



City Birth Trauma Scale for Maternity Staff

This questionnaire asks about your experiences as a health professional working with women during pregnancy, birth or postpartum. It asks about potential traumatic events which you may have found stressful. These events might not necessarily have happened in the place in which you are currently working. Please think about one or two such events and tick the responses closest to your experience.

These questions relate to the event you have in mind that you were either directly or indirectly involved in.

During the clinical event:	Yes	No
Did you think the woman or her baby would be seriously injured?		
Did you think the woman or her baby would die?		
Was the woman or her baby seriously injured?		
Did the woman or her baby die?		

The next questions ask about symptoms you might have experienced. Please indicate how often you experienced the following symptoms in the last week:

Symptoms surrounding the event	NOT AT ALL	ONCE	2 - 4 TIMES	5 OR MORE TIMES
Recurrent unwanted memories of the event (or parts of the event) that you can't control				
Bad dreams or nightmares about the event (or related to the event)				
Flashbacks to the event and/or reliving the experience				
Getting upset when reminded of the event				
Feeling tense or anxious when reminded of the event				
Trying to avoid thinking about the event				
Trying to avoid things that remind me of the event (e.g. people, places, meetings)				
Not able to remember details of the event				
Blaming myself or others for what happened during the event				
Feeling strong negative emotions about the event (e.g. fear, anger, shame)				

Symptoms that began or got worse since the event	NOT AT ALL	ONCE	2 - 4 TIMES	5 OR MORE TIMES
Feeling negative about myself or thinking something else awful will happen				
Lost interest in activities that were important to me				
Feeling detached from other people				
Not able to feel positive emotions (e.g. happy, excited)				
Feeling irritable or aggressive				
Feeling self-destructive or acting recklessly				
Feeling tense and on edge				
Feeling jumpy or easily startled				
Problems concentrating				
Not sleeping well				
Feeling detached or as if you are in a dream				
Feeling things are distorted or not real				

If you have any of these symptoms:

When did these symptoms start?	
Before the specific clinical event	
In the first 6 months after the event	
More than 6 months after event	
Not applicable (I have no symptoms)	

How long have these symptoms lasted?	
Less than 1 month	
1 to 3 months	
3 months or more	
Not applicable (I have no symptoms)	

Do these symptoms cause you a lot of distress?	Yes	No	Sometimes
Do they prevent you doing things you usually do (e.g. socialising, daily activities)?	Yes	No	Sometimes
Could any of these symptoms be due to medication, alcohol, drugs, or physical illness?	Yes	No	Maybe

Thank you for completing this questionnaire