

## Validation of the Arabic version of the Geriatric Anxiety Scale among Lebanese population of older adults

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### Summary

#### Objectives

To translate the Geriatric Anxiety Scale (GAS) to Arabic for use in elderly patients in Lebanon, check its validity, reproducibility and responsiveness to the adapted version of the questionnaires and assess the risk factors associated with anxiety in these Lebanese geriatrics.

#### Methods

This case-control study was conducted between June and August 2016 on 500 patients.

#### Results

For the GAS total score, the internal consistency was excellent ( $\alpha = 0.908$ ). The reliabilities of the GAS subscale scores were as follows: Cognitive ( $\alpha = 0.756$ ); Somatic ( $\alpha = 0.810$ ); Affective ( $\alpha = 0.845$ ). The three subscales of the GAS were highly inter-correlated, with  $r$  varying from 0.523 to 0.816 ( $p < 0.001$ ).

Mild and severe stress, as showed by the Beirut Distress Scale (BDS) score, would significantly increase the total GAS score ( $p < 0.001$ , Beta = 5.14, CI 3.817-6.464 and  $p < 0.001$ , Beta = 6.847 and CI 5.790-7.903 respectively). Mild and severe depression, as showed by the Geriatric Depression Scale (GDS) score, being divorced or widowed as compared to being single, would significantly increase the total GAS score ( $p < 0.001$ , Beta = 7.448, CI 4.222-10.675 and  $p < 0.001$ , Beta = 11.889, CI 8.172-15.606;  $p = 0.001$ , Beta = 6.127, CI 2.647-9.607 and  $p = 0.026$ , Beta = 3.027, CI 0.369-5.685 respectively). The complementary, secondary and university levels of education would increase the total GAS score as compared to illiteracy ( $p = 0.018$ , Beta = 3.030, CI 0.531-5.528;  $p < 0.001$ , Beta = 5.606, CI 2.751-8.460 and  $p < 0.001$ , Beta = 12.014, CI 8.922-15.107 respectively). In opposite, age significantly lowered the total GAS score ( $p = 0.001$ , Beta = -0.159, CI -0.248-0.070).

#### Conclusions

These preliminary results suggest that the Arabic version of the GAS has promising psychometric properties. On the basis of these findings, periodic screening for anxiety, depression, nutritional status and stress is required among geriatric people living in Lebanon.

#### Key words

Anxiety • Nutritional status • Depression • Factors • Elderlies • Lebanon

### Introduction

Anxiety is an emerging problem that aspects individuals across their lifespan. Anxiety may range in severity from mild, adaptive anxiety, wherein it enhances one's normal functioning and maintains one's sense of safety, to severe and debilitating symptoms that are characteristic of anxiety disorders<sup>1</sup>.

Anxiety disorders are among the most prevalent mental disorders worldwide<sup>2,3</sup> and are more common among older adults<sup>2,4</sup>. The knowledge about anxiety disorders in geriatric patients is less developed, although they are

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more common than depressive disorders in the elderly population<sup>5,6</sup>.

Anxiety disorders in older adults are common, with a prevalence that ranges between 3.2% and 14.2%<sup>6</sup>. Moreover, subsyndromal anxiety symptoms in late life are even more prevalent, ranging between 15 to 52.3% in community samples and 15 to 56% in clinical samples<sup>5</sup>. Anxiety was the most common among all disorders with a prevalence of 16.7%, according to the lifetime prevalence of mental disorders in Lebanon conducted on adults aged 18 years and more<sup>7</sup>.

Clinically significant anxiety is associated with a variety of adverse outcomes such as poor physical health, sleep problems, or urinary incontinence<sup>8,9</sup>. Excessive anxiety causes considerable subjective distress, and is associated with a loss of physical activity and depressive symptoms such as reduced life satisfaction, poor self-perceptions of health, and increased loneliness<sup>10,11</sup>. Many scales were developed as a tool to screen for anxiety among adults and elderly, such as the Adult Manifest Anxiety Scale (AMAS) for younger adults and elderly<sup>12</sup>, the Geriatric Anxiety Inventory (GAI)<sup>13</sup> and the Geriatric Anxiety Scale (GAS)<sup>14</sup>.

None of these scales are validated among our Lebanese population of elderly patients. We chose the GAS scale because of its promising psychometric properties and for its capability of measuring several components of anxiety: somatic, affective and cognitive symptoms. Thus, the primary objective of this study is to translate the GAS scale to Arabic for use in elderly patients in Lebanon, to check its validity, reproducibility and responsiveness to the adapted version of the questionnaires. The secondary objective is to assess the risk factors associated with anxiety in these Lebanese geriatrics.

## Methods

### Study design

This case-control study was conducted between June and August 2016. 250 cases were chosen from three nursing homes in 3 districts in Lebanon. After the nursing homes administration's approval, the questionnaire was distributed to the elderly, after obtaining both verbal and written informed consents. On the other hand, 250 controls were randomly chosen from the general population from public places (malls, pharmacies, shops, etc.). The interviewed persons were not aware of the exact objective of the study.

### Questionnaire and variables

The permission to use the original GAS scale was obtained from Professor Daniel Segal. The GAS was translated from English to Arabic through an initial transla-

tion and back translation process. The English version was translated into Arabic by a mental health specialist, then this translation was translated again into English by another specialist. Upon completion of this process, the translators compared the English versions of GAS to determine whether the variables had the same meaning. One trained person was responsible for the data collection, via a personal interview with each patient. This person was independent of this study. A pilot test was conducted on 15 patients to check if the questions were well understood. To note that these 15 answers were not entered in the final database.

### Geriatric Anxiety Scale

The GAS<sup>14</sup> contains 25 self-report items used for scoring, as well as five additional items, that tap into common topical concerns of anxiety among older adults and help clinicians identify areas of concerns for the patient. To note that these 5 questions do not load on the final GAS score of each participant. The GAS includes three subscales that study the somatic, cognitive and affective symptoms respectively. Each of these domains include 8 to 9 questions.

Participants are asked to rate symptoms of anxiety or stress by indicating how often they have experienced each symptom during the past week on a Likert-type scale that ranges from 0 (not at all) to 3 (all of the time). Possible scores range from 0 to 75, with higher scores indicating higher levels of anxiety.

### Sample size calculation

Using the Epi info program for the calculation of the minimal sample size needed for our study, with an acceptable margin of error of 5% and an expected frequency of anxiety of 16.7%<sup>7</sup> for a 4 million inhabitants in Lebanon, the results showed that we need 428 patients to be enrolled in the study<sup>15</sup>.

### Statistical analysis

Data analysis was performed on SPSS software, version 22. To confirm the GAS questionnaire construct validity in the Lebanese population, a factor analysis was launched for the whole scale and its 3 subscales respectively, using the principal component analysis technique, with a promax rotation since the extracted factors were found to be significantly correlated. The Kaiser-Meyer-Olkin measure of sampling adequacy and Bartlett's test of sphericity were ensured to be adequate. The retained number of factors corresponded to Eigenvalues higher than one. Moreover, Cronbach's alpha was recorded for reliability analysis for the total score and for subscale factors. Moreover, a multivariate linear regression, using a forward stepwise method, was applied taking the GAS total score as dependent variable and several independent variables (BDS stress

score, GDS score, MNA status, level of education, age, gender, marital status, etc.).

## Results

### Reliability

Internal item consistency for the Arabic version of the GAS was evaluated by Cronbach's alpha coefficient. For the GAS total score, the internal consistency was excellent (alpha = 0.908). The reliabilities of the GAS subscale scores were as follows: Cognitive (alpha = 0.756); Somatic (alpha = 0.810); Affective (alpha = 0.845). The three subscales of the GAS were highly intercorrelated, with  $r$  varying from 0.523 to 0.816 ( $p < 0.001$ ) (Table I). Furthermore, the correlation between the GAS 10 items scale and the GAS total scale with the other 3 subscales was high as well as shown in Table I. Furthermore, these data provide evidence of convergent validity of the translated GAS in this Lebanese sample.

### Geriatric Anxiety Scale validity checking

Out of all the items asked in the questionnaire, all variables could be extracted from the list, with no items that over-correlated to each other ( $r > 0.9$ ), having a low loading on factors ( $< 0.3$ ) or because of a low communality ( $< 0.3$ ).

The factor analysis for the GAS was run over the whole sample (Total = 500). The total GAS scale converged over a solution of 3 factors, explaining a total of 58.08% of the variance. A high Cronbach's alpha was found for the whole scale 0.908. A Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of 0.605 was found, with a significant Bartlett's test of sphericity ( $p < 0.001$ ). The *GAS somatic subscale* items converged over a solution of 3 factors that had an Eigenvalue over 1, explaining a total of 70.02% of the variance. A KMO measure of sampling adequacy of 0.672 was found, with a significant Bartlett's test of sphericity ( $p < 0.001$ ). Moreover, a high Cronbach's alpha was found for the somatic subscale (0.756). The *GAS cognitive subscale* items converged

over a solution of 2 factors that had an Eigenvalue over 1, explaining a total of 65.64% of the variance. A KMO measure of sampling adequacy of 0.726 was found, with a significant Bartlett's test of sphericity ( $p < 0.001$ ). Moreover, a high Cronbach's alpha was found for the somatic subscale (0.810). The *GAS affective subscale* items converged over a solution of 3 factors that had an Eigenvalue over 1, explaining a total of 81.84% of the variance. A KMO measure of sampling adequacy of 0.678 was found, with a significant Bartlett's test of sphericity ( $p < 0.001$ ). Moreover, a high Cronbach's alpha was found for the affective subscale (0.845).

### Gender difference

A series of independent samples t-tests was used to compare gender differences on the GAS total score (10 and 30 items scales) and on the GAS subscale scores (Table III). Since older women typically have higher levels of anxiety symptoms and higher rates of anxiety disorders than older men<sup>6</sup>, these analyses were conducted to assess whether gender differences exist in older stages of life in our Lebanese sample. The results showed that there was no significant difference between genders for any of these scales except for the GAS somatic scale ( $p = 0.014$ ).

### Factors affecting the total anxiety score

The results of the multivariate analysis taking the total GAS score as dependent variable, showed that mild and severe stress, as showed by the BDS score, would significantly increase the total GAS score by 5.14 and 6.847 points respectively ( $p < 0.001$ , Beta = 5.14, CI 3.817-6.464 and  $p < 0.001$ , Beta = 6.847 and CI 5.790-7.903 respectively). In addition, mild and severe depression, as showed by the GDS score, would significantly increase the total GAS score by 7.4 and 11.8 points respectively ( $p < 0.001$ , Beta = 7.448, CI 4.222-10.675 and  $p < 0.001$ , Beta = 11.889, CI 8.172-15.606 respectively). Being divorced or widowed would significantly increase the GAS total score, as compared to being single, by

TABLE I. Correlations between the different GAS subscales.

	GAS 10 items	GAS total score	GAS somatic subscale	GAS cognitive subscale	GAS affective subscale
GAS 10 items scale	-	0.927	0.703	0.862	0.859
GAS total scale	0.927	-	0.803	0.912	0.902
GAS somatic subscale	0.703	0.803	-	0.584	0.523
GAS cognitive subscale	0.862	0.912	0.584	-	0.816
GAS affective subscale	0.859	0.902	0.523	0.816	-

$p < 0.001$  for all correlations between all subscales.

**TABLE II.** Descriptive analysis and factor loading of the Arabic GAS (N = 500 patients).

Question	Item	Subscale	Min-Max	Loading factor
My heart raced or beat strongly	1	Somatic	0-3	0.936
My breath was short	2	Somatic	0-3	0.842
I had an upset stomach	3	Somatic	0-3	0.814
I had difficulty falling asleep	8	Somatic	0-3	0.908
I had difficulty staying asleep	9	Somatic	0-3	0.908
I had a hard time sitting still	17	Somatic	0-3	0.654
I felt tired	21	Somatic	0-3	0.770
My muscles were tense	22	Somatic	0-3	0.582
I had back pain, neck pain or muscle cramps	23	Somatic	0-3	0.459
I felt like things were not real or like I was outside of myself	4	Cognitive	0-3	0.865
I felt like I was losing control	5	Cognitive	0-3	0.881
I had difficulty concentrating	12	Cognitive	0-3	0.934
I felt like I was in a daze	16	Cognitive	0-3	0.661
I worried too much	18	Cognitive	0-3	0.504
I could not control my worry	19	Cognitive	0-3	0.536
I felt like I had no control over my life	24	Cognitive	0-3	0.891
I felt like something terrible was going to happen to me	25	Cognitive	0-3	0.698
I was afraid of being judged by others	6	Affective	0-3	0.910
I was afraid of being humiliated or embarrassed	7	Affective	0-3	0.943
I was irritable	10	Affective	0-3	0.907
I had outbursts of anger	11	Affective	0-3	0.894
I was easily startled or upset	13	Affective	0-3	0.880
I was less interested in doing something I typically enjoy	14	Affective	0-3	0.516
I felt detached or isolated from others	15	Affective	0-3	0.999
I felt restless, keyed up or on edge	20	Affective	0-3	0.823

Cronbach's alpha for the whole GAS scale  $\alpha = 0.908$ ; for the somatic scale  $\alpha = 0.756$ ; for the cognitive subscale  $\alpha = 0.810$ ; for the affective scale  $\alpha = 0.845$ .

6.1 and 3 points respectively ( $p = 0.001$ , Beta = 6.127, CI 2.647-9.607 and  $p = 0.026$ , Beta = 3.027, CI 0.369-5.685 respectively). Furthermore, the complementary, secondary and university levels of education would increase the total GAS score as compared to illiteracy, by 3.03, 5.6 and 12 points respectively ( $p = 0.018$ , Beta = 3.030, CI 0.531-5.528;  $p < 0.001$ , Beta = 5.606, CI 2.751-8.460 and  $p < 0.001$ , Beta = 12.014, CI 8.922-15.107 respectively). In opposite, age significantly lowered the total GAS score by 0.159 points ( $p = 0.001$ , Beta = -0.159, CI -0.248- -0.070).

## Discussion

### Validation of the GAS scale

In the current study, we were able to validate the Arabic version of the GAS questionnaire, intended specifically

for use among elderlies in Lebanon. Results provide initial evidence supporting the reliability and validity of the scale as a screening instrument for anxiety in geriatric patients. The findings showed that the two reliability estimates of the new measure used (Cronbach's alpha and inter-item correlations) were all adequate and similar to reliability data for the English version<sup>14 16 17</sup>. The three identified factors of the GAS scale demonstrated good psychometric properties, with excellent internal consistency for this scale. Thus, the scale can be used in the Lebanese population.

### Validity

To assess validity, relationships between the GAS total scale and its subscales were done using the correlation coefficients. In fact, strong positive correlations ( $p < 0.001$  for all subscales) were found between the to-

**TABLE III.** Gender differences in the GAS scale and subscales scores.

Factor	N	Mean ± SD	p
<b>GAS total score</b>			<b>0.208</b>
Male	226	32.69 ± 14.84	
Female	274	30.99 ± 15.23	
<b>GAS 10 items scale</b>			<b>0.146</b>
Male	226	13.53 ± 7.15	
Female	274	12.59 ± 7.23	
<b>GAS somatic score</b>			<b>0.014</b>
Male	226	11.83 ± 5.80	
Female	274	10.56 ± 5.63	
<b>GAS cognitive score</b>			<b>0.648</b>
Male	226	9.18 ± 5.17	
Female	274	8.96 ± 5.26	
<b>GAS affective score</b>			<b>0.218</b>
Male	226	11.68 ± 6.18	
Female	274	11.46 ± 6.44	

tal scale and its subscales (cognitive  $r = 0.912$ ; somatic  $r = 0.803$ ; affective  $r = 0.902$ ) similar to the original GAS scale that showed strong relationships with its subscales as well (cognitive  $r = 0.91$ ; somatic  $r = 0.86$ ; affective  $r = 0.92$ )<sup>14</sup>. Additionally, each subscale was significantly correlated with the other subscales, ranging between  $r = 0.523$  between somatic and affective subscales to  $r = 0.816$  between affective and cognitive subscales in the Arabic version, as compared to a range between  $r = 0.61$  to  $r = 0.82$  in the original scale.

Another issue to be discussed is construct validity. It consisted in comparing the initial GAS with our version of the questionnaire using Cronbach's alpha reliability coefficient and factor analysis. The internal consistency reliability for the total GAS scale was  $\alpha = 0.908$ , whereas the internal consistency estimated for the three subscales was good as well (cognitive  $\alpha = 0.810$ , somatic  $\alpha = 0.756$ , affective  $\alpha = 0.845$ ), similar to the original values obtained  $\alpha = 0.93$ ,  $\alpha = 0.85$ ,  $\alpha = 0.80$  and  $\alpha = 0.82$  for the same original scales respectively.

#### Factors affecting the anxiety score

Our results showed a significant correlations between anxiety from one end, and stress and depression for another end. Our results showed that mild and severe depression would increase anxiety. In fact, the co-occurrence of anxiety and depression in elderly patients is strongly associated with symptomatic overlap and frequent progression of anxiety to depression over time<sup>18</sup>. Furthermore, this combination in elderly patients is a true fact with very strong association between them as detected by Brenes et al.<sup>19</sup>, Abdel Rahman et al.<sup>20</sup> and Ahmed et al.<sup>21</sup>. Our results are also in line with the findings of van Zelst et al.<sup>23</sup> that showed that stressful life events were significantly associated with increased anxiety.

Age is a common predictor for depression, anxiety, and mixed form. This may be attributed to the fact that with increasing age, people experience a greater loss of physiological, psychological, and social functioning and become increasingly prone to mental disorders<sup>23</sup>. The results of Ahmed et al. revealed that the occurrence of depression and anxiety increases with age Egypt, in opposite to our study where age was shown to

**TABLE IV.** Multivariate analysis with total GAS score as dependent variable.

Factor	Unstandardized Beta	Standardized Beta	p-value	Confidence interval	
BDS severe stress	6.847	.628	< 0.001	5.790	7.903
BDS mild stress	5.140	.328	< 0.001	3.817	6.464
University level of education*	12.014	.308	< 0.001	8.922	15.107
Secondary level of education*	5.606	.148	< 0.001	2.751	8.460
GDS score severe depression	11.889	.380	< 0.001	8.172	15.606
GDS score mild depression	7.448	.246	< 0.001	4.222	10.675
Age	-.159	-.123	.001	-.248	-.070
Divorced**	6.127	.121	.001	2.647	9.607
Complementary level of education*	3.030	.092	.018	.531	5.528
Widowed**	3.027	.078	.026	.369	5.685

BDS = Beirut Distress Scale; GDS = Geriatric Depression Scale.

\* Levels of education as compared to illiteracy. \*\* Marital status as compared to being single.

decrease anxiety<sup>21</sup>. Our results are however similar to those of Acierno et al. who showed that older adults are more resilient than younger adults with regard to mental health outcomes<sup>24</sup>.

With regards to social factors, the marital status and the level of education appeared to be related with an increased level of anxiety. Being divorced or widowed was associated with increased anxiety, in line with the findings of Mohamed EM et al.<sup>25</sup> that demonstrated that a divorced/ separated marital status was associated with geriatric depression and anxiety in both sexes and also in the overall sample<sup>25</sup>. This might also be explained by the feeling of loneliness, a strong predictor of anxiety, which is a subjective, negative feeling related to the person's own experience of deficiency in social relations<sup>26 27</sup> and by the lack of social support<sup>28 29</sup>.

In addition, the complementary, secondary and university levels of education were associated with an increased risk of anxiety in our study. Although some studies showed an association between lower education and anxiety<sup>30 31</sup>, others showed that higher education and intelligence might be associated with higher levels of anxiety<sup>32 33</sup>. The results we obtained might be due to the fact that elderlies in our sample are more intelligent and more educated people that would have more responsibilities and would think more about the future, leading to an increased anxiety level.

### Limitations

Although the preliminary results in this study are promising, further research should explore the psychometrics of the Arabic GAS in future larger studies, including older

adults with psychiatric problems. Future studies should also investigate the extent to which self-report administration is comparable to oral administration of the GAS. However, since this scale was studied on nursing home geriatrics and elderlies living in their own houses, our results can be extended to the general population.

### Conclusions

These preliminary results suggest that the Arabic version of the GAS has promising psychometric properties. Based on this study, health care professionals and researchers can readily use the GAS total score to estimate the overall severity of anxiety in Lebanon and in all Arabic-speaking populations, including the Gulf and most North African countries, and in all Arab immigrants around the world. Increasing awareness among nursing home personnel and family members, creating recreational activities for these elderlies, encouraging family bonds would definitely help improve the psychological status of these geriatrics, and thus, their quality of life.

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### Competing interests

None declared.

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إسم العتلة:	الإسم الأول:	الجنس:	العمر:	الوزن (كجم):	الطول (سم):	التاريخ:
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اتعمل المسح الأولي بملأ العريعات بالأرقام (النقاط) المناسبة. إجمع النقاط للحصول على المجموع النهائي للتقاط المحرزة لهذا المسح.

المسح الأولي	
A	<p>أ. هل ناص تناول الطعام خلال الثلاثة أشهر الماضية نتيجة لفقدان الشهية أو مشاكل في الهضم أو صعوبات في المضغ أو البلع؟</p> <p>0 = فقدان شديد للشهية 1 = فقدان متوسط للشهية 2 = لا يوجد فقدان للشهية</p>
B	<p>ب. مدى فقدان الوزن خلال الأشهر الثلاثة الأخيرة؟</p> <p>0 = فقدان الوزن أكثر من 3 كجم 1 = غير معروف 2 = فقدان الوزن من 1 إلى 3 كجم 3 = لا يوجد فقدان في الوزن</p>
C	<p>ج. القدرة على الحركة</p> <p>0 = ملازم للكراسي أو الكرسي 1 = قادر على القيام من الكرسي / الكرسي ولكنه غير قادر على مغادرة المنزل 2 = يقدر المنزل</p>
D	<p>د. أي إصابة يضبط نفسي أو مرض حاد في الأشهر الثلاثة الماضية</p>
E	<p>0 = نعم 2 = لا.</p> <p>هـ. أي إصابات عصبية وتغذية</p> <p>0 = تخرف شديدة أو اكتئاب 1 = خرف شديدة خفيف (معتدل)</p>
F1	<p>2 = غير مصاب بأمراض</p> <p>و. معدل كتلة الجسم [(الوزن بالكيلوجرام) ÷ (الطول بالمتر)<sup>2</sup>]</p> <p>0 = معدل كتلة الجسم أقل من 19 1 = معدل كتلة الجسم من 19 إلى أقل من 21 2 = معدل كتلة الجسم من 21 إلى أقل من 23</p>
<p>إذا نحر حساب معدل كتلة الجسم . استعمل السؤال و-1 بالسؤال و-2. لا تجب عن السؤال و-2 إذا كنت الاجابة على السؤال و-1.</p>	
F2	<p>و. محيط كتلة (بطانة) الساق (بالمستقيم)</p> <p>0 = أقل من 31 سم 1 = 31 سم أو أكثر</p>
<p>مجموع النقاط المحرزة في المسح الأولي (الحد الأقصى 14 نقطة)</p> <p>12-14 نقطة : الحالة الغذائية طبيعية. 8-11 نقطة : معرض لخطر سوء تغذية. 0-7 نقطة : حالة سوء تغذية.</p>	

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لمزيد من المعلومات : [www.mna-shortform.com](http://www.mna-shortform.com)

مقياس قلق الشيخوخة				
فيما يلي قائمة من الأعراض الشائعة لحالة القلق أو التوتر. يرجى قراءة كل بند في القائمة بعناية واختيار الجواب المناسب بوضع إشارة				
طوال الوقت	في معظم الأحيان	أحيانا	على الاطلاق	
				قلبك ينبض بشدة .
				كانت أنفاسك قصيرة .
				كان لديك اضطراب في المعدة
				شعرت أن الأمور لم تكن حقيقية أو كأنك خارج من نفسك .
				شعرت كأنك فاقد السيطرة .
				كنت خائفا من الحكم عليك من قبل الآخرين .
				كنت تخشى المهانة والخرج .
				كان لديك صعوبة في النوم .
				كان لديك صعوبة في البقاء نائما .
				كنت عصبي .
				كان لديك نوبات غضب .
				كان لديك صعوبة في التركيز .
				كنت تذهل أو تستاء بسهولة .
				كنت مهتماً أقل في القيام بشيء كنت تستمتع به عادة .
				شعرت بأنك منفصل أو منعزل عن الآخرين .
				شعرت وكأنك كنت في حالة ذهول .
				كان لديك صعوبة في الجلوس في مكان واحد .
				قلقت أكثر من اللازم .
				لم تستطع أن تتحكم بالأمور
				شعرت بأنك لا تستطيع البقاء مكانك أو متوتر أو على أعصابك .
				شعرت بالتعب .
				كنت تشعر بتوتر عضلات .
				كان لديك آلام في الظهر، أو في الرقبة، أو تشنجات في العضلات .
				شعرت وكأنك لم يكن لديك السيطرة على حياتك .
				شعرت أن شيئا رهيبا سيحدث لك
				لقد كنت قلقا حيال المسائل المادية .
				لقد كنت قلقا على صحتك .
				لقد كنت قلقا على أطفالك .
				كنت تخشى الموت .
				كنت تخشى أن تصبح عبئا على عائلتك أو الأطفال .

تحت الجواب المطابق لعدد المرات التي شهدت كل الأعراض خلال الأسبوع الماضي، بما في ذلك اليوم.