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‘You’ve got a healthy baby’: A qualitative study of traumatic birth, silencing, and perinatal suicidal behaviour

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'You've got a healthy baby': A qualitative study of traumatic birth, silencing, and perinatal suicidal behaviour

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Abstract

Problem: The relationship between traumatic birth experiences and perinatal suicidal ideation and behaviour remains poorly understood.

Background: Suicide is a leading cause of maternal death, and birth trauma is common and associated with perinatal mental health difficulties. Women's accounts of how traumatic birth and suicidal behaviour connect are largely absent from the literature.

Aims: To explore how women with lived experience of perinatal suicidal behaviour described traumatic birth and its aftermath, how they understood the relationship between the two, and what they identified as harmful, helpful, or preventative in the care they received or did not receive.

Methods: Reflexive thematic analysis, within a critical realist orientation, of sixteen semi-structured interviews with women in Australia who had experienced both traumatic birth and perinatal suicidal behaviour, drawn from a larger co-designed family-based study.

Findings: Two themes comprising seven subthemes were constructed: the silenced birth and routes into suicidal behaviour. Women described obstetric violence, medical emergency, loss of control, and lasting physical injury. Family members and clinicians often minimised or closed these accounts down by focussing on the healthy baby, and many women struggled for years to name their experiences. Participants attributed their suicidal ideation and behaviour to birth trauma as the final harm added to an already heavy load, and to physical birth injury experienced as a loss of function, role, and imagined future.

Conclusion: Recognising and validating traumatic birth experiences across maternity, mental health, and primary care services is critical for timely support, trauma-informed care planning, and reduced perinatal suicidal behaviour.

Keywords: birth trauma; perinatal suicidal behaviour; obstetric violence; trauma-informed care; qualitative research

Introduction

Statement of Significance

Problem or Issue	Suicide is a leading cause of maternal death. The relationship between traumatic birth and perinatal suicidal ideation and behaviour is poorly understood.

What is Already Known	Birth trauma is common and is associated with perinatal suicidal ideation. Quantitative studies rarely examine the association between traumatic birth experiences, self-harm, suicide attempts, or suicide deaths. Qualitative accounts of these experiences are lacking.
What this Paper Adds	This research contributes new insights regarding women's lived experiences of traumatic birth and suicidal ideation and behaviours. This knowledge is important for developing trauma-informed intervention and prevention approaches that validate women's experiences, reduce adverse outcomes, and improve care.

Suicide is a leading cause of maternal death (Chin et al., 2022). A meta-analysis of 71 studies estimated the pooled prevalence of perinatal suicidal ideation at 8%, with rates of 10% antenatally and 7% postnatally (Xiao et al., 2022). Reported suicide attempts are rarer, with pooled worldwide estimates of 680 per 100,000 women during pregnancy and 210 per 100,000 in the first postpartum year (Rao et al., 2021). Despite this impact, a recent systematic review identified few interventions developed for, or evaluated against, suicidal behaviour in perinatal women (Scarth et al., 2026a). Prevention therefore depends on services recognising and responding to the experiences that women themselves connect to their suicidal distress.

Birth trauma has been associated with an increased risk of perinatal suicidal ideation, although its relationship with self-harm, suicide attempts and suicide deaths remains less clear (Bright et al., 2022). In a Spanish observational study, women who felt that they were treated inadequately during childbirth carried a higher risk of both postpartum depression and suicidality (Martínez-Galiano et al., 2025), and in a United States cohort, severe perineal laceration was associated with doubled odds of self-harm ideation during postpartum depression screening (Kim et al., 2015). To date, research specifically examining the association between birth trauma and perinatal suicide risk or suicide deaths is lacking. As such, the pathways by which a traumatic birth may become entangled with a woman's suicidal distress are poorly understood (De Backer et al., 2024a).

An Australian scoping review concluded that traumatic birth is frequently reported and remains poorly recognised and insufficiently treated (Watson et al., 2021). In addition, 40.6% of women in the United Kingdom appraised their birth as traumatic against DSM-5 stressor criteria and 5.9% met criteria for childbirth-related post-traumatic stress disorder (CB-PTSD) (Webb et al., 2026). A meta-analysis also estimated that 19.4% of women who experience a traumatic birth develop post-traumatic stress disorder (Lai et al., 2023). Birth trauma spans psychological trauma and lasting physical injury (Gilbert et al., 2024). Psychological trauma includes births experienced as frightening emergencies, and care experienced as coercive or violating, which is increasingly referred to as obstetric violence (Küçük and Yeşilçiçek Çalik, 2025), although women rarely apply that term to their own care (Middleton, 2025). Lasting physical injury remains under-recognised. Systematic review evidence found that women were unprepared for the possibility of such injury and dissatisfied with how clinicians discussed it with them (VanWiel et al., 2025). Prior mental health difficulties, adverse life events before pregnancy, and features of the birth itself, including complications and low satisfaction with care, can increase birth trauma risk and post-traumatic stress symptoms (Webb et al., 2026).

Qualitative research has examined women's experiences of birth trauma (Watson et al., 2021) and, separately, women's experiences of discussing suicidal distress in maternity care (Dudeney et al., 2024). However, there is limited qualitative research that has explored birth trauma and suicidal behaviour together through the first-hand accounts of women who have experienced both. This is important because such accounts may provide insight into how risk unfolds through encounters with services, as well as the approaches to care that women feel may have prevented their suicidal behaviour.

Therefore, the aims of this study were to: (i) explore how women with lived experience of perinatal suicidal behaviour described traumatic birth and its aftermath; (ii) examine how

these women understood the relationship between their traumatic birth experiences and their suicidal ideation and behaviour; and (iii) identify what women described as harmful, helpful, or preventative in the care they received or did not receive.

Participants, Ethics and Methods

Design

This qualitative study forms part of a larger co-designed research programme on family support for perinatal suicidal behaviour prevention, conducted within a participatory action research orientation (Cornish et al., 2023). Five lived-experience co-design sessions were undertaken, four with a group of five mothers and one with five male family members, which shaped recruitment, instruments, and analytic priorities. With members' consent, recordings of these sessions were also included as data.

Participants and recruitment

Three participant groups were eligible to take part in the wider programme, all aged 18 or over: women with lived experience of perinatal suicidal behaviour during pregnancy and/or within three years postpartum family members or friends of women who had experienced it; and perinatal health professionals or key stakeholders who had worked directly with these women. Sample size was guided by the Information Power approach (Malterud et al., 2016), which emphasises richness and relevance of the data over saturation. Up to 15 participants were sought per group and recruited through the networks formed by the lived-experience co-design groups, snowball sampling, perinatal mental health and suicide prevention organisations, social media, and the study website. Interview participants received a $50 supermarket voucher.

Across the wider programme, forty-three participants took part: 38 interviewees across 37 semi-structured interviews (one a joint couple interview), three practitioner surveys, and two lived-experience co-design members who contributed through a co-design session only. Twenty-seven women had lived experience of their own perinatal suicidal behaviour.

The present analysis draws on the accounts of sixteen women, whose interviews addressed traumatic birth in the context of perinatal suicidal behaviour. Traumatic birth was among the most prevalent trauma histories disclosed across the corpus. Excerpts from the mothers' co-design sessions are also cited in the Findings.

Data generation

The lead researcher conducted, transcribed and de-identified all interviews, working with an interpreter for one participant so she could be interviewed privately in her first language. Participants chose their interviewer from four researchers introduced on the study website, reflecting the co-design groups' emphasis on choice and safety; all chose the lead researcher. Participants could bring a spouse or family member as support, and two took part in a joint couple interview. Most interviews were conducted by Zoom (two in person) between March and June 2026 and lasted approximately 60 to 180 minutes. Interviews began with a readiness check and ended with a debrief that signposted support resources. Participants could also complete a wellbeing plan beforehand and were offered a follow-up check-in.

The semi-structured interview guides were co-designed with the lived-experience groups and asked about experiences of disclosure and non-disclosure, encounters with screening and services, what helped and hindered, and a 'magic wand' question inviting participants to design prevention without resource constraints.

Co-design sessions ran via Zoom and were recorded and transcribed with consent. The mothers' sessions were co-facilitated by the lead researcher and a lived-experience peer

practitioner, and the male family members' session by a male researcher with an interpreter as needed.

Ethical considerations

The study was approved by the Monash University Human Research Ethics Committee (MUHREC), project ID 50913 (qualitative interviews), approved 20 February 2026, and project ID 49134 (co-design workshops), approved 6 October 2025.

All participants, including co-design members, provided informed consent to participation and to publication of de-identified material. Participation was voluntary, and participants could decline any question or withdraw at any time. A stepped distress protocol applied to all data collection, moving from pausing and offering support, to contacting a nominated support person, to referral, to contacting emergency services and staying with the participant until help arrived. Its use was documented for team review, and no acute risk incidents occurred.

Data analysis

The lead researcher conducted reflexive thematic analysis (Braun and Clarke, 2025) within a critical realist orientation, combining ontological realism with epistemological relativism (Bhaskar, 2009). Participants' accounts were treated as fallible but informative evidence about real generative mechanisms, and themes as interpretive constructions. The analysis attended to experiences, to the events they related to, and to the mechanisms that plausibly generated them (Fryer, 2022). Where participants described their birth trauma as having contributed to their suicidal ideation or behaviour, causal language is reported as the participant's understanding of causation rather than as a relationship the design can establish. Interview and co-design data contributing to this analysis were pooled and analysed together, while staying alert to differences between participant groups. The source of each excerpt is indicated after each quote.

Coding was inductive and deductive, so the data drove the findings, and the co-designed questions framed the analysis. Theme development was interpretive and predominantly latent, attending to meanings and mechanisms beneath the surface content of participants' accounts. The lead researcher coded the entire dataset systematically and wrote the interpretive memos through which themes were constructed. There was no second coder and, consistent with a reflexive approach, no intercoder agreement was calculated (Braun and Clarke, 2021). Interpretations were developed through sustained memo-writing and tested against disconfirming cases. Candidate themes were refined through a sense-making session with the mothers' co-design group and in discussion with co-authors. Reporting was guided by the Reflexive Thematic Analysis Reporting Guidelines (Braun and Clarke, 2024).

Reflexivity and positionality

This analysis was conducted by the lead researcher, a mother and researcher-practitioner with twenty-five years' experience in mental health, family violence, and suicide prevention and postvention. The co-authors, who read and challenged the analysis against their clinical and research knowledge, include a female post-doctoral researcher with expertise in perinatal suicidality who has completed training in identifying and signposting suicide risk and in conducting sensitive qualitative interviews for research purposes, a First Nations mother and grandmother, and Doctoral Candidate, with multigenerational lived experience and 36 years of professional cross sectoral practice, and a female perinatal psychiatrist with forty years' experience.

Definitions

In this paper, perinatal suicidal behaviour is defined as any suicidal ideation, planning, feelings, attempts, or self-harm during pregnancy and/or up to three years after birth, regardless of the type or outcome of the pregnancy. The study's lived-experience co-design

groups specified the three-year window, having identified that suicidal distress connected to birth and early parenting extends well beyond the twelve-month limit usually applied in services and research (Roddy Mitchell et al., 2023). Birth trauma is defined subjectively: what makes a birth traumatic is the woman's own assessment of threat, violation, or profound loss of control during the birth or in its immediate aftermath, as opposed to how the birth is classified clinically.

Findings

Participant characteristics

The sixteen women whose accounts inform this analysis all have lived experience of perinatal suicidal behaviour and described a traumatic birth or traumatic care in its immediate aftermath. All sixteen disclosed suicidal ideation or suicidal feelings, seven disclosed self-harm, five disclosed one or more suicide attempts, and one disclosed a suicide plan, with many disclosing more than one type of suicidal behaviour. Self-reported diagnostic histories were extensive and frequently included anxiety, depressive and trauma-related conditions. Ten of the sixteen women also reported diagnosed or suspected neurodivergence. The group included Aboriginal and migrant women alongside white Australian-born women, and included women living with lasting physical birth injury. Participants in this group ranged in ages from late adolescence to mid-fifties.

Main findings

Two main themes, comprising seven subthemes, were constructed from the data (Table 1). Theme boundaries are interpretive choices, and some extracts speak to more than one theme.

Main theme	Subthemes

1. The silenced birth	What made the birth traumatic; 'You've got a healthy baby'; Naming it, years later; Compounded harm: racism, migration, and fear of child removal
2. Routes into suicidal behaviour	The last weight added; A loss lived in the body; Repair: naming, validation and trauma-informed care

Table 1. Themes and subthemes.

Theme 1: The silenced birth

What made the birth traumatic. Participants described four overlapping kinds of traumatic birth experiences. The first was the care in which clinicians physically and emotionally overrode the women they were assigned to care for. One participant, whose husband was not allowed in the room despite her requests, recalled:

> *'**physically** pushing me forward (…) injecting this epidural in and out, in and out six times (…) it just felt like I was getting electrocuted.' (P9, mother)*

Another mother described procedures performed without explanation during an induction:

> *'I thought they were just checking how far along I was. But instead, like, next minute, my cervix is being, like, ripped apart. I was like, that's **really fun**, thank you, for the heads up on that.' (P18, mother)*

The second kind was the frightening medical emergency in which a woman feared for her own life or her baby's, as described by one mother who was told '*if I had not birthed that day, he would have been stillborn'* (P13, mother). For another mother, an induction of labour cascaded into surgery she had not been prepared for, and in her words:

> *'As soon as they induced me, the baby, his heart rate went through the roof, so I went and had an emergency caesarean, but they couldn't get the epidural in.' (P12, mother)*

The third way a birth became traumatic was through a profound loss of control and not being heard, as described by a mother who was in active labour for four days while clinicians declined to intervene despite her repeated requests. As she concluded:

> *'You can't get much bloody worse than trying to kill yourself, can you?' (P11, mother)*

Another mother had her induction deferred for more than two weeks while '*everybody was making out' that 'I was being irrational'* (P17, mother). After an eventual emergency caesarean, she felt frightened, disoriented, and disconnected from her baby:

> *'I was **fairly certain** the baby they gave me was my baby, but I wasn't **really sure**. She didn't feel like mine.' (P17, mother)*

For another mother, requests for pain relief during a long labour were declined, and she was told to 'just get back under the hot shower'. She traced what followed to that dismissal:

> *'I think I felt really dismissed, and I felt unsafe, and I think my body must have just clammed up.' (P23, mother)*

The fourth was lasting physical injury, which is too often overlooked. One mother, who lives with a severe pelvic floor injury for which there is *'no fix'* (P2, mother), observed that women are not warned that such severe injuries can follow childbirth. Another mother's first birth left the same category of harm:

> *'It was, like, forceps, and… I haemorrhaged, and… got sawed in half, basically (…) it took 3 hours of reconstructive surgery to put me back together.' (P7, mother)*

Another very young mother described a caesarean in which the regional anaesthetic took on one side only. She told the theatre staff during the surgery that she could feel it, and they continued:

> *'One side was fine, but this side felt everything. They didn't believe me. They cut all the way through to the uterus (…)' (P19, mother)*

These four kinds of experience describe the birth itself.

'You've got a healthy baby'. The birthing event was the first injury, and the silence that followed was often the second; for some women, the silence, minimisation and dismissal was the more damaging harm. The phrase 'but you've got a healthy baby' recurred across the accounts as the mechanism that family members and clinicians used to close a woman's experience down. In effect, the phrase reframed her distress as ingratitude. One mother '*felt silenced'* when she tried to tell her family, and her own mother's reassurance *('look, your baby's here'*) shut the conversation down:

> *'**when** I say I was silenced, it wasn't metaphorical silencing, it was like, no, no, no, don't talk about that, look at your baby.' (P9, mother)*

When she tried to talk to a nurse at the hospital, *'no one would talk to me about it. It was, like (…) **a really inconvenient** thing to bring up when you've got a **brand new** healthy baby' (*P9, mother).

Minimisation was used to shut mothers down by clinicians and partners alike, with one woman's partner *'treating my birth injury as a joke'* (P1, mother), and another's physiotherapist telling her, *'You don't have prolapse, you're fine'*, although, as she later discovered on requesting her records, *'it was already written that I have prolapse, I just wasn't told'* (P16, mother).

The healthy-baby script also shaped what care attended to. One mother, separated from her baby after an emergency caesarean and a maternal infection, summarised her postnatal care: *'a midwife checked me, checked my wound (…) Like, basically no care for Mum'* (P18, mother). Another, whose caesarean itself was *'all fine'*, located the trauma in what came

immediately after, in postnatal care she likened to *'filing people in and out like a production line'* and in comments that minimised her surgical recovery:

> *'[she would] say to me… it's taking you a while to, like, get better, isn't it? And I'm like, it's day fucking two!' (P6, mother)*

Naming it, years later. Many women had no name for what they had been through, sometimes for a decade or more. One participant realised she had experienced birth trauma only when she read a news article years later and it was *'like a light bulb'*. Another searched for an explanation and found nothing:

> *'I got home from that physio appointment, and I literally googled physical birth trauma. And nothing came up. So, I just thought, well, I must be the only one. I'm a freak.' (P2, mother)*

Another mother used the term only in retrospect:

> *'**that** was a very traumatic birth, which I have birth trauma from. Didn't even know there was such a thing as birth trauma.' (P14, mother)*

For another, it took eighteen months of repeated emergency department presentations for unexplained physical symptoms postpartum, until a neurologist cleared her scans and then asked, *'now, tell me about the birth of your son': 'he was the first one that started naming it (…) once I had that sort of label (…) I started exploring that avenue'* (P21, mother). When a name for the trauma did finally arrive, it did substantial work: *'giving it, giving it its space'* and *'allowing room for it to be validated'* (P9, mother).

Compounded harm: racism, migration, and fear of child removal. For Aboriginal and migrant women, birth events resembling those described above took place inside systems these women had reason to distrust, so the same events carried threats that other women did not face, and the trauma was inseparable from institutional harm. For one Aboriginal mother,

the trauma of an emergency birth was inseparable from care she described as *'very, very racist'* (P24, mother), and from an acute fear of child removal. Hours after the birth, *'one of the nurses, like, woke me up, like, aggressively the first morning I was there yelling at me for not waking up and feeding my baby'*, an experience she summarised as *'Really fucking scary'* (P24, mother).

For one migrant mother, the maternity system clashed with the care she had expected, and clinicians' dismissal compounded the harm:

> *'Made me lose trust in the medical profession completely… not a single person said, well, you know what, you do have an option of an elective C-section. Have you considered that? Because I would say, yes, please! I did not know, I did not know.' (P16, mother)*

For the young mother whose caesarean anaesthetic failed, fear of child removal governed what she could safely say. She did not want to complain because:

> *'Fuck because then they would take the child, they would take the child, think I'm fucking crazy.' (P19, mother)*

Her reasoning went past the removal itself to what would follow it: *'if I fucking tell anybody about how I really feel, then they'll take her away, and then she'll be put in a system where that's fucking not safe'* (P19, mother). She experienced hospital admission during that complex, high-risk pregnancy as containment, and left repeatedly:

> *'They would say, right, you're gonna have to stay. And I'd say to the guy, I've got to get a toothbrush and I would fuck off (…) I wouldn't be contained. I just kept running away.' (P19, mother)*

Theme 2: Routes into suicidal behaviour

The last weight added. Participants' accounts described two distinct pathways from birth trauma to suicidal behaviour, both attributed by the women themselves. The first was cumulative, whereby birth trauma was the *'last'* adverse experience before the hormonal and sleep upheaval of the early postpartum. One mother listed the adverse experiences that preceded her traumatic birth (gestational diabetes, family and domestic violence, pregnancy losses, a high-risk pregnancy) and reasoned that *'the birth pushed me over the edge'*:

> *'How many adverse experiences can you have before you* ***snap?…*** *birth trauma is the last experience you have in your pregnancy. It's the last thing to happen before your hormones completely shift.' (P9, mother)*

For another woman, birth trauma was *'another compounding factor'* (P1, mother); for a mother diagnosed with bipolar disorder, the accumulation led to relapse:

> *'I wish someone had said to me, if you have bipolar and you have a baby, you've got a 90% chance of a relapse. Throw in a traumatic birth, you know, and a baby that won't breastfeed, and, you know, like, all those things, and you've got probably a 99% chance of a relapse.' (P12, mother)*

A loss lived in the body. A second pathway ran through the body itself. For women living with lasting physical injuries, the loss of function, identity and an imagined future generated suicidal ideation in its own right. One participant described her lasting physical injuries as follows:

> *'(There is) no fix… it feels like a life sentence… I was told I would not be able to lift my child anymore. She was 16 months old. I was told I shouldn't do any exercise (…) I just felt like, I am gonna be just this sub-part human, I'm gonna be a shit mum (…) there's no point in me being alive.' (P2, mother)*

She concluded:

> *'I didn't realise that suicide would be a pain relief option.' (P2, mother)*

Standard mental health advice, such as *'exercise, walking, being social'* (P2, co-design group), presumed a body these women no longer had, and the mismatch led to shame, which participants named *'a huge contributor to suicide'* (P2, co-design group). The lack of forewarning worsened the trauma:

> *'You don't go into birth knowing that can happen… it's pretty confronting to have your pelvic organs, in some cases, sit outside of your body, and nobody warns you that that can happen after birth.' (P2, mother)*

Repair: naming, validation and trauma-informed care. These participants were clear about what supported recovery, or what might have pre-empted the harm altogether. Peer connection recurred as the most helpful support, *'taking away the stigma and the shame'* (P2, mother) and reframing the process as acceptance rather than *'recovery'*. The opportunity to debrief, denied to P9 at the time, was named as something she had needed:

> *'I just wanted someone to just go, this is fucked. And then to support me in telling my family what I needed.' (P9, mother)*

For one mother, a later well-supported birth was itself part of repair: '*I birthed her, and that was exhausting, but… very healing, I think'* (P23, mother).

Trauma-informed maternity care (a partner permitted to remain, a clinician who listens, a name for the trauma offered rather than withheld) would, in these accounts, have interrupted the pathway to suicidal behaviour. Very small acts could also be protective. For one mother, a stranger's offer of coffee interrupted her suicide attempt:

> *'He's never met me. He came to me and said, are you okay? Do you need any help? How about I take you for coffee? (…) And it was just this… tiny little act of humanity*

that I… you know, did not receive for any… from anyone else, essentially. That made me snap back and did not continue.' (P16, mother)

Discussion

This study explored how women with lived experience of perinatal suicidal behaviour described traumatic birth and its aftermath, how they understood the relationship between the two, and what they identified as harmful, helpful, or preventative in the care they received or did not receive. Three findings warrant emphasis: (i) the silencing that followed traumatic birth, which participants experienced as a second injury; (ii) the participant-attributed routes by which birth trauma became entangled with suicidal ideation and behaviour; and (ii) the consistency, and the modesty, of what participants said would have helped. As one participant summarised it, the physical, psychological and social dimensions of birth trauma are '*so closely intertwined (…) and yet nobody's connecting the dots'* (P2, mother).

First, the harm that participants described did not end with the trauma at birth. The 'healthy baby' script, whereby a woman's distress was answered by pointing to her healthy child, recast that distress as ingratitude and denied women both closure and a name for what they had experienced. A companion analysis of the same data demonstrated how concealment becomes a rational response in environments where it is not safe to tell (Scarth et al., 2026b). Where the experience remained unnamed, sometimes for a decade or more, women could neither seek nor be offered targeted support, so when naming finally arrived, it was described in terms of validation and the beginning of repair. Dismissal of this kind is a consistent finding in the qualitative birth-trauma literature (Beck, 2004; Byrne et al., 2017; Fenech and Thomson, 2014; Shorey and Wong, 2022).

Second, the two routes to suicidal behaviour that participants described add first-person detail to a risk-factor literature that has established an association between birth trauma and

perinatal suicidal ideation (Martínez-Galiano et al., 2025). However, comparable published evidence for the association of birth trauma with self-harm, suicide attempts, and suicide deaths is lacking (Bright et al., 2022; De Backer et al., 2024b). The cumulative route positions birth trauma as an unprocessed harm meeting the physiological and social upheaval of early motherhood. Yet, the embodied route is rarely described in the published literature. For women living with physical birth injury, suicidal ideation was described here as a response to the loss of function, role and imagined future, compounded by shame and by an iatrogenic mismatch in which standard behavioural advice presumed a body these women no longer had. The closest published counterpart identified is a single cohort study in which severe perineal laceration was associated with doubled odds of suicidal ideation (OR 2.1, 95% CI 1.0 to 4.4) (Kim et al., 2015). That interval touches the null, and the outcome was thoughts of self-harm endorsed on a depression screening item, not a direct measure of suicidal ideation. The estimate is best read as provisional, and as a measure of how little is known. Validated measures of birth trauma exist, including the City Birth Trauma Scale (Ayers et al., 2018). Routine perinatal mental health assessment, however, rarely asks about the birth or about the body, and an assessment that never asks, risks missing both routes.

The accounts of women for whom birth trauma was inseparable from institutional harm need urgent attention. Where care is experienced as racist, and where fear of child removal is present in the birth room, birth trauma sustains historical and ongoing institutional racism and harm (Kornfield et al., 2026). This cannot be read as an aberration within an otherwise safe system, because women of colour are at higher risk of a traumatic birth and are under-represented in research (Kornfield et al., 2026). Fear of child removal is documented elsewhere as a barrier to disclosure and help-seeking after a traumatic birth (Scarth et al., 2026b), and mothers have avoided specialist support because they feared being judged unfit and losing their baby (De Backer et al. 2024b). Women in this study concealed suicidal

ideation or plans because they feared child removal, and women in other studies answered ‘no’ to screening questions for the same reason (Dudeney et al. 2024). Women who entered an unfamiliar maternity system after migration described compounding vulnerability and dismissal, and in both cases the durable harm was relational as women lost their capacity to trust the very services that suicide prevention depends on. Culturally safe, continuity-based and trustworthy maternity care therefore forms part of perinatal suicide prevention itself (Curtis et al., 2019; De Backer et al., 2024b).

Third, what participants said would have helped was modest. Recognition and naming of the harm was described as protective, as was the opportunity to debrief, peer connection that ‘took away the stigma and the shame’, trauma-informed maternity care, and, in one account, a stranger’s act of kindness at the point of an attempt. Such requests for care are consistent with other literature on perinatal suicide prevention (Ahlers-Schmidt et al., 2026; Dudeney et al., 2024). The evidence for formal birth debriefing is weak, with benefits described as unclear or inconclusive (Simpson and Catling, 2016) and NICE guidance advising against offering it to all women as standard (NICE, 2014). However, the participants in this study were not asking for a manualised intervention, but simply to be asked about their experience, heard, and validated.

Perinatal mental health and primary care contacts could ask directly about the birth experience, rather than relying on mood screening alone. Maternity services could provide anticipatory information that physical injury can follow childbirth, with clear pathways when it does, and medico-legal considerations should not outweigh the provision of optimal care (Toma-Tumbar et al., 2025). Naming and validation could be treated as clinical acts in their own right, with peer connection resourced as a pathway to both. Follow-up for birth-related harm should extend well beyond the early postpartum, within services that treat birth trauma as a nameable experience that can increase suicide risk (Chin et al., 2022).

Limitations

This is a situated, interpretive analysis, and its claims are limited to that context. Rather than offering generalisations, readers are invited to judge transferability to comparable settings. Interviews addressed birth trauma in varying depth, and claims about the relationship between birth trauma and suicidal behaviour are participant-attributed rather than causally established by the design. De-identification requirements meant some participant characteristics were grouped, which reduced descriptive precision.

Conclusion

For the women in this study, a traumatic birth was rarely a single moment. It was an event, then a silence, then an unnamed weight carried into the most physiologically and socially demanding season of their lives, and, by their own account, into their suicidal distress. Their charge to services is to connect the dots between body and mind, between the birth room and the mental health system, and between a mother and the family around her, so that the silence that follows a traumatic birth does not become the second injury.

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Data availability. Due to the identifying nature of these qualitative interviews, full transcripts cannot be shared for ethical and privacy reasons.

Declaration of interest. The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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