

Diagnosing in the dark: The childbirth-related post-traumatic stress disorder GP evidence gap

Corresponding author: Dr Megan Foreman, PhD MRCGP

NHS GP and NIHR Clinical Lecturer in General Practice, Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ

ORCID iD 0009-0000-9019-9858

Dr Sarah Hillman, PhD MRCOG MRCGP

NHS GP and Clinical Associate Professor of Women's health and Primary Care, School of Health Sciences, University of Birmingham, Edgbaston, Birmingham, B15 2TT

ORCID iD 0000-0002-3560-2074

Professor Jane Cross, Ed D

Professor of Health Services Research and Director of Norwich Clinical Trials Unit, Norwich Medical School, School of Health Sciences, University of East Anglia, Norwich, NR4 7TJ

ORCID iD 0000-0002-7003-1916

Dr Sarah Hanson, PhD

20 Associate Professor of Community Health, School of Health Sciences, University of East
21 Anglia, Norwich, NR4 7TJ

22 ORCID iD 0000-0003-4751-8248

23

24 Dr Helen Parretti, PhD MRCP

25 NHS GP and Consultant Clinical Associate Professor, Norwich Medical School,
26 University of East Anglia, Norwich, NR4 7TJ

27 ORCID iD 0000-0002-7184-269X

28

29 Professor Susan Ayers, PhD

30 Professor of Maternal and Child Health, School of Health Sciences, City St George's,
31 University of London, Northampton Square, London, EC1V 0HB

32 ORCID iD 0000-0002-6153-2460

33

34 **Keywords**

35 General Practice, Post-Traumatic Stress Disorder, Postnatal Care, Maternal Health
36 Services, Mental Health

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38 **Analysis**

With the ongoing national independent investigation into maternity and neonatal services and the formation of the national maternity and neonatal taskforce, policy makers, clinicians and academics are exploring strategies for making UK maternity care safer, more equitable and responsive. Perinatal mental health provision has repeatedly been flagged as an area where standards of care fall short, with perinatal mental health conditions disproportionately affecting deprived and minoritised groups. The MBRRACE report 2025 demonstrated that in the UK between 2021 and 2023, maternal suicides remained the leading cause of deaths between six weeks and one year after pregnancy. (1) Maternal suicides represent not only potentially preventable deaths which have a devastating impact on the child and family, but also the ‘tip of the iceberg’, with many more women living with perinatal mental health conditions unable to access appropriate care.

Concurrently, UK general practice is facing significant challenges, with access and continuity of care often limited, mounting administrative burdens and GPs being asked to ‘do more with less’. GPs remain the chief gatekeepers to most secondary care services, including perinatal mental healthcare. National guidance places GPs at the forefront of community perinatal mental health provision. The NICE clinical guideline CG192 on antenatal and postnatal mental health (2) advises healthcare professionals to direct postnatal women with all but the most severe mental health conditions to their GP. Similarly, the Royal College of Psychiatrists’ perinatal guidance states “mild to moderate disorders should usually be managed by primary care services or IAPT [Talking Therapies]”. (3) A recent parliamentary briefing supporting policy change in perinatal mental healthcare identified primary care as the first point of contact for women. (4) A 2025 charity report estimated that annually, 115,000 UK women requiring perinatal

63 mental health support fall below the threshold for specialist services. (5) If standards of
64 care are to improve, it is imperative that GPs are given the knowledge and tools to assess
65 and support women with perinatal mental health conditions within the time and resource
66 constraints imposed upon them.

67 A traumatic perinatal experience can result in overwhelming distress, negatively
68 impacting a woman's health and wellbeing, termed 'birth trauma'. If severe symptoms
69 persist, women may meet the diagnostic criteria for childbirth-related post-traumatic
70 stress disorder (CB-PTSD). The symptoms and aetiology of CB-PTSD are detailed
71 elsewhere. (6–8) A diagnosis of CB-PTSD requires the presence of a traumatic event or
72 events related to pregnancy, birth or the postnatal period, accompanied by symptoms of
73 re-experiencing, avoidance, hypervigilance, and negative cognitions and mood for at
74 least 1 month. Birth trauma is subjective, and CB-PTSD can occur following a medically
75 uncomplicated birth. Previous trauma, mental health conditions and inadequate support
76 increase the risk, whilst high quality maternity care, effective communication, and
77 support during pregnancy and birth are protective, even when complications occur. (8)

78 Untreated CB-PTSD can have profound effects on women and families. (7) For some, the
79 associated anxiety can lead to increased utilisation of healthcare appointments for the
80 women and infant. (9) For others, CB-PTSD can lead to avoidance of healthcare contacts,
81 including in future pregnancies. Some women may choose an elective caesarean in
82 subsequent pregnancies, attempting to maintain control, whereas others may choose to
83 reject aspects of care during pregnancy and labour, or opt for a home birth against
84 medical advice to avoid intervention, (10) potentially increasing the risks to the mother

and baby. The MBRRACE report also includes cases where CB-PTSD contributed to suicide. (1)

Despite an estimated prevalence of 4.7% in postnatal women, (11) and the association with suicidality, there is no established CB-PTSD assessment tool for use in primary care. Birth trauma and CB-PTSD are specifically mentioned in national guidance for GPs including the NICE guideline CG192, (2) NHS England’s guidance on the GP postnatal consultation, (12) and the NHS England ‘Maternal Care Bundle’, (13) but with no framework for assessment. Clinicians are directed to the NICE guideline NG116 on PTSD, (14) which states that “GPs should take responsibility for assessment and initial coordination of care”, but again given no information on how to determine symptom severity or risk.

The All Party Parliamentary Group (APPG) birth trauma report highlighted that women may struggle to access appropriate care through their GP. (15) Surveys suggest that many UK healthcare practitioners, including many GPs, feel they lack confidence and skills in supporting women with birth trauma. (16,17) A UK study demonstrated that, despite half of GPs recognising trauma-related features when reviewing case vignettes describing CB-PTSD, their most common diagnosis was postnatal depression. (18) Misdiagnosis can be detrimental, since the management of the conditions differs. Antidepressants are less effective for PTSD than specialist psychological interventions and are therefore not recommended by NICE as a first line treatment. (14) Whilst PTSD and depression are frequently comorbid, increasing the risk of suicidality, (19) there is also evidence that treating depression alone may not improve co-existing CB-PTSD. (20)

107 NHS England guidance on the 6-to-8-week postnatal check (12) and clinical practice
108 articles aimed at GPs (6) suggest several questions to ask women to identify CB-PTSD.
109 However, evidence is lacking as to which questions effectively identify clinically
110 significant symptoms. Although the APPG report recommended the development of two
111 standard birth trauma screening questions to be asked at the GP postnatal check, (15)
112 there is no research evidence for this approach. As well as addressing both physical and
113 mental health concerns, the 6-to-8-week postnatal appointment may be combined with
114 an appointment for the baby and immunisations, which can dominate the consultation.
115 This can make assessing the mother's mental health challenging, particularly if they
116 attend alone with the child. In addition, some women may not feel able to discuss a
117 traumatic birth immediately as it may be retriggering. Asking inappropriate questions at
118 an inappropriate time risks GPs being falsely reassured, and women left feeling unable to
119 ask for help and potentially more traumatised.

120 Research is required to explore strategies for improving CB-PTSD recognition. Promoting
121 educational resources [Box 1] could improve GPs' diagnostic confidence. Screening for
122 postnatal depression has generally been demonstrated to be acceptable to women, (21)
123 and is recommended by NICE. (2) However, studies suggest that, in the case of postnatal
124 depression, screening tools must be delivered appropriately and alongside supportive
125 conversations to be acceptable to women. (21,22) Paired with increasing awareness and
126 clinician education, a sensitively implemented CB-PTSD screening tool validated for use
127 at the 6-to-8-week GP appointment could provide the framework for a consultation
128 deliverable within the time constraints of primary care, which both identifies patient need
129 and gives the clinician greater confidence in their diagnosis. However, any tool would

need to be integrated within a robust pathway promoting timely referral to specialist services when indicated.

GPs are in a unique position to assess and understand a woman's perinatal mental health in the context of their history and social environment, to advocate for access to specialist support, and to provide ongoing, holistic care for CB-PTSD. Further research must be prioritised to equip GPs with evidence-based guidance on the assessment and management of women with CB-PTSD in primary care, to improve outcomes and to mitigate harm to women and families.

Box 1: GP birth trauma and CB-PTSD resources

1. NHS England eLearning for healthcare "Perinatal Mental Health Birth Trauma": three learning modules which build on a trauma informed approach to birth trauma. (Created 17 Mar 2025).
2. NHS Healthier Together birth trauma information for patients:
<https://www.healthiertogether.nhs.uk/pregnancy-and-birth/birth-trauma>
3. Birth Trauma Association: UK charity providing patient and professional resources around birth trauma diagnosis, support, treatment and prevention:
<https://www.birthtraumaassociation.org/>
4. Make Birth Better: UK charitable organisation providing birth trauma information and educational resources: <https://www.makebirthbetter.org/>
5. PANDAS: UK charity providing support for families affected by perinatal mental illness: <https://pandasfoundation.org.uk/>

6. SANDS: UK charity providing support for pregnancy loss including professional resources: <https://www.sands.org.uk>

7. MASIC: UK charity supporting women who have suffered severe perineal injuries during childbirth, including professional resources: <https://masic.org.uk/>

Footnote

This article uses the terms “women” and “mothers” to refer to people who have carried a pregnancy, whilst recognising that some birthing people are not represented by these terms.

Funding

Megan Foreman is supported by a National Institute for Health and Care Research (NIHR) Clinical Lectureship. No specific funding was sought for the presented analysis. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

Ethical approval

This study used publicly available information only. No ethical approval was required.

Competing interests

Professor Susan Ayers developed the City BiTS-short form described in the article. The authors have no other competing interests to declare.

References

1. Felker A, Patel R, Kotnis R, Kenyon S, Knight M (Eds.) on behalf of MBRRACE-UK. (2025). Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. Oxford: National Perinatal Epidemiology Unit, University of Oxford. doi: 10.5287/ora-4javr692x
2. National Institute for Health and Care Excellence (2020) Antenatal and postnatal mental health: clinical management and service guidance CG192. (NICE, London) <https://www.nice.org.uk/guidance/cg192>. (Accessed 22 Apr 2026).
3. Royal College of Psychiatrists (2018) Perinatal specialist community mental health team service specification template. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/perinatal/nccmh-perinatal-specialist-community-mental-health-team-service-spec-template-may2018.pdf?sfvrsn=aa70cd14_4. (Accessed 22 Apr 2026).
4. O'Brien A, Lally C. (17 Apr 2026) Parliamentary Office of Science and Technology: Mental health during and after pregnancy. <https://researchbriefings.files.parliament.uk/documents/POST-PN-0765/POST-PN-0765.pdf>. doi:10.58248/PN765. (Accessed 22 Apr 2026).
5. Alyousefi-van Dijk K, Hopson H, Richards L, Haynes A, Rosan C. (2025) Integrate: A guide to integrating psychological support for common perinatal mental health

195 difficulties into universal services. [https://www.annafreud.org/research/past-](https://www.annafreud.org/research/past-research-projects/the-integrate-report/)
196 [research-projects/the-integrate-report/](https://www.annafreud.org/research/past-research-projects/the-integrate-report/). (Accessed 22 Apr 2026).

197 6. Slade P, Murphy A, Hayden E. Identifying post-traumatic stress disorder after
198 childbirth. *BMJ*. 2022 May 10;377:e067659. doi:10.1136/bmj-2021-067659

199 7. Horsch A, Garthus-Niegel S, Ayers S, Chandra P, Hartmann K, Vaisbuch E, et al.
200 Childbirth-related posttraumatic stress disorder: definition, risk factors,
201 pathophysiology, diagnosis, prevention, and treatment. *Am J Obstet Gynecol*. 2024
202 S1116–27. doi:10.1016/j.ajog.2023.09.089

203 8. Rauh Garrido C, Okunbor J, Boettcher LB, Kuller JA, Dotters-Katz S, Kimmel MC. Birth
204 Trauma and Postpartum Childbirth-related Posttraumatic Stress Disorder: A
205 Narrative Review of Pathology, Risk Factors, and Practice Recommendations. *Obstet*
206 *Gynecol Surv*. 2026 Apr;81(4):177–85. doi:10.1097/OGX.0000000000001493

207 9. Moran PM, Best C, Meades R, Hutton U, Doungsong K, Pisavadia K, et al. Postpartum
208 post-traumatic stress disorder and health service use: A longitudinal cohort study. *J*
209 *Affect Disord*. 2026 May;400:121171. doi:10.1016/j.jad.2026.121171

210 10. Holopainen A, Stramrood C, van Pampus MG, Hollander M, Schuengel C.
211 Subsequent childbirth after previous traumatic birth experience: women’s choices
212 and evaluations. *Br J Midwifery*. 2020 Aug 2;28(8):488–96.
213 doi:10.12968/bjom.2020.28.8.488

214 11. Heyne CS, Kazmierczak M, Souday R, Horesh D, Lambregtse-van den Berg M, Weigl
215 T, et al. Prevalence and risk factors of birth-related posttraumatic stress among
216 parents: A comparative systematic review and meta-analysis. *Clin Psychol Rev*.
217 2022;94. doi:10.1016/j.cpr.2022.102157

- 218 12. NHS England. (19 Feb 2025). GP six to eight week maternal postnatal consultation –
219 what good looks like guidance. [https://www.england.nhs.uk/long-read/gp-six-to-](https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/)
220 [eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/](https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-postnatal-consultation-what-good-looks-like-guidance/).
221 (Accessed 22 Apr 2026).
- 222 13. NHS England. (6 Mar 2026). The Maternal Care Bundle: A care bundle for reducing
223 maternal mortality and morbidity. [https://www.england.nhs.uk/long-read/the-](https://www.england.nhs.uk/long-read/the-maternal-care-bundle/)
224 [maternal-care-bundle/](https://www.england.nhs.uk/long-read/the-maternal-care-bundle/). (Accessed 22 Apr 2026).
- 225 14. National Institute for Health and Care Excellence. (2018). Post-traumatic stress
226 disorder, NICE guideline NG116. (NICE, London).
227 <https://www.nice.org.uk/guidance/ng116>. (Accessed 22 Apr 2026).
- 228 15. The All-Party Parliamentary Group on Birth Trauma. (2024). Listen to Mums: Ending
229 the Postcode Lottery on Perinatal Care. [https://www.theo-](https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf)
230 [clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-](https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf)
231 [05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf](https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf).
232 (Accessed 22 Apr 2026).
- 233 16. Delicate A, Ayers S, McMullen S. Health care practitioners' views of the support
234 women, partners, and the couple relationship require for birth trauma: Current
235 practice and potential improvements. *Prim Health Care Res Dev.* 2020;21.
236 doi:10.1017/S1463423620000407
- 237 17. Make Birth Better (2025) National birth trauma survey - Assessing knowledge in GPs
238 & HVs.
239 [https://static1.squarespace.com/static/5ed8a1b746cc235b44a50be1/t/6937e29c0](https://static1.squarespace.com/static/5ed8a1b746cc235b44a50be1/t/6937e29c0ee2157266169bf4/1765270172579/%23TTN+National+Birth+Trauma+Survey+For+HVs+%26+GPs_DEF.pdf)
240 [ee2157266169bf4/1765270172579/%23TTN+National+Birth+Trauma+Survey+For+](https://static1.squarespace.com/static/5ed8a1b746cc235b44a50be1/t/6937e29c0ee2157266169bf4/1765270172579/%23TTN+National+Birth+Trauma+Survey+For+HVs+%26+GPs_DEF.pdf)
241 [HVs+%26+GPs_DEF.pdf](https://static1.squarespace.com/static/5ed8a1b746cc235b44a50be1/t/6937e29c0ee2157266169bf4/1765270172579/%23TTN+National+Birth+Trauma+Survey+For+HVs+%26+GPs_DEF.pdf). (Accessed 22 Apr 2026).

- 242 18. Mortimer H, Habash-Bailey H, Cooper M, Ayers S, Cooke J, Shakespeare J, et al. An
243 exploratory qualitative study exploring GPs' and psychiatrists' perceptions of post-
244 traumatic stress disorder in postnatal women using a fictional case vignette. *Stress*
245 *Health*. 2022 Aug;38(3):544–55. doi:10.1002/smi.3114
- 246 19. Panagioti M, Gooding PA, Tarrier N. A meta-analysis of the association between
247 posttraumatic stress disorder and suicidality: the role of comorbid depression.
248 *Compr Psychiatry*. 2012 Oct;53(7):915–30. doi:10.1016/j.comppsy.2012.02.009
- 249 20. Ayers S, McKenzie-McHarg K, Eagle A. Cognitive behaviour therapy for postnatal
250 post-traumatic stress disorder: case studies. *J psychosom obstet gynecol*. 2007 Jan
251 7;28(3):177–84. doi:10.1080/01674820601142957
- 252 21. Gemmill AW, Leigh B, Ericksen J, Milgrom J. A survey of the clinical acceptability of
253 screening for postnatal depression in depressed and non-depressed women. *BMC*
254 *Public Health*. 2006 Aug 17;6. doi:10.1186/1471-2458-6-211
- 255 22. Shakespeare J, Blake F, Garcia J. A qualitative study of the acceptability of routine
256 screening of postnatal women using the Edinburgh Postnatal Depression Scale.
257 *BJGP*. 2003 Aug;53(493):614-619. PMID: 14601337