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Hearing the Mother's Voice
Birth Trauma in Utah

Insights from Utah women who experienced birth trauma highlight opportunities to strengthen maternity care and postpartum support.

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To the survivors who reached back into the shadows to share their light: You shared a piece of yourselves to ensure that no one else has to walk that path alone. This report is dedicated to your courage, your vulnerability, and your unwavering demand for a better way forward. We heard you.

-Utah Department of Health and Human Services

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Analysis in Brief

Birth trauma, or having a traumatic childbirth experience, is common, but largely remains unrecognized within maternity care. It occurs when unexpected childbirth experiences cause overwhelming and often shattering physical or emotional pain, resulting in lasting distress regardless of clinical outcomes. A delivery can be medically successful and still traumatic for the mother, provider, or others present during the birth.

Some women are at greater risk for birth trauma, including those with pre-existing mental health conditions, a fear of childbirth, poor physical health, and a history of trauma or sexual abuse.

While all births involve risk, maternity care team actions, as well as family and friend support, play an important role in shaping how individuals experience and recover from birth.

Drawing on interviews with women residing in Utah who experienced birth trauma, this report documents contributing factors, impacts, and opportunities to strengthen maternity care and postpartum support.

Key Findings

- **Birth trauma is common –** National estimates indicate between 9% and 44% of moms report experiencing trauma from their childbirth.
- **Care experiences contribute to birth trauma –** Experiences can include emergency cesarean delivery, obstetric emergencies or medical complications, fear for one's own life or the newborn's life, separation from the newborn for medical care, loss of patient autonomy, poor maternity care team communication, and lack of emotional validation. While many of these interventions are medically necessary and lifesaving, they can have lasting physical and psychological effects for some women.
- **Birth trauma impacts –** Untreated birth trauma can result in persistent mental health challenges, negative perceptions or mistrust of the health system, disrupted newborn bonding, strained family relationships, anxiety about or avoidance of future pregnancies, and for some families, the grief accompanying the loss of the ability to have more children.
- **Opportunities to mitigate birth trauma –** Interview participants expressed a desire for more thorough debriefs with their care providers, mental health education, universal mental health checks before hospital discharge, proactive postpartum outreach, additional postpartum check-ups, and the need for more maternal mental health specialists and provider training.
- **Community-based supports could play a role –** Participants also noted that peer support, public education on maternal mental health, and efforts to reduce barriers to seeking mental health care (such as cost, stigma, and childcare) can improve awareness, reduce isolation, and address practical barriers that affect access.
- **Evidence-based approaches can reduce birth trauma risk and support recovery –** Trauma-informed care practices, early identification of distress, targeted mental health treatment, coordinated postpartum support, and informal and structured social support are evidence-based strategies that reduce trauma risk and improve postpartum recovery.
- **A growing number of resources provide a foundation for support –** An increasing number of state-level resources for mothers, families, and maternity care teams are helping improve awareness of birth trauma, support recovery, and strengthen trauma-informed maternity care.

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Introduction

Birth trauma, or having a traumatic childbirth experience, is common, but largely remains unrecognized within maternity care. It occurs when unexpected childbirth experiences cause overwhelming and often shattering physical or emotional pain, resulting in lasting distress regardless of clinical outcomes. A medically successful delivery can still create trauma for the mother, provider, or others present during the birth.

Some women are at greater risk for birth trauma, including those with pre-existing mental health conditions, a fear of childbirth, poor physical health, and a history of trauma or sexual abuse. While all births involve risk, maternity care team actions, as well as family and friend support, play an important role in shaping how individuals experience and recover from birth.

How Common Is Birth Trauma?

National research estimates between 9% and 44% of mothers report feeling traumatized by their childbirth experience, indicating birth trauma is common and can occur even when severe medical complications are not present.[1] Estimates likely underreport occurrences of birth trauma, meaning the prevalence could be higher.[2]

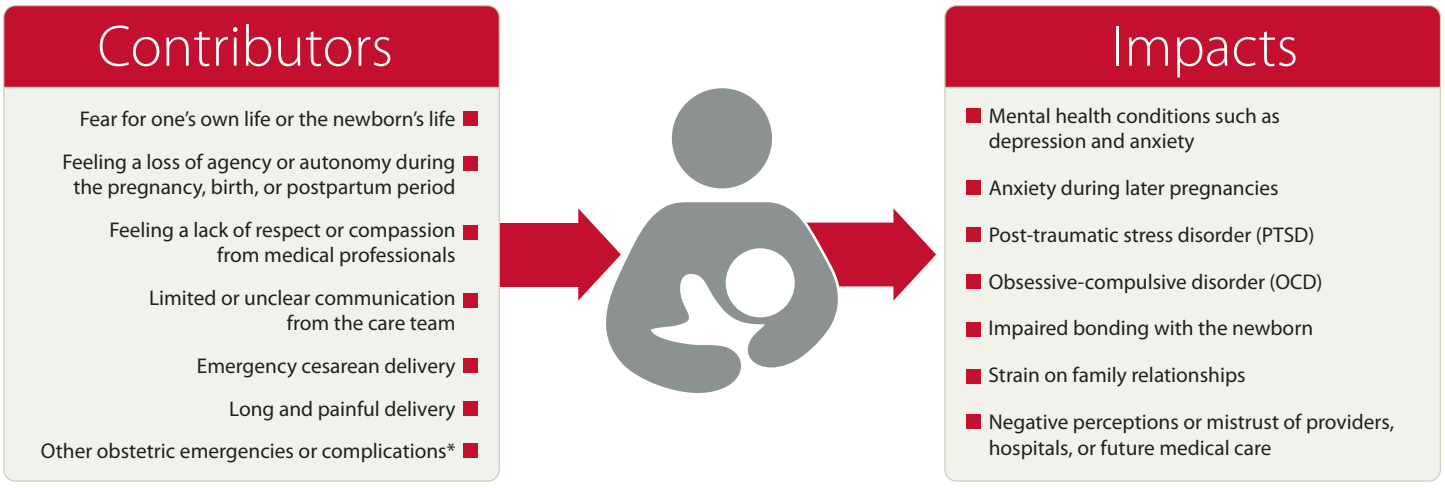
This report highlights information and experiences related to birth trauma in Utah. Recognizing and understanding birth trauma creates opportunities to acknowledge those affected, develop and promote support services, and improve systems that shape maternity care.

Background

Research identifies several common contributors to birth trauma including: (1) fear for one's own life or the newborn's life; (2) feeling a loss of agency or autonomy during the pregnancy, birth, or postpartum period; (3) feeling a lack of respect or compassion from medical professionals; (4) limited or unclear communication from the care team; (5) emergency cesarean delivery; (6) a long and painful delivery; and (7) other obstetric emergencies or complications (i.e., significant blood loss, preterm birth, perinatal loss, resuscitation of the parent or newborn, hysterectomy, separation from the newborn due to maternal or infant health needs, etc.).[3]

Effects of a traumatic birth experience can include mental health conditions such as depression, anxiety (including anxiety during later pregnancies), post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD); impaired bonding with the newborn; strained family relationships; and negative perceptions or mistrust of providers, hospitals, or future medical care.[4,5,6]

The actions and support of a woman's maternity care team can mitigate or reduce trauma symptoms when care is responsive and validating—and trigger or worsen symptoms when care is dismissive and impersonal.[7]



* May include significant blood loss, preterm birth, perinatal loss, resuscitation of the parent or newborn, hysterectomy, separation from the newborn due to maternal or child health needs, etc.

Interviews

This report analyzes 39 semi-structured, in-depth interviews conducted with women residing in Utah who experienced birth trauma. The Utah Department of Health and Human Services conducted interviews between October 2023 and January 2025. The Gardner Institute qualitatively analyzed the de-identified interview transcripts.

Participants self-selected into the study following community-based outreach through trusted networks and public platforms, including flyers distributed by Utah Women and Newborn Quality Collaborative (UWNQC) committee members, word-of-mouth referrals, and outreach through a public episode of the Sad Moms Club Podcast featuring the UWNQC Birth Trauma Patient and Family Partner. Participants represented a broad range of experiences, including having births within the past year as well as a few that occurred decades earlier. Most participants gave birth in Utah, although some participants described birthing experiences that took place outside of Utah. A native Spanish speaking interpreter assisted with one interview conducted with a Spanish-speaking mother.

An interviewer with lived experience of birth trauma conducted the interviews to support participant comfort and trust. The study used trauma-informed qualitative interviewing practices, allowing participants to determine the depth of disclosure and share only experiences they felt comfortable discussing. As a result, some experiences may have been selectively discussed or omitted.

Interviews explored participants' descriptions of their traumatic birth experiences, perceived strengths and gaps in hospital-based care, and whether maternity care teams discussed the complication or traumatic event after birth. Interviews also asked participants whether mental health needs and resources were discussed during the hospital stay, whether they experienced any barriers to accessing mental health treatment, their preferred pathways for accessing care, and resource needs for individuals experiencing birth trauma.

The following section summarizes themes that emerge from the participant interviews. The report organizes the themes into four sections: (1) common contributing factors associated with participants' birth trauma experiences; (2) effects of birth trauma on the women and their families, including mental health challenges and early parenting experiences; (3) opportunities participants identified to mitigate birth trauma; and (4) additional community-based and other resources participants recommended to support families experiencing birth trauma and maternal mental health challenges. Findings reflect recurring themes across interviews rather than individual cases.[8]

Findings

Common Contributing Factors

Interviews described various factors associated with birth trauma that span both clinical events and care experiences. For the purposes of this report, clinical events refer to medical complications or interventions that occur during the perinatal period, while care experiences refer to how care is delivered, including communication, consent, emotional support, and patient involvement in decision-making.

Participants frequently described unplanned emergency cesarean sections, long and painful deliveries, other obstetric emergencies or complications (i.e., significant blood loss, preterm birth, perinatal loss, resuscitation of the parent or newborn, hysterectomy, etc.), and fear for one's own life or the life of the newborn. Some mothers also found separation from the newborn—due to maternal or infant health needs—to be traumatizing, particularly when mothers lacked clear information about the reason for or duration of the separation.

Beyond clinical events, participants emphasized loss of autonomy and exclusion from decision-making as key drivers of trauma. When providers failed to consider their perspectives during pregnancy, childbirth, or postpartum care, participants reported diminished trust in their maternity care team and a loss of control over care for themselves and their infants.

> *"I felt like I was never in control and it was never my choice."*

Other participants raised concerns with predetermined medical care decisions and limited opportunity for meaningful involvement, particularly during emergency situations or first births.

> *"I felt like the decisions were made for me. I didn't feel very involved. Some of that was probably my ignorance and lack of experience. In later deliveries, I was able to speak up more and advocate for myself."*

Participants also described inadequate communication and lack of validation as contributing to birth trauma. Participants reported that when maternity care teams failed to clearly explain what was happening, why decisions were being made, or what to expect next, they felt confused and powerless. Many also described feeling dismissed or "not heard" when raising concerns about symptoms, needs, or negative birth experiences, reinforcing feelings of fear, isolation, and mistrust.

"I was told they admitted [my newborn] to the NICU. I don't feel like I was given an explanation. That was probably the hardest thing, the 12 hours of not seeing [my newborn] and not knowing what was going on. I don't think [the care team] realized, 'No one has checked in with the mom and told her what's going on.'"

When asked to reflect on the strengths or positive aspects of their birth experiences, participants commonly highlighted the benefit of clear and consistent communication from the maternity care team, providers who offer information and emotional validation, and family and social networks that support the transition home and postpartum recovery.

Effects of Birth Trauma

Findings from the interviews indicate untreated birth trauma can result in persistent mental health challenges, negative perceptions or mistrust of the health system, disrupted newborn bonding, strained family relationships, and grief related to the loss of the ability to have more children. Common mental health challenges described in the interviews include symptoms consistent with PTSD such as intrusive and involuntary memories, avoidance of trauma reminders, elevated anger or agitation, and anxiety about or avoidance of future pregnancies. Participants also reported depression, anxiety, and obsessive-compulsive (OCD) symptoms alongside feelings of shame or guilt for experiencing mental health challenges rather than only gratitude after giving birth.

"I don't remember much postpartum. I don't remember my daughter's first nine months of life. I had PTSD and I would relive what I went through [during birth] every single day, sometimes multiple times a day. I remember one time walking into my bathroom and seeing an operating room (OR). I saw the OR and that's when I realized I really did have something wrong. I didn't realize that PTSD could happen because of birth."

For some women, complications from their traumatic birth experience resulted in an unplanned hysterectomy or other outcomes that prevented future pregnancies. Interview participants described profound grief and emotional distress associated with the sudden loss of the ability to have more children and the change it had on their future family plans.

Table 1: Participant Quotes Describing the Effects of Birth Trauma

Effects	Participant Description
Post-traumatic stress disorder (PTSD)	· "My mental health really struggled after my miscarriage. I was suicidal. I was extremely depressed. During my pregnancy following the miscarriage, I had flashbacks and panic attacks. I was experiencing PTSD." · "I was terrified to fall asleep; I don't want to fall asleep and not wake up. I did not realize that my fear was because of the emergency c-section until later."
Anxiety	· "Recovery was really hard. I developed a lot of anxiety. I didn't sleep for almost two weeks at one point because I was so terrified that something would happen to my baby. If something this bad happened to me, it could happen to my baby. I eventually went to therapy and got some medication, but it was a long process." · "It was not until my second pregnancy that I realized I had trauma, a lot of trauma. And I still get it even though we are done having babies, I will still wake up with a panic."
Feeling like a failure	· "I felt worthless. I couldn't give birth to my baby the way society and anatomy says that we should [vaginally]. My body didn't work. It failed me. I had to have a c-section. I wasn't enough of a woman to give birth the way I wanted to or the way that society tells us we have to."
Disrupted infant bonding	· "No one talks about not having that instant connection or bond with your baby. I did not even know it was possible to not feel that instant connection." · "I had postpartum depression and I didn't want to admit how hard it was. I felt like I was doing something wrong. I felt like I should just love my baby and not have issues. And I remember this one moment when I was holding her and I remember feeling numb, I didn't feel anything. And I felt so much shame because of it." · "[During postpartum] I was totally stoic. I had no emotions. I felt no connection to [my daughter] at all."
Breastfeeding challenges	· "I felt worthless because I couldn't breastfeed my baby because I had gone through so much trauma my body wouldn't allow me to produce enough milk. I felt like my baby is better off without me, that it would be okay if I was not here. I'm not worthy of being a mom. I'm not a good enough mom already." · "[My newborn] wouldn't nurse because they gave her bottles in the NICU. I regret that so much because she never liked to breastfeed. My mental health was so horrible. Every time I pumped, I would get severely depressed, because she didn't like to breastfeed. She just wanted the bottle and that was really hard on me because breastfeeding was a big goal for me."
Future pregnancy anxiety	· "With my second child, I was terrified during my entire pregnancy. I felt so much anxiety that I switched OBs because I couldn't mentally deliver at the same hospital." · "While the doctor was prepping me, I had a full-blown panic attack. I felt like I couldn't breathe and I was crying because I was having all these flashbacks."
Loss of the ability to have more children	· "I felt like I was given permanent infertility. Whether you have a hysterectomy or not, it changes your birthing journey and you need to grieve that."
Husband/ partner trauma	· "It was really tough for me to talk [my husband] into having a second kid after [our birth trauma experience]. He was super affected by the whole thing. He had to watch it all happen. He was like, 'I don't want to go through that again.'" · "It took my husband a long time to be able to talk about what happened because it was very traumatizing to him."

Birth trauma can also impact early parenting and family bonding. Participants described impaired bonding with their infants—often accompanied by self-blame or a sense of failure—and disruptions to breastfeeding that intensified emotional distress. Interview participants also described how trauma-related symptoms—such as emotional withdrawal, hypervigilance, irritability, and depression—impacted their family by straining communication and reducing the emotional connection with their partners and other children.

"It started to affect my marriage. And I remember one time my husband told me, 'I'm sorry that I'm going to say this, but I see you every day and I come home and we're sitting at this dinner table and there's not a single word from you. You don't talk to me. You don't tell me what's going on. You don't look like yourself. You look like a zombie... I want to support you, but if you're not telling me how you feel, I can't support you.'"

Birth trauma can extend beyond the mother as well, with partners, providers, and others present during the birth reporting PTSD-related symptoms.

Finally, many participants reported lasting distrust in providers, hospitals, or future medical care as well as anxiety about or avoidance of future pregnancies.

Table 1 presents select participant quotes that illustrate the range of effects associated with birth trauma, including PTSD, anxiety, disrupted infant bonding, concerns about future pregnancy, infertility, and challenges with breastfeeding. Quotes are included to provide context and depth to the themes identified in the analysis.

Opportunities to Mitigate Birth Trauma

The interviews asked participants to reflect on what could improve the birth experience for women, including those with existing birth trauma. Their responses highlight how birth trauma often reflects unmet emotional, informational, and support needs during pregnancy, childbirth, and postpartum. Participants identified communication, education, mental health support, and continuity of care as key factors that support recovery and reduce re-traumatization.

Clear and Consistent Communication and Education

Participants emphasized the importance of clear, consistent communication from their care team regarding conditions, risks, potential complications, recovery, and reasons for changes to their birth plan. Many reported having limited preparation for possible complications during pregnancy or postpartum, which constrained their ability to anticipate and prepare for adverse outcomes.

Participants expressed a desire for honest discussions about risks and complications, noting that preparation—even for difficult outcomes—would have improved their emotional readiness.

"If somebody would have told me [about birth complications], I would have been more prepared mentally."

Others described how limited or incomplete information affected their ability to make informed decisions, noting that more comprehensive information could have altered their decisions or recovery approaches.

"There was no information before giving birth about the difference between a c-section and a vaginal birth and the recovery. I may have made a different decision had I had more information on the difference."

Debriefs with Providers Following Traumatic Birth Experiences

Participants frequently described the absence of structured debriefs with their care providers (formal conversations to review what occurred during the birth and discuss future implications) as intensifying the impacts of their traumatic births. Many reported prolonged confusion about what occurred during the birth experience and emphasized that debriefs could support emotional processing, improve understanding of medical decisions, and help plan for future pregnancies.

"Talking with your doctor, the validation of having everything explained to you. We want to know [about what happened during birth]. Tell me why, or what happened, and give me more information about it. Is what just happened to my body going to happen again? Is this going to last for a while? I don't know. Just knowing more or being told what's happening would be nice."

Several participants also associated the limited explanation of what occurred during their birth experience with their heightened mental health symptoms, including anxiety and PTSD. Participants described how unanswered questions about the causes of complications, recovery, and future risk prolonged distress and uncertainty.

"I never got a debrief, like 'let's sit down, let's talk about the reasons why this could have happened. Let's talk about things that you're going to need to be aware of if you want to try this again. Things that you're going to need to be aware of and mindful of so that you're safe.'"

Integration of Maternal Mental Health Education Into Birth Preparation

Participants reported that while prenatal education primarily focuses on physical labor and delivery, that education includes limited preparation for the mental and emotional impacts of childbirth. Interviews emphasized the need for maternal mental health education for women and families, including information about the common signs and symptoms of mental health distress and when to seek support. Participants suggested that incorporating this education into standard prenatal classes and care could reduce stigma and delays in seeking care.

"We prepare our bodies for birth, but where are the classes for maternal mental health?"

Universal Mental Health Checks and Proactive Outreach

Participants supported the implementation of routine, in-hospital mental health check-ins before hospital discharge with social workers or maternal mental health specialists. These specialists should acknowledge that symptoms may emerge immediately or may take weeks to months to develop postpartum.

Most participants reported receiving a mental health questionnaire or screening during their postpartum appointment. That said, many did not find the questionnaire helpful. Reasons include: (1) the questionnaire did not adequately describe their experiences or symptoms; (2) concerns about the consequences of admitting to mental health challenges (e.g., having a child taken away); (3) feeling their provider was not equipped to respond to their mental health challenges or dismissed their symptoms as common 'baby blues' leading to delays in receiving needed care; (4) feeling that their provider viewed the screening as a procedural requirement rather than an opportunity to identify symptoms and begin a supportive conversation; and (5) discomfort with the impersonal or dismissive approach the provider used when administering the screening, which led some participants to feel unsafe disclosing symptoms.

"[The mental health questionnaire] was read off like a checklist and they are very intense questions 'Are you having thoughts about killing your baby?' The provider going through the checklist with me laughed at some of the questions - making fun of them. I remember thinking, 'I am grateful I am not experiencing some of these things, because I would not feel safe admitting I was.'"

Participants also described feeling overwhelmed by the process of finding appropriate mental health resources and navigating access to care while postpartum. Many emphasized the importance of the care team in initiating outreach and directly connecting individuals to mental health and support services. They noted that validation and early engagement from the care team can help normalize help-seeking and facilitate access to care.

"It would be helpful if your care team could address it first, asking if you need anything to help with depression or anxiety. To validate that you might be struggling and it is okay to get help."

Finally, participants stressed the need to include partners in postpartum mental health education and support, noting that trauma and mental health challenges can affect the entire family.

"My husband felt like he had to be strong for me, that he did not have the right to think about his trauma until I was out of physical and emotional danger. Everyone focuses on the mother and the baby, and husbands are so far down the line of who is thought about during the birth experience."

Additional Postpartum Follow-Ups

Participants consistently described a sharp drop-off in support following childbirth and noted that a single postpartum visit often does not adequately address physical recovery or mental health needs. Many emphasized the value of additional follow-up visits that integrate physical recovery and mental health screening.

"You are so closely watched until you give birth. After birth you get one appointment and then you are sent off into the wild."

Participants also identified telehealth as a helpful option for follow-up care, particularly when travel, childcare, or scheduling barriers make in-person visits difficult. They noted that ongoing contact—whether virtual or in person—could better support maternal well-being during the postpartum period.

Maternal Mental Health Specialists and Provider Training

Participants emphasized the need for greater access to maternal mental health specialists and improved provider training specific to pregnancy, childbirth, and postpartum-related mental health. Several participants noted that not all mental health providers are familiar with the clinical presentation, timing, or treatment of postpartum mental health conditions. They expressed a desire for providers with specialized training in maternal mental health and trauma as well as clearer pathways to identify and connect with these specialists.

Participants also suggested strengthening general provider education and required training related to maternal mental health and trauma. This could include expanding education and training in maternal mental health among obstetric, pediatric, and family practice providers.

Additional Resources to Support Families

Interview participants identified several community-based and other resources that can support families experiencing birth trauma or maternal mental health challenges. These resources complement clinical care by improving awareness, reducing isolation, and addressing practical barriers that affect access to support.

Peer Support Groups and Online Communities

Participants identified peer support groups and online communities as valuable resources for reducing isolation and validating lived experiences. They described these spaces as opportunities to share experiences, recognize common challenges, share coping strategies, and feel understood by others with similar experiences. Participants emphasized that connecting with peers helped reinforce that they were not alone and that their reactions were valid responses to difficult birth experiences.

Public Education and Awareness of Maternal Mental Health

Participants also emphasized the value of public education efforts that increase awareness of maternal mental health conditions including postpartum depression, anxiety, OCD, and other trauma-related symptoms. Participants described how clear messaging and increased awareness could improve recognition of symptoms and encourage earlier support-seeking by reducing stigma.

Reducing Barriers to Mental Health Care Access

Participants identified practical barriers that limit access to postpartum mental health services including cost, stigma, time constraints, and childcare needs. Cost emerged as one of the most frequently cited concerns, even among those with health insurance. Stigma also influenced participants' mental health care-seeking behavior. As noted above, some participants described fear of judgment or negative consequences, which affected how they responded to mental health screenings.

> *"I felt very depressed when I did the mental health assessment. I remember wanting to answer the questions correctly, but I was so afraid they would take my baby away."*

Time and childcare demands further constrain access to mental health care, with participants describing the difficulty of prioritizing appointments amid caregiving responsibilities.

> *"It is hard as a mom because you have to deal with childcare. If you are going to make an appointment, I have four kids, and my husband works full time. Being able to access appointments is challenging."*

Evidence-Based Approaches to Reduce Birth Trauma Risk

Limited research on evidence-based strategies to prevent or treat birth trauma exists to date. Few interventions are designed or tested specifically for birth trauma and recommended approaches draw largely from the evidence associated with PTSD treatment and industry best practices related to patient care.[9]

This section describes prevention and mitigation approaches that focus on care delivery with the purpose of increasing the recognition and treatment of birth trauma. These approaches include: (1) reducing distress during pregnancy, childbirth, and postpartum; and (2) strengthening trust between patients and providers.

Trauma-Informed Care

Trauma-informed care provides a foundational strategy to reduce the risk of birth trauma and support recovery when trauma occurs. This approach recognizes that trauma is common and that routine maternity care practices can unintentionally cause distress. In practice, trauma-informed care prioritizes emotional and physical safety, respectful communication, informed consent, and patient choice. Providers explain procedures, ask permission before exams, acknowledge patient concerns, and adapt care to individual needs. While trauma-informed care does not replace mental health treatment, it helps reduce re-traumatization and creates safer care environments for patients and families.[10,11]

Trauma-Informed Care Priorities

Source: White, A., Saxer, K., Raja, S., & Hall, S. L. (2022). A trauma-informed approach to postpartum care. Clinical Obstetrics and Gynecology, 65(3), 550–562.

Early Identification

Birth trauma is often an unrecognized part of maternity care.[12] Research finds health systems do not routinely screen for birth trauma during pregnancy or the postpartum period, and therefore individuals experiencing symptoms are less likely to be identified or offered treatment.

Multiple barriers limit early identification including: (1) low awareness about birth trauma among patients and health professionals; (2) no clinical guidelines on how or when to screen for birth trauma; and (3) limited research on the diagnostic accuracy of commonly used screening tools for identifying birth trauma.[13]

Early recognition of distress is critical despite these gaps. Improving awareness of birth trauma among health professionals and patients may help identify those who need support sooner and reduce the risk that their trauma symptoms worsen or persist. Research emphasizes that identification of trauma is more effective when providers have the time and resources to listen, respond empathically, and connect patients to appropriate services.[14,15]

Targeted Mental Health Interventions

Evidence from PTSD-related research shows that structured, trauma-focused therapies can reduce trauma symptoms after a distressing event. When adapted for birth trauma, these approaches include brief counseling, trauma-focused cognitive behavioral therapy, and other evidence-based mental health treatments delivered by trained mental health professionals. These interventions appear to be most effective when offered to individuals who show early or ongoing symptoms of distress, rather than applied universally to all birthing women.[16]

Care Coordination and Ongoing Support

Care coordination improves access to mental health and social services by helping individuals navigate complex systems of care. Research shows that perinatal patients with mental health needs who receive coordinated care are more likely to access services and remain engaged in treatment.[17] Effective models include clear referral pathways to providers with maternal mental health expertise and coordination across obstetric, primary care, pediatric, and mental health services. Evidence supports both provider-led and public health-led coordination models.

National clinical guidance also emphasizes ongoing postpartum contact (rather than a single visit) as a way to monitor emotional well-being, identify emerging concerns, and respond early.[18] Together, these approaches support timely identification, sustained engagement, and coordinated responses for patients experiencing distress following childbirth.

Informal and Structured Social Support Programs

A growing body of research identifies social supports as key factors in supporting maternal mental health and maternal-infant bonding. Support from partners, family members, and broader social networks reduces maternal stress and supports responsive caregiving, which is critical to strengthening mother-infant bonds.[19,20]

In addition to informal social supports, research shows structured social support interventions that combine emotional support, parenting education, and assistance navigating and connecting to health and social services (e.g., home visiting programs, peer support or counseling, and other community-based programs) can improve maternal mental health, increase engagement with needed care, and promote stronger partner relationships. These approaches support maternal recovery and mother-infant relationships by reducing isolation, normalizing help-seeking, teaching parenting and relationship skills, and providing consistent contact during the postpartum period.[21,22]

Conclusion

Birth trauma is complex and often goes unrecognized. Trauma-related symptoms, including shame and self-blame, can make it difficult for individuals to share their experiences and may delay help-seeking. This report aims to increase awareness and understanding of birth trauma to help improve recognition and strengthen systems that support women and families.

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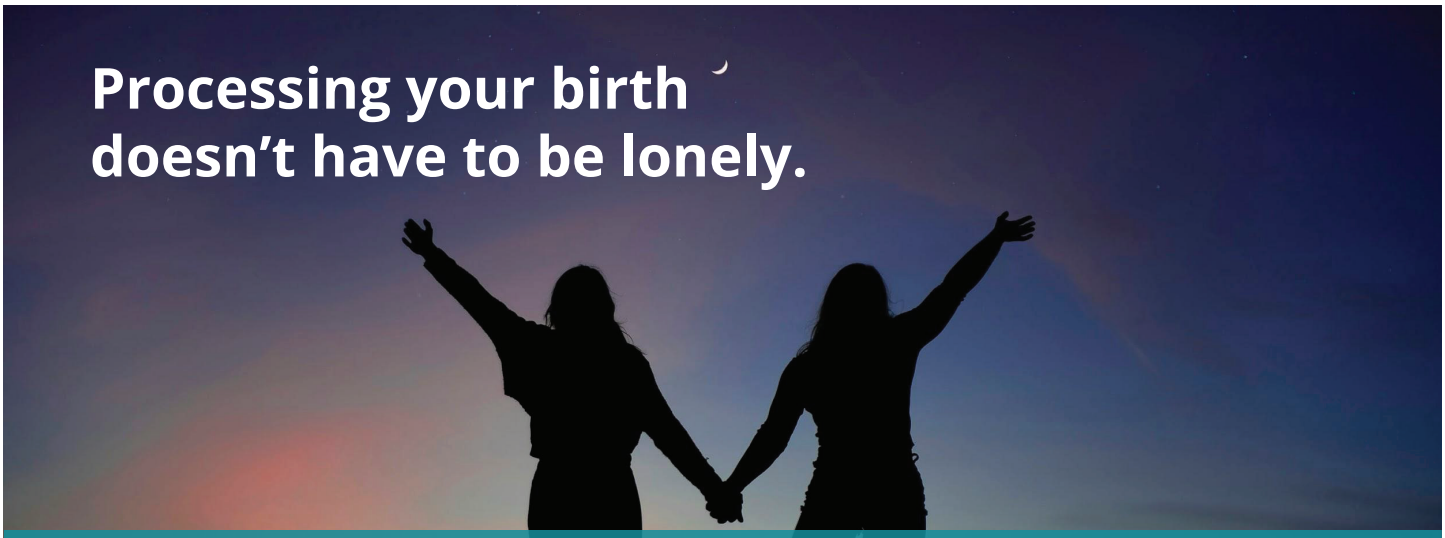
Appendix: Utah Department of Health and Human Services Resources



Processing your birth doesn't have to be lonely.

3 ways to find free emotional support after birth:

1 Did your birth feel traumatic? Get information and support at BirthTrauma.utah.gov.

Up to 45% of new moms report having birth trauma. Birth trauma is when a traumatic experience happens during birth and causes lasting distress. This can happen no matter how successful your delivery may have been. Birth trauma is determined by the individual.

Birth trauma can happen when there is:

- Fear for you or your newborn's life.
- A feeling of not being in control during labor.
- Emergency cesarean section (c-section).
- A significant loss of blood during birth.
- Lack of respect or compassion from medical team.
- Other obstetric emergencies or complications.
- Pelvic floor injuries.
- Preterm birth.
- Perinatal loss.
- Need for resuscitation.
- NICU stay.*

***This is not meant to be an exhaustive list, birth trauma can happen for many reasons.**

2 Join an online support group.

Find one on our website, BirthTrauma.utah.gov.

3 Talk to a mental health professional.

Call or text 1-833-852-6262 (1-833-TLC-MAMA) for the National Maternal Mental Health hotline.
For suicide and crisis support dial 9-8-8.

Scan here to visit our website.

Utah Department of Health & Human Services

UWNQC
Utah Women & Newborns Quality Collaborative

08/07/2025

If you had a traumatic birth, you are not alone.

This is Desiree.
Hear her story on our website.

Questions?

Email birthtrauma@utah.gov

Birth trauma is common, yet many individuals find it difficult to talk about. If you or someone you know has experienced a traumatic birth, you do not have to navigate recovery alone. Support is available, including free or low-cost options such as online support groups and mentorship programs. Resources are listed below.

Call 988 for the National Suicide & Crisis Lifeline

988 provides emotional and mental health support from trained crisis workers. It's free, confidential, and available 24 hours a day, 7 days a week. Call. Text. Chat.

Postpartum Support International (PSI) Helpline

Call 800-944-4773 to talk with other moms who have struggled with their mental health. PSI volunteers are trained to help provide support and resources. For text, text "HELP" to 800-944-4773 for English, or for Spanish, text 971-203-7773. Support is available from 6 a.m. to 9 p.m. MST. If calling outside these hours, leave a voicemail and expect a return call within 1–2 business days. PSI resources are available at postpartum.net

PSI Peer Mentor Program

This program pairs individuals in need of support with a trained volunteer who has also experienced and recovered from a Perinatal Mood Disorder (PMD). Establishing a one-to-one connection with someone who has navigated a PMD offers valuable insight, encouragement, and hope. To learn about PSI's peer mentor program, reach out by email at: peermentor@postpartum.net.

PSI Online Support Groups

Support groups offer compassionate peer support for birth trauma, pregnancy loss, infant loss, fertility challenges, and more. All groups are free, over Zoom, and facilitated by trained peer supporters. More information available at https://postpartum.net/get-help/psi-online-support-meetings/

Birth Trauma Association (UK)

Information, podcasts, research and training videos on birth trauma. Available at: birthtraumaassociation.org

National Maternal Mental Health Hotline

Call 833-852-6262 to access a free, confidential hotline for pregnant and postpartum mothers. Trained maternal mental health specialists are available to listen, connect callers with local support groups or organizations, and provide referrals to other health care professionals. The hotline is available 24 hours a day, 7 days a week, and offers interpretation in more than 60 languages.

Maternal Mental Health Referral Network

An online directory of Utah professionals and support groups with training in perinatal mental health. Listed providers and resources offer support for depression, anxiety, infertility, miscarriage, birth trauma, and other related concerns. Available at maternalmentalhealth.dhhs.utah.gov

Specialized resources on BirthTrauma.utah.gov

Specialized organizations and resources are available for specific experiences including NICU stays, placenta accreta, cesarean delivery, and other birth-related complications. Many offer support groups, peer networks, and other resources. BirthTrauma.utah.gov provides resources and information on birth trauma for providers and patients.

Additional maternal mental health resources

Contact information and links to additional maternal mental health resources including care coordinators, emergency childcare, domestic violence support, and more. Available at: https://mihp.utah.gov/wp-content/uploads/Maternal-mental-health-resources-1.pdf

Individuals interested in learning more about or getting involved in the Utah Women and Newborns Quality Collaborative (UWNQC) birth trauma initiative may contact uwnqc@utah.gov. Opportunities include sharing lived experiences, helping disseminate resources, or participating in training. UWNQC also offers education on birth trauma and available resources for maternal-facing providers including medical, mental health, and community health professionals.

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