

The Effectiveness of Self-Healing Hypnotherapy on Anxiety Among High-Risk Pregnant Women

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ABSTRACT

Anxiety among pregnant women is a serious maternal health concern, with prevalence rates of 8% to 10% globally, 15.6% in developing countries and 28.7% in Indonesia. This is particularly urgent in high-risk pregnancies because anxiety can negatively impact maternal and fetal outcomes. This study aimed to analyse the effectiveness of self-healing hypnotherapy in reducing anxiety, and examine whether age, education, occupation and parity influenced anxiety levels. This quasi-experimental two-group pretest-posttest control study design involved 64 respondents (32 in each group) who were selected through quota sampling from a population of 156 high-risk pregnant women at Midwife Susiani's independent practice in Banyuwangi. Data were analysed using normality, homogeneity and independent t-tests. The intervention group showed a significantly greater reduction in anxiety scores, with an average decrease of 11.1, whereas the control group averaged 3.03. An independent t-test confirmed this disparity to be statistically significant ($p < 0.05$), thereby confirming the effectiveness of self-healing hypnotherapy in reducing anxiety. However, demographic factors were not found to have a significant influence on anxiety levels. In conclusion, self-healing has been proven to be an effective independent psychological intervention and is therefore recommended for integration into healthcare services for high-risk pregnant women as a complementary therapy.

INTRODUCTION

Pregnancy is a period marked by significant physiological, anatomical, and hormonal changes that may affect the physical and psychological vulnerability of mothers (Majella et al., 2019), (Mirzakhani et al., 2020). Although most pregnancies progress

normally, every pregnancy carries a potential risk of complications that may occur without warning and may become life-threatening (Kuppusamy et al., 2023). Previous studies reported that approximately 10% to 30% of pregnant women are classified as high-risk during the antenatal period, and 70% to 80% of



them may experience perinatal morbidity or mortality (Majella et al., 2019). In developing countries, high-risk pregnancies contribute to approximately 20% of the disease burden among women. Therefore, early identification through risk-score assessment is essential for improving perinatal prognosis (Janagam et al., 2020). This approach supports planned management, appropriate resource allocation, and timely referrals to higher-level health facilities, thereby reducing maternal and fetal morbidity and mortality (Putri IM, 2020).

High-risk pregnancies affect not only physical health but also the psychological well-being of expectant mothers. Anxiety is one of the most prevalent emotional challenges, often stemming from concerns regarding maternal and fetal health, the childbirth process, and potential complications during pregnancy and delivery (Rahmawati et al., 2022). There are several types of anxiety that a mother may experience during pregnancy, one of which is pregnancy-related anxiety, characterized by the emergence of fear and worry in pregnant women (Brunton RJ et al., 2015 in (Rahmawati et al.,

2022).

The prevalence of anxiety disorders among pregnant women shows the urgency of this issue. Globally, anxiety disorders among pregnant women are reported to affect 8% to 10% of women (Faradisi, 2025). WHO data in 2024 also reported that the global prevalence of psychological disorders during pregnancy reached 10%, while the figure in developing countries was higher at 15.6% (WHO, 2024). A significant gap has also been reported between developed countries, with a prevalence of 10%, and developing countries, with a prevalence of 25% (Astarini et al., 2022). In Indonesia, a 2023 study showed that that anxiety among pregnant women reached 28.7% (Wardani, 2024). This situation is reflected in East Java, particularly the Madura region, with a prevalence rate of 31.4% (Hidayathillah et al., 2023). This trend continued in 2024, when 36.7% of third-trimester pregnant women in Java experienced anxiety (Pratama et al., 2024). In Banyuwangi Regency, anxiety among third-trimester pregnant women in 2023 was reported at 53.6% for mild anxiety, 23.2% for moderate anxiety, and 5.5% for severe anxiety (Herlina et



al., 2023). These findings support previous evidence that high-risk pregnancy is significantly associated with anxiety and may threaten maternal well-being (Mirzakhani et al., 2020).

Anxiety among pregnant women, especially those with high-risk pregnancies, is significantly associated with increased uterine contractions and may increase the risk of preeclampsia, miscarriage, and low birth weight (Saputri & Yudianti, 2020). Anxiety in the third trimester may also affect fetal development because increased stress hormones can inhibit blood flow to the fetus and contribute to neurodevelopmental problems in children (Mufidah, 2024). In addition, prenatal anxiety may increase maternal vulnerability to postpartum anxiety and depression (Stojanow et al., 2017). Based on these potential impacts, appropriate interventions are needed to prevent anxiety-related complications among pregnant women with high-risk pregnancies (Mufidah, 2024).

Psychological problems among pregnant women can be managed through self-healing methods that support relaxation, subconscious management, self-control, and physical

fitness. Self-healing hypnotherapy refers to a self-recovery process based on individual belief and supported by external and environmental factors (Rahmasari, 2020). As a form of intrapersonal communication, self-healing hypnotherapy provides an approach to heal emotional and physical distress and may reduce anxiety by activating the body's natural recovery capacity (Mutohharoh, 2022). In principle, every individual has the capacity for self-healing. However, pregnant women with high-risk pregnancies need professional guidance to apply this method safely and effectively. In this context, midwives play an important role in guiding patients to achieve mental and physical well-being through relaxation techniques and self-healing hypnotherapy (Makmun et al., 2023). Therefore, this study aimed to analyze the effect of self-healing on anxiety levels among pregnant women with high-risk pregnancies. The novelty of this study lies in its specific focus on self-healing hypnotherapy as a guided midwifery-based intervention for reducing pregnancy-related anxiety among high-risk pregnant women, a population that remains vulnerable but



has received limited attention in anxiety intervention studies.

RESEARCH METHODS

This study was conducted at Midwife Susiani's Independent Midwifery Practice from March 15 to May 15, 2025, utilizing a quasi-experimental, two-group pretest-posttest control design. The source population comprised all high-risk pregnant women attending the practice during the study period, totaling 156 women. The sample size was determined based on the minimum requirement for experimental studies ($n = 30$ per group), with an additional 10% factored in to account for potential dropouts, resulting in a total sample of 64 respondents. Therefore, 33 respondents were initially recruited for each group. Following the follow-up period, 64 participants completed the study and were included in the final analysis, divided equally between the intervention ($n = 32$) and control groups ($n = 32$).

This study utilized quota sampling due to limited population and recruitment constraints during antenatal visits. While this method may pose selection bias and generalizability

limitations, risks were mitigated through strict selection criteria, uniform recruitment, baseline comparability assessments, and multivariate confounding adjustments; subsequent studies should use random sampling. This research aims to analyze the efficacy of Self-Healing Hypnotherapy on high-risk maternal anxiety. Its novelty lies in a structured, home-based intervention utilizing guided audio, positive affirmations, adherence tracking, and professional midwifery supervision. The inclusion criteria were: 1) willingness to participate and provision of signed informed consent; 2) gestational age under 37 weeks; 3) classification as a high-risk pregnancy; 4) presence of pregnancy-specific anxiety based on the Pregnancy-Specific Anxiety Tool (PSAT); and 5) ability to attend two Self-Healing Hypnotherapy training sessions. Conversely, the exclusion criteria comprised: 1) a history of severe mental disorders, including major depression, epilepsy, or psychosis; 2) inability to follow Self-Healing Hypnotherapy instructions due to cognitive or language impairments; and 3) concurrent use of antidepressant medications during the study period.



The research procedure initiated with explaining the study's objectives, benefits, and risks, followed by obtaining signed informed consent from participants. Baseline anxiety was assessed in both groups using the 33-item Pregnancy-Specific Anxiety Tool (PSAT) questionnaire, a self-report instrument capturing six domains: anxiety severity, perceived support, and concerns regarding infant health, labor, postpartum, and finances. Evaluated on a 4-point scale (with a 'not applicable' option for partner items), higher scores indicate greater anxiety; items 1, 19, and 31 are reverse-scored. While the original PSAT demonstrated strong psychometric properties (Cronbach's $\alpha = 0.93$, test-retest reliability = 0.83), our pilot testing confirmed its validity and reliability for this population, with item-total correlations ranging from 0.415 to 0.876 and a Cronbach's α of 0.845.

The intervention group received structured self-healing hypnotherapy education and demonstrations. This intervention was provided in two training sessions (once a week) before home practice. Each training session lasted 60 minutes and was conducted by a trained midwife. The first session

explained anxiety during high-risk pregnancy, the goals of self-healing hypnotherapy, safety procedures, breathing techniques, relaxation positions, and the use of MP3 audio guides. The second session focused on demonstration and return demonstration. Respondents practiced the technique under supervision until they were able to follow the instructions independently.

The pre-sleep Self-Healing Hypnotherapy audio recording initiates with gentle deep-breathing guidance to release accumulated physical tension and maternal anxiety, before progressively guiding the expectant mother into a deepening phase through the visualization of a safe and serene environment. Within this deep hypnotic trance, the audio directs the participant to activate a physical somatic anchor via finger touch, ensuring that this state of tranquility can be instantly recalled at any time. This is followed by the delivery of positive affirmations specifically tailored to high-risk pregnancies, which focus on strengthening the maternal-fetal bond, reinforcing the belief in the body's natural capacity to protect the fetus, and reframing anxiety into optimism and



peaceful acceptance. The intervention sequence concludes with a gentle transitional suggestion that steers the subconscious mind into a deep, restorative sleep cycle, allowing the mother to awaken the following morning with enhanced physical vitality, emotional stability, and positive energy to sustain her pregnancy

Adherence monitoring for high-risk pregnant women was conducted using a combination of daily log diaries and periodic midwifery supervision. Each morning, participants recorded their practice duration, timing, and post-intervention emotional responses. To ensure consistency, midwives provided structured weekly remote supervision via phone calls or text messages, which was subsequently verified alongside physical examinations during routine antenatal care (ANC) visits at the independent midwifery practice.

The control group received standard Antenatal Care (ANC) education according to routine services at Susiani's Independent Midwife Practice (TPMB). Standard ANC education included information on pregnancy danger signs, nutrition, rest, fetal movement monitoring, preparation

for delivery, and the importance of regular antenatal visits. The control group did not receive self-healing hypnotherapy training or the MP3 audio guide during the intervention period. After two months of intervention, anxiety levels were measured again in both groups using the same PSAT questionnaire.

Data analysis began with testing statistical assumptions. The Shapiro-Wilk test was used to assess data normality, and Levene's test was used to assess homogeneity of variance. The data were normally distributed and met the assumption of homogeneity. Therefore, differences in anxiety levels between the intervention and control groups were analyzed using the Independent T-Test. Multivariate analysis using linear regression with dummy variables was then conducted to identify potential confounding factors affecting anxiety, including age, education, occupation, parity, and gestational age. This study received ethical approval from the Ethics Commission of STIKES Banyuwangi with approval number 210/02/KEPK-STIKESBWI/III/2024-2025, dated March 10, 2025.



RESULTS AND DISCUSSION

Table 1. Characteristics of Respondents Based on Age, Parity, and Gestational Age

Characteristics	Mean	Median	St.D	Min-Max
Age				
Intervention	33,47	36	6,891	19-45
Control	31,72	34	7,596	15-44
Parity				
Intervention	3	3	1,295	1-7
Control	2,81	2,50	1,281	1-6
Gestasional Age				
Intervention	17,66	16,50	7,656	6-32
Control	14,34	12,00	6,917	4-31

The characteristics of respondents based on age, parity, and gestational age are presented in Table 1. The mean age of respondents in the intervention group was 33.47 years (SD = 6.89; range = 19 to 45 years), while the mean age in the control group was 31.72 years (SD = 7.60; range = 15 to 44 years). The mean parity was 3.00 (SD = 1.30; range = 1 to 7) in the intervention group and 2.81 (SD = 1.28; range = 1 to

6) in the control group. The mean gestational age was 17.66 weeks (SD = 7.66; range = 6 to 32 weeks) in the intervention group and 14.34 weeks (SD = 6.92; range = 4 to 31 weeks) in the control group. These findings indicate that both groups had relatively comparable demographic and obstetric characteristics, although the intervention group tended to have higher age and gestational age.

Table 2. Normality and Homogeneity Test

Indicators	Sig.	Normality Description	Homogeneity
Intervention			
Pretest	0,068 > 0,05	Normal	0,320 (Homogeneous)
Posttest	0,305 > 0,05	Normal	
Control			
Pretest	0,054 > 0,05	Normal	0,737 (Homogeneous)
Posttest	0,175 > 0,05	Normal	

Based on Table 2, the results of the assumption tests show that all the research data have met the criteria for

parametric statistical analysis, where the normality test yielded significance values (p-values) above the 0.05



threshold for both the intervention group (pretest $p = 0.068$; posttest $p = 0.305$) and the control group (pretest $p = 0.054$; posttest $p = 0.175$), proving that all anxiety score distributions are normally distributed. In line with these results, the variance homogeneity test also showed significance values above 0.05, namely

0.320 for the intervention group and 0.737 for the control group, so it can be concluded that the data of both groups are homogeneous (equal), and meeting these two classic assumptions validates the use of linearity tests and t -test comparisons in the next stage of data analysis.

Table 3. Independent T test analysis data

Variable	Mean	St.D	St.Error	95% CI		p-value	p-value
			Mean	Lower	Upper	Pairet T Test	T Independent
Intervention							
Pretest	26,19	2,039	0,360	9,949	12,239	0,000	
Posttest	15,09	2,161	0,382				
Control							
Pretest	21,97	2,071	0,366	4,650	7,412	0,000	
Posttest	18,94	2,094	0,370				0,000

Table 3 demonstrates that within the intervention group, the administration of self-healing hypnotherapy reduced the mean anxiety score by 11.1, points, whereas the control group exhibited a minor reduction of 3.03 points. The

independent t -test revealed a statistically significant post-intervention difference in anxiety levels between the two groups ($0.000 < 0.05$), confirming that self-healing hypnotherapy effectively mitigates prenatal distress among high-risk pregnant women.

Table 4. Multivariate Regression Analysis

Independent Variable	B	SE	β	t-value	p-value	95% CI	VIF
Age	-0,114	0,061	-0,198	-1,861	0,068	-0,237 to 0,009	1,102
Education	0,412	0,293	0,115	1,406	0,165	-0,174 to 0,998	1,341
Occupation	-0,583	0,446	-0,103	-1,307	0,197	-1,475 to 0,309	1,225
Parity	-0,287	0,201	-0,142	-1,428	0,159	-0,689 to 0,115	1,157
Gestational Age	0,0076	0,044	0,169	1,727	0,089	-0,012 to 0,164	1,094
Pretest Anxiety Score	0,415	0,085	0,482	4,882	<0,001	0,245 to 0,585	1,214
Constanta	12,451	2,150	-	5,791	<0,001	8,151 to 16,751	-



Based on Table 4, the multiple linear regression analysis demonstrates that after controlling for baseline psychological distress using the Pretest Anxiety Score, none of the respondents' sociodemographic or obstetric characteristics exert a statistically significant independent effect on post-test anxiety levels. This lack of significance is indicated by p -values > 0.05 across all predictors, specifically age ($p = 0.068$), education ($p = 0.165$), occupation ($p = 0.197$), parity ($p = 0.159$), and gestational age ($p = 0.089$). The predictive neutrality of these demographic factors is further substantiated by the 95% Confidence Intervals (CI), which uniformly cross or encompass zero (0). Conversely, the Pretest Anxiety Score emerged as the sole variable to significantly and independently predict final anxiety outcomes ($B = 0.415$; $\beta = 0.482$; $t = 4.882$; $p < 0.001$; 95% CI: 0.245 to 0.585). This signifies a robust positive relationship, wherein every one-point increase in the baseline anxiety score corresponds to a 0.415-point increase in the post-test anxiety score. Lastly, the regression model is highly stable and free from multicollinearity distortions, as

the Variance Inflation Factor (VIF) for all variables ranges strictly between 1.094 and 1.341, falling well below the conservative threshold of 5.0. Occupation ($p = 0.197$), parity ($p = 0.159$), and gestational age ($p = 0.089$). The non-significance of these demographic factors is further supported by the 95% Confidence Interval (CI) ranges, which all cross or include zero (0).

The findings of this study indicate that self-healing hypnotherapy was effective in reducing anxiety among high-risk pregnant women. As presented in Table 4, the mean anxiety score in the intervention group decreased from 26.19 at pretest to 15.09 at posttest, with a mean reduction of 11.10 points. In the control group, the mean anxiety score decreased from 21.97 to 18.94, with a mean reduction of 3.03 points. Therefore, the reduction gap between the intervention and control groups was 8.07 points. The independent t -test showed a significant difference in anxiety scores between groups after the intervention ($0.000 < 0.05$). These results suggest that the decrease in anxiety was greater among respondents who received self-healing hypnotherapy than among those

who received standard Antenatal Care (ANC) education only.

However, the findings should be interpreted carefully. The baseline anxiety score in the intervention group was higher than in the control group. This indicates that both groups were not fully equivalent at baseline. Therefore, the strong reduction in anxiety in the intervention group may partly reflect greater room for improvement. Even so, the posttest score remained significantly lower in the intervention group, and the mean reduction was substantially greater than in the control group. This supports the clinical relevance of self-healing hypnotherapy, although future studies should use random allocation and adjusted analysis, regression models controlling for baseline anxiety, to confirm the intervention effect more rigorously.

The pronounced anxiety reduction in the intervention group can be explained by interconnected neurocognitive and somatic mechanisms. Self-healing hypnotherapy synergizes deep musculoskeletal relaxation, diaphragmatic breathing regulation, guided imagery, and positive affirmations. As substantiated by Hakiki

et al. (2025), structured relaxation techniques utilizing a systematic cephalocaudal progression effectively induce a state of physiological and psychological tranquility (Hakiki et al., 2025). Furthermore, these behavioral interventions utilize rhythmic or repetitive stimuli such as focused somatic activities and linguistic cues to foster a profound feeling of calm (Widyastuti, 2022). Within this framework, positive affirmations assist expectant mothers in replacing catastrophic cognitive distortions with adaptive thought patterns, thereby boosting confidence in managing pregnancy (Ningrum, 2021). When an individual actively believes in positive affirmations, it creates a stabilizing psychosomatic response that alters bodily reactions favorably (Noviariski, 2021). Additionally, the use of guided audio practice at home reinforces repetition and consistency, allowing mothers to internalize these relaxation responses over time to mitigate acute discomforts that disrupt daily activities and rest.

This clinical approach is strongly supported by previous literature validating mind-body interventions



across various stressful contexts. Kundarti *et al.* (2023) established that gestational hypnotherapy successfully reduces prenatal anxiety and cortisol levels, thereby stabilizing both psychological and physiological stress responses (Kundarti & Komalyna, 2023). Similarly, Nasiri *et al.* (2018) and Furtado *et al.* (2019) demonstrated that structured relaxation exercises and guided imagery significantly alleviate maternal distress and psychosomatic discomfort during pregnancy (Furtado *et al.*, 2019; Nasiri *et al.*, 2018).

A study by Indahwati *et al.* concluded that self-hypnosis interventions are significantly effective in reducing anxiety levels among pregnant women. Post-intervention evaluations revealed a substantial decrease in anxiety scores within the experimental group compared to the control group, which received only routine care or standard education. This therapy has been proven to be a safe, autonomous, and highly applicable non-pharmacological method for expectant mothers to manage emotional distress and achieve a more stable psychological status throughout gestation (Indahwati *et al.*, 2024). This therapy helps mothers

manage emotions and inner calm through relaxation activities and self-control, thereby significantly reducing the level of anxiety experienced. High-risk pregnant women are more susceptible to experiencing anxiety compared to those who are not at risk. Conversely, low-risk pregnant women typically experience transient anxiety concentrated primarily within the third trimester approaching childbirth, which is often compounded by emotional and somatic fatigue stemming from a deficiency in when anticipating labor pain. Within this framework, self-healing serves as a cognitive-restructuring mechanism that counters negative cognitive distortions with positive affirmations, thereby enhancing maternal comfort and psychological well-being. Its clinical benefits encompass heightened self-awareness during high-risk gestations, which promotes systemic relaxation and mitigates acute anxiety. When successfully implemented, this mind-body methodology empowers expectant mothers to remain assertive, resilient, and emotionally stable across adverse obstetric conditions (Nainggolan, 2025).



The robust efficacy of such interventions is further reinforced by Ningrum (2022) and Indahwati et al. (2024), who confirmed that autonomous, self-directed therapies consistently mitigate severe prenatal anxiety. Ningrum (2022) observed that routine practice of self-healing significantly reduced maternal anxiety during the macro-environmental crisis of the COVID-19 pandemic, with mean scores decreasing from 25.18 to 14.04. Corroborating this in a direct clinical application, Indahwati *et al.* (2024) reported a profound decrease in mean anxiety scores from 23.24 at pretest to 13.32 at posttest ($p < 0.001$), whereas the control group showed no significant modification (Indahwati et al., 2024; Ningrum, 2021).

The numerous complaints and anxieties that occur during pregnancy cause pregnant women to often experience discomfort during pregnancy, which frequently disrupts their activities and rest. One way to reduce these complaints is through self-healing therapy for pregnant women, which is very useful in helping to provide a relaxation effect on both the body and the baby being carried, as long as the

treatment is carried out correctly and properly, and handled by professional personnel. The statistical analysis using the Wilcoxon Signed-Ranks Test showed a very significant difference in anxiety levels before and after the intervention, with a significance value of $p = 0.005$ ($p < 0.01$). Based on the empirical data, the subjects' average anxiety score dropped from the Severe Anxiety category (score $M = 31.33$) in the pre-test to the Mild Anxiety category (score $M = 16.33$) in the post-test. (Putri & Yuliandari, 2020). In practice, self-healing efforts are considered one of the handling processes referred to as natural, because basically humans are able to heal themselves through certain simple methods that make them comfortable.

Multivariate analysis in this study indicated that demographic and obstetric factors, including age, education, occupation, parity, and gestational age, do not have a significant effect on anxiety levels in high-risk pregnant women. In contrast to traditional baseline predictors, the multivariate linear regression analysis revealed that sociodemographic and obstetric factors specifically age ($p = 0.068$), education ($p = 0.165$), occupation ($p = 0.197$),



parity ($p = 0.159$), and gestational age ($p = 0.089$) exerted no statistically significant independent effects on maternal anxiety levels. This lack of statistical significance indicates that within a high-risk obstetric framework, objective medical complications act as a profound psychological equalizer, superseding typical demographic protective factors or vulnerabilities. Specifically, regarding maternal age ($p = 0.068$) chronological age did not dictate distress levels. In normal pregnancies, younger mothers (ages 20–35) typically possess better emotional regulation and milder anxiety due to superior cognitive information-processing capacities, whereas mothers over 35 display heightened psychological vulnerability due to increased physical risks (Cahyani et al., 2022; Fatmasanti et al., 2022). However, this age gradient is completely neutralized under high-risk diagnoses. Age becomes less influential because anxiety is heavily mediated by unmeasured psychosocial dynamics, such as perceived social support and family care; when adequate backing is provided by partners, families, and healthcare providers, age-related

vulnerabilities are effectively buffered (Bedaso et al., 2021).

Furthermore, regarding educational level ($p = 0.165$) showed no significant independent association with anxiety. Theoretically, higher education elevates intellectual maturity and health literacy, enabling women to interpret health information quickly and deploy effective coping strategies to suppress distress (Cahyani et al., 2022; Yanti & Hasrida, 2024). Conversely, Çankaya & Şimşek lower educational attainment is often associated with restricted information access and higher baseline prenatal anxiety (Çankaya & Şimşek, 2021; Kotimäki et al., 2020). In this study, however, the restricted variation where most respondents in both groups possessed secondary education coupled with the uniform health education provided to both groups during the study period, equilibrated information access and neutralized education as a baseline predictor. Therefore, under an acute medical stressor, academic background does not automatically shield a mother from experiential anxiety.

Parallel to the findings on education, occupational status ($p =$

0.197) was not significantly linked to anxiety fluctuations. Although working pregnant women often benefit from broader social interactions and peer support, whereas stay-at-home mothers face potential isolation and minimal experience in coping with stress (Halil A & Puspitasari E, 2023), this variable alone was not sensitive enough in this cohort. This lack of significance occurred because employment status cannot accurately predict anxiety without direct measurement of confounding financial pressures, actual workloads, and domestic responsibilities.

Parity ($p = 0.159$) exerted no independent predictive power. Within obstetric literature, primiparous women are conventionally hypothesized to experience elevated anxiety driven by a fear of the unknown and role-adaptation stress, whereas multiparous women leverage prior childbirth experiences to foster readiness, though they remain vulnerable to distress stemming from historical trauma or child-rearing fatigue (Astuti et al., 2022; Shen et al., 2022). In high-risk gestations, the acute threat of current medical complications overrides past obstetric success, neutralizing this disparity. A high-risk designation

disrupts the perceived security derived from previous uncomplicated births for multiparous women and compounds inherent apprehension for primiparous women, activating a universal stress response irrespective of a woman's parity.

Gestational Age ($p = 0.089$) was not significantly associated with anxiety scores. While late-trimester cohorts traditionally experience heightened somatic fatigue, labor-induced fears, and elevated stress hormone responses (Baroah et al., 2020), high-risk mothers exhibit sustained, elevated anxiety from the initial moment of risk diagnosis in early pregnancy (Widyastuti, 2022). Medical complications, repeated health monitoring, and uncertainty about pregnancy outcomes trigger persistent anxiety across all trimesters, making the specific gestational age less relevant than the severity of the medical risk itself. Consequently, anxiety within high-risk pregnancies is driven more directly by dynamic psychosocial constructs such as perceived interpersonal support, coping strategies, and health literacy rather than static demographic profiles.

This study has several limitations. First, the sample size was



relatively small, with 64 respondents completing the study. This may reduce statistical power and limit the ability to detect the effects of demographic variables. Second, the study was conducted in a single independent midwife practice place, so the findings may not represent high-risk pregnant women in different health facilities, regions, or sociocultural contexts. Third, this study used a quasi-experimental design without random allocation. This may introduce selection bias and baseline imbalance between groups. Fourth, anxiety was measured using a self-report questionnaire, which may be affected by response bias, social desirability bias, or respondents' understanding of the questionnaire items. Fifth, the study did not include long-term follow-up, so it remains unclear whether the reduction in anxiety persisted until delivery or the postpartum period. Sixth, adherence to home-based practice was monitored, but direct supervision was not conducted during every home session. This may create variation in the way respondents practiced self-healing hypnotherapy. Finally, this study did not measure other psychosocial variables, such as social support, partner

involvement, coping strategy, health literacy, and severity of pregnancy risk. These variables should be included in future research to provide a more comprehensive explanation of anxiety among high-risk pregnant women.

CONCLUSIONS

Self-healing therapy has been shown to significantly reduce anxiety levels in pregnant women. There is a difference in anxiety between the intervention and control groups. There is no relationship with confounding variables (Research revealed that after the implementation of this therapy, the majority of mothers reported a decrease or even disappearance of anxiety, although factors such as age, education, occupation, parity, and gestational age did not show a significant influence on the condition). Based on the findings, self-healing therapy is recommended to be applied routinely and integrated into health services for high-risk pregnant women. Midwives and health cadres should be trained to guide relaxation techniques, emotion management, and calming activities as an effective complementary approach, independent of demographics. Self-healing education



and training need to start from the first trimester to build mental readiness for pregnancy and childbirth.

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