

Section 9 - GENERAL ANXIETY

Statement W

Now I'd like to ask you about times in your life when you may have been tense, nervous, or worried over a long period of time.

1a. Have you EVER had a time lasting at least 6 months when you felt tense, nervous, or worried most of the time?	1 <input type="checkbox"/> Yes - <i>SKIP to 3</i> 2 <input type="checkbox"/> No
b. Have you EVER had a time lasting at least 6 months when you felt very tense, nervous or worried most of the time about everyday problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i>
3. Now I'd like you to think about your WORST period lasting at least 6 months when you were the most tense, nervous or worried. During your worst period of feeling tense, nervous or worried for 6 months or more, did you EVER . . . <i>(Repeat phrase frequently)</i>	
(1) Worry a lot about things you usually didn't worry about?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Worry about more than one thing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Find it difficult to stop being tense, nervous or worried?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Worry about things that were very unlikely to happen?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Think that your worrying was excessive?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Worry about things that weren't really serious?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Worry about what other people might do or what would happen to them?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4. During your worst period of 6 months or more when you were very tense, nervous or worried, did you OFTEN . . . <i>(Repeat entire phrase frequently)</i>	
(1) Get tired easily?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Become startled easily?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Have tense, sore or aching muscles?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Become so restless that you fidgeted, paced, or couldn't sit still?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Feel keyed up or on edge?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) Have trouble concentrating or keeping your mind on things?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Feel irritable?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8) Have trouble falling asleep or staying asleep?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(9) Have times when you forgot what you were talking about or your mind went blank?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(10) Feel your heart racing, skipping, or pounding in your chest?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

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<p>4. During your worst period of 6 months or more when you were very tense, nervous or worried, did you OFTEN . . . <i>(Repeat entire phrase frequently)</i></p>	
<p>(11) Perspire or sweat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(12) Have cold and clammy hands?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(13) Have a dry mouth?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(14) Feel dizzy, lightheaded, or like you might faint?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(15) Feel nauseous, have an upset stomach, or feel like you might vomit or have diarrhea?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(16) Urinate frequently?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(17) Have trouble swallowing or feel like you had a lump in your throat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(18) Have pain or pressure in your chest?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(19) Find yourself trembling or shaking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(20) Have trouble catching your breath or feel like you were smothering?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.3 Are at least 3 items marked "Yes" in 4(1) - 4(20), pages 101 - 102?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i></p>
<p>5. Now I'd like to ask you about some things that might have happened to you during your worst period when you felt nervous or worried most of the time for at least 6 months and had some of the other experiences you just mentioned at the same time. During that period, did you. . . <i>(Repeat phrase frequently)</i></p>	
<p>(1) Feel uncomfortable or upset about feeling nervous or anxious or by any of these other things that were going on at the same time?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(2) Have arguments or friction with family, friends, people at work or anyone else?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(3) Have difficulty doing things you were supposed to do - like working, doing your schoolwork, or taking care of your home or family?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(4) Restrict your usual activities in any way?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>(5) Find that you were unable to do something you wanted to do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>6a. About how old were you the FIRST time you BEGAN to feel tense, nervous or worried for at least 6 months and also had some of the other experiences you mentioned?</p>	<p>_____ Age</p>
<p>CHECK ITEM 9.4 Is respondent's age in 6a within 1 year of his/her present age or is present age or 6a unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 7</i></p>
<p>6b. Did this FIRST time BEGIN to happen during the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. In your ENTIRE LIFE, how many SEPARATE times lasting at least 6 months were there when you felt tense, nervous or worried for most of the time and had some of the other experiences you mentioned? By separate times, I mean times separated by at least 2 months when you DIDN'T feel tense, nervous or worried AND you DIDN'T have ANY of these OTHER experiences.</p>	<p>_____ Number</p>

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CHECK ITEM 9.5	Is number entered in 7, 2 or more or unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9e</i>
8a.	How old were you the MOST RECENT time you BEGAN to feel tense, nervous or worried most of the time for at least 6 months and also had some of those other experiences?	_____ Age
CHECK ITEM 9.6	Is respondent's age in 8a within 1 year of his/her present age or is present age or 8a unknown?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9a</i>
8b.	Did this MOST RECENT time when you felt tense, nervous or worried BEGIN to happen in the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
9a.	How long did this MOST RECENT period last when you felt tense, nervous, or worried? <i>(Must be at least 6 months.)</i>	_____ Month(s) OR _____ Year(s)
b.	Since this MOST RECENT time BEGAN, have there been at least 2 months when you DIDN'T feel tense, nervous or worried AND DIDN'T have any of the OTHER experiences you mentioned?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 9d</i>
c.	Did this MOST RECENT time when you DIDN'T feel tense, nervous or worried 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 felt tense, nervous or worried most of the time? <i>(Must be at least 6 months.)</i>	_____ Months } OR } <i>SKIP to Check Item 9.7</i> _____ Year(s) }
e.	How long did that period last when you felt tense, nervous, or worried most of the time? <i>(Must be at least 6 months.)</i>	_____ Month(s) OR _____ Year(s)
f.	Since that time BEGAN, have there been at least 6 months when you DIDN'T feel tense, nervous or worried AND DIDN'T have any of the OTHER experiences you mentioned?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.7</i>
CHECK ITEM 9.6A	Is 6b marked "Yes"?	1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 9.7</i> 2 <input type="checkbox"/> No
9g.	Did that time when you DIDN'T feel tense, nervous or worried BEGIN to happen during the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 9.7	<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 12</i> 2 <input type="checkbox"/> No
10.	Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months 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 12</i>
11.	Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months 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
12.	Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months BEGIN to happen AFTER using a medicine or drug?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.8</i>
13.	Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months 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 9.8	Is at least 1 item marked "Yes" in 10, 11, 12 OR 13?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 15, page 105</i>
CHECK ITEM 9.9	Is Check Item 9.5 marked "No"?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.10, page 104</i>

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<p>14a. 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 15, page 105</i></p>
<p>b. Did you CONTINUE to feel tense, nervous or worried 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 15, page 105</i></p>
<p>CHECK ITEM 9.10 Is 6b marked "Yes" or 8b marked "Yes" or 9c marked "Yes" or 9b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.10A</i></p>
<p>14c. Did ANY of those times in the last 12 months when you were tense, nervous or worried for at least 6 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 9.10A</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/medicine 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 were tense, nervous or worried for at least 6 months after (drinking heavily/using a medicine or drug), did you STOP (drinking/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 9.10A</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 feel tense, nervous or worried 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 9.10A</i></p>
<p>h. Did you CONTINUE to feel tense, nervous or worried 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 9.10A Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 15, page 105</i> 2 <input type="checkbox"/> No</p>
<p>14i. Did ANY of those times BEFORE 12 months ago when you were tense, nervous or worried for at least 6 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 15, page 105</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 were tense, nervous or worried for at least 6 months 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 15, page 105</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/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 feel tense, nervous or worried 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 15, page 105</i></p>
<p>n. Did you CONTINUE to feel tense, nervous or worried for at least 1 month AFTER ALL of those times?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

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<p>15. Did you EVER go to any kind of counselor, therapist, doctor, psychologist or any person like that because you were feeling tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>16a. Did you EVER go to an emergency room to get help for feeling tense, nervous or worried?</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 you were feeling tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17. Did a doctor EVER prescribe any medicines or drugs to help calm you down or quiet your nerves?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.11 Is at least 1 item marked "Yes" in 15 - 17?</p> <p>Did respondent ever seek help for feeling tense, nervous or worried for at least 6 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.11A</i></p>
<p>18a. About how old were you the FIRST time you went anywhere or saw anyone to get help for feeling tense, nervous or worried?</p>	<p>_____ Age</p>
<p>b. How old were you the MOST RECENT time you went anywhere or saw anyone to get help for feeling tense, nervous or worried?</p>	<p>_____ Age OR 0 <input type="checkbox"/> Happened only once</p>
<p>CHECK ITEM 9.11A 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 9.11B</i> 2 <input type="checkbox"/> No</p>
<p>19a. Did you EVER drink to calm down or help quiet your nerves when you felt tense, nervous or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.11B</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 9.11B</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 9.11B 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 9.12</i> 2 <input type="checkbox"/> No</p>
<p>20a. Did you EVER take any medicine or drugs ON YOUR OWN, that is, without a prescription, in greater amounts, or more often or longer than prescribed to help calm down or quiet your nerves when you felt tense, nervous, or worried?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.12</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 9.12</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 9.12 Is Check Item 9.5 marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.13</i></p>
<p>21a. Did that time when you were tense, nervous or worried for at least 6 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 22a, page 106</i></p>
<p>b. Did a doctor or other health professional tell you that this time was related to your physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes } <i>SKIP to 22a, page 106</i> 2 <input type="checkbox"/> No }</p>
<p>CHECK ITEM 9.13 Is 6b marked "Yes" or 8b marked "Yes" or 9c marked "Yes" or 9b marked "No"?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.13A, page 106</i></p>
<p>21c. Did ANY of the times when you were tense, nervous or worried in the last 12 months 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 Check Item 9.13A, page 106</i></p>

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<p>21d. Did ALL of those times when you were tense, nervous or worried in the last 12 months ONLY BEGIN to happen DURING times 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 21f</i></p>
<p>e. 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 9.13A</i> 2 <input type="checkbox"/> No</p>
<p>f. Did a doctor or other health professional tell you that ANY of the times like this were related to you physical illness or medical condition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.13A Is 6b marked "Yes"?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 22a</i> 2 <input type="checkbox"/> No</p>
<p>21g. Did ANY of the times BEFORE 12 months ago when you were tense, nervous or worried 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 22a</i></p>
<p>h. Did ALL of those times BEFORE 12 months ago when you were tense, nervous or worried ONLY BEGIN to happen DURING times 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 21j</i></p>
<p>i. 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 22a</i> 2 <input type="checkbox"/> No</p>
<p>j. 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>22a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were worrying 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 23a</i></p>
<p>b. Did ALL of those times 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>23a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were frightened, 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 - <i>SKIP to 24a</i></p>
<p>b. Did ALL of those times 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>24a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months 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 25a</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid of being contaminated by dirt germs?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>25a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable - like counting, checking, ordering or repeating things over and over?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 26a</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid you might be embarrassed by having to do something over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>26a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were afraid that you WOULDN'T be able to do things over and over to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 27a, page 107</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid that you WOULDN'T be able to do things over and over again to make yourself comfortable?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

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<p>27a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were very worried about gaining weight or getting too fat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 28a</i></p>
<p>b. Did ALL of those times ONLY happen when you were very worried about gaining weight or getting too fat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>28a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you thought you had a serious physical illness even though a doctor assured you there was nothing physically wrong?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 29a</i></p>
<p>b. Did ALL of those times ONLY happen when you thought you had a serious illness even though a doctor assured you there was nothing physically wrong?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>29a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you had numerous physical problems that a doctor couldn't fully explain?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.14</i></p>
<p>b. Did ALL of those times ONLY happen when you had numerous physical problems that a doctor couldn't fully explain?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.14 Is "Yes" marked in Check Item 6.3, Section 6, page 83?</p> <p>Did respondent ever have a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.15</i></p>
<p>30a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen when you were afraid of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.15</i></p>
<p>b. Did ALL of those times ONLY happen when you were afraid of having a panic attack?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.15 Is "Yes" marked in Check Item 4.3, Section 4A, page 62?</p> <p>Has respondent ever had a period of low mood?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.16</i></p>
<p>31a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a period you mentioned earlier when you felt sad, blue, depressed, or down (<i>PAUSE</i>) or when you didn't care about things or enjoy things that you usually cared about or enjoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.16</i></p>
<p>b. Did ALL of those times ONLY happen when you felt very sad, blue, depressed, or down (<i>PAUSE</i>) or when you didn't care about things or enjoy things?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.16 Is "Yes" marked in Check Item 5.3, Section 5, Page 77?</p> <p>Has respondent ever had a period of high mood or irritability?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.17</i></p>
<p>32a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a period you mentioned earlier when you felt extremely good, excited or hyper (<i>PAUSE</i>) or when you felt extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 9.17</i></p>
<p>b. Did ALL of those times when you were tense, nervous or worried ONLY happen when you felt extremely good, excited or hyper or when you extremely irritable or easily annoyed?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 9.17 Is "Yes" marked in Check Item 7.0, Section 7, page 88?</p> <p>Has respondent ever had a fear or avoidance of social situations?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 10, page 109</i></p>

Section 9 - GENERAL ANXIETY (Continued)

33a. Did (that time/ANY of those times) when you were tense, nervous or worried for at least 6 months happen during a time when you were experiencing a strong fear or avoidance of social situations?

- 1 Yes
- 2 No - *SKIP to Section 10, page 109*

b. Did ALL of those times ONLY happen when you were experiencing a strong fear or avoidance of social situations?

- 1 Yes
 - 2 No
- } *Go to Section 10, page 109*