFT therapy is more effective in reducing anxiety in primigravida pregnant women than educational videos for pregnant women.

Keywords: Anxiety, primigravida, spiritual emotional freedom technique

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Introduction

Pregnancy is a natural process resulting from the fertilization of an ovum by a sperm cell and implantation in the uterus, typically lasting around 40 weeks or nine months. During this period, pregnant women undergo a transition to motherhood, experiencing various biological, psychological, and social changes that can lead to discomfort and complex emotional disturbances.[1]

Psychological changes during pregnancy vary between trimesters. In the first trimester, hormonal fluctuations and morning sickness can alter mood and emotions.[1,2] In the second trimester, psychological conditions are generally stable as mothers adapt and begin to feel more comfortable with their pregnancy.[2,3] However, the third trimester brings increased physical discomfort, concerns about pregnancy risks, and anxiety about childbirth and the baby's well-being, which can potentially cause significant anxiety.[4,5] The anxiety level experienced among pregnant women varies across trimesters, with anxiety peaking towards the end of pregnancy. The stress and anxiety felt by pregnant women gradually increase throughout pregnancy and reach their highest intensity in the final trimester.[2,3]

Anxiety is a common mental health issue among pregnant women, with global prevalence rates ranging from 11.4% to 63%.[4] Anxiety disorders affect between 1% and 26% of women, with 1% to 37% of pregnant women in low- and middle-income countries. Various countries report anxiety rates during pregnancy, including 44.9% in Benin, 25% in Tanzania, and 15.2% in South Africa.[6] Anxiety prevalence among pregnant women in Indonesia shows a trimester-related increase, from 8.3% in the first trimester to 17.2% and 18.4% in the second and third trimesters, respectively. Anxiety is particularly higher in primigravida women, by 7.7% compared to multigravida women.[7] In West Java, 36.2% of pregnant women experience anxiety, with rates in Bandung showing 46% for mild anxiety, 43% for moderate anxiety, and 11% for severe anxiety.[8]

When left unmanaged, maternal anxiety may result in adverse pregnancy outcomes, including preeclampsia, increased uterine activity, preterm delivery, miscarriage, inadequate prenatal care, reduced breastfeeding frequency, as well as postpartum stress and depression.[9,10] Psychological stress during pregnancy has been shown to interfere with fetal brain development and uteroplacental blood circulation. This condition is linked to a higher likelihood of unfavorable outcomes, including congenital abnormalities, premature delivery, low birth weight, birth asphyxia, intrauterine growth restriction (IUGR), intrauterine fetal death (IUFD), and long-term emotional, cognitive, and behavioral difficulties in children.[3,5,7,10]

Given the severe impact of prenatal anxiety, psychosocial support, preventive

measures, early detection, and management of maternal anxiety are crucial to prevent its escalation into serious mental disorders. Healthcare providers should offer comprehensive midwifery care, emphasizing psychosocial aspects to help pregnant women adapt to their changes. Complementary psychosocial approaches, such as Spiritual Emotional Freedom Technique (SEFT), may contribute to anxiety reduction.[11]

SEFT is an alternative therapy combining spiritual and body energy systems through tapping on specific body points to improve emotional, mental, and behavioral conditions. SEFT involves three methods: the set-up, the tune-in, and the tapping, each incorporating spiritual elements like prayer throughout the therapy. Adding spiritual elements can enhance the therapeutic effect, fostering acceptance, hope, and resilience.[12]

Previous studies demonstrate SEFT's effectiveness in reducing cortisol levels, stress, and anxiety in pregnant women, highlighting its role in modulating the physiological markers of the stress response.[13] These findings suggest that the integration of spiritual elements and meridian tapping can effectively stabilize the hypothalamic-pituitary-adrenal (HPA) axis.[14] However, other research, such as the study by Hidayat, suggests that SEFT's effect on anxiety is not always statistically significant, which may be attributed to variations in delivery methods, the duration of the intervention, or the participants' level of focus during the procedure.[15] This discrepancy indicates a significant need for further studies to validate SEFT's efficacy in addressing obstetric issues. Specifically, exploring more standardized delivery formats, such as audiovisual-based media, may provide a more consistent therapeutic experience and clarify the potential of SEFT as a reliable non-pharmacological strategy for managing pregnancy-related anxiety.[16,17]

This study aims to address these gaps by using audiovisual media to deliver SEFT, making it easier for pregnant women to understand and practice independently. Additionally, this study will employ randomization to minimize confounding variables affecting maternal anxiety, enhancing the validity and quality of SEFT recommendations for reducing anxiety. The present study would also compare audiovisual SEFT therapy to educational video classes for pregnant women to assess their relative effectiveness in managing anxiety in primigravida women.

Methods

The research applied a quasi-experimental design with a nonequivalent pretest–posttest control group to assess the impact of audiovisual-based SEFT therapy on anxiety reduction in primigravida women. This approach was selected because random assignment of participants was not entirely practical within the primary health care context, yet it enabled comparison of

anxiety levels before and after the intervention between the treatment and control groups. The study took place from March to April 2024 across the service areas of Garuda, Sukajadi, Sukarasa, and Pasir Kaliki Primary Health Centers in Bandung City, Indonesia.

The study sample comprised primigravida women in their third trimester who were receiving antenatal care at the designated primary health centers. Eligibility criteria included being in the first pregnancy, currently in the third trimester, experiencing anxiety, having adequate communication skills, and agreeing to participate through informed consent. Pregnant women with diagnosed psychiatric disorders, pregnancy complications requiring intensive medical treatment, or those currently undergoing other psychological interventions were excluded.

Sampling was carried out using a non-probability consecutive approach, where eligible participants were enrolled in sequence until the target sample size was achieved. The data collection process was conducted by the primary researcher, assisted by trained midwives at several community health centers in Bandung, including Puskesmas Garuda, Puskesmas Sukajadi, Puskesmas Sukarasa, and Puskesmas Pasir Kaliki, to ensure consistency and minimize technical bias. After recruitment, participants were assigned to either the intervention or control group through block permutation randomization. Maternal anxiety was measured using the Indonesian version of the Pregnancy-Related Anxiety Questionnaire-Revised 2 (PRAQ-R2), originally developed by Huizink *et al*.[18] To ensure the instrument's stability in the local context, the researcher performed a preliminary reliability test on 30 primigravida women, which yielded a Cronbach's alpha coefficient of 0.868, confirming high internal consistency. Participants completed the 10-item questionnaire independently in a private setting at the respective health centers before the intervention and three days after treatment. Data were then analyzed using the Wilcoxon test for intra-group changes and the Mann-Whitney test for inter-group comparisons.

Result

Table 1 presents the baseline characteristics of the participants, including age, education level, and occupational status. The homogeneity analysis yielded *p-values* > 0.05 across all variables, confirming that there were no significant demographic differences between the intervention and control groups at the start of the study. This comparability is crucial as it ensures that the subsequent changes in maternal anxiety levels can be attributed directly to the audiovisual-based SEFT intervention rather than pre-existing individual differences.

Table 1. Characteristics of study subjects.

Characteristics	Group (n,%)		*p*-value
	Intervention (n = 27)	Control (n = 27)	
Age (years)			
20 – 25	14 (51.9%)	18 (66.7%)	0.268
26 – 34	13 (48.1%)	9 (33.3%)	
Mean (SD)	25.8 (3.0)	23.5 (2.9)	
Min-Max	21 – 33	20 – 29	
Education			
Secondary	18 (66.7%)	19 (70.4%)	0.770
Higher	9 (33.3%)	8 (29.6%)	
Work			
Work	9 (33.3%)	8 (29.6%)	0.770
Not working	18 (66.7%)	19 (70.4%)	

Chi-square test

The descriptive statistics in Table 2 illustrate the trend of anxiety scores before and after the treatment period. While both groups started with relatively similar baseline scores, a notable disparity emerged following the intervention. The intervention group experienced a substantial decline in anxiety scores, whereas the control group, which received conventional educational videos, showed only a marginal reduction. This descriptive trend suggests that the integration of audiovisual SEFT therapy provides a more clinically significant impact on lowering anxiety compared to passive educational methods.

The statistical evaluation presented in Table 3 confirms a significant disparity in the therapeutic outcomes between the two groups. While both cohorts demonstrated lower anxiety levels over time, the inter-group analysis using the Mann-Whitney test reveals that the audiovisual-based SEFT therapy produced a substantially more effective clinical response compared to the control group. The median decrease in the intervention group indicates a robust shift toward emotional stability, whereas the minimal change in the control group suggests that conventional educational videos alone are less sufficient in addressing the acute psychological needs of primigravida women in their third trimester. These findings highlight that the structured combination of spiritual elements and meridian tapping delivered through audiovisual media provides a superior advantage in alleviating pregnancy-related anxiety.

Table 2. Descriptive statistics of anxiety score before and after treatment.

Anxiety score	Statistical measures				*p*-value
	Average	SD	Median	Range	
Pre					
Intervention	20.85	5.55	19	14 – 35	0.015
Control	18.81	5.72	16	12 – 29	0.004
Post					
Intervention	14.70	3.91	14	10 – 27	0.011
Control	17.74	5.72	16	11 – 29	0.007
Decrease in anxiety scores					
Intervention	6.15	3.59	6	1 – 16	0.010
Control	1.07	1.17	1	-1 – 3	0.031

SD: Standard Deviation.
Shapiro-Wilk test. Data is normally distributed if $p>0.05$.

Table 3. Comparison of anxiety scores before and after treatment in both groups.

Anxiety Score	Group		*p-value**
	Intervention (n = 27)	Control (n = 27)	
Pre			
Median (Min-Max)	19 (14-35)	16 (12-29)	0.099
Post			
Median (Min-Max)	14 (10-27)	16 (11 – 29)	**0.046**
Pre vs post comparison	***p* <0.001****	***p* <0.001****	
Decrease			
Median (Min-Max)	6 (1-16)	1 (-1 – 3)	**<0.001**

*) Mann-Whitney U test, **) Wilcoxon Signed-Rank test

Discussion

Primigravida mothers are particularly vulnerable to anxiety, especially in the third trimester, as part of their psychological adaptation to pregnancy. Anxiety activates the hypothalamus, which stimulates both the autonomic nervous system and the endocrine system, leading to increased cortisol secretion that amplifies emotional stress responses.[14,15] This heightened psychological burden may negatively affect maternal and fetal health, increasing

the risk of complications during pregnancy and delivery.[8,10]

Psychotherapy techniques such as music therapy, aromatherapy, progressive muscle relaxation, meditation, endorphin massage, dhikrtherapy, belly dance, breathing relaxation, and SEFT have been shown to reduce anxiety without adverse effects on the mother or fetus.[19,20] Therefore, antenatal care should integrate psychological well-being alongside physical health, with midwives having a key role in the early identification of anxiety, stress, and depressive symptoms, as well as in delivering emotional support and appropriate health education. The integration of complementary therapies such as SEFT into antenatal services offers a holistic approach to maintaining maternal mental health and reducing pregnancy-related anxiety.[20]

SEFT therapy has been shown to produce a relaxing effect that reduces anxiety in primigravida pregnant women. Developed from Emotional Freedom Technique (EFT), SEFT integrates energy therapy with relaxation and meditation, emphasizing elements of surrender and belief. The tune-in process, involving verbal repetition of spiritual surrender, functions as a form of self-hypnotherapy that stabilizes hormonal release, reduces muscle tension, and promotes mental calmness. SEFT further combines spiritual practices such as prayer and sincerity with energy psychology principles through three steps: set-up, tune-in, and tapping. Tapping on meridian energy points while affirming positive statements stimulates parasympathetic activity, thereby enhancing relaxation. When self-control is achieved, electromagnetic regulation supports optimal physiological functioning.[12,17]

The present analysis revealed a significant reduction in median anxiety scores within the intervention group, illustrating a substantial clinical shift toward emotional stability following the treatment. In contrast, the control group did not exhibit a notable change, suggesting that standard education alone is less effective in addressing acute psychological distress. Theoretically, the effectiveness of SEFT is attributed to its ability to induce a deep relaxation response through a combination of focus, sincerity, and resignation, which helps neutralize emotional blockages. This aligns with findings by Sarimunadi, who demonstrated that the spiritual and psychological components of SEFT effectively stabilize the mother's emotional condition by fostering a state of calm and psychological resilience as childbirth approaches.[21] Consequently, these results confirm that audiovisual-based SEFT therapy is a potent and effective non-pharmacological strategy in alleviating anxiety among primigravida women.

Similar therapeutic benefits were reported by Rejeki *et al.,* who found that SEFT significantly reduced anxiety levels in pregnant women during the preoperative phase of a cesarean section. The intervention facilitated a calmer state of mind and promoted positive

cognitive reappraisal, which are essential for maintaining both maternal and fetal well-being.[22] The efficacy of this three-day intervention is attributed to the synergistic effect of physical tapping and the five spiritual pillars: *Khusu, Ikhlas, Pasrah, Yakin,* and *Syukur*. This combination induces a profound relaxation response that neutralizes negative emotional triggers and restores psychological balance.[12]

The Mann-Whitney analysis confirmed a significant disparity in post-intervention anxiety levels between the two groups, with the intervention group demonstrating a substantially more pronounced median reduction in anxiety scores compared to the control group. This marked decline suggests that the structured delivery of SEFT via audiovisual media provides a more potent therapeutic stimulus than standard antenatal education. These results are consistent with research by Putranti, which also reported that SEFT therapy yields a significantly greater reduction in anxiety levels among pregnant women compared to conventional methods.[23] Furthermore, the effectiveness of this intervention aligns with evidence regarding the long-term impact of SEFT in stabilizing maternal emotional states, not only during the prenatal phase but extending into the postpartum period, thereby reinforcing its role as a versatile complementary therapy.[24] Collectively, these findings strengthen the evidence that audiovisual-based SEFT is a robust, safe, and effective non-pharmacological strategy for mitigating maternal anxiety.

SEFT therapy reduces anxiety through tapping on acupoints, which decreases amygdala activity and suppresses the *fight-or-flight* response, resulting in relaxation. This mechanism involves modulating the body's physiological markers of stress, including a significant reduction in cortisol levels, which helps stabilize the emotional state.[13,17] The mechanism involves spiritual aspects such as khusyu', ikhlas, and surrender, combined with stimulation of 18 meridian energy points, thereby realigning the body's internal energy system to release and reduce negative emotions. Deep breathing as the final stage of SEFT further supports oxygenation, improves ventilation, and reduces physical and emotional stress.[12]

The integration of audiovisual media significantly enhances the effectiveness of SEFT by delivering a more interactive and synchronized educational experience. Unlike conventional passive education, this format facilitates better independent practice, allowing pregnant women to internalize the therapy more effectively. This finding is supported by Saefulhadi *et al.*, who emphasized that audiovisual interventions can bridge the gap in maternal understanding and encourage active engagement, which is vital for stabilizing emotional states during the third trimester.[25]

On the other hand, the present study acknowledges certain limitations. Specifically, the

researcher could not fully control the external environment or the participants' individual level of focus during their independent practice at home. These factors may have influenced the consistency of the relaxation response achieved.

Conclusion

This research confirms the effectiveness of audiovisual-based SEFT therapy in lowering anxiety levels among primigravida women. Moreover, the reduction in median anxiety scores within the SEFT audiovisual group was significantly greater than that observed in the group provided with conventional antenatal educational videos, suggesting that audiovisual SEFT therapy offers superior advantages in addressing pregnancy-related anxiety. Accordingly, healthcare providers should consider integrating audiovisual SEFT as a non-pharmacological alternative for anxiety management, while pregnant women are encouraged to practice this technique independently to enhance emotional control and foster maternal-fetal well-being.

Conflicts of Interest

This research was carried out independently, and the authors declare no conflict of interest

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