

## Burns Depression Checklist \* (Revised)

**Instructions:** Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
<b>Thoughts and Feelings</b>					
1. Feeling sad or down in the dumps					
2. Feeling unhappy or blue					
3. Crying spells or tearfulness					
4. Feeling discouraged					
5. Feeling hopeless					
6. Low self-esteem					
7. Feeling worthless or inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
10. Difficulty making decisions					
<b>Activities and Personal Relationships</b>					
11. Loss of interest in family, friends, or colleagues					
12. Loneliness					
13. Spending less time with family or friends					
14. Loss of motivation					
15. Loss of interests in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
<b>Physical Symptoms</b>					
18. Feeling Tired					
19. Difficulty sleeping or sleeping too much					
20. Decreased or increased appetite					
21. Loss of interest in sex					
22. Worrying about your health					
<b>Suicidal Urges</b>					
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
<b>Please Total Your Score on Items 1 to 25 here →</b>					

\*Copyright© 1984 by David D. Burns, M.D. (Revised, 1996.)

\*\*Anyone with suicidal urges should seek help from a mental health professional.

## Burns Anxiety Checklist \* (Revised)

**Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.**

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
<b>Anxious Thoughts and Feelings</b>					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated, or on edge					
8. Feeling stressed					
9. Feeling uptight					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
<b>Anxious Physical Symptoms</b>					
13. Feeling dizzy, lightheaded, or off balance					
14. Rubbery or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing, or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
<b>Please Total Your Score on Items 1 to 25 here →</b>					

\*Copyright© 1984 by David D. Burns, M.D. (Revised, 1996.)

\*\*Anyone with suicidal urges should seek help from a mental health professional.

# Short Screening Scale for PTSD

---

DSM- IV items that constitute the 7-item screening scale. In: Breslau N, Peterson EL, Kessler RC. Short screening scale for DSM-IV posttraumatic stress disorder. Am J Psychiatry 1999;156:908-911.[17]

C2 Did you avoid being reminded of this experience by staying away from certain places, people or activities? (Remind respondent of life event if necessary)

1. Yes
2. No

C4 Did you lose interest in activities that were once important or enjoyable? (Remind respondent of life event if necessary)

1. Yes
2. No

C5 Did you begin to feel more isolated or distant from other people? (Remind respondent of life event if necessary)

1. Yes
2. No

C6 Did you find it hard to have love or affection for other people? (Remind respondent of life event if necessary)

1. Yes
2. No

C7 Did you begin to feel that there was no point in planning for the future? (Remind respondent of life event if necessary)

1. Yes
2. No

D1 After this experience were you having more trouble than usual falling asleep or staying asleep? (Remind respondent of life event if necessary)

1. Yes
2. No

D5 Did you become jumpy or get easily startled by ordinary noises or movements? (Remind respondent of life event if necessary)

1. Yes
2. No

Based on the Diagnostic Interview Schedule for DSM-IV (DIS-IV), Washington Univ., St Louis, 1995).

The 7-item scale screens for DSM-IV PTSD in persons exposed to traumatic events as defined in DSM-IV. It is intended to be used only after establishing that the respondent has experienced a qualifying event. Please read the paper carefully. It contains all the information needed for using the scale. As we emphasise in the paper, the screening scale is not an adequate substitute for a psychiatric diagnosis.

## LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

<i>Event</i>	<i>Happened to me</i>	<i>Witnessed it</i>	<i>Learned about it</i>	<i>Not Sure</i>	<i>Doesn't apply</i>
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

## Severity of Posttraumatic Stress Symptoms—Adult\*

### \*National Stressful Events Survey PTSD Short Scale (NSESSS)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

Please list the traumatic event that you experienced: \_\_\_\_\_

Date of the traumatic event: \_\_\_\_\_

**Instructions:** People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having “flashbacks,” that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Thinking that a stressful event happened because you or someone else (who didn’t directly harm you) did something wrong or didn’t do everything possible to prevent it, or because of something about you?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being “super alert,” on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

Kilpatrick DG, Resnick HS, Friedman, MJ. Copyright © 2013 American Psychiatric Association. All rights reserved.  
This measure can be reproduced without permission by researchers and by clinicians for use with their patients.

## Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1-----	2-----	3-----	4-----	5-----
almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)
_____	1) I am clear about my feelings.			
_____	2) I pay attention to how I feel.			
_____	3) I experience my emotions as overwhelming and out of control.			
_____	4) I have no idea how I am feeling.			
_____	5) I have difficulty making sense out of my feelings.			
_____	6) I am attentive to my feelings.			
_____	7) I know exactly how I am feeling.			
_____	8) I care about what I am feeling.			
_____	9) I am confused about how I feel.			
_____	10) When I'm upset, I acknowledge my emotions.			
_____	11) When I'm upset, I become angry with myself for feeling that way.			
_____	12) When I'm upset, I become embarrassed for feeling that way.			
_____	13) When I'm upset, I have difficulty getting work done.			
_____	14) When I'm upset, I become out of control.			
_____	15) When I'm upset, I believe that I will remain that way for a long time.			
_____	16) When I'm upset, I believe that I will end up feeling very depressed.			
_____	17) When I'm upset, I believe that my feelings are valid and important.			
_____	18) When I'm upset, I have difficulty focusing on other things.			
_____	19) When I'm upset, I feel out of control.			
_____	20) When I'm upset, I can still get things done.			
_____	21) When I'm upset, I feel ashamed at myself for feeling that way.			
_____	22) When I'm upset, I know that I can find a way to eventually feel better.			
_____	23) When I'm upset, I feel like I am weak.			
_____	24) When I'm upset, I feel like I can remain in control of my behaviors.			
_____	25) When I'm upset, I feel guilty for feeling that way.			
_____	26) When I'm upset, I have difficulty concentrating.			
_____	27) When I'm upset, I have difficulty controlling my behaviors.			
_____	28) When I'm upset, I believe there is nothing I can do to make myself feel better.			
_____	29) When I'm upset, I become irritated at myself for feeling that way.			
_____	30) When I'm upset, I start to feel very bad about myself.			
_____	31) When I'm upset, I believe that wallowing in it is all I can do.			
_____	32) When I'm upset, I lose control over my behavior.			
_____	33) When I'm upset, I have difficulty thinking about anything else.			
_____	34) When I'm upset I take time to figure out what I'm really feeling.			
_____	35) When I'm upset, it takes me a long time to feel better.			
_____	36) When I'm upset, my emotions feel overwhelming.			

Reverse-scored items (place a subtraction sign in front of them) are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34.

**Calculate total score by adding everything up.** Higher scores suggest greater problems with emotion regulation.

**SUBSCALE SCORING\*\*:** The measure yields a total score (SUM) as well as scores on six sub-scales:

1. Nonacceptance of emotional responses (NONACCEPT): 11, 12, 21, 23, 25, 29
2. Difficulty engaging in Goal-directed behavior (GOALS): 13, 18, 20R, 26, 33
3. Impulse control difficulties (IMPULSE): 3, 14, 19, 24R, 27, 32
4. Lack of emotional awareness (AWARENESS): 2R, 6R, 8R, 10R, 17R, 34R
5. Limited access to emotion regulation strategies (STRATEGIES): 15, 16, 22R, 28, 30, 31, 35, 36
6. Lack of emotional clarity (CLARITY): 1R, 4, 5, 7R, 9

Total score: sum of all subscales

\*\*"R" indicates reverse scored item

### REFERENCE:

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41-54.