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Abstract

An exploratory qualitative study exploring GPs' and psychiatrists' perceptions of post-traumatic stress disorder in postnatal women using a fictional case vignette

Postnatal post-traumatic stress disorder (PTSD) affects 3%-4% of women who give birth. It is underdiagnosed and undertreated. Thus far, no studies have investigated doctors' perceptions of PTSD in postnatal women. We investigated whether GPs and psychiatrists perceive PTSD symptoms after birth to indicate pathology and what diagnosis and management they would offer.

Semi-structured interviews were conducted with six GPs and seven psychiatrists using a fictional vignette featuring a woman experiencing PTSD following a traumatic birth. A framework analysis approach was used.

Despite half the GPs recognizing trauma-related features in the vignette their most common diagnosis was postnatal depression whereas six of the seven psychiatrists identified PTSD. Management plans reflected this. Both GPs and psychiatrists lacked trust in timeliness of referrals to psychological services. Both suggested referral to specialist perinatal mental health teams.

Results suggest women are unlikely to get a PTSD diagnosis during initial GP consultations, however the woman-centred care proposed by GPs means that a trauma-focussed diagnosis later in the care pathway was not ruled out. Further research is needed to confirm these findings, which suggest that an evidence base around best management for women with postnatal PTSD is sorely needed, especially to inform GP training.

1. Introduction

Childbirth is a common life event perceived generally by society as a positive time in women's lives. From a physical health perspective giving birth has never been safer (Knight et al., 2017; Organization, 2019; World Health Organization, 2019). However approximately a third of women describe their experience of childbirth as psychologically traumatic (Creedy et al., 2000; Ghanbari-Homayi et al., 2019; O'Donovan et al., 2014; Soet et al., 2003) and it is well documented that post-traumatic stress disorder (PTSD) can result (Ayers & Pickering, 2001; Cigoli et al., 2006; Garthus-Niegel et al., 2013; Goutaudier et al., 2012). Risk factors for postnatal PTSD include instrumental deliveries, emergency caesarean sections and if a woman's subjective experience of the birth is negative, regardless of delivery type (Ayers et al., 2016; Beck, 2004). Postnatal PTSD may also be associated with a perceived lack of care from healthcare professionals during the birth (Ayers, 2017; Ayers et al., 2016; Baxter, 2020; De Schepper et al., 2016).

PTSD is a condition whereby, in response to a significant stressor, a person develops symptoms of re-experiencing and avoidance as well as negative alterations in cognition and alterations in arousal and reactivity. In accordance with The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria these symptoms must be present for more than 1 month and interfere with the person's daily functioning (American Psychiatric Association, 2013). Postnatal PTSD has an estimated incidence of 3-4% (Grekin & O'Hara, 2014; Yildiz et al., 2017). It is also increasingly being recognised that birth partners of both genders can develop PTSD from witnessing birth trauma (Daniels et al., 2020).

Beyond the distress experienced by the individual, studies have shown that PTSD in the postnatal period impacts on family relationships, parent-infant bonding (Davies et al., 2008; Fenech & Thomson), breastfeeding decisions (Garthus-Niegel et al., 2018) and women's future reproductive choices (Allen, 1998). Perinatal mental health also represents a significant economic burden (Bauer et al., 2014). Improving service provision for severe perinatal mental illness has been prioritised in several countries ((NHS), 2014, 2019), however reviews of the

perinatal mental health literature have exposed the sparsity of research concerning optimal health services for PTSD in the postnatal period, leading to calls for further research focusing on recognition and management.

Evidence-based treatments for PTSD are recommended by the National Institute for Health and Care Excellence (NICE) in the UK. These include trauma-focused cognitive behaviour therapy (CBT), eye movement desensitisation and reprocessing (EMDR) ([NICE], 2018), which can be delivered via Primary Care Psychological services (PCPS) (known in England as 'Improving Access to Psychological Therapy' (IAPT)) (The National Collaborating Centre for Mental Health, 2019), as well as limited role for pharmacological therapy ([NICE], 2018). PTSD following childbirth has been shown to have similar symptomatology to PTSD following other traumatic events (Ayers et al., 2009; Ayers et al., 2015) and there is evidence that the same trauma-focused psychological therapies are appropriate for postnatal women (Furuta et al., 2018; Peeler et al., 2013).

Self-referral processes, present in several countries, to PCPS theoretically remove the healthcare professional from the initial referral process. However, studies investigating the lived experience of postnatal women seeking help for mental health problems have suggested women feel uncertain whether they have a legitimate problem and are reluctant to self-refer due to concerns around stigma and worries that their babies might be taken into care (Dennis & Chung-Lee, 2006; Millett et al., 2018; Smith et al., 2019). They therefore often rely on doctors to refer them to the appropriate pathways. In England this is likely to be a GP but, out-of-hours, a woman presenting to the Emergency Department may be assessed by a psychiatrist from a liaison team and, due to difference in health care structuring internationally, psychiatrists are much more likely to be involved in the initial assessment of a woman presenting in the postnatal period with mental health symptoms hence why doctors from both specialities were included in this study.

Previous research suggests that PTSD after any event is under-recognised and under-diagnosed by clinicians in primary care (Brewin et al., 2008; Ehlers et al., 2009; Greene et

al., 2016; Munro et al., 2004). Literature on women's postnatal interactions with primary care suggest that when women present to doctors in the postnatal period, their mental health symptoms are normalised, their description of symptoms does not always lead to a diagnosis and they are often not referred to an appropriate, evidence-based management pathway (Chew-Graham et al., 2009; Dennis & Chung-Lee, 2006; E. Ford, S. Lee, et al., 2017; E. Ford, J. Shakespeare, et al., 2017; Trust, 2017). Some evidence, for example, suggests that as few as 10% of women experiencing postnatal depression will be treated adequately for their condition (Gavin et al., 2015). This is likely to be even fewer for women experiencing PTSD.

Despite the key role GPs and psychiatrists play in the journey of women with postnatal PTSD from recognition to effective management, little is known about the doctor-patient interaction when these women present and, thus far, no research has investigated these doctors' perceptions of PTSD in this unique population.

This study aimed to investigate GPs' and psychiatrists' perceptions and experience of caring for women with PTSD in the postnatal period. We explored whether GPs and psychiatrists see the experience of childbirth as a stressor as per DSM-5 criteria and investigate whether they perceive PTSD symptoms after birth to be indicative of a disorder, or as a non-pathological reaction which would resolve spontaneously. Further to this we investigated what diagnosis GPs and psychiatrists would give a patient with a classic set of PTSD symptoms; what management or service pathway they would be offered, and to explore whether clinicians would follow guidelines for the treatment of PTSD. This was an exploratory study, using qualitative methods, to generate hypotheses for future research.

2. Material and Methods

2.1. Ethical Approval

This data collection was part of a wider study investigating PTSD care pathways. The project was approved by [edited out for blind review] University Research Governance and Ethics

Committee (RGEC) (ER/BSMS3633/1) and granted Health Research Authority (HRA) Research and Development (R&D) approval (IRAS ID 230342). An amendment was approved by RGEC for this secondary analysis (ER/BSMS9GE0/2).

2.2. Funding

The project was funded by the Royal College of Psychiatrists. The funder had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

2.3. Participant recruitment

Participants were eligible if they were qualified GPs or psychiatrists or were doctors in a training programme for either specialty and currently working within the NHS. Participants were recruited by email invitation to GP surgeries and the local psychiatry network; posters were also displayed within University and NHS premises inviting clinicians to take part. GPs and psychiatrists who were involved in teaching at the medical school were invited to participate via email. Written, informed consent was obtained from all participants. Gender of participants was captured. Participants were financially compensated for their time guided by the National Institute of Health Research suggested rate of £80 per hour; interviews were expected to last 30-40 minutes and as such £50 was agreed to be paid per interview. Individuals were excluded if they were not doctors; were doctors of other specialties, doctors who were not currently practising within the NHS or foundation doctors. Of those who initially agreed to participate none later declined or dropped out of the study.

2.4. Interviews

Semi-structured interviews were conducted on NHS or University premises by a female (HHB) or male medical student (DA), both of whom had prior experience of conducting qualitative research and training in interview techniques. They had no prior relationship with the participants. Mean interview duration was 34 minutes. Although several participants were

working within the same geographical area they did not know one another and there were no opportunities provided to discuss the vignettes or potential diagnoses between participants.

Interviews were structured using a topic guide (see Appendix 1) and fictional case-based vignettes of two classic presentations of PTSD: one involving a postnatal woman exhibiting PTSD symptoms (see Box 1) and one involving an asylum-seeker. There was also scope for the doctors to talk about patients they had seen in their own clinical practice who had experienced trauma. In this study we focussed specifically on parts of interviews which related to the postnatal vignette and doctors' own clinical experience. The vignettes were written using an iterative process of drafting and refinement among the research team. It was intended to represent a case of PTSD with no co-morbid psychological problems. The decision to stop interviewing was a compromise agreed by multiple members of the author team. Time and financial constraints were considered along with preliminary data analysis looking for early signs of data saturation. This approach is in keeping with inductive methods used widely by other qualitative studies (Saunders et al., 2018).

The multidisciplinary author team had backgrounds in psychology, psychiatry, general practice and general medicine. They ranged in seniority from medical students to senior lecturers, professors, consultants and an experienced GP with a special interest in perinatal mental illness. The mixed-gender team worked to bring together a range of expertise and understanding of the phenomena under study, including clinical care for patients with the conditions under study, extensive research and clinical training, and shared values in improving patient care. We anticipated that these multidisciplinary perspectives would reduce the amount of bias in our analysis and interpretation.

2.5. Data analysis

Interviews were recorded then transcribed verbatim and checked for accuracy by a different member of the research team. A framework approach, a type of thematic analysis, (Braun & Clarke, 2006; Gale et al., 2013) was used as it is well suited for analysing semi-structured

interviews and making comparisons within and between interviewees. In addition it leaves a clear audit trail between raw data and final themes (Gale et al., 2013). An inductive approach was used meaning the production of themes was data-driven (Braun & Clarke, 2006).

The framework process was guided by methods described by Gale et al (Gale et al., 2013). Following immersion and familiarisation, the resultant transcripts and audio files were searched manually for themes. At first a broad approach was used, and all identified themes were given codes. This coding process was assisted by *NVivo* 12 software. From these initial codes, a working analytical framework was established. The data from GPs and psychiatrists was firstly analysed separately and then secondly together. This framework was dynamic and as analysis progressed further codes were added for new themes identified. The whole dataset was charted using the framework. Analysis of the dataset continued until no new themes were being extracted indicating a degree of saturation had occurred. Themes were grouped together into sub-themes and the most significant were highlighted. Significance was determined by the importance, as well as frequency, of the theme. Relative importance of themes was determined by discussion throughout the process between the authors with reference back to the framework. All themes selected for inclusion were supported by statements from multiple participants. As in the methodology described by Braun and Clarke (Braun & Clarke, 2006) those themes which provided context to the research questions were deemed most significant. This determining of themes was a collaborative process involving the multidisciplinary author team in keeping with the methodology described by Gale et al (Gale et al., 2013).

To ensure the integrity of our data and the results drawn from it the COREQ criteria were used to inform our methodology and reporting (Tong et al., 2007) (see Appendix 2).

3. Results

Six GPs and seven psychiatrists took part in the study, for genders of participants, see Table

1. No further details of participants are given to protect participant privacy.

3.1. Themes

Four GP themes and three psychiatrist themes were identified, as well as one theme common to both groups (see Box 2).

3.1.1. General practitioners

3.1.1.1. Childbirth is not always considered a trauma by healthcare professionals

Some GPs defined the events in the vignette as traumatic whereas others saw the birth as within the range of what could be expected from a 'normal delivery'. A change in perceptions of normal pregnancy was also described. They acknowledged that in the past it was more common for doctors to think that births - even those like the one in the vignette – were considered 'normal' life events but now, they said, this view was outdated:

"Well she's suffered trauma hasn't she?" GP 4 (Male).

"In days gone by, the [birth] would have... been... a more normal life event that you would have to cope with and get on with, but now you would have to recognise it's a traumatic event... Say a 100 years ago, people who we say now have PTSD, it would have been lack of moral fibre or whatever." GP 3 (Male).

Ideas consistent with this more 'outdated' view were exhibited by several other participants: central to this was a notion that mothers may not be prepared for common complications during childbirth:

"I have actually had someone in, last week, who had a difficult forceps delivery recently...and she's struggling 2 weeks on... she's fussing" GP 5 (Female).

"I also think this may not necessarily be a medical condition, it may be a traumatic event that is not classified as a serious mental illness. I would imagine that many women who go through labour... [find that it's] ... different to what would have been imagined". GP 6 (Male).

3.1.1.2. Majority of GPs recognised 'trauma features' but opted for a diagnosis of depression

Four of the six GPs recognised that the vignette had 'trauma features' and three identified that the woman was exhibiting traits they associated with PTSD:

"Well the first vignette does strike me as having features of what you would probably consider as a bit of postnatal depression with, there are some features of trauma there, I mean she's talking about the vivid nightmares, dreams and the being on edge." GP 2 (Male).

"This is an account from a woman who has gone through a labour and delivery of her baby ...describing distress that she has felt at various points...I think medical conditions could include psychological trauma which might result in post-traumatic stress disorder." GP 6 (Male).

Despite the recognition of features of PTSD most GPs said that the primary diagnosis was postnatal depression. This was true even of those GPs who described the birth as clearly traumatic.

"We'll call vignette one depression but we'll treat that depression in a trauma informed way." GP 2 (Male).

"This is a normal delivery that has gone wrong, that the person has been well treated and recovered but has obviously been left with some psychological trauma after the event...She is depression and mild, mild to moderate post-traumatic stress disorder." GP 3 (Male).

One GP suggested that postnatal depression was responsible for a distorted view of the birth experience.

"I think she's having postnatal depression and therefore that's affecting, possibly, how she's perceiving what happened." GP 5 (Female).

GPs were reluctant to make a PTSD diagnosis without specialist input, whereas they were comfortable making a depression diagnosis. They expressed the sentiment that general

practice was not an appropriate place for a person to receive a PTSD diagnosis; instead, they suggested, it should be a psychiatrist who made that diagnosis.

“You have that sort of thing of ‘I’m a GP so is it right that I place that label there?’ It certainly seems to fit, but I don’t have the resources to make that diagnosis... to any degree of certainty ... is it ‘just a GP’ in inverted commas that’s given that label, in which case that has less gravity than a consultant psychiatrist.” GP 2 (Male).

One consequence of this reticence was uncertainty over how to document a diagnosis. Ultimately, this could lead to ambiguity in medical records.

“I would probably say something like ‘post-traumatic stress disorder ‘question mark’” GP 1 (Male).

3.1.1.3. GPs’ management plans reflected the depression diagnosis

A variety of management strategies were discussed by GPs for the woman. As indicated, the predominant diagnosis suggested by the GPs was postnatal depression and proposed management plans reflected this: antidepressant medication (n=2), CBT (n=4). Referral to Specialist Perinatal Mental Health Teams (SPMHTs) was also suggested (n=1) as was watchful waiting (n=3).

Patient choice was emphasised strongly by GP participants as the ultimate guiding factor on what they would offer.

“I would want to talk to her more, talk to her about what sort of help she would like.” GP 3 (Male).

“If the patient wants referral, I’m more likely to refer them.” GP 6 (Male).

Some GP participants suggested trialling an anti-depressant.

“I would want to... think about whether antidepressant medication would help.” GP 3 (Male).

Whilst CBT was suggested, they did not trust that signposting patients to PCPS for CBT would conclude with the patient receiving timely therapy.

“I would... think about whether some sort of psychological intervention would help too.” GP 3

“It’s not clear whether CBT is the best thing to do for these kind of people and... it’s very difficult to get it [CBT] for patients.” GP 1 (Male).

“They do a triage session within about 2 weeks...but the problem is then the waiting list to start the treatment so you know that’s currently running at about 8 months.” GP 5 (Female).

GPs described themselves as less likely to refer to general secondary psychiatry services due to long waiting times and risk-based triage assessments which, some felt, incorrectly prioritised patients. There was discussion around patients who fell outside of certain demographics or geographic areas and they highlighted that secondary services could be fragmented. Overall there was a strong sense of dissatisfaction and distrust of referral processes to secondary psychiatry services.

“As a GP, often your use of services is, guided by what is available...Frustratingly you would have a non-clinician somebody who has had some fairly low level of training undertaking an assessment based on your referral letter and sometimes a phone call with the patient, and then would write back to you saying, 'No its fine, the patient is low risk, you can manage this' - My goodness... My impression... was that unless they were about to jump in front of a car or cause harm to other people... then the patient didn't meet their threshold because that particular service didn't have capacity.” GP 2 (Male).

The local specialist perinatal mental health team was suggested by several GPs. They felt positively towards this service and did not report the same referral concerns that they had with general secondary care psychiatric services.

“There’s an additional service set up for maternal mental health... so I would access that...[but] they probably have a specific set up around providing her with support and that usually... lasts for about a year after baby is born, beyond that, they, I believe get transferred

into general adult services which would probably then see an end to the intensive support.”

GP 2 (Male).

3.1.1.4. GPs wanted to avoid over-medicalising the problem

Half the GPs suggested that this presentation would likely resolve spontaneously and that it was in the women's best interests to avoid over-medicalising the situation and use watchful waiting.

“Without taking anything away from the trauma and distress suffered, there is a chance that this also could be something this woman could work through and doesn't necessarily see a doctor about and manages to recover from quite well without needing medical intervention.”

GP 6 (Male).

GPs commonly offered alternative management strategies within the community. This approach involved establishing a relationship, promoting family support and health visitor involvement.

“I think support, and support includes psychological support, practical support and another appointment with the surgery to start with... finding out who she has to help her, who she has to talk to, whether she has any questions about, about, whether she is going to haemorrhage for example. How she is doing physically, whether she has support from her health visitor and her family before going down, sort of, before putting her into a medical box.” GP 6 (Male).

Several GPs described autonomy over offering longer or follow-up appointments, although some felt this was a thing of the past. GPs also described the benefit of already having a relationship with the woman prior to childbirth.

“In terms of our time... general practice is a bit under pressure but we can always make time for the people if we need to... we're our own bosses so we can do what we like.” GP 4

(Male).

“Before the event she would likely to be one of our patients, so I would have experienced her quite straight forward pregnancy, I’d know her medical background, whether she had had any mental illnesses before, how healthy she had been and what her thoughts were about her first pregnancy... hopefully having a relationship with the patient before, encouraging her to open up and share her concerns, and take it from there.” GP 6 (Male).

“It’s our privilege [as GPs] to develop and maintain and cultivate that relationship in which somebody feels that they can trust us to share those sorts of things. What enormously frustrates me is that... the time that you have is less stretchy than it used to be... you could previously run a bit late and there might be enough slack... Giving people double appointments?...[there’s] not the physical capacity for that now. A lot of my patients wait 4-6 weeks to book a routine appointment with me... it’s enormously frustrating and it does them a disservice.” GP 2 (Male).

Debriefing services are offered by many trusts, whereby a postnatal woman can go through their medical notes from the birth with a midwife and discuss the events they remember. GPs felt positively towards these services; they were discussed within the context of GPs’ own experience with patients who had experienced traumatic birth.

“I offered her ‘Birth Stories’ which is something they do up at the hospital... they do a really good sort of thing for people who have had really difficult deliveries.” GP 5 (Female).

3.1.2. Psychiatrists

3.1.2.1. Psychiatrists suggested the diagnosis was PTSD

The psychiatrists almost all identified the vignette as a PTSD presentation and acknowledged the trauma present in the birth events. However, despite the vignette being designed to be a classic PTSD presentation, several suggested that her symptoms were a combination of postnatal depression and PTSD, there was also a suggestion that the case could be an adjustment disorder which might be self-limiting.

“There’s a lot of post-traumatic symptoms ... it’s not uncommon for women to be very traumatised by the impact of childbirth but you’ve [also] got the worrying impact of postnatal depression” Psychiatrist 1 (Male).

“It sounds like a highly traumatic hospital birth... I’d probably hold off on diagnosis for the time being. Of course it could be sort of adjustment disorder... she’s had a very, a very difficult event which she’s still dealing with... I’d probably leave her with adjustment disorder, that’s a safe, sort of, diagnosis. Not totally clear we need to start including in any more sort of serious psychiatric diagnosis like depression or PTSD at this point.” Psychiatrist 6 (Male).

3.1.2.2. Psychiatrists’ management plans reflected this PTSD diagnosis: referral to a specialist perinatal team and patient choice were considered most important

Psychiatrists, like their GP colleagues, were very patient centred in their management plans.

“It totally depends on what the patient thinks will be helpful.” Psychiatrist 6 (Male).

“Well I guess it’s that kind of the importance of the formulation, really understanding the background... to make sure they’re linked in appropriately with the right kind of support that’s most likely going to work for them, it’s that everyone being an individual, everyone being unique.” Psychiatrist 1 (Male).

The psychiatry participants planned, like the GPs, to seek advice from or refer directly to the specialist perinatal mental health team emphasising the need for specialist rather than general psychiatry services for these women.

“Well I think this will need coordination really of several services, we’ve got a perinatal service in [the region where I work] that’s now more resourced, I think they’ve got a psychiatrist attached to them, so I would refer to them.” Psychiatrist 5 (Female).

“Probably getting some advice, so there’s a perinatal and postnatal mental health team ... where I work... so I’d be wanting to get some advice from them really about kind of specialist interventions.” Psychiatrist 3 (Female).

“You could link her in with the perinatal psychiatry team.” Psychiatrist 2 (Female).

Unsurprisingly psychiatrists suggested a wider range of pharmacological options than the GPs: antidepressants, anxiolytics, sleeping tablets and antipsychotics were all proposed taking into account patient choice and whether the woman was breastfeeding. The evidence basis for pharmacological treatments was also discussed.

“I would discuss medication but I would be very honest that I think that the evidence for this medication isn’t great.” Psychiatrist 7 (Male).

“Some people are very medication orientated, they should be supported in that... If these kinds of symptoms she’s getting haven’t resolved with an antidepressant you could try a different one and depending on severity you could even add another one in, even an antipsychotic, if the anxiety and mood swings are really severe... She mentioned trouble sleeping too, you could look at her sleep hygiene, you could think about sleeping tablets-cautiously.” Psychiatrist 6 (Male).

Debriefing services were also favoured:

“There’s also a service that’s not a mental health or psychiatric service but it can be very helpful to women who have had traumatic births, they go through your notes literally line by line and it’s not a therapy session but what it is very helpful for, because when you’re a patient you don’t understand what’s going on, you feel that things are done without you and that could be very useful for getting things explained that seem unexplainable or out of control.” Psychiatrist 5 (Female).

3.1.2.3. Psychiatrists were also frustrated by waiting times for psychological therapies

The psychiatrists suggested referral of the woman for trauma focused CBT and EMDR but echoed the GPs when describing, from their clinical practice, how it could often be difficult to access.

“In terms of the psychological options, which are particularly important in post-traumatic stress disorder, I think things such as CBT for PTSD or EMDR, other therapies, they might be worthwhile considering [for the woman in the vignette]... We did manage to get her [patient from own experience] access to that [EMDR] but that was a real one-off, I think that's why this case came to mind actually, it was such a one off where someone was able to access a psychological therapy that they needed.” Psychiatrist 3 (Female).

3.1.3. Common to both groups

3.1.3.1. GPs and psychiatrists felt there should be more responsibility within healthcare systems for preventing iatrogenic psychological harm during childbirth

Participants from both groups felt sad or angry reading the vignette and raised the question of prevention. Suggestions were from two distinct angles: that staff should have engaged the patient more on the labour ward and provided better care in hospital during the birth, but also that the woman should have had more antenatal care and been more ‘prepared’ for potential traumatic events, prior to the birth.

“The difficulties she's encountered have been ...related to care and the difficulties with care..., you can imagine that sense... kind of iatrogenic harm from the care she's received...the sad thing is there seems to be something about the ‘mis-care’, if you like, impacting on her and her baby... so it's a very sad indictment of the healthcare she received.” Psychiatrist 1 (Male).

“Okay, so it sounds like a highly traumatic hospital birth... highly stressful, and, possibly not very well handled, and on the medical side of things not very well handled... sounds like the hospital didn't do a very good job in terms of making her feel sort of supported and safe.” Psychiatrist 6 (Male).

“I felt really sad for her, I felt that a lot of the antenatal care could have gone through that [instrumental delivery and possible complications] ...I wasn't sure what her personal

circumstances were... I did wonder why she felt so disempowered on the ward... just stayed in a room for 4 hours in pain and didn't seek help... I don't know if there was a low socio-economic group or a different culture, maybe a different language ... I felt that there must be some sort of social factors that maybe could have been unpicked... by... the booking staff and during the 9 months of pregnancy before the birth.” GP 5 (Female).

4. Discussion

4.1. Summary

In this study GPs, despite recognition of features of PTSD within the case vignette, suggested the most likely diagnosis would be postnatal depression, and their suggested management reflected this. The preponderance of a depression diagnosis may be due to not all GPs regarding the birth in the vignette as a traumatic event. Additionally, GPs expressed uncertainty about giving a PTSD diagnosis without specialist input, even among those who recognised the birth as a trauma. Depression is a condition commonly managed in general practice hence potentially why this was a favoured diagnosis. In contrast to the GPs, the psychiatrists clearly identified the vignette to be a presentation of PTSD, although they too identified elements of depression despite the vignette being intended to represent purely PTSD features. Both the psychiatrists and GPs emphasised patient choice when choosing management options and both lacked trust in the referral process both to psychological therapy via PCPS and secondary psychiatry services expressing frustration at long waiting times as well as risk-based screening criteria.

Both groups were keen to refer this patient to the specialist perinatal mental health team as both groups felt a postnatal woman was likely to require specialist services regardless of what they thought the diagnosis was.

Also common to both groups was a feeling that the distress the woman in the vignette experienced was potentially iatrogenic in nature and could have been prevented by better antenatal care or better care from the staff on labour ward.

4.2. Comparison with the literature

Our findings suggest that the woman in the vignette would be likely to leave the GP surgery without a diagnosis of PTSD following an initial presentation and disclosure. This is consistent with the literature that shows both perinatal mental health conditions and PTSD are widely under-recognised in the community (Dennis & Chung-Lee, 2006; Ehlers et al., 2009; Khan, 2015; Munro et al., 2004). Some GPs' non-recognition of the events in the vignette as traumatic stimulus potentially supports why many were enthusiastic to not overly medicalise the problem and offered 'watchful waiting'. This series of events supports the lived experience data in the literature from many women who have attended primary care with mental health problems for whom find their symptoms normalised (Chew-Graham et al., 2009; Dennis & Chung-Lee, 2006; E. Ford, S. Lee, et al., 2017; E. Ford, J. Shakespeare, et al., 2017; National Childbirth Trust, 2017; Trust, 2017).

Prior studies have also shown that GPs are reluctant to label a patient with a serious mental health diagnosis in the community (Ford et al., 2016; Elizabeth Ford et al., 2017), especially in early presentations, preferring to use "time as a tool" to aid diagnosis (Ford et al., 2016). GPs' frustration with waiting times and referral processes to PCPS and secondary psychiatric services is also commonly reported in the literature (Brewin et al., 2008; Noonan et al., 2018).

GPs and psychiatrists in our study were quick to suggest referral to specialist perinatal mental health services. The woman in the vignette would likely meet criteria for treatment by the participants' local specialist perinatal mental health service and therefore the decision of these locally based clinicians to refer was appropriate. However, not all clinicians would have this choice (Maternal Mental Health Alliance, 2018). Whilst the NHS England Specialist Perinatal Services Community Development Fund has improved the coverage of services (NHS England, 2019) as part of the 2015 "5 Year Forward View for Mental Health" ((NHS), 2014), regional variation in terms of service provision still undeniably exists in other areas of the UK (Gregoire, 2018). In addition, where there are specialist services, not all will accept referrals of women with simple PTSD symptoms, focussing instead on women with more complex needs. For this reason, it is important that both GPs and psychiatrists are

empowered through training and timely access to evidenced based psychological therapies within PCPS services to manage these women in areas where there might not be a specialist service in place.

Both GPs and psychiatrists in this study felt positively towards debriefing services. This reflects the literature in that these services are popular with postnatal women and clinicians (Baxter et al., 2014; Meades et al., 2011) despite the lack of an evidence-basis for benefit to the woman ([NICE], 2018). Interestingly, despite debriefing services often having long waiting lists and idiosyncratic referral processes our participants did not express the same frustration that they felt with referring to secondary psychiatric services or PCPS.

Finally, GPs and psychiatrists both expressed sadness and anger reading the vignette and raised the question of whether the scenario may have been preventable either from better antenatal care or by improving the woman's experiences on labour ward. The vignette was specifically designed to illustrate that both stress of birth events, and negative interactions with caregivers, can be stressors during a difficult birth (Ford & Ayers, 2009).

4.3. Strengths and limitations

This is the first study to look at doctors' thought process and perceptions using a case vignette of PTSD in a postnatal woman, and as such, it is an exploratory study. Its strengths include that it used transparent and well-established methods to analyse the data; both methods and reporting were conducted with reference to the COREQ criteria (Tong et al., 2007). The framework design increased triangulation; allowing comparison between the themes and the demographics of the participants who had contributed resulting in a degree of mixed methods analysis to contextualise the data. We were limited, however, in that gender was the only collected demographic about each participating doctor.

A notable limitation to this study is the small number of participants, and within those, that, only one female GP was interviewed. It is therefore possible that our framework did not reach saturation. Our conclusions must therefore be interpreted cautiously as female GPs may have responded differently compared to males not least as they may have had life

experience of childbirth. In addition, older studies suggest female patients may preferentially seek to consult with female GPs for psychosocial issues (Britt et al., 1996), and that there are gender differences in practice style among GPs (Bensing et al., 1993). In practice, however, women are seen by GPs of both genders and, as part of a wider gender gap in research, there is a lack of data available to suggest whether the gender of the GP biases the care offered to the woman. It is within this context that our findings must cautiously be interpreted. Further research is needed to understand the full range of GP attitudes and perspectives on birth trauma as this is a small exploratory study, however this study does allow us to generate a number of new hypotheses.

As this was a convenience sample, several of the GPs interviewed were involved in medical education at the local medical school. It is therefore possible that they may not represent 'typical' GPs in terms of awareness of new developments and local service provision. Further limitations include that all participants were recruited from one geographical area. Of note this area had a well-established specialist perinatal mental health team at the time of the research, which may reflect why so many were keen to refer the patient to the specialist service.

Finally this study was a secondary analysis of a larger study, so it is possible that comparison and contrast with the other case vignette presented during the interviews, a more 'typical' PTSD presentation, may have affected participant responses. In addition the opening questions in the topic guide invited participants to discuss patients from their own practice who may have experienced trauma (see Appendix 1) potentially priming participants to be thinking of pathology that might follow trauma however most GP participants, even with this potential prompt, still did not recognise the vignette as a PTSD presentation.

4.4. Future directions

There are likely multiple factors behind the low recognition rate of postnatal PTSD. Firstly women are reluctant to disclose mental health problems in the perinatal period (Bambridge

et al., 2017; Smith et al., 2019), and experience a number of barriers to help-seeking (Button et al., 2017; Dennis & Chung-Lee, 2006). This is exemplified in postnatal women's reluctance to self-refer to PCPS (Dennis & Chung-Lee, 2006; Millett et al., 2018; Smith et al., 2019). Any disclosure of mental distress from a postnatal women should therefore be regarded by healthcare professionals as a 'red flag' (Khan, 2015). Raising both psychiatrists' and GPs' awareness of this is key. Perinatal mental health as a whole has very little space on the trainee GP curriculum (Khan, 2015; Walter, 2019). Research suggests GPs would welcome further continued professional development (CPD) in this area (Noonan et al., 2018). Resources are slowly being developed, for example the online Royal College of GPs' *'Perinatal mental health toolkit'*, but because of the lack of evidence available for a range of perinatal mental health problems, the focus of training for GPs is still predominately on postnatal depression and postpartum psychosis. Further research on PTSD and anxiety in the postnatal period is needed before training modules on these disorders can be fully incorporated into training (E. Ford, S. Lee, et al., 2017; E. Ford, J. Shakespeare, et al., 2017).

A recent innovative pilot project is aiming to provide GPs with further training around perinatal mental health: The 'Spotlight on Perinatal Mental Health Project'. This "train the trainer" programme then allows the GP to disseminate their learning to local colleagues (Ladd, 2018). Programmes such as this could eventually be extended nationally (Royal College of General Practitioners, 2016). From April 2020, new mothers in England are being offered a maternal health check-up from their GP at 6 weeks postpartum in addition to the pre-existing 6 week baby check-up (British Medical Association & NHS England, 6 February 2020; National Childbirth Trust, 2017). It is thus timely to focus on the development of evidence-based training in postnatal mental health issues.

Interestingly, in this study we found that not all GPs recognised the birth experience in the vignette as a trauma and therefore may not have been prompted to think about pathology that follows traumatic events in their differential diagnoses. Those who did recognise that the women in the vignette had had an experience traumatic enough to cause pathology,

suggested that this view may not be typical of all their GP colleagues. Tackling this 'normalisation' of traumas that happen as part of childbirth and putting emphasis on the subjective nature of trauma is another possible next step to explore for improving GPs' recognition of PTSD in the postnatal population.

5. Conclusion

In this study most GPs, despite recognition of features of PTSD within the case vignette, suggested the likely diagnosis would be postnatal depression. Some GPs tended to demedicalise psychological symptoms occurring in response to what they perceived as a normal life event like childbirth and GPs were reluctant to make a PTSD diagnosis in a postnatal woman without specialist input, thus their management decisions reflected their tendency to diagnose depression. Both GPs and psychiatrists lacked trust in the timeliness of referral pathways to PCPS. Although these results are exploratory, they suggest that women are unlikely to access a diagnosis of PTSD during early visits with the GP, although the woman-centred care proposed by GPs means that a trauma-focussed diagnosis later in the care pathway was not ruled out. Further research is needed to confirm these findings, which suggest that an evidence base around best management and treatment for women with postnatal PTSD is sorely needed, especially to inform GP training programmes. There is a clear demand from clinicians for specialist perinatal mental health services across the UK which have wide acceptance criteria to which women with less common postnatal mental health problems could be referred.

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TABLES

Table 1:

Participant Demographics

	Gender	
	Male	Female
Psychiatrists (N=7)	4 (Psychiatrists 1, 4, 7)	3 (Psychiatrists 2, 3, 5)
General Practitioners (N=6)	5 (GPs 1, 2, 3, 4, 6)	1 (GP 5)

FIGURES

Box 1: Postnatal case vignette shown to GP and psychiatrist participants:

“My pregnancy was quite straightforward and I was really looking forward to the birth of my first child. When I started having mild contractions my partner and I went to hospital and were told I was still in the early stages. I was then left, with my partner, alone for the next 4 hours with the midwife popping in and out, I felt like they'd forgotten about me. This lasted for another 6 hours and I was in a terrible amount of pain just on gas and air. At that point they had to induce me and put a special heart monitor for the baby, I started to get really worried. After pushing for what seemed like forever they said they had to use forceps and I was terrified. I was in a huge amount of pain and the room was full of people I didn't know, medical students, midwives- I felt I'd completely lost my dignity. Finally, my daughter was born and I saw her briefly until she was taken away for checks. At this point I started to become drowsy and, until I passed out, I thought I was dying. My partner told me that I'd haemorrhaged, there was blood everywhere and that I had a serious tear which had to be repaired in theatre. I had to have a transfusion and stay in hospital for a few days.

I was in so much pain for the next few weeks, it was difficult to get up and about to feed the baby- I feel like our bonding suffered and felt guilty because of that. A few months later I started to have trouble sleeping with nightmares and kept on thinking about the incident with the forceps and feeling the terror of the pain- I couldn't get those images out of my head. My partner told me during that time I was quite jumpy and on edge, startling at the sound of the baby crying- that was unlike me. Recently I've been really worried about my periods as well, that I'm going to start haemorrhaging again. I've not been able to face taking the baby to the GP for check-ups and immunisations- it's too distressing to see doctors and medical equipment so I had to ask my partner to do that”

Box 2: Themes:

GP themes:

- Childbirth is not always considered a trauma by healthcare professionals
- Majority of GPs recognised ‘trauma features’ but opted for a diagnosis of depression
- GPs’ management plans reflected the depression diagnosis
- GPs wanted to avoid over-medicalising the problem

Psychiatrist themes:

- Psychiatrists suggested the diagnosis was PTSD
- Psychiatrists’ management plans reflected this PTSD diagnosis: referral to a specialist perinatal team and patient choice were considered most important
- Psychiatrists were also frustrated by waiting times for psychological therapies

Common to both groups:

- GPs and psychiatrists felt there should be more responsibility within healthcare systems for preventing iatrogenic psychological harm during childbirth