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Psychological Burden of High-Risk Labeling: A Phenomenological Study of Maternal Identity, Self-Efficacy, and Emotional Well-Being in Women with Complicated Pregnancies

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Abstract. The high-risk pregnancy label assigned by healthcare providers not only indicates a clinical condition but also triggers complex psychological burdens on pregnant women. The psychological impact of this labeling is often overlooked in midwifery care approaches that focus primarily on biomedical aspects. This study aimed to explore the lived experiences of women labeled with high-risk pregnancies, focusing on maternal identity, self-efficacy, and emotional well-being. Methods: Descriptive phenomenological qualitative research. Twelve participants were selected through purposive sampling from the high-risk obstetric outpatient clinic at RSUD Kepri, Batam. Data were collected through semi-structured in-depth interviews and analyzed using Colaizzi's method. Results: Six major themes emerged from the analysis: (1) maternal identity disorientation, (2) erosion of self-efficacy, (3) multilayered emotional distress, (4) changing relational dynamics, (5) resilience and meaningful adaptation, and (6) therapeutic communication gaps. Participants described profound psychological struggles characterized by fear, guilt, uncertainty, social isolation, and disrupted perceptions of motherhood. Spiritual coping and family support emerged as important adaptive mechanisms, while inadequate therapeutic communication from healthcare professionals intensified emotional distress. Conclusion: High-risk labeling creates multidimensional psychological burdens that significantly affect the quality of life of pregnant women. An integrated care approach addressing both clinical and psychosocial aspects, along with enhanced therapeutic communication competencies among healthcare providers, is urgently needed.

Keywords: Emotional Well-Being;High-Risk Pregnancy; Phenomenology; Psychological Burden; Self-Efficacy.

1. INTRODUCTION

High-risk pregnancy is defined as a pregnancy condition that has a greater probability of maternal-perinatal morbidity and mortality than the general population (Johnson et al., 2024). Globally, an estimated 15% of all pregnancies are categorized as high risk due to various medical, obstetric complications, and psychosocial factors (Yang & Chen, 2025). In Indonesia, the prevalence of high-risk pregnancies reaches 22-27% of total recorded pregnancies, with the highest distribution in urban areas such as Batam, Riau Islands, which have complex demographic characteristics (Kementrian Kesehatan RI, 2023).

In contemporary obstetric clinical practice, labeling pregnant women as "high-risk" has become a standard procedure intended to facilitate triage and efficient allocation of healthcare resources (Brown, 2025). However, scientific literature over the past two decades has consistently indicated that this labeling process is not psychologically neutral. The high-risk label not only represents a clinical status but also functions as a social construct that fundamentally alters how women perceive themselves as pregnant subjects (Manago & Mize, 2024).

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The Maternal Identity Theory, proposed by Rubin (1984) and further developed by Ramona T Mercer (2004) through the concept of "Becoming a Mother," emphasizes that pregnancy is a critical period in the formation of a woman's identity as a mother. This process involves the internalization of the maternal role, adjustment of self-concept, and reconstruction of the meaning of existence. When this process is disrupted by the stigma of a high-risk label, women are at risk of experiencing what Sandberg et al (2021) call a "maternal identity crisis," a condition in which the self-image of a competent mother collapses along with a threatening diagnosis.

From the perspective of Self-Efficacy Theory Bandura (1977), a woman's confidence in her ability to navigate pregnancy and childbirth is a strong predictor of obstetric and psychological outcomes. A longitudinal study by Huizink et al. (2004) showed that self-perception as an "incompetent mother" was significantly correlated with increased maternal cortisol, decreased adherence to medical advice, and an increased risk of peripartum depression. The paradox is that a label intended to promote safety can actually worsen psychological outcomes, impacting the physiology of pregnancy itself.

Existing quantitative research tends to measure anxiety and depression as separate variables without exploring the holistic phenomenological experiences underlying these conditions. A qualitative phenomenological approach is needed to understand the structure of women's lived experiences within the context of high-risk labeling, a region that remains largely underexplored, particularly within the context of Indonesian and Southeast Asian cultures, which have unique psychosocial nuances.

In Batam, an industrial city with high population mobility and rapidly expanding access to healthcare services, unique demographics influence the experiences of high-risk pregnancies. Migration, economic pressures, distance from extended family, and differences in cultural values among migrants from various regions in Indonesia create layers of psychosocial complexity that have not been academically documented.

Based on this background, this study aims to explore in-depth the phenomenological experiences of women labeled as having high-risk pregnancies in Batam, focusing on their impact on maternal identity, self-efficacy, and emotional well-being. The research findings are expected to provide theoretical contributions to the development of a more holistic and woman-centered midwifery care model.

2. RESEARCH METHOD

Research Design

This study employed a descriptive phenomenological design within a qualitative research paradigm. The phenomenological approach was chosen because of its ability to reveal the essence and structure of human life experiences as experienced first-person, without reducing them to predetermined theoretical categories Edmund Husserl (1970). The data analysis method followed Paul F. Colaizzi (1978) seven-step procedure, which has been tested for phenomenological studies of nursing and midwifery.

This approach was chosen based on the epistemological consideration that the psychological experiences of women with high-risk pregnancies are subjective, contextual, and cannot be reduced to mere numerical measurements. This research is positioned within the constructivist post-positivist tradition, which recognizes that the reality of human experience is shaped by interpretation, cultural context, and social relations.

Types of research

Qualitative research with a descriptive phenomenological approach. This research does not aim to produce statistical generalizations, but rather theoretical transferability, that is, an in-depth understanding that can provide new perspectives for health practitioners, researchers, and policymakers in contexts with similar characteristics. This study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Time and Place of Research

The study was conducted over four months from January 2025 to April 2025. Data collection took place from February to March 2025. The study location was the Obstetrics Polyclinic of the Riau Islands Regional General Hospital, Batam, which is a tertiary referral center for complex obstetric cases in the Riau Islands.

Population

The population in this study was all women undergoing antenatal care with a diagnosis of high-risk pregnancy at the Obstetrics Polyclinic of the Riau Islands Regional Hospital, Batam, during the data collection period (February–March 2025). Based on medical records, an average of 20–40 new patients with a high-risk pregnancy diagnosis visit per month.

Samples and Sampling Techniques

The sample size was set at 12 participants. In phenomenological research, sample size is determined not based on statistical representativeness, but rather on data saturation, the point at which new information no longer produces fundamentally distinct themes (Guest et al.,

2006). Phenomenological research typically reaches saturation with 8–12 participants (Dahal et al., 2024), and this study selected 12 participants to ensure sufficient data richness.

The sampling technique was purposive sampling with strict inclusion and exclusion criteria. Snowball sampling was used as a complementary technique to identify participants with unique perspectives but who were underrepresented through mainstream recruitment channels.

Inclusion Criteria: (1) Pregnant women who have been explicitly diagnosed with a "high-risk pregnancy" by a health professional; (2) Gestational age between 16-38 weeks; (3) Able to communicate in Indonesian; (4) Willing to participate voluntarily and sign an informed consent; (5) Not experiencing an acute medical condition requiring intensive care at the time of the interview; (6) Domiciled in Batam. Exclusion Criteria: (1) Women with a history of uncontrolled major psychiatric disorders (schizophrenia, acute episode bipolar disorder); (2) Participants who refused to have the interview recorded; (3) Women who experienced a fetal loss in the last 2 weeks.

Data collection

Data were collected through individual semi-structured in-depth interviews. Each interview lasted 60-120 minutes and was conducted in a counseling room provided by the hospital to ensure the privacy and comfort of the participants.

The interview guide was developed based on the research's theoretical framework and validated by two expert judges in clinical psychology and obstetrics. The interview guide was flexible and served as a guide for exploration, rather than a rigid list of questions. The guiding questions covered the following dimensions: (1) initial response to a high-risk diagnosis, (2) changes in self-perception as a mother, (3) daily emotional experiences, (4) impact on interpersonal relationships, (5) sources of support and coping used, and (6) expectations of the healthcare system.

All interviews were recorded using a digital audio recorder with the participants' consent and then transcribed verbatim by two trained research assistants. The principal investigator also took field notes during and immediately after the interviews to document non-verbal and contextual aspects.

Research instruments

The main research instrument is the researcher himself (human instrument), in accordance with the principles of phenomenological qualitative research (Lincoln & Guba, 1985). The supporting instruments used include: (1) a semi-structured interview guide consisting of 18 guiding questions; (2) an audio recording device; (3) Field notes; (4) a

researcher's reflexive journal; (5) an informed consent form; and (6) a participant demographic data form.

Researcher Reflexivity

The principal interviewer was a female midwifery researcher with experience in qualitative maternal health research. Before data collection, the researcher conducted reflexive bracketing to identify personal assumptions regarding high-risk pregnancy. A reflexive journal was maintained throughout the study to document methodological decisions, emotional responses, and potential interpretive biases. Regular peer debriefing sessions were conducted to enhance reflexivity and analytical rigor.

Research Procedures

The research procedure was carried out in four stages: Stage 1 – Preparation: Submission and obtaining ethical clearance from the Batam University Ethics Committee; development and validation of research instruments; training of research assistants; and outreach to healthcare workers at the Obstetrics Polyclinic of the Riau Islands Regional General Hospital.

Stage 2 – Participant Recruitment: Identification of potential participants through coordination with the polyclinic midwives; dissemination of research information; obtaining informed consent; and collection of demographic data.

Stage 3 – Data Collection: Conducting in-depth interviews; verbatim transcription; initial member checking; and data saturation.

Stage 4 – Data Analysis and Validation: Data analysis using the Colaizzi method; final member checking; peer debriefing; and preparation of a findings report.

Data analysis

Data were analyzed using Paul F. Colaizzi (1978) seven-step method: (1) Reading the entire phenomenological description to gain a sense of the whole; (2) Extracting significant statements from each transcript; (3) Formulating meanings from each significant statement; (4) Organizing the formulated meanings into theme clusters; (5) Integrating findings into a comprehensive essential description; (6) Formulating a clear and concise essential description; (7) Returning the essential description to participants for validation (member checking).

Analysis was conducted manually using an "immersive engagement" approach—the researchers repeatedly read each transcript before beginning coding. The coding process was conducted by two researchers independently, then consolidated through discussion to minimize interpretive bias.

Data validity

Data validity was determined through Lincoln and Guba's (1985) four criteria: (1) Credibility through member checking, prolonged engagement, and source triangulation; (2) Transferability through thick description of the research context; (3) Dependability through a documented audit trail; and (4) Confirmability through bracketing and peer debriefing. Details of the strategies are presented in Table 4.

Ethical considerations

This research has received approval from the Batam University Health Research Ethics Committee (No.215/LPPM-UNIBA/PI-EC/XII/2024). The research ethics principles applied include: (1) Autonomy: All participants received complete information and signed informed consent; the right to withdraw was guaranteed without any consequences. (2) Beneficence: The research was designed to provide benefits for the development of midwifery care. (3) Non-maleficence: Interviews were conducted using a trauma-informed approach; psychological referral services were available for participants who needed them. (4) Justice: All participants who met the criteria had an equal opportunity to participate. (5) Confidentiality: Participant identities were anonymized, and data were stored securely. (6) Scientific honesty: The entire process was transparently documented in the research audit trail.

3. RESULT AND DISCUSSION

Result

Participant Characteristics

The twelve participants in this study ranged in age from 25 to 42 years (mean 32.2 years). Most participants (58.3%) were multigravida. Their educational levels ranged from elementary school to postgraduate, reflecting the demographic diversity of Batam. The medical diagnoses underlying the high-risk label included a variety of complex obstetric conditions, including severe preeclampsia, placenta previa, gestational diabetes mellitus, multiple gestation, oligohydramnios, antiphospholipid syndrome (APS), placenta accreta, intrauterine growth restriction (IUGR), uterine myoma accompanied by pregnancy, vasa previa, and polyhydramnios. Complete participant characteristics are presented in Table 1.

Table 1. Demographic and Clinical Characteristics of Research Participants.

Participants	Age	Parity	Education	Work	Diagnosis	Gestational Age
P1	28	Primigravida	Bachelor	Nursing	PEB	32 week
P2	34	Multigravida	Senior High School	Housewife	Placenta Previa	28 week
P3	31	Primigravida	Diploma	Midwife	Gestational DM	26 week
P4	37	Multigravida	Elementary School	Housewife	Gemelli Pregnancy + PEB	30 week
P5	29	Primigravida	Bachelor	Private sector employee	Oligohydramnios	34 week
P6	42	Multigravida	Junior High School	Housewife	APS + Abortion History	22 week
P7	25	Primigravida	Bachelor	Lawyer	Placenta Accreta	36 week
P8	33	Multigravida	postgraduate	Manager	IUGR + Hypertension	29 week
P9	39	Multigravida	Senior High School	Self-employed	Uterine Myoma	20 week
P10	36	Primigravida	Diploma	Government employees	Preeclampsia + Obesity	31 week
P11	30	Primigravida	Bachelor	Counselor	Vasa Previa	27 week
P12	32	Multigravida	Senior High School	Housewife	Polihidramnion	33 week

PEB = Severe Preeclampsia; APS = Antifosfolipid Syndrome; IUGR = Intrauterine Growth Restriction

Research Results Themes

Data analysis using the Paul F. Colaizzi (1978) method, which was consolidated into six main themes with 18 sub-themes. A summary of these themes is presented in Table 2.

Table 2. Main Themes from the Results of Phenomenological Analysis

No	Main Theme	Sub-theme	Description
1	Maternal Identity Disorientation	Loss of Self; Role Conflict; Duality of Expectations vs. Reality	Participants experienced a fundamental shift in how they perceived themselves as expectant mothers after receiving the 'high risk' label.
2	Erosion of Self-Efficacy	Perceived Incapacity; Medical Dependence; Loss of Autonomy	The high-risk label leads to decreased self-confidence in one's body's abilities and capacity as a mother.

3	Layered Emotional Distress	Anticipatory Anxiety; Guilty feeling; Complex Grief	Layered emotional experiences include anxiety about the future, guilt towards the fetus, and grief over the loss of a 'normal' pregnancy
4	Changing Relational Dynamics	Social Isolation; Shifting Couple Relationships; Burden on the Family	Interpersonal relationships undergo significant changes, including isolation from social groups and pressure on marital relationships.
5	Resilience and Meaningful Adaptation	Active Acceptance; Spirituality; Reconstruction of Meaning	Positive adaptive mechanisms that develop over time, including reframing situations and strengthening spiritual resources.
6	Therapeutic Communication Gap	Inadequate Information; Desensitization of Health Workers; Need for Psychological Support	Dissatisfaction with the way health workers deliver diagnoses and the lack of structured psychological support

Theme 1: Maternal Identity Disorientation

All 12 participants (100%) reported experiencing a fundamental shift in how they perceived themselves as expectant mothers after receiving the high-risk label. This process involved three interrelated subthemes: loss of self, role conflict, and the duality between the expectation of an ideal pregnancy and the reality of a problematic pregnancy.

Participants described how a pregnancy, previously anticipated as a joyful event, became a source of existential threat. The high-risk label suddenly positioned their bodies as something that was “not working properly” or “endangering the baby.” Some participants from the healthcare professions (P1, P3, P11) experienced even more acute cognitive dissonance, where their clinical knowledge of the risks exacerbated their anxiety rather than providing reassurance.

Theme 2: Erosion of Self-Efficacy

Eleven of the 12 participants (91.7%) described a significant decline in confidence in their bodies' ability to carry a pregnancy. This erosion of self-efficacy manifested in three dimensions: perceived incompetence, over-reliance on medical interventions, and loss of autonomy in pregnancy-related decisions.

A prominent phenomenon was what the researchers termed "hyper-vigilance paralysis," a condition in which hypervigilance to warning signs limits daily activities to a degree beyond medical recommendations. Participants described a fear of moving, eating, working, or even sleeping in certain positions for fear of worsening their condition.

Theme 3: Multilayered Emotional Distress

All participants experienced multilayered emotional distress, not just a single anxiety, but rather layers of emotions that compounded each other. Three layers of emotions consistently emerged: anticipatory anxiety about complications and death, internalized guilt about the fetus's condition, and complex grief over the loss of a "normal" pregnancy experience.

Several participants described experiencing "pregnancy grief"—grief over a pregnancy that should have been enjoyable but felt robbed by a medical condition. Guilt was a dominant theme, with many participants, without any clinical evidence, internalizing their medical condition as the result of personal actions or omissions.

Theme 4: Changing Relational Dynamics

Nine of the 12 participants (75%) described significant changes in their interpersonal relationship patterns. These changes occurred in three domains: relationships with partners (strains in spousal relationships), relationships with broader social networks (social isolation), and relationships with healthcare professionals (healthcare relationship dynamics).

Several participants reported that their partners experienced "sympathetic anxiety"—an anxiety that was transmitted so that instead of being a source of support, their partners became a source of additional burden. Conversely, several participants from the stay-at-home mom group reported deep feelings of guilt due to feeling like an "economic burden" when unable to work due to pregnancy.

Theme 5: Resilience and Meaningful Adaptation

Eight of the 12 participants (66.7%) demonstrated positive adaptation patterns that developed after the initial crisis period. This adaptation included active acceptance, distinct from passive resignation, the activation of spiritual and religious resources, and a process of meaning-making that transformed the experience of illness into a meaningful personal narrative.

The religious context of Indonesia played a significant role in this theme. Many participants used Islamic spiritual frameworks as an interpretive lens, helping them reframe their condition from a "punishment" to a "test containing wisdom." Religious practices such as prayer, dhikr (remembrance of God), and Quranic recitation were described as effective sources of calm and were actively used as coping strategies.

Theme 6: Therapeutic Communication Gap

Eleven of the 12 participants (91.7%) expressed dissatisfaction with the way healthcare professionals communicated high-risk diagnoses and management. This

dissatisfaction was structured into three subthemes: insufficient information provided, healthcare professionals' desensitization to the psychological impact, and the absence of structured psychological support within the care system.

Participants consistently described experiences where diagnoses were communicated in technical-medical terms without exploring the patient's emotional readiness or providing space to express emotional responses. Several participants reported that they first received detailed information about their condition not from healthcare professionals, but from the internet or fellow patients.

Table 3. Representative Verbatim Per Theme.

No	Theme	Representative Verbatim	Participants
1	Identity Disorientation	"When the doctor told me 'I had a high-risk pregnancy, I immediately felt like I wasn't a normal woman anymore. Like there was something wrong with me that I couldn't fix...."	P1 (Severe Preeclampsia)
2	Erosion of Self-Efficacy	"I was afraid to do anything. I was afraid to walk too far, I was afraid to eat the wrong thing, I was afraid to sleep in the wrong position. My body felt like a ticking time bomb that could explode at any moment...."	P5 (Oligohydramnios)
3	Emotional Distress	"I cried almost every night. I felt like a failure as a mother even before my baby was born. Even though I hadn't done anything wrong, I still felt guilty...."	P3 (Diabetes Mellitus Gestational)
4	Social Isolation	"My pregnant friends could travel, work normally, and have fun. I couldn't. After a while, I stopped talking about it because I was tired of explaining my condition...."	P8 Intrauterine Growth Restriction (IUGR) + Hipertention)
5	Resilience	"I've made peace with this condition. This is a test from God. I can't change this diagnosis, but I can change how I deal with it. I'm fighting for my baby...."	P6 (APS) Antifosfolipid Syndrome
6	Communication Gap	"The doctor simply said, "This is high risk," and then handed me a piece of paper. I didn't understand what it meant, and no one explained it further. I went home in a panic...."	P9 (Uterine Myoma)

Table 4. Data Validity Strategy (Lincoln & Guba, 1985).

Legitimacy Strategy	Procedures Performed	Results
Member Checking	Send transcripts and theme summaries to participants for verification	10 of 12 participants confirmed, 2 provided minor clarifications which were accommodated.
Source Triangulation	Cross-validation of interview data with observation notes and the researcher's reflective journal	High consistency between verbal and non-verbal data during the interview
Peer Debriefing	Regular discussions with 2 experienced qualitative research colleagues	Regular discussions with 2 experienced qualitative research colleagues

Thick Description	In-depth description of the research context and participant characteristics	Allows transferability to contexts with similar characteristics
Bracketing (Epoché)	Researchers document and postpone biases before analysis.	A 42-entry reflexive journal helps maintain analytical neutrality

Discussion

Maternal Identity Disorientation from a Theoretical Perspective

The findings on maternal identity disorientation align with and extend Fuadah (2022) conceptualization of the "Becoming a Mother" process. Mercer stated that the transition to maternal identity involves four stages: anticipatory, formal, informal, and personal. This study found that the high-risk label dramatically disrupts this normal transition, creating what can be conceptualized as an "interrupted maternal transition," a condition that has not been explicitly documented in previous literature.

This finding resonates strongly with Goffman (1963) concept of "spoiled identity" in stigma theory. The high-risk medical label functions as a social stigma that shifts a woman's identity status from "normal mother-to-be" to "problem patient." This process is invasive and often irreversible; even when the medical condition has improved, the psychological impact on identity continues (Mahpara et al., 2022).

In the Indonesian context, the collective dimension of identity becomes relevant. In contrast to similar studies in Western contexts that emphasize the individual dimension, participants in this study experienced dual pressures: not only perceived personal failure, but also anxiety about the expectations of the extended family and community. This is consistent with research by Maher et al. (2022) on the influence of gender and ethnicity on experiences of reproductive complications.

Erosion of Self-Efficacy: Between Protection and Pathology

The findings of self-efficacy erosion reinforce and extend the research of Frankham et al. (2024) and Susanti et al. (2023), which demonstrated a correlation between risk perception and decreased maternal self-efficacy (Suhaimi et al., 2025). However, this study provides a richer phenomenological dimension that the erosion of self-efficacy is not simply a "reduced self-confidence," but rather an experience of body alienation.

From the perspective of Bandura (1977), Self-Efficacy Theory, the high-risk label directly undermines three of the four sources of self-efficacy: mastery experiences (perceived bodily failure), vicarious experiences (comparison with normal pregnancies), and

physiological/affective states (persistent anxiety). Only social persuasion, in some cases, remains functional through partner and family support.

The "hypervigilance paralysis" found in this study represents a novel conceptual contribution. This condition illustrates the paradox where intended protection actually creates additional suffering. These findings have important clinical implications: intervening in hyper-vigilance paralysis through self-efficacy-based psychoeducation may be an important component in the psychological management of high-risk pregnancies.

Multilayered Emotional Distress: Beyond the Diagnosis of Anxiety

This study found that emotional distress in women with high-risk pregnancies extends beyond the diagnostic constructs of anxiety and depression used in quantitative approaches. The multilayered emotional distress identified reflects a complexity of experience that cannot be fully captured by instruments such as the Edinburgh Postnatal Depression Scale (EPDS) or the Spielberger State-Trait Anxiety Inventory (STAI).

The concept of "pregnancy grief" emerging in this study bears similarities to disenfranchised grief Doka (2002), grief over a loss that is not socially recognized. Women with high-risk pregnancies grieve the loss of a normal pregnancy experience, but this grief is denied legitimate social space because they are nominally still pregnant.

The prominent guilt in these findings is consistent with Viana (2022) research on maternal guilt in problematic pregnancies. However, this research provides a contextual contribution that in Indonesian culture, this sense of guilt has a complex theological dimension. On the one hand, the condition is interpreted as a divine test, but on the other hand, there is anxiety about whether the condition is a consequence of past actions or sins.

These findings highlight the necessity of expanding maternal mental health frameworks within obstetric care. Emotional experiences in high-risk pregnancy should not be reduced solely to measurable psychiatric symptoms, but rather understood as complex emotional responses involving identity, meaning, uncertainty, and social belonging.

Relational Dynamics: Complex Social Support Systems

The findings on altered relational dynamics extend Seol et al. (2025) research on the impact of high-risk pregnancy on couples' relationships. This study found that the relational impact is not unidirectional (from the medical condition to the relationship), but rather bidirectional and circular, decreased relationship quality then exacerbates psychological distress, which in turn worsens the medical condition through physiological stress mechanisms.

A significant contribution of this study is the identification of "sympathetic anxiety transmission" within couples. This phenomenon has not been explicitly documented in the

Indonesian literature and has practical implications: psychological interventions should ideally involve the couple as a unit, not just the mother individually.

Resilience: Spirituality as a Contextual Coping Resource

The findings on spirituality-based resilience provide an important contribution to the perspective of transcultural nursing. The use of a religious framework as a primary coping resource found among the majority of Muslim participants is consistent with Taufik et al. (2025) research on meaning-based coping, but has contextual dimensions specific to Indonesian Muslim culture.

Interestingly, spirituality functions not simply as a passive mechanism (resignation), but as a source of active agency, participants feel they have direct access to a source of strength that transcends medical limitations. This creates a locus of control that differs from traditional concepts in Western psychology and needs to be recognized and integrated into psychosocial care models.

The Therapeutic Communication Gap: A Practice Reform Imperative

One of the most significant clinical findings in this study was participants' dissatisfaction with therapeutic communication from healthcare professionals. Women consistently described receiving diagnostic information in a highly technical, terse, and unemotional manner. Participants felt that healthcare providers focused solely on biomedical risks while ignoring psychological reactions and emotional needs. This study confirms and extends the findings of Gizachew et al. (2022) that the way healthcare professionals communicate risk impacts far beyond information transfer; it shapes participants' self-narratives about their condition.

Communicating the term "high risk" itself appeared to carry substantial emotional consequences. Participants often interpreted the diagnosis catastrophically, especially when explanations were limited or delivered without emotional preparation. Some women reported seeking clarification from online sources or other patients because they felt inadequately informed by healthcare professionals.

These findings emphasize that communication in maternal and fetal medicine is not only informative but also highly relational and psychologically impactful. Risk communication shapes how women understand their pregnancies, their bodies, and their futures as mothers. Consequently, insensitive or overly biomedical communication can inadvertently reinforce fear, helplessness, and emotional trauma.

These findings strongly support the integration of trauma-informed care and patient-centered communication training into midwifery and obstetrics education. Healthcare

professionals must be equipped not only with clinical competence but also with psychological communication skills capable of supporting emotional adaptation during complicated pregnancies.

Clinical Implications for Maternal and Fetal Care

The findings of this study have several important implications for maternal and fetal healthcare practices. First, psychosocial screening should be a routine component of high-risk antenatal care rather than solely focusing on biomedical monitoring. Screening for emotional distress, maternal self-efficacy, and social support can help identify women in need of early psychological intervention.

Second, healthcare professionals should adopt a more trauma-informed and empathetic communication approach when discussing pregnancy risks. The language used during diagnosis should minimize unnecessary fear while maintaining honesty and clinical accuracy. Third, a multidisciplinary care model that integrates obstetricians, midwives, psychologists, and mental health professionals can provide more comprehensive support for women with complicated pregnancies. Such an integrated approach can improve not only psychological well-being but also treatment adherence and maternal and fetal health outcomes. Finally, a culturally responsive care approach that recognizes spirituality, family dynamics, and sociocultural expectations can enhance the effectiveness of psychosocial support in the context of maternal healthcare in Southeast Asia.

Strengths and Limitations

This study makes an important contribution by offering an in-depth phenomenological understanding of the psychological burden associated with high-risk pregnancy labeling in the Indonesian context, which remains underrepresented in maternal mental health literature. Colaizzi's use of phenomenological analysis, prolonged engagement, member checking, and reflective strategies strengthens the credibility and trustworthiness of the findings.

However, several limitations need to be acknowledged. This study was conducted in a single tertiary hospital, which may limit its applicability to different healthcare settings or cultural contexts. The relatively small sample size inherent in phenomenological research may not capture all possible experiences of women with high-risk pregnancies. Furthermore, participants were predominantly Indonesian Muslim women, meaning that coping processes and sociocultural experiences may differ across more diverse populations. Researcher interpretation bias also remains possible despite the use of reflective strategies and discussions with colleagues.

Future studies may benefit from longitudinal qualitative approaches that examine how psychological experiences develop during pregnancy and the postpartum period, as well as comparative studies across different sociocultural settings

4. CONCLUSION AND SUGGESTIONS

This phenomenological study reveals that the label "high-risk pregnancy" creates a multidimensional psychological burden that goes beyond measurable clinical anxiety. Six key themes identified maternal identity disorientation, erosion of self-efficacy, layered emotional distress, altered relational dynamics, meaningful spirituality-based resilience, and gaps in therapeutic communication collectively construct a highly complex experience often hidden from the gaze of the biomedical-oriented health system.

This study contributes to the development of new conceptual frameworks: (1) "Interrupted Maternal Transition" as a concept to describe the disruption of maternal identity formation caused by the high-risk label; (2) "Hyper-vigilance Paralysis" as a psychological phenomenon specific to the context of high-risk pregnancy; and (3) "Contextual Spiritual Coping" as a resilience mechanism unique to Indonesian Muslim culture that needs to be recognized in care models.

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