

## **POST-NATAL STRESS INVENTORY**

**PLEASE CIRCLE "Y" IF YOU HAVE HAD ANY OF THESE EXPERIENCES SINCE THE BIRTH OF YOUR HIGH- RISK BABY. CIRCLE "Y" ONLY IF THE PARTICULAR EXPERIENCE LASTED FOR MORE THAN 1 MONTH DURING THIS TIME.**

- Y N 1. Did you have several bad dreams of giving birth or of your baby's hospital stay?
- Y N 2. Did you have several upsetting memories of giving birth or of your baby's hospital stay?
- Y N 3. Did you have any sudden feelings as though your baby's birth was happening again?
- Y N 4. Did you try to avoid thinking about childbirth or your baby's hospital stay?
- Y N 5. Did you avoid doing things which might bring up feelings you had about childbirth or your baby's hospital stay (for example, not watching a TV show about babies)?
- Y N 6. Were you unable to remember parts of your baby's hospital stay?
- Y N 7. Did you lose interest in doing things you usually do? (For example, did you lose interest in your work or in your family?)
- Y N 8. Did you feel alone and removed from other people? (For example, did you feel like no one understood you?)
- Y N 9. Did it become more difficult for you to feel tenderness or love with others?
- Y N 10. Did you have unusual difficulty falling asleep or staying asleep?
- Y N 11. Were you more irritable or angry with others than usual?
- Y N 12. Did you have greater difficulties concentrating than before you gave birth?
- Y N 13. Did you feel more jumpy? (For example, did you feel more sensitive to noise, or more easily startled?)
- Y N 14. Did you feel more guilt about the childbirth than you felt you should have?