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The Relationship Between Self-Therapy Education for Pregnant Women in Their Third Trimester and Anxiety About Childbirth

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ABSTRACT

Purpose: This study aims to identify the relationship between the Spiritual Emotional Freedom Technique (SEFT) education and anxiety levels in pregnant women in their third trimester. The primary focus is on the effectiveness of SEFT intervention as a non-pharmacological approach in helping to manage anxiety, as well as providing a comprehensive overview of the characteristics of the respondents and changes in anxiety levels before and after the intervention.

Research Method: This study used a pre-experimental one-group pretest-posttest design with a sample size of 30 pregnant women in their third trimester. The intervention took the form of structured SEFT education with materials, demonstrations, and guided independent practice by health workers. Data collection included measuring anxiety levels before and after the intervention using standard instruments, which were then analyzed to observe any changes that occurred.

Results and Discussion: The results showed a significant decrease in anxiety after SEFT education. Before the intervention, the majority of respondents experienced mild anxiety, while after the intervention, the majority did not experience anxiety. Respondents in the "Good" SEFT education category were mainly in the "No Anxiety" category, supporting the view that targeted education can improve the mental preparedness of pregnant women before childbirth.

Implications: This study emphasizes the importance of integrating SEFT education into antenatal care programs as a promotive and preventive strategy. Practically, SEFT can be an easily implemented intervention in primary healthcare facilities at a low cost, yet with a high impact. Recommendations for further research include the use of a control group design, a larger sample size, and a longer observation period to strengthen the validity of the findings.

Keywords: self; anxiety; pregnant women; non-pharmacological interventions; antenatal care.

Introduction

Pregnancy is a crucial transitional phase in a woman's life, triggering significant physiological, psychological, and social changes. These changes become more complex in the third trimester, when the body prepares for the process of childbirth, often triggering high levels of anxiety (Soma-Pillay *et*

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al., 2016). Anxiety before childbirth can be triggered by various factors, such as concerns about the baby's safety, fear of childbirth pain, and uncertainty about the birth process (Yoviana *et al.,* 2024). This phenomenon is not only a clinical issue but also a global public health issue. The WHO (2022) reports that 10–15% of pregnant women worldwide experience high anxiety, with a higher prevalence in developing countries. In Indonesia, data from the Ministry of Health (2021) show that 25.8% of pregnant women experience significant anxiety, which can potentially affect the health of mothers and fetuses, including increasing the risk of premature birth, unstable blood pressure, and postpartum depression. Unmanaged anxiety can trigger increased levels of stress hormones, such as cortisol and adrenaline, which may slow down the labor process, increase the need for medical intervention, and lead to complications like gestational hypertension (Nurbaya & Munawaroh, 2023). In Indonesia, the Maternal Mortality Rate (MMR) remains a critical health indicator requiring urgent attention. According to the 2020 Population Census, as reported in the Ministry of Health's Health Profile (2023), the MMR was recorded at 189 per 100,000 live births, approaching the 2024 National Medium-Term Development Plan (RPJMN) target of 183. In Southeast Sulawesi Province, the 2023 MMR was recorded at 127 per 100,000 live births, with anxiety and childbirth complications being significant risk factors (Southeast Sulawesi Provincial Health Office, 2023). Data from Baubau City show a decrease in MMR from 11 cases in 2021 to 3 cases in 2023; however, there are still areas with low antenatal coverage, such as Katobengke (65.6%) and Melai (74.5%), which pose a potential risk for unsafe childbirth (Baubau City Health Department, 2023).

Recent studies indicate that efforts to address anxiety in pregnant women in the third trimester are shifting from pharmacological therapy toward safer, more accessible, and empowering non-pharmacological interventions. Antepartum health education is an effective strategy to help mothers prepare physically and mentally for childbirth. Through structured education, pregnant women can increase their knowledge, develop positive attitudes, and learn stress management skills necessary to cope with fear and anxiety before childbirth (Guyatt & Rennie, 1993). Several studies have demonstrated that antenatal education programs, including relaxation technique training, can significantly reduce anxiety levels by improving mental preparedness and self-confidence (Nurbaya & Munawaroh, 2023). In addition to health education, the Spiritual Emotional Freedom Technique (SEFT) has also gained attention as a relevant complementary therapy in the context of midwifery. SEFT combines principles of energy psychology and spiritual approaches through tapping techniques on the body's meridian points, accompanied by positive affirmations (Zainuddin, 2012). Research by Rahayu & Sariyati (2020) shows that SEFT is effective in reducing anxiety and pain in laboring mothers, through mechanisms involving stress response regulation and cognitive restructuring of threatening thoughts. The integration of health education and SEFT has synergistic potential, as it not only targets the reduction of anxiety symptoms but also equips pregnant women with practical skills that can be applied independently. However, the implementation of a structured SEFT education model for pregnant women in the third trimester in primary care settings remains rare, resulting in limited scientific evidence regarding its effectiveness in such contexts.

Although various studies have demonstrated the effectiveness of antenatal health education and SEFT in reducing anxiety in pregnant women and postpartum mothers, there remains a significant gap between scientific evidence and its implementation in practice. Most previous studies have only tested SEFT as a single intervention in specific clinical contexts, such as pain management or general anxiety, without integrating it into a structured antenatal education framework. This approach tends to focus on short-term outcomes, while evidence regarding the long-term impact on birth preparedness

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and the sustainability of independent practices among pregnant women remains limited. From a health education perspective, interventions are often general and not specifically designed to teach mind-body anxiety management techniques such as SEFT, thereby limiting the potential to optimize the benefits of both approaches. Theoretically, existing literature has not extensively linked the implementation of SEFT education with health promotion models or stress management theories in the maternal context. This leaves room for developing a conceptual framework explaining how appropriate education can enhance pregnant women's self-efficacy in applying SEFT techniques independently and consistently. From an empirical perspective, studies conducted in Indonesia have rarely involved third-trimester pregnant women at the primary care level, such as community health centers, despite this group's unique characteristics regarding access to services, mental readiness, and social support. Therefore, research that integrates health education and SEFT in a structured manner within the context of antenatal care at primary health facilities is crucial for expanding scientific evidence and addressing the need for evidence-based practice in the field.

The novelty of this study lies in its approach, which combines antenatal health education with the Spiritual Emotional Freedom Technique (SEFT) therapy within a structured intervention framework. It analyzes it comprehensively through a Systematic Literature Review (SLR) method. Unlike previous studies that have tended to test the effectiveness of SEFT or health education separately, this study aims to map existing scientific evidence, identify patterns, and evaluate the consistency of findings from various studies related to the relationship between SEFT education and anxiety reduction in pregnant women in their third trimester, as they approach childbirth. The SLR approach enables an in-depth review of relevant literature, both at the national and international levels, thereby providing a stronger and evidence-based synthesis of knowledge. Another novelty is the research focus on the primary health care context in Indonesia, particularly the Wajo Health Center area, which has been relatively understudied in this topic. By integrating theoretical aspects, such as health promotion models and stress management theory, into the analysis, this study not only contributes to the practical level but also expands the conceptual foundation for explaining the mechanism by which SEFT education influences maternal anxiety. The primary objective of this study is to identify, evaluate, and synthesize scientific findings related to the effectiveness of SEFT education in reducing anxiety among pregnant women in their third trimester, while formulating implementation recommendations that can be adapted for use in puskesmas-based antenatal services. The study results are expected to serve as a reference for healthcare providers, policymakers, and researchers in developing safe, practical, and evidence-based non-pharmacological interventions to improve the mental health of pregnant women approaching childbirth.

Literature Review and Hypothesis Development

Spritual Emotional Freedom Technique (SEFT)

Spiritual Emotional Freedom Technique (SEFT) is a form of complementary therapy that integrates the principles of energy psychology with a spiritual approach through tapping techniques on meridian points of the body, accompanied by positive affirmations, to balance a person's emotional, mental, and spiritual conditions (Abdullah *et al.,* 2024; Zainuddin, 2012). This method was developed from the concept of Emotional Freedom Technique (EFT), which focuses on stimulating the body's energy system. However, SEFT adds a spiritual dimension that makes it relevant in cultural contexts where religious values are considered integral to mental health (Hidayat, 2024a). The underlying

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principle is that emotional disturbances, such as anxiety, fear, or stress, arise due to disruptions or blockages in the body's energy flow, by tapping on specific points on the body—similar to acupressure points in traditional Chinese medicine—negative energy is believed to be released, thereby stabilizing emotions (R & Limbong, 2024). This process is reinforced with positive affirmations that not only serve to modify negative thought patterns but also cultivate a sense of surrender and faith in divine assistance. The integration of spiritual elements in SEFT has been shown to provide additional therapeutic benefits, contributing to increased feelings of calmness, acceptance of circumstances, and self-confidence (Blasius *et al.,* 2023; Gayatri & Purnamayanti, 2024). Some studies suggest that these spiritual elements trigger positive physiological responses, including reduced cortisol levels, a normalized heart rate, and increased heart rate variability, all of which indicate deep relaxation. This is particularly effective for specific groups, such as pregnant women, chronic patients, or individuals experiencing psychological trauma.

The mechanism of SEFT involves two main complementary pathways. The first pathway is the physiological pathway, which focuses on stimulating meridian points in the body associated with the autonomic nervous system, particularly areas that influence the fight-or-flight response. When these points are stimulated through tapping, the resulting nerve impulses can affect the brain's limbic system—the emotional regulation center—thereby helping to reduce anxiety levels and regulate the stress response (Permatasari *et al.,* 2020). The second pathway is the cognitive-spiritual pathway, which involves cognitive restructuring through the use of positive affirmations during tapping sessions. These affirmations are designed to foster acceptance, break negative thought cycles, and strengthen self-confidence in facing anxiety-inducing situations (Permatasari *et al.,* 2020). Emadi et al. (2023) found, through a randomized clinical trial on EFT techniques, that stimulating meridian points consistently reduced the fear of childbirth in primiparous women, providing empirical evidence for the effectiveness of similar methods, such as SEFT. The uniqueness of SEFT lies in its integration of spiritual elements, enabling clients not only to undergo cognitive processes to change negative thoughts but also to build a transcendental connection that provides a sense of safety and surrender to a higher power (Abdullah *et al.,* 2024; Hidayat, 2024). The study by Gayatri & Purnamayanti (2024) on cancer patients further supports these findings, showing that SEFT reduces psychological burden, improves quality of life, and strengthens spiritual coping, thereby providing sustained benefits for patients' quality of life. This dual mechanism—physiological and cognitive-spiritual—makes SEFT a unique and effective intervention technique, particularly in addressing emotional issues rooted in traumatic experiences or complex psychological burdens.

As research progresses, SEFT is being increasingly applied in various healthcare settings and to diverse populations. Asmawati et al. (2020) demonstrated that SEFT application among substance abuse residents significantly reduced anxiety levels, which in turn facilitated the recovery process from addiction. These findings suggest that SEFT can be used with groups requiring intensive mental support and high stress levels. On the other hand, Blasius *et al.,* (2023) found that SEFT effectively reduces anxiety in hypertensive patients, which also positively impacts blood pressure reduction. Hidayat (2024) specifically studied the application of SEFT on pregnant women in the third trimester, with results showing that this technique enhances self-confidence, mental preparedness, and reduces anxiety before childbirth. Permatasari *et al.,* (2020) even highlighted that SEFT not only lowers blood pressure in hypertensive pregnant women but also helps them feel calmer and better able to control their emotional reactions. Furthermore, a systematic review conducted by Rachmawardany *et al.,* (2024) demonstrated that SEFT can improve psychological well-being across various target groups, both in clinical and

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community settings. However, the review also emphasized the importance of structured, consistent, and individualized implementation to optimize benefits. The combination of ease of application, minimal side effects, and its ability to address emotional and spiritual aspects makes SEFT a promising non-pharmacological intervention for integration into community-based mental health programs.

Anxiety in Pregnant Women

Prenatal anxiety, or antenatal anxiety, is an emotional condition that arises during pregnancy and is characterized by excessive worry, tension, and concerns about various aspects of the pregnancy process, childbirth, or the role of motherhood (Shariatpanahi *et al.,* 2023). This form of anxiety can range from mild to severe and may affect the quality of life of pregnant women if not adequately addressed. According to Val *et al.,* (2025), the triggers for antenatal anxiety are multifactorial, including hormonal changes that affect emotional stability, physical health conditions, traumatic experiences from previous pregnancies, a history of anxiety disorders or depression, low social support, and economic uncertainty. Caffieri *et al.,* (2024) emphasize that the global prevalence of antenatal anxiety is relatively high, but it often goes unidentified because many pregnant women do not report the symptoms they experience. This is exacerbated by the belief that feeling worried during pregnancy is normal, so symptoms pointing to anxiety disorders do not always receive adequate medical attention. From a health perspective, Nielsen-Scott *et al.,* (2022) reveal that anxiety during pregnancy can reduce maternal adherence to antenatal care, trigger unhealthy eating patterns, disrupt sleep, and increase the risk of maladaptive behaviors. Furthermore, Fraga *et al.,* (2024) explain that persistent anxiety can trigger physiological responses such as increased cortisol levels, which may potentially affect fetal brain development.

Recent research shows that maternal anxiety during pregnancy not only impacts the mother's mental health but can also affect physical health, increase the risk of obstetric complications, and influence birth outcomes (Ayers *et al.,* 2025). For example, Shariatpanahi et al. (2023) noted that excessive fear of childbirth, pain, and the baby's safety is one of the leading causes of increased anxiety levels in pregnant women. Other contributing factors include the mother's age (too young or too old), educational level, economic status, relationship with the partner, and the presence of comorbidities during pregnancy (Val *et al.,* 2025). In low- and middle-income countries, Fraga *et al.,* (2024) found that limited access to healthcare services, social stigma surrounding mental health issues, and a shortage of trained professionals are significant barriers to addressing antenatal anxiety. Meanwhile, a meta-analysis conducted by Caffieri *et al.,* (2024) revealed variations in the prevalence of antenatal anxiety across countries, but overall rates remain high, warranting serious attention. From a biological perspective, Sherer *et al.,* (2023) identified a link between maternal anxiety and changes in autonomic nervous system function that trigger chronic stress responses, which may affect fetal growth and lead to preterm birth.

Strategies for managing maternal anxiety increasingly emphasize the importance of routine screening and evidence-based interventions. Rondung *et al.,* (2024) conducted a systematic review and meta-analysis evaluating various screening tools, including the Edinburgh Postnatal Depression Scale (EPDS) and the Generalized Anxiety Disorder-7 (GAD-7), which have been proven effective in detecting antenatal anxiety when used structurally during antenatal visits. This is relevant because many pregnant women are unaware that they are experiencing anxiety or are reluctant to disclose their feelings (Nielsen-Scott *et al.,* 2022). Comprehensive screening approaches should be accompanied by psychological interventions, such as counseling, cognitive-behavioral therapy, and health education that involves partners and families, as social support is a significant protective factor (Fraga *et al.,* 2024).

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Ayers et al. (2025) also emphasize the need to improve access to mental health services, particularly in remote areas, through telehealth or community programs that can reach a greater number of pregnant women. Val *et al.,* (2025) underscore that reproductive health policies should include anxiety prevention and management programs as part of standard antenatal care, given their significant impact on maternal and infant health. The management of antenatal anxiety is not only aimed at reducing symptoms in mothers but also at preventing long-term effects on children, such as cognitive and emotional development issues.

Childbirth

Childbirth is a complex physiological process that marks the end of pregnancy, during which the fetus, placenta, and amniotic membranes are expelled from the uterus through the birth canal, either spontaneously or through medical intervention based on specific indications (Vaajala *et al.,* 2023). This process is a significant biological event influenced by the interaction of hormonal, nervous, and mechanical systems of the body, accompanied by significant emotional and psychological dynamics. According to Halliday *et al.,* (2022), childbirth is divided into three stages: the cervical dilation stage, the fetal expulsion stage, and the placental expulsion stage. Each stage requires specific management to ensure the safety and comfort of the mother and the healthy birth of the baby. In modern obstetric practice, labor management not only includes medical interventions such as monitoring fetal heart rate and maternal blood pressure but also provides emotional support and clear information to help the mother feel safe during the birth process. Højstrup *et al.,* (2025) emphasize that a mother's subjective experience during childbirth is influenced by the quality of communication with healthcare providers, trust, and opportunities to participate in decision-making. In addition to clinical aspects, childbirth is also influenced by mental preparedness, self-confidence, and the management of fear or anxiety (Vaajala, Kekki, *et al.,* 2023). Therefore, the definition of childbirth for pregnant women should not only focus on the biological mechanisms of birth but also encompass a multidimensional experience involving physiological, psychological, social, and cultural aspects. A comprehensive understanding of this complexity is essential for healthcare providers to deliver comprehensive care, ensuring that childbirth is not only medically safe but also a positive and meaningful experience for the mother and her family.

Childbirth can occur through various methods, ranging from spontaneous vaginal birth, assisted birth using tools such as vacuum extraction or forceps, to cesarean section, which is chosen based on the mother's health condition, the fetus's condition, and existing risk factors (Combellick *et al.,* 2023). Globally, vaginal birth remains the most common method. However, the trend toward cesarean sections is increasing in many countries, both for medical reasons such as placenta previa and fetal distress, and non-medical reasons such as elective requests (Baart *et al.,* 2025). Pain management is a critical aspect of the childbirth process, with epidural anesthesia recognized as the most effective and widely used analgesic method in many countries (Halliday *et al.,* 2022). (Vaajala *et al.,* 2023) identified a link between fear of childbirth and increased demand for epidural, while Højstrup *et al.,* (2025) emphasized that the decision to use analgesia is often influenced by antenatal education, support from healthcare providers, and the mother's personal preferences. In the context of care, a midwife-led continuous care model has proven effective in reducing medical interventions, lowering cesarean section rates, and improving maternal satisfaction with the childbirth experience (Chantry *et al.,* 2025). This approach places the mother at the center of care and prioritizes two-way communication, making her feel more valued and

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supported. The success of childbirth, therefore, is not only measured by the healthy birth of a baby but also by the positive experience of the mother, minimal physical or emotional trauma, and the growth of self-confidence postpartum.

Childbirth is not merely a medical event but also an emotional experience that can have long-term impacts. Ayers *et al.,* (2024) reported that approximately 4% of women experience post-traumatic stress disorder (PTSD) due to traumatic childbirth, which can affect mental health, bonding with the baby, and future reproductive decisions. Childbirth trauma is often associated with uncontrolled pain, emergency procedures such as sudden cesarean sections, lack of information, and insufficient emotional support during the birthing process. Lobmaier *et al.,* (2019) emphasize the importance of woman-centered care, an approach that prioritizes the needs, preferences, and values of the mother in childbirth care. Baart *et al.,* (2025) noted that continuity of care, from the antenatal period through the postpartum period, can enhance feelings of safety, strengthen trust between mothers and healthcare providers, and reduce the risk of psychological complications. Preventing traumatic childbirth requires comprehensive strategies, including realistic antenatal education, relaxation technique training, adequate pain management, and creating an emotionally supportive childbirth environment. Chantry *et al.,* (2025) demonstrate that a calm atmosphere, responsive medical staff, and active maternal involvement in decision-making can transform the childbirth process into an empowering experience.

Theoretical Framework

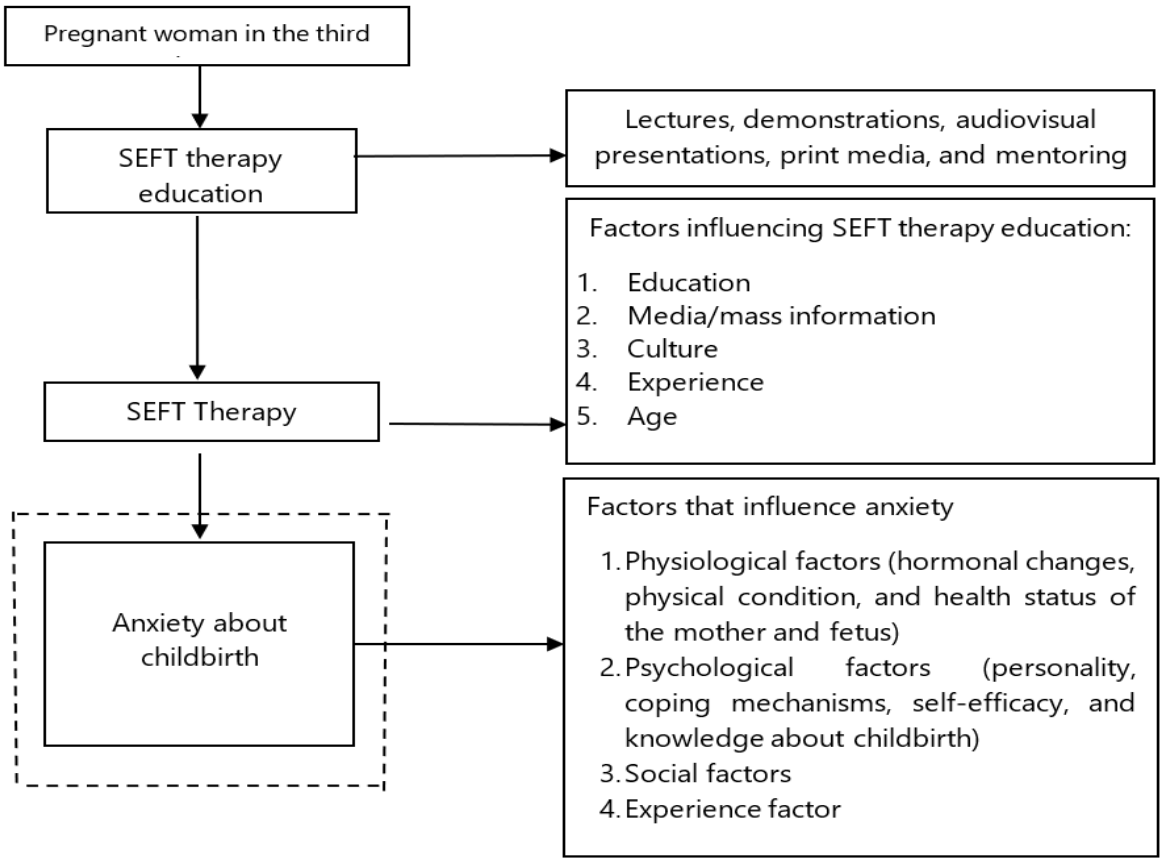

Figure 1. Theoretical Framework

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Research Method

Research Design

This study employed a quantitative approach with a pre-experimental design, specifically a one-group pretest-posttest design (Sugiyono, 2019). This design involves a single group of subjects who receive an intervention without a control group, with anxiety levels measured twice: before (pretest) and after (posttest) the educational intervention using the Spiritual Emotional Freedom Technique (SEFT). This model enables researchers to observe changes in anxiety levels directly after the intervention is administered, allowing for more accurate identification of the intervention's effects. The research design scheme is represented as O_1 X O_2, where O_1 is the initial anxiety level measurement, X is the SEFT educational intervention, and O_2 is the final anxiety level measurement.

Population and Sample

The population in this study consisted of all pregnant women in their third trimester (28–42 weeks of pregnancy) from the working area of the Wajo Community Health Center during the data collection period. Based on initial data, the population was recorded as 30 people. The sampling technique used was total sampling, where all members of the population were included in the study sample (Arikunto 2017). Inclusion criteria included pregnant women without life-threatening pregnancy complications, willing to participate in the intervention, able to communicate effectively, and who had not previously received SEFT training. Exclusion criteria included women with severe diagnosed psychological disorders, use of other anxiety therapies that could potentially influence the results, contraindications in the tapping areas, or pregnancy complications requiring special care.

Data Collection Techniques and Instrument Development

Primary data were collected through two methods: questionnaires and observation. Anxiety levels were measured using the Perinatal Anxiety Screening Scale (PASS) translated version validated by Somerville et al. (2014) with a reliability of 0.983. The PASS consists of 31 questions with a rating scale of 0–3, categorized into no anxiety (0–20), mild anxiety (21–26), moderate anxiety (27–40), and severe anxiety (41–93). Additionally, an observational checklist was used to evaluate the implementation of SEFT education, covering three main stages: Set-Up, Tune-In, and Tapping. This checklist comprises 20 items with content validity (Aiken's V > 0.80) and high inter-rater reliability (Cohen's Kappa = 0.82). Secondary data were obtained from scientific journals, health department reports, and official sources such as the WHO to support the research background.

Data Analysis Techniques

Data analysis was conducted in stages. Univariate analysis was used to describe the characteristics of respondents and the distribution of anxiety levels before and after the intervention. Bivariate analysis was performed to test differences in anxiety levels before and after the SEFT educational intervention, using a Paired Sample t-test if the data were normally distributed, or a Wilcoxon Signed-Rank Test if the data were not normally distributed. The relationship between SEFT education and anxiety reduction was analyzed using the Chi-Square test, with a significance level of 0.05. The analysis process included data reduction, data presentation in the form of tables, graphs, and

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diagrams, and drawing conclusions based on statistical test results and comparisons with previous studies.

Table 1. Operational Definition

No	Variable	Operational Definition	How to Measure	Measuring Instruments	Measurement Results	Measurement Scale
Variabel independent						
1	SEFT Therapy Education	A structured learning process on SEFT techniques, including theory and practice of tapping on meridian points and spiritual affirmations.	Observation of the implementation of SEFT education and practice by respondents.	Checklist	a. Less = 0 -19 b. Enough = 20 - 29 c. Good = 30 - 40	Ordinal
Variable dependent						
2	Anxiety About Childbirth	Feelings of worry experienced by pregnant women	Using the PASS (Perinatal Anxiety Screening Scale) questionnaire translated by Ulafa, 2017, consisting of 31 items, with the following answers: a. Never: skor 0 b. Sometimes, skor: 1 c. Often: 2 d. Always : 3 (Somerville et al. 2024)	Questionnaire PASS	a. No worries : skor 0 - 20 b. Mild anxiety : skor 21 - 26 c. Moderate anxiety : skor 27 – 40 d. Severe anxiety: skor 41 – 93 (Somerville et al. 2024)	Ordinal

Results and Discussion

Analysis Result

Univariate analysis

The results of Table 2 show that the majority of respondents were aged 26-30 years, totaling 13 people (43.3%). The majority of respondents had a college education, totaling 16 people (53.3%), the majority of respondents were nulliparous, totaling 14 people (46.7%), the majority of respondents worked as housewives, totaling 19 people (63.3%), and a minority worked as private employees, totaling three people (10.0%).and a minority of respondents had a high school education, totaling 14 people (46.7%).

Based on Table 3, it can be interpreted that before being given Spiritual Emotional Freedom Technique (SEFT) therapy education, most respondents were in the mild anxiety category, namely 13 pregnant women or 43.3% of the total respondents. This shows that mild anxiety was a dominant

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phenomenon among pregnant women in the area before the intervention was carried out. Conversely, the number of respondents with severe anxiety was the lowest, at only one person (3.3%), indicating that severe anxiety cases were relatively rare before the intervention. After receiving SEFT therapy education, there was a significant change in the distribution of anxiety levels.

Table 2. Frequency Distribution of Respondent Characteristics

Characteristics	F	%
Age (year)		
20-25	9	30.0
26-30	13	43.3
31-35	5	16.67
36-40	2	6.7
41-45	1	3.3
Education		
High school graduate	14	46.7
Higher Education	16	53.3
Work		
Entrepreneur	4	13.3
civil servant	4	13.3
Private employee	3	10.0
Housewife	19	63.3
Parity		
Nullipara	14	46.7
Primipara	8	26.7
Multipara	6	20.0
Grandemultipara	2	6.7
Total	**30**	**100.0**

Source: Primary Data 2025

Anxiety Before and After SEFT Therapy Education

Table 3. Frequency Distribution of Respondents' Anxiety Before and After Receiving SEFT Therapy Education

Anxiety Category	Pre-Test F	Pre-Test %	Post-Test F	Post-Test %
No worries	11	36.7	27	90.0
Mild anxiety	13	43.3	2	6.7
Moderate anxiety	5	16.7	1	3.3
Severe anxiety	1	3.3	0	0.0
Number	30	100.0	30	100.0

Source: Primary Data 2025

The majority of respondents fell into the 'no anxiety' category, totaling 27 individuals, or 90.0% of the total respondents. This change indicates a substantial decrease in anxiety levels following the intervention. Meanwhile, the number of respondents with moderate anxiety decreased to 1 individual (3.3%), and there were no longer any respondents experiencing severe anxiety.

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SEFT therapy education

Table 4. Frequency Distribution of Respondents Given SEFT Therapy Education

SEFT therapy education	F	%
Less	0	0.0
Enough	3	10.0
Good	27	90.0
Total	**30**	**100.0**

Source: Primary Data 2025

The results of Table 4 show that the majority of respondents who received SEFT therapy education had good skills, totaling 27 pregnant women (90.0%). In contrast, the minority of respondents had adequate skills, totaling three people (10.0%).

Bivariate Analysis

Changes in Anxiety Levels in Pregnant Women in the Third Trimester Before and After Receiving SEFT Therapy Education.

Table 5. Changes in Anxiety Levels Before and After SEFT Therapy Education for Pregnant Women in Their Third Trimester

Anxiety variables	Mean ± SD	Mean difference	95% Confidence Interval of the Difference		t-value	df	p-value
			Lower	Upper			
Pretest	21.93 ± 8.225	8.20	6.593	9.807	10.439	29	0.00
posttest	13.73 ± 5.452						
Total (N) =	30						

Source: Primary Data 2025

Based on Table 5, the results of the Paired t-Test indicate that there was a decrease in anxiety levels among pregnant women in the third trimester after receiving SEFT therapy education. Thirty respondents experienced a reduction in anxiety levels, and the test results showed a significant difference between anxiety levels before and after receiving SEFT education. The average anxiety score before SEFT education was 21.93 ± 8.225, while the average anxiety score after SEFT education decreased to 13.73 ± 5.452, with a Mean Difference of 8.20 points. Additionally, the results of the 95% Confidence Interval of the Difference indicate that the average decrease in anxiety levels is estimated to be within the range of 6.593 to 9.807, meaning that statistically, it can be confidently stated that 95% of the average decrease in anxiety levels among pregnant women who received SEFT education will fall within that range. The calculation results also show a t-value of 10.439 with 29 degrees of freedom (df).

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The p-value of 0.00 (p < 0.05) indicates that the difference in the average anxiety level before and after receiving SEFT education is statistically significant.

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Table 6. Relationship between SEFT Therapy Education and Anxiety Levels in Third Trimester Pregnant Women

SEFT Education	Post-test anxiety								number		P-value
	None		Light		Currently		Weight				
	F	%	F	%	F	%	F	%	F	%	
Less	0	0.0	0	0.0	0	0.0		0.0	0	0.0	
Enough	0	0	1	3.3	1	3.3		0.0	2	6.6	0.00
Good	27	90.0	1	3.3	0	0.0		0.0	28	93.3	
Total	27	90.0	2	6.6	1	3.3		0.0	30	100	

Based on Table 6, the results of the Chi-Square test indicate that there is a significant relationship between the level of Spiritual Emotional Freedom Technique (SEFT) education and the level of anxiety in pregnant women in their third trimester when facing childbirth. The Pearson Chi-Square value of 21.964, with a p-value (Asymp. Sig.) of 0.000 (p < 0.05), indicates that the alternative hypothesis (H_a) is accepted, meaning there is a relationship between SEFT therapy education and anxiety levels in third-trimester pregnant women. Thus, it can be concluded that the better the level of SEFT education, the lower the anxiety levels experienced by pregnant women. This is supported by the finding that most respondents, namely 27 people (90.0%) who received SEFT education in the good category, were in the category of not experiencing anxiety, and there were no respondents who experienced severe anxiety after the intervention was carried out.

Discussion

Respondent Characteristics

Based on a study conducted with 30 pregnant women in their third trimester in the working area of the Wajo Community Health Center, it was found that the majority of respondents were aged 26-30 years (43.3%). This finding aligns with a study by Putri et al. (2022), which states that the optimal reproductive age is between 20 and 35 years, as women in this age group tend to have better physical and mental readiness to cope with pregnancy and childbirth. Optimal maternal age is associated with the ability to adapt to stress and anxiety during pregnancy (Wulandari & Sari, 2023). The majority of respondents (53.3%) held a college education. This supports the effectiveness of the SEFT therapy education provided, as Andriyani & Susanti (2021) found that higher education levels influence a mother's ability to understand and apply relaxation techniques. Higher education is also correlated with a better understanding of health information (Rahmawati *et al.,* 2024). The characteristics of the respondents' occupations indicate that the majority are housewives (63.3%). This condition provides an advantage in terms of time to practice SEFT techniques regularly. According to Hasanah & Fitriani (2020), homemakers have better time flexibility to participate in health education programs. In terms of

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parity, the majority of respondents were nulliparous (46.7%). Primigravida tend to experience higher anxiety levels compared to multigravida due to a lack of experience in childbirth (Nurjanah *et al.,* 2022). This is relevant to the finding that SEFT intervention is highly effective in this group.

Anxiety Levels Before and After SEFT Therapy Education

Anxiety Before Intervention

The results of this study indicate that before receiving SEFT therapy education, the majority of respondents experienced mild anxiety at 43.3%, while 36.7% did not experience anxiety. This percentage is similar to the findings of Maharani & Puspitasari (2023), who reported that approximately 45% of pregnant women in the third trimester experienced mild to moderate anxiety as they approached childbirth. This indicates that mild anxiety is indeed common among pregnant women in the late stages of pregnancy, including the respondents in the Wajo Health Center area. This phenomenon aligns with the theory proposed by Dewi et al. (2021) that anxiety in pregnant women during the third trimester often arises due to uncertainty about the childbirth process, fear of childbirth pain, potential complications, and concerns about the baby's safety. These factors were also identified among the study participants, particularly among nulliparous pregnant women. These findings support the view of Putri & Wardani (2022) that if antepartum anxiety is not managed correctly, it can potentially hinder the labor process and affect the health condition of the newborn. Therefore, the data from this study further emphasize the importance of SEFT educational interventions to help pregnant women manage their anxiety levels before the labor process begins.

Anxiety After Intervention

After receiving SEFT therapy education, the results of this study showed significant changes in the anxiety levels of the respondents, with the majority (90%) no longer experiencing anxiety. These results indicate that SEFT education has a highly effective impact in helping pregnant women in the third trimester reduce anxiety before childbirth. These findings are consistent with the study by Safitri et al. (2023), which also demonstrated that SEFT techniques can reduce anxiety in pregnant women by up to 85%. Additionally, these results are supported by Hidayat's (2024) study, which found that the application of SEFT in primigravida pregnant women effectively reduces stress and anxiety during the final trimester of pregnancy. Similar findings were reported by Yunitasari & Riska, (2025) who explained that SEFT can trigger an increase in endorphin and serotonin hormones, making mothers feel calmer and more emotionally stable. Theoretically, SEFT combines acupressure techniques, which involve tapping specific meridian points in the body, with spiritual affirmations recited in setup and reminder phrases (Zainuddin, 2019). This meridian stimulation helps neutralize emotional disturbances that trigger anxiety. The spiritual component of SEFT also provides additional calming effects by enhancing feelings of acceptance, trust, and self-confidence in facing the childbirth process (Islamiyah & Pratiwi, 2024). Thus, the results of anxiety reduction in this study further strengthen the evidence that SEFT education can serve as a practical, safe, and appropriate non-pharmacological intervention for pregnant women in primary healthcare facilities such as the Wajo Health Center.

The Effectiveness of SEFT Therapy Education

The results of this study indicate that SEFT therapy education has a significant positive impact on reducing anxiety levels in pregnant women in their third trimester. Before receiving intervention,

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most respondents were in the higher anxiety category, characterized by feelings of tension, worry, and emotional discomfort before childbirth. After the SEFT therapy education sessions, there were significant changes in psychological conditions, with the majority of pregnant women reporting feelings of calmness, confidence, and better control over their thoughts. SEFT therapy helped them understand how to manage fear and anxiety through relaxation techniques, focusing on positive thoughts, and accepting the pregnancy and childbirth process they were about to undergo. This educational process not only provides information but also equips mothers with practical skills to cope with the mental stress that often arises before childbirth. Many respondents stated that after practicing the techniques taught, they felt their mental burden had decreased and they were more mentally prepared to face childbirth. Additionally, the SEFT approach, which combines emotional, cognitive, and spiritual elements, makes pregnant women feel more holistically cared for, thereby supporting the creation of a more stable psychological condition. The results of this study support the findings of Hidayat (2024), who also demonstrated that the application of SEFT can significantly reduce anxiety levels in primigravida pregnant women in the third trimester. According to Yunitasari & Riska (2025), SEFT works by stimulating specific acupressure points that trigger the release of endorphins and serotonin. These hormones play a role in inducing relaxation, regulating mood, and reducing stress levels in pregnant women. Additionally, a literature review by Nasution & Rachmawati (2024) also supports these findings. They explain that SEFT is not only beneficial during pregnancy but can also be applied during childbirth and the postpartum period. This is because SEFT combines spiritual, emotional, and physical approaches that provide mental calmness and a sense of comfort for pregnant women.

Structured education is also a supporting factor in the success of the SEFT technique. Education delivered, accompanied by direct practical guidance, can increase self-efficacy or self-confidence in pregnant women in managing their anxiety (Wulandari & Sari, 2023). With increased self-efficacy, pregnant women will feel more confident to practice SEFT independently at home when anxiety arises. This aligns with the findings of Putri & Yuliana, (2023), who stated that educational methods involving hands-on practice are easier to understand and apply compared to theoretical explanations alone. Based on these results, it can be concluded that SEFT education provided in a targeted manner and accompanied by hands-on practice can serve as an effective non-pharmacological intervention alternative for maintaining the mental health of pregnant women in the third trimester. Therefore, it is hoped that this SEFT technique can be implemented sustainably, particularly in the Wajo Health Center's service area by 2025, so that pregnant women are better prepared to face pregnancy with improved psychological well-being.

The Relationship Between SEFT Education and Anxiety Levels

The results of this study reveal a clear correlation between the quality of Spiritual Emotional Freedom Technique (SEFT) education and anxiety levels in pregnant women in their third trimester. Pregnant women who received high-quality SEFT education tended to exhibit more stable psychological conditions and felt better prepared for childbirth. SEFT education does not merely provide knowledge about relaxation techniques and emotion management, but also involves a structured guidance process, enabling pregnant women to practice these steps independently in their daily lives. This approach helps them overcome fear, anxiety, and negative thoughts that often arise as the due date approaches. Thus, SEFT education can serve as an effective non-pharmacological method for improving inner calm and self-confidence in pregnant women (Putranti, 2021). Pregnant women who receive high-intensity, high-

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quality SEFT guidance tend to understand the importance of the connection between the mind, feelings, and body in maintaining mental health during pregnancy.

The techniques taught in SEFT, such as focusing on positive affirmations, stimulating specific points on the body, and breathing exercises, have been proven to help alleviate physical and emotional tension. The empathetic and interactive educational process also fosters a positive relationship between the educator and participants, making the material more easily accepted and understood. This allows pregnant women to feel the immediate benefits of the practices taught, even in a relatively short period. These results are in line with the research by Saleh et al. (2023), which showed that SEFT therapy accompanied by systematic education was proven to improve the mental health of pregnant women, especially during the pandemic. Sarimunadi et al. (2021) also explain that SEFT is effective if participants receive theoretical understanding and repeated practical guidance. Similar findings were reported by Shava (2023), who found that SEFT significantly reduces anxiety if mothers understand and perform the SEFT steps correctly. Furthermore, Astuti et al. (2022) reinforced these findings by demonstrating that SEFT can be applied during active labor, and its effectiveness increases when education is provided directly and repeatedly. Kapitan et al. (2024) also emphasized that the involvement of healthcare providers in delivering SEFT education has a significant influence on anxiety reduction outcomes. In addition to SEFT theory, a structured educational approach also supports the success of interventions. Nasution & Rachmawati (2024) emphasize, through a literature review, the importance of continuous SEFT education from pregnancy to the postpartum period. In the study by Marifah et al. (2022), it was shown that SEFT is effective for patients with severe anxiety when conducted under the guidance of competent healthcare providers.

Hidayat, (2024) study demonstrated that SEFT is most effective when pregnant women are accompanied by competent healthcare providers, allowing for the performance of tapping techniques and affirmations according to protocol. Yunitasari & Riska (2025) also supported this finding, reporting that SEFT education combined with practical simulations resulted in greater anxiety reduction compared to theoretical lectures alone. Wulandari & Sari, (2023) also found that improvements in self-efficacy among pregnant women occur when education is provided repeatedly and in a structured manner. Rahayu *et al.,* (2022) demonstrated that higher formal education levels facilitate pregnant women's understanding of SEFT material. Pratiwi & Lestari, (2023) added that formal education supports the acceptance of relaxation technique information, thereby enhancing mothers' self-confidence. Husna & Azizah, (2021) explained that healthcare workers' communication skills are a key factor in the successful delivery of SEFT education.

Meanwhile, Putri & Rahmawati, (2022) emphasize that prenatal classes using hands-on methods are more effective in improving understanding of SEFT techniques compared to one-way lectures. Although most theories support this, some researchers highlight the limitations of SEFT. Fitria & Nurhasanah (2023) mention that some mothers feel uncomfortable performing SEFT tapping without intensive guidance. Safitri & Nugroho, (2022) also state that physical and hormonal conditions can influence the success of SEFT, making medical intervention still necessary. Putra & Cahyani (2021) emphasize that family support is also a crucial factor for pregnant women to willingly perform SEFT independently. Although most theories support the findings of this study, individual characteristics, family conditions, and methodological limitations must be considered to ensure optimal implementation of SEFT. Based on these results, the Alternative Hypothesis (Ha) is accepted because the significance value is < 0.05, indicating a significant relationship between SEFT education and reduced anxiety. Conversely, the Null Hypothesis (H0) is rejected because the data results prove a

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considerable relationship. It can be concluded that the quality of SEFT education, respondents' educational level, and healthcare provider support mutually reinforce each other in reducing anxiety among pregnant women in the third trimester in the Wajo Health Center's service area in 2025.

Conclusion

This study was conducted to explore the relationship between the Spiritual Emotional Freedom Technique (SEFT) education and anxiety levels in pregnant women in their third trimester. In general, this study provides a comprehensive overview of the characteristics of the respondents, their anxiety levels before and after the intervention, and the relationship between the quality of education and anxiety reduction. This approach focused on providing SEFT education as a non-pharmacological intervention oriented toward emotional balance, peace of mind, and mental readiness of pregnant women before childbirth. This study addressed research questions by demonstrating a significant relationship between the quality of education and the psychological well-being of the respondents, while also highlighting the potential of SEFT as part of an antenatal education program.

From a scientific perspective, this study contributes to the advancement of knowledge in the field of midwifery, particularly in the area of holistic approaches to anxiety management during pregnancy. Practically, the study results can serve as a basis for healthcare providers to integrate SEFT into routine antenatal care programs, accompanied by training for healthcare workers, implementation guidelines, and adequate supporting resources. From a managerial perspective, the implementation of SEFT can be an innovative service-oriented toward the mental health of pregnant women, improving patient satisfaction, and enhancing the image of health services that are attentive to the emotional needs of patients. The originality of this study lies in its focus on SEFT intervention among pregnant women in their third trimester within a primary healthcare setting.

Although it yields significant findings, this study has limitations, including a relatively small sample size, a pre-experimental design without a control group, and a short follow-up period. Therefore, further research is recommended to employ a randomized controlled trial design with a larger sample size, a longer observation period, and diverse research locations to strengthen the generalizability of the results. Additionally, future research could expand the focus by exploring other variables influencing the effectiveness of SEFT, linking it to childbirth outcomes, and testing this intervention model on populations with different characteristics to assess the consistency of its efficacy.

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