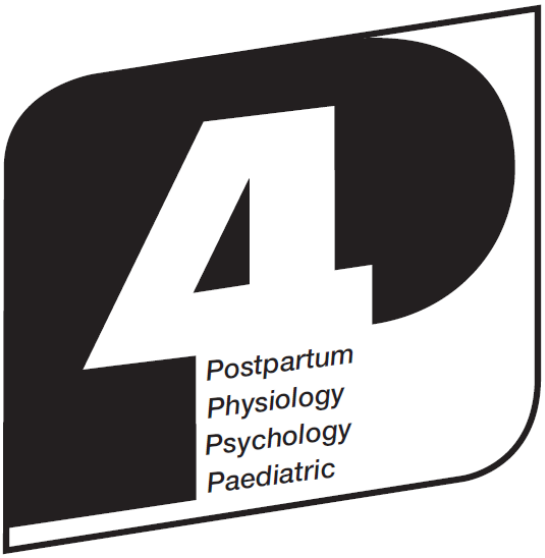


POSTPARTUM PHYSIOLOGY, PSYCHOLOGY & PAEDIATRIC FOLLOW-UP STUDY

FIRST ASSESSMENT (6 months)

Thank you for taking part in the P4 Study where we are looking into women's and infant's health after pregnancy and birth. As part of this study, we are interested in hearing about you, your health and how you have been feeling. To assist us with our research please take the time to fill out the following questionnaire.

How to fill in the questionnaire

Some of the questions require a short answer and some ask you to mark the answer that best applies to you. Separate instructions are given in the questionnaire where necessary to help you.

STUDY ID: **GROUP: 1. N 2. HT** **DATE:**

Section One – About you *Please circle your answer and give details as needed*

These first few questions are to find out about you, your background, and occupation.

A. What ethnic group do you and your partner identify with?

YOURSELF	**PARTNER**
1. Caucasian	1. Caucasian
2. Asian	2. Asian
3. Aboriginal or Torres Strait Islander	3. Aboriginal or Torres Strait Islander
4. Polynesian	4. Polynesian
5. European	5. European
6. Other_____	6. Other_____
	7. N/A

B. What are you and your partner's highest level of formal education?

YOURSELF	**PARTNER**
1. Secondary school	1. Secondary school
2. Trade/Cert/Diploma	2. Trade/Cert/Diploma
3. University degree	3. University degree
	4. N/A

C. What is/was the occupation of you and your partner?

YOURSELF (before the baby was born)	**PARTNER**
_____	_____

Section Two – Your Health *Please circle your answer and give details as needed*

These next questions are about your general health habits.

A. Please provide the details of current medications you are taking.

_____

B. Do you or anyone in your family have a history of the following? *Please circle if answer is yes.*

YOU	**FAMILY**
1. Stroke	1. Stroke
2. Heart attack	2. Heart attack
3. Angina	3. Angina
4. High blood pressure	4. High blood pressure
5. Kidney problems	5. Kidney problems
6. Diabetes	6. Diabetes
7. Anxiety	7. Anxiety
8. Depression	8. Depression
9. Eating Disorder	9. Eating Disorder
10. Significant illness	10. Significant illness
11. Other	11. Other

If you answered yes to any of the questions above, please provide further details

_____
_____

C. Do you currently smoke cigarettes?

1. No, I have never smoked
2. No, but I am an ex-smoker. Please state when you quit smoking_____
3. Yes I currently smoke. Please state how many cigarettes you smoke in a day_____

D. On average, how many standard drinks would you have in a week?_____

E. Have you ever taken any drugs (for example, marijuana, cocaine, heroin)? If yes, please provide details.

_____
_____

F. How many times a week would you do physical activity that makes you breathless and sweaty?_____

Section Three – Pregnancy *Please circle your answer and give details as needed*

These next questions are about your pregnancy experiences.

A. Did you ever have problems with falling pregnant?

1. No

2. Yes. If yes, please provide details_____

_____

B. How many times have you been pregnant?_____

Of these pregnancies how many have resulted in a

Miscarriage or termination?_____

Premature baby - born before 37 weeks of pregnancy?_____

Full-term baby - born after 37 weeks of pregnancy?_____

C. How many living children do you have? _____

D. Are you currently pregnant?

1. No

2. Yes. If yes, how many weeks pregnant are you?_____

E. Are you currently in a relationship?

1. No

2. Yes

F. Is your current partner the father of the baby you had about 6 months ago?

1. No

2. Yes

G. Have you had a change in partner between any of your pregnancies?

1. No

2. Yes. If yes, please provide details_____

_____

3. Not applicable, this is my first baby

H. Was the pregnancy that resulted in the birth of your baby 6 months ago

1. Planned?
2. Unplanned?

I. Have you had high blood pressure in any of your pregnancies?

1. No
2. Yes. If yes, please provide details_____

_____

J. Have you had gestational diabetes in any of your pregnancies?

1. No
2. Yes. If yes, please provide details_____

_____

K. Are you currently breastfeeding?

1. No, I didn't breastfeed
2. No, I have stopped now. When did you stop? _____
3. Yes

Section Four – Labour and Birth

A. Giving birth can be an overwhelming experience, physically as well as emotionally. How would you describe your experience of labour and birth? *Please complete this section whether you had a vaginal birth or a caesarean section. Please circle ONE number for each of the following statements. If the statement is not applicable go to the next one.*

i. During labour and birth, I felt free to express my feelings….

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

ii. During labour and birth, I felt I was….

Completely out of control 1 2 3 4 5 6 7 In complete control

iii. Physically, I coped….

Worse than expected 1 2 3 4 5 6 7 Better than expected

ix. Emotionally, I coped….

Worse than expected 1 2 3 4 5 6 7 Better than expected

v. When looking back at labour and birth, I feel….

Not at all proud of myself 1 2 3 4 5 6 7 Very proud of myself

vi. Overall, how would you describe your **care** during labour and birth?

Very poor 1 2 3 4 5 6 7 Very good

B. Please describe any things about your labour and/or the birth that you were

i. Particularly happy with

_____
_____
_____
_____

ii. Particularly unhappy with

_____
_____
_____
_____

Section Five – Your health since your recent pregnancy *Please circle your answer and give details as needed*

Since having your baby about 6 months ago:

A. Have you seen a doctor about your blood pressure?

1. No
2. Yes. If yes, please give details_____

B. Have you seen your local doctor about any other health problems?

1. No
2. Yes, If yes, please give details_____

_____

C. Have you been referred to a specialist doctor for health problems?

1. No
2. Yes. If yes, please give details_____

_____

D. Have you seen your local doctor about any mental health concerns?

1. No
2. Yes, If yes, please give details_____

_____

E. Have you been referred to a specialist doctor or psychologist for mental health concerns?

1. No
2. Yes. If yes, please give details_____

_____

F. Have you been started on any new medications?

1. No
2. Yes. If yes, please give details_____

G. Have you experienced stress in the past 6 months (besides the stress of pregnancy and parenthood)?

1. No
2. Yes. If yes, was the stress due to
    - I. Financial difficulties
    - II. Relationship worries
    - III. Loss/death
    - IV. Housing changes
    - V. Significant isolation
    - VI. Other_____

Section Six – How you have been feeling

We would now like to hear about how you have been feeling emotionally since having your baby.

*Please circle the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.*

In the past **7 days**:

1. I have been able to laugh and see the funny side of things

    As much as I always could

    Not quite so much now

    Definitely not so much now

    Not at all

2. I have looked forward with enjoyment to things

    As much as I ever did

    Rather less than I used to

    Definitely less than I used to

    Hardly at all

3. I have blamed myself unnecessarily when things went wrong

    Yes, most of the time

    Yes, some of the time

    Not very often

    No, never

4. I have been anxious or worried for no good reason

    No, not at all

    Hardly ever

    Yes, sometimes

    Yes, very often

5. I have felt scared or panicky for no very good reason

    Yes, quite a lot

    Yes, sometimes

    No, not much

    No, not at all

6. Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

8. I have felt sad or miserable

Yes, most of the time

Yes, quite often

Not very often

No, not at all

9. I have been so unhappy that I have been crying

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. The thought of harming myself has occurred to me

Yes, quite often

Sometimes

Hardly ever

Never

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-itemEdinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

*For the following question please place a tick, alongside each phrase, in the box that best describes how you have felt in the **PAST 2 WEEKS**, not just how you feel today.*

Over the past **2 WEEKS** how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

1. Not difficult at all
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JB, et al. 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med. 166(10):1092-7.*

These next few questions are about your feelings for your child since he/she was born. Some words are listed below which describe some of the feelings mothers have had towards their baby. *Please place a tick, alongside each word, in the box which best describes how you have felt towards your child in the* ***PAST 2 WEEKS***.

	Very much	A lot	A little	Not at all
Loving				
Resentful				
Neutral or felt nothing				
Joyful				
Dislike				
Protective				
Disappointed				
Aggressive				

Source: Taylor A, Atkins R, Kumar R, Adams D, and Glover V. 2005. A new Mother-to-Infant Bonding Scale: links with early maternal mood. *Arch Women's Men Health 8:45–51.*

PTSD Scale-Self Report for DSM-5

(PS-SR5)

TRAUMA SCREEN

Have you ever experienced, witnessed, or been repeatedly confronted with any of the following:
(Check all that apply)

- ☐ Serious, life threatening illness (heart attack, etc.)
- ☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)
- ☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ☐ Military combat or lived in a war zone
- ☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)
- ☐ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ☐ Natural disaster (severe hurricane, flood, earthquake, etc.)
- ☐ Other trauma (Please describe briefly):

_____

_____

_____

- ☐ None

*** If NONE, please STOP and return this questionnaire ***

If you marked any of the above items, which single traumatic experience is on your mind and currently bothers you the most:
(Check only one)

- ☐ Serious, life threatening illness (heart attack, etc.)
- ☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)
- ☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ☐ Military combat or lived in a war zone
- ☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)
- ☐ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ☐ Natural disaster (severe hurricane, flood, earthquake, etc.)
- ☐ Other trauma (Please describe briefly):

_____

_____

_____

PTSD Scale-Self Report for DSM-5

(PS-SR5)

Instructions: Below is a list of problems that people sometimes have after experiencing a traumatic event. Write down the most distressing traumatic event that you checked on the last page:

Please read each statement carefully and circle the number that best describes how often that problem has been happening and how much it upset you over THE LAST MONTH. Rate each problem with respect to the traumatic event that you wrote above.

For example, if you've talked to a friend about the trauma one time in the past month, you would respond like this: (because one time in the past month is less than once a week)

Talking to other people about the trauma

0	(1)	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

1. Unwanted upsetting memories about the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

2. Bad dreams or nightmares related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

3. Reliving the traumatic event or feeling as if it were actually happening again

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

4. Feeling very EMOTIONALLY upset when reminded of the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

5. Having PHYSICAL reactions when reminded of the trauma (for example, sweating, heart racing)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

6. Trying to avoid thoughts or feelings related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

PTSD Scale-Self Report for DSM-5

(PS-SR5)

7. **Trying to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

8. **Not being able to remember important parts of the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

9. **Seeing yourself, others, or the world in a more negative way (for example "I can't trust people," "I'm a weak person")**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

10. **Blaming yourself or others (besides the person who hurt you) for what happened**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

11. **Having intense negative feelings like fear, horror, anger, guilt or shame**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

12. **Losing interest or not participating in activities you used to do**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

13. **Feeling distant or cut off from others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

14. **Having difficulty experiencing positive feelings**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

15. **Acting more irritable or aggressive with others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

16. Taking more risks or doing things that might cause you or others harm (for example, driving recklessly, taking drugs, having unprotected sex)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

17. Being overly alert or on-guard (for example, checking to see who is around you, being uncomfortable with your back to a door)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

18. Being jumpy or more easily startled (for example when someone walks up behind you)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

19. Having trouble concentrating

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

20. Having trouble falling or staying asleep

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

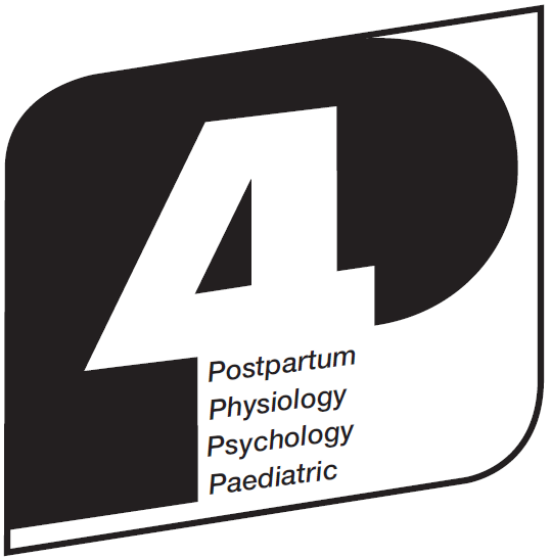
22. How much have these difficulties been interfering with your everyday life (for example relationships, work, or other important activities)?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month



POSTPARTUM PHYSIOLOGY, PSYCHOLOGY & PAEDIATRIC FOLLOW-UP STUDY

2 YEAR FOLLOW UP QUESTIONNAIRE

Thank you for your continuing participation in the P4 Study where we are looking into women's and infant's health after pregnancy and birth. As part of the study, we are interested in hearing about your health and how you have been feeling since the birth of your baby two years ago. Please take the time to fill out this questionnaire and assist us with our research.

How to fill in the questionnaire

Some of the questions require a short answer and some ask you to mark the answer that best applies to you. Separate instructions are given in the questionnaire where necessary to help you.

NAME: _____

STUDY ID: _____

DATE YOU COMPLETED THIS QUESTIONNAIRE _____

Section One – About You *Please circle your answer and give details as needed.*

These first few questions are to find out about you and what you have been doing ***since the birth of your baby 2 years ago.***

A. What country were you born in?

_____

B. What country was the father of your 2 year old born in?

_____

C. Are you currently in a relationship?

1. No.
2. Yes. *If yes*, is your current partner the father of your 2 year old?
    a. No.
    b. Yes.

D. Have you been in paid employment in the past 2 years?

1. No, and I wasn't in paid employment prior to having my baby.
2. No, I have not returned to work and don't plan to.
3. No, I have not returned to work but plan to.
4. Yes. I*f yes*, is your employment
    a. Full time _____hours/week.
    b. Part time _____hours/week.
    c. Casual _____hours/week.

    If yes, how old was your child when you returned to work?

    _____

E. Have you been involved in other activities besides raising your child and working?

1. No.
2. Yes, I have been studying.
3. Yes, I have been doing volunteer work.
4. Yes, other activity (please provide details).

    _____
    _____

Section Two – Breast feeding and pregnancy *Please circle your answer and give details as needed.*

The next set of questions is about feeding your 2 year old and planning another pregnancy.

A. Did you breast feed your 2 year old child at any time?

   1. No.
   2. Yes. *If yes*, after bringing your baby home and before introducing solids, did you

      a. Breast feed exclusively?

      b. Breast feed and bottle feed with expressed breast milk?

      c. Breast feed and bottle feed with formula?

      d. N/A, I breast fed only while in the hospital.

      If yes, how long did you breast feed for?

      a. _____

         Please provide details of the reason/s you stopped breast feeding.

         _____
         _____
         _____

      b. Still breast feeding this child.

B. Have you tried to become pregnant since the birth of your child 2 years ago?

   1. No.
   2. Yes.

C. Have you actually become pregnant since the birth of your child 2 years ago?

   1. No.
   2. Yes. *If yes*, how many times have you become pregnant?

      a. 1 time.

      b. 2 times.

      c. More than 2 times.

If yes, are you pregnant now?

a. No.

b. Yes. When is your baby due? _____

If yes, how many pregnancies have resulted in

a. miscarriage or termination before 20 weeks of pregnancy? _____

b. baby born before 37 weeks of pregnancy?_____

c. baby born after 37 weeks of pregnancy?_____

If yes, please provide details of any complications in you pregnancy (Eg. high blood pressure, diabetes).

_____
_____
_____
_____

D. How many children do you have? _____

Section Three - Your Health *Please circle your answer and give details as needed.*

The following questions are about your health ***in the past 18 months***.

A. Have you seen your local doctor about your blood pressure?

1. No.
2. Yes. *If yes*, please give details.

_____
_____
_____

B. Have you seen your local doctor about any other health problems?

1. No.
2. Yes. *If yes*, please give details.

_____
_____
_____

C. Have you been referred to a specialist doctor for health problems?

1. No.
2. Yes. *If yes*, please give details.

_____
_____
_____

D. Have you been admitted to hospital?

1. No.
2. Yes. *If yes*, please provide details.

_____
_____
_____

E. Have you seen your local doctor about any mental health or emotional concerns?

1. No.
2. Yes. *If yes*, please give details.

_____
_____
_____

F. Have you been referred to, or sought help from, a specialist doctor, psychologist, or counsellor, for mental health or emotional concerns?

1. No.
2. Yes. If yes, please give details.

_____
_____
_____

G. In general, would you say your health is?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

H. Please give details of any medication you are currently taking.

_____
_____
_____

I. Do you currently smoke cigarettes?

1. No, I have never smoked.
2. No, but I am an ex-smoker. Please state when you quit smoking _____
3. Yes. Please state how many cigarettes you smoke in a day_____

J. On average, how many standard drinks would you have in a week? _____

K. How many times a week would you do physical activity that makes you breathless and sweaty?

_____

L. Have you experienced stress in the past 18 months (besides the stress of parenthood)?

1. No
2. Yes. *If yes*, was the stress due to
    a. Financial difficulties
    b. Relationship worries
    c. Loss/death
    d. Housing changes
    e. Significant isolation
    f. Other_____

Section Four – How you have been feeling

We would now like to hear about how you have been feeling emotionally.

*Please circle the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.*

In the past ***7 days***:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

8. I have felt sad or miserable

Yes, most of the time

Yes, quite often

Not very often

No, not at all

9. I have been so unhappy that I have been crying

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. The thought of harming myself has occurred to me

Yes, quite often

Sometimes

Hardly ever

Never

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-itemEdinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

*For the following question please place a tick, alongside each phrase, in the box that best describes how you have felt in the **PAST 2 WEEKS**, not just how you feel today.*

Over the past **2 WEEKS** how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

1. Not difficult at all
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JB, et al. 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med. 166(10):1092-7.*

These next few questions are about your feelings for your 2 year old child. Some words are listed below which describe some of the feelings mothers have had towards their child.

Please place a tick, alongside each word, in the box which best describes how you have felt towards your 2 year old child in the ***PAST 2 WEEKS***.

	Very much	A lot	A little	Not at all
Loving				
Resentful				
Neutral or felt nothing				
Joyful				
Dislike				
Protective				
Disappointed				
Aggressive				

Source: Taylor A, Atkins R, Kumar R, Adams D, and Glover V. 2005. A new Mother-to-Infant Bonding Scale: links with early maternal mood. *Arch Women's Men Health 8:45–51.*

PTSD Scale-Self Report for DSM-5

(PS-SR5)

TRAUMA SCREEN

Have you ever experienced, witnessed, or been repeatedly confronted with any of the following:
(Check all that apply)

- ☐ Serious, life threatening illness (heart attack, etc.)
- ☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)
- ☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ☐ Military combat or lived in a war zone
- ☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)
- ☐ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ☐ Natural disaster (severe hurricane, flood, earthquake, etc.)
- ☐ Other trauma (Please describe briefly):

_____

_____

_____

☐ None

*** If NONE, please STOP and return this questionnaire ***

If you marked any of the above items, which single traumatic experience is on your mind and currently bothers you the most:
(Check only one)

- ☐ Serious, life threatening illness (heart attack, etc.)
- ☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)
- ☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ☐ Military combat or lived in a war zone
- ☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)
- ☐ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ☐ Natural disaster (severe hurricane, flood, earthquake, etc.)
- ☐ Other trauma (Please describe briefly):

_____

_____

_____

PTSD Scale-Self Report for DSM-5

(PS-SR5)

Instructions: Below is a list of problems that people sometimes have after experiencing a traumatic event. Write down the most distressing traumatic event that you checked on the last page:

Please read each statement carefully and circle the number that best describes how often that problem has been happening and how much it upset you over THE LAST MONTH. Rate each problem with respect to the traumatic event that you wrote above.

For example, if you've talked to a friend about the trauma one time in the past month, you would respond like this: (because one time in the past month is less than once a week)

Talking to other people about the trauma

0	(1)	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

1. Unwanted upsetting memories about the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

2. Bad dreams or nightmares related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

3. Reliving the traumatic event or feeling as if it were actually happening again

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

4. Feeling very EMOTIONALLY upset when reminded of the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

5. Having PHYSICAL reactions when reminded of the trauma (for example, sweating, heart racing)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

6. Trying to avoid thoughts or feelings related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

PTSD Scale-Self Report for DSM-5

(PS-SR5)

7. **Trying to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

8. **Not being able to remember important parts of the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

9. **Seeing yourself, others, or the world in a more negative way (for example "I can't trust people," "I'm a weak person")**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

10. **Blaming yourself or others (besides the person who hurt you) for what happened**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

11. **Having intense negative feelings like fear, horror, anger, guilt or shame**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

12. **Losing interest or not participating in activities you used to do**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

13. **Feeling distant or cut off from others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

14. **Having difficulty experiencing positive feelings**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

15. **Acting more irritable or aggressive with others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

16. Taking more risks or doing things that might cause you or others harm (for example, driving recklessly, taking drugs, having unprotected sex)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

17. Being overly alert or on-guard (for example, checking to see who is around you, being uncomfortable with your back to a door)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

18. Being jumpy or more easily startled (for example when someone walks up behind you)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

19. Having trouble concentrating

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

20. Having trouble falling or staying asleep

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

22. How much have these difficulties been interfering with your everyday life (for example relationships, work, or other important activities)?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month