

Section 8 - SPECIFIC SITUATIONS

Statement V

The next few questions are about objects or OTHER situations which may have made you nervous at some time in your life.

1a. Some people have such a strong fear of SPECIFIC SITUATIONS or OBJECTS that they become very frightened and nervous in such situations or THINKING ABOUT such objects or situations, or they try to avoid them.

Have you EVER had a strong fear or avoidance of . . .
(Repeat phrase frequently)

- | | |
|---------------------------------------------------------------|-----------------------------------------------------------------|
| (1) Insects, snakes, birds or other animals? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (2) Heights - like tall buildings, bridges or mountains? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (3) Storms, thunder or lightning? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (4) Being in or on the water - like swimming or boating? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (5) Flying? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (6) Being in a crowd or standing in a line? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (7) Being in closed spaces - like a cave, tunnel or elevator? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (8) Seeing blood or getting an injection? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (9) Traveling in buses, cars or trains? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (10) Going to the dentist? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (11) Visiting or being in a hospital? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| (12) Being outside your home alone? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |

b. Have you EVER had a strong fear or avoidance of any other SPECIFIC object or situation? Do not include social situations.

1 Yes
2 No

CHECK ITEM 8.0

Is at least 1 item marked "Yes" in 1a (1) - (12) or in 1b?

- 1 Yes
2 No - SKIP to Section 9, page 101

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 2. When you had to be near any of these objects or in any of these situations, did you USUALLY become upset, nervous or anxious? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| 3. Did THINKING about any of these objects or situations ALMOST ALWAYS make you nervous, frightened or anxious? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| 4. Did you ever go near any of these objects or into any of these situations because you had to be there, even though they made you very nervous, frightened or anxious? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| 5. Did you avoid any of these objects or situations because of your STRONG FEAR OF THEM? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| 6. Did you ever think that you were more frightened and nervous of these objects or situations than most people? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |
| 7. Did you ever think that your fear of any of these objects or situations was stronger than it should have been? | 1 <input type="checkbox"/> Yes
2 <input type="checkbox"/> No |

Section 8 - SPECIFIC SITUATIONS (Continued)

CHECK ITEM 8.1	Is Check Item 6.3, Section 6, page 83, marked "Yes"?	
	Did respondent ever have a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 13</i>
8a.	When you were near any of these objects or in any of the situations that made you frightened, nervous or anxious, did you EVER have a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9</i>
b.	Did your panic attacks ONLY happen when you were near any of these objects or in any of these situations or when you thought you might have to be near them or in them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
9.	Were you ever frightened of any of these objects or situations because you were afraid of having a panic attack or afraid you might be embarrassed or not able to find help if you had a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
10.	Did you avoid any of these objects or situations because you were afraid of having a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
11.	Did you ever go near any of these objects or go into any of these situations because you had to, even though you were worried about having a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
12.	When you had to be near any of these objects or in any of these situations, did you need to bring someone along with you in case you had a panic attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
13.	<p>Did being near any of these objects or in any of these situations, or THINKING ABOUT THEM or avoiding them, EVER . . . (Repeat phrase frequently)</p> <p>(1) Upset you or make you feel uncomfortable?</p> <hr/> <p>(2) Interfere with your relationships with other people - like arguing with them or avoiding them?</p> <hr/> <p>(3) Interfere with doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p> <hr/> <p>(4) Restrict your usual activities in any way?</p> <hr/> <p>(5) Keep you from doing something you wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
14a.	About how old were you the FIRST TIME you BEGAN to experience a strong fear or avoidance of any of these objects or situations?	_____ Age
CHECK ITEM 8.2	Is respondent's age in 14a within 1 year of his/her present age or is present age or 14a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 14c</i>
14b.	Did this FIRST time BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c.	<p>In your ENTIRE LIFE, how many SEPARATE times were there when you had a strong fear or avoidance of any of these objects or situations?</p> <p>By separate times, I mean times separated by at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them.</p> <p><i>If respondent says "All my life" or "There was never a time when I didn't fear or avoid object or situation", code 1.</i></p>	_____ Number
CHECK ITEM 8.2A	Is number entered in 14c, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 17a, page 97</i>
15a.	How old were you the MOST RECENT time you BEGAN to experience a strong fear or avoidance of any of these objects or situations?	_____ Age

Section 8 - SPECIFIC SITUATIONS (Continued)

CHECK ITEM 8.3A	Is respondent's age in 15a within 1 year of his/her present age or is present age or 15a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16a</i>
15b.	Did this MOST RECENT time when you feared or avoided any of these objects or situations BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
16a.	How long did this MOST RECENT time last when you were afraid of or avoided any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s)
b.	Since the MOST RECENT time BEGAN, have there been at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16d</i>
CHECK ITEM 8.3B	Is 15b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to 16d</i> 2 <input type="checkbox"/> No
16c.	Did this MOST RECENT time when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d.	In your ENTIRE LIFE, what was the LONGEST period you had when you were afraid or avoided of any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s) } <i>SKIP to Check Item 8.4</i>
17a.	How long did that period last when you were afraid of or avoided any of these objects or situations?	____ Week(s) OR ____ Month(s) OR ____ Year(s)
b.	Since that time BEGAN, have there been at least 2 months when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.4</i>
CHECK ITEM 8.3C	Is 14b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.4</i> 2 <input type="checkbox"/> No
17c.	Did that time when you WEREN'T afraid of any of these objects or situations and you DIDN'T try to avoid them BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 8.4	<i>Refer to Check Item 2.0, Section 2A, page 9.</i> Is respondent a lifetime abstainer of alcohol?	1 <input type="checkbox"/> Yes - <i>SKIP to 20</i> 2 <input type="checkbox"/> No
18.	Did (that time/ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen AFTER you were drinking heavily or a lot more than usual?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 20</i>
19.	Did (that time/ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of drinking?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
20.	Did (that time/ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen AFTER using a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.5</i>
21.	Did (that time/ANY of those times) when you had a strong fear or avoidance of these objects or situations BEGIN to happen DURING a period when you were experiencing the bad aftereffects of a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 8.5	Is at least 1 item marked "Yes" in 18, 19, 20 OR 21?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i>
CHECK ITEM 8.6A	Is Check Item 8.2A marked "No"?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6B, page 98</i>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>22a. During that time, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23</i></p>
<p>b. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } <i>SKIP to 23</i></p>
<p>CHECK ITEM 8.6B Is 14b marked "Yes" or 15b marked "Yes" or 16c marked "Yes" or 16b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>22c. Did ANY of the times when you had a strong fear or avoidance of these objects or situations in the last 12 months BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>d. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. During ANY of those times in the last 12 months when you had a strong fear or avoidance of these objects or situations after (drinking heavily/using a medicine or drug), did you STOP (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>f. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>g. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ANY of those times in the last 12 months when you STOPPED (drinking heavily/using any medicines or drugs/ experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.6C</i></p>
<p>h. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.6C Is 14b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 23, page 99</i> 2 <input type="checkbox"/> No</p>
<p>22i. Did ANY of the times when you had a strong fear of avoidance of these objects or situations BEFORE 12 months ago BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>j. Did they ALL BEGIN to happen (after drinking heavily/using a medicine or drug/when you were experiencing the bad aftereffects of drinking/medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>k. During ANY of those times BEFORE 12 months ago when you had a strong fear or avoidance of these objects or situations after (drinking heavily/using a medicine or drug) did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>l. During ALL of those times, did you STOP (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking or medicines or drugs) for at least 1 month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>m. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ANY of those times BEFORE 12 months ago when you STOPPED (drinking heavily/using any medicines or drugs/experiencing the bad aftereffects of drinking/ medicines or drugs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 23, page 99</i></p>
<p>n. Did you CONTINUE to have a strong fear or avoidance of any of these objects or situations for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>23. Did you EVER go to any counselor, therapist, doctor, psychologist or any person like that to get help for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>24a. Did you EVER go to an emergency room to get help for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Were you EVER a patient in any kind of hospital overnight or longer because of your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>25. Did a doctor EVER prescribe any medicines or drugs for your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.7 Is at least 1 item marked “Yes” in 23 - 25?</p> <p>Did respondent ever seek help for his/her fear or avoidance of an object or situation?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.7A</i></p>
<p>26a. About how old were you the FIRST time you went anywhere or saw anyone to get help for your fear or avoidance of any of these objects or situations?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for your fear or avoidance of any of these objects or situations?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 8.7A Refer to Check Item 2.0, Section 2A, page 9.</p> <p>Is the respondent a lifetime abstainer of alcohol?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.7B</i> 2 <input type="checkbox"/> No</p>
<p>27a. Did you EVER drink alcohol to reduce your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.7B</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.7B</i></p>
<p>c. Did this happen before 12 months ago, that is, before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.7B Refer to Check Item 3.10, Section 3B, page 39.</p> <p>Is the respondent a lifetime non-drug user?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.8</i> 2 <input type="checkbox"/> No</p>
<p>28a. Did you EVER take any medicines or drugs ON YOUR OWN, that is without a prescription, in greater amounts, or more often or longer than prescribed to reduce your fear or avoidance of any of these objects or situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.8</i></p>
<p>b. Did this happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.8</i></p>
<p>c. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.8 Is Check Item 8.2A marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9A</i></p>
<p>29a. Did your fear or avoidance of these objects or situations BEGIN to happen during a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 31a, page 100</i></p>
<p>b. Did a doctor or other health professional tell you that your fear of these objects or situations was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 31a, page 100</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 8.9A Is 14b marked “Yes” or 15b marked “Yes” or 16c marked “Yes” or 16b marked “No”?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9B, page 100</i></p>
<p>30a. Did ANY of the times when you feared or avoided these objects or situations in the last 12 months BEGIN to happen DURING a time when you were physically ill or getting over being physically ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 8.9B, page 100</i></p>

Section 8 - SPECIFIC SITUATIONS (Continued)

<p>30b. Did ALL of those times when you feared or avoided these objects or situations in the last 12 months ONLY BEGIN to happen DURING times when you were physically ill or getting being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 30d</i></p>
<p>c. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 8.9B</i> 2 <input type="checkbox"/> No</p>
<p>d. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 8.9B Is 14b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 31a</i> 2 <input type="checkbox"/> No</p>
<p>30e. Did ANY of the times when you feared or avoided these objects or situations BEFORE 12 months ago BEGIN to happen DURING a time when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 31a</i></p>
<p>f. Did ALL of those times when you feared or avoided these objects or situations BEFORE 12 months ago ONLY BEGIN to happen DURING times when you were physically ill or getting over being ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 30h</i></p>
<p>g. Did a doctor or other health professional tell you that ALL of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 31a</i> 2 <input type="checkbox"/> No</p>
<p>h. Did a doctor or other health professional tell you that ANY of the times like this were related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>31a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were THINKING ABOUT an extremely stressful experience you had in the past - like being in a war, being attacked, or being in a bad accident or a fire?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 32a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were thinking about an extremely stressful experience you had in the past?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>32a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were frightened, nervous or worried about being away from home or away from people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 33a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were nervous or worried about being away from home or away from the people who were important to you?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>33a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 34a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid of being contaminated by dirt or germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>34a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid of having to do something over and over to make yourself comfortable - like counting, checking, ordering, and repeating things over and over?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 35a</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>35a. Did your fear or avoidance of these objects or situations EVER happen during a time when you were afraid that you WOULDN'T be able to do things over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 9, page 101</i></p>
<p>b. Did your fear of these objects or situations ONLY happen when you were afraid you WOULDN'T be able to do things over and over to make yourself feel comfortable?</p>	<p>1 <input type="checkbox"/> Yes } <i>Go to Section 9, page 101</i> 2 <input type="checkbox"/> No }</p>