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Assessment of the SABAS cutoff point based on studies in problematic smartphone use

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Introduction: The SABAS is a single-factor measure of problematic smartphone use, with higher scores indicating a potential addictive tendency. Some researchers (Peng et al., 2023) suggest a cutoff point of 23 out of a maximum available score of 36. Other researchers consider a high mean a guideline without suggesting a possible threshold. This score will indicate the presence of the problematic factor under investigation, regardless of age.

Objectives: Our study aims to identify a score for problematic smartphone use that may already indicate vulnerability to addiction. The research investigates the proposal of a possible cutoff point for problematic smartphone use based on several SABAS surveys over 9 years.

Methods: In our research, 1228 participants completed four online surveys between 2015 and 2023. The age distribution was 9-73 years, with 41.2% male and 58.8% female. Our research instrument was the Smartphone Application-Based Addiction Scale (Csibi et al., 2018) questionnaire, a 6-question questionnaire designed to detect problematic smartphone use. We hypothesized that SABAS scores that show a significant relationship with cutoff scores of clinical questionnaires with convergent validity (NMP-Q, SPAI, SHAI, FNPQ) could be as cutoff scores within the measure.

Results: Our results showed a significant correlation between SABAS and NMP-Q scores ($r(238) = .63$, $p = .001$), with the mean of the moderate-severity nomophobia score (88.5 points) being the mean of the SABAS 23 score. For the response distribution corresponding to the NMP-Q prevalence of severe nomophobia (100 points or more), the SABAS score mean was 29 points. The mean scores on the SPAI questionnaire were 85.82 (*SD*=22.76) and 97.17 (*SD*=31.65), respectively, for the subscales Functional Impairment 22.47 (*SD*=8.41) and 27.29 (*SD*=9.59), Compulsive Behaviour 29.48 (*SD*=9,03) and 34.41 (*SD*=11.64), Withdrawal 21.77 (*SD*=6.41) and 23.41 (*SD*=8.55), and Tolerance 12.10 (*SD*=3.61) and 12.05 (*SD*=4.64). The correlation was also evident for the SHAI ($r(439) = .67$, $p = .001$), its subscales, and the FNPQ scale ($r(398) = .27$, $p = .001$).

Conclusions: The mean SABAS score indicating problematic smartphone use was 23 points, with scores above this point indicating increasingly severe use of analyzed behavior. Those with a score of severe nomophobia scored 29 or higher on the SABAS scale. The SABAS shows a significant relationship with the cutoff scores of the convergent validity questionnaires along the mean scores indicated above (23,29), so we suggest using these scores as cutoffs.

Disclosure of Interest: None Declared

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Gone with the Protocol: Searching for unpublished documents from unregistered clinical trials

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Introduction: Trial protocols and manuals are critical documents outlining core elements of a clinical trial, such as theoretical background, recruitment strategies, intervention structure and components, and control comparators. Availability of these documents is essential as it prevents trial duplication, helps detect or avoid research misconduct, and facilitates tracking of trial results. Moreover, a detailed description of intervention components is crucial for the methodological rigor of advanced meta-research approaches, such as component network meta-analysis (cNMA). However, clinical trials often fail to make these documents publicly accessible, either before or after the trial ends, for instance as supplementary materials to publications. Attempts to obtain these documents by contacting researchers directly are frequently unsuccessful. Therefore, alternative avenues for retrieving these materials must be explored.

Objectives: This study aims to assess the feasibility of retrieving trial protocols and manuals through alternative sources, such as ethics committees/IRBs, funding bodies, and sponsors.

Methods: In the context of a cNMA on psychotherapeutic interventions for eating disorders, we identified 34 published studies (12 on anorexia nervosa and 22 on bulimia nervosa); for each, we reviewed the full-text publications to identify potential sources to retrieve trial protocols and manuals. To this end, we adopted a systematic, stepped approach, investigating: 1) explicit mentions of published trial protocols; 2) trial registration details, including ethics committees/IRBs; 3) institutions or clinics whose ethics committees approved the protocol; 4) specific trial sites or study sponsors/funders; 5) first author's affiliation.

Results: Of the 34 publications analyzed: 1) 2 studies had published trial protocols; 2) 11 studies were registered in trial databases and reported ethics committee or IRB details; 3)16 studies identified the ethics committee or IRB that approved the protocol; 4) 26 studies reported one or more specific trial sites or funding bodies/sponsors; 5) 31 studies provided the first author's institutional affiliation.

Overall, 26 studies had at least one contact associated with organizations that would have reviewed the trial documents, and 31 studies had at least one institutional contact potentially connected to the trial's documentation. For 3 studies no information on ethics committees, trial site, or author affiliation was available.

Conclusions: Despite the recognized importance of making trial protocols publicly available, spontaneous dissemination remains rare in clinical trials on psychotherapeutic interventions. In the absence of published protocols or trial registration details, our feasibility study highlights that full-text publications of trial results can offer multiple potential points of contact that may provide access to such documentation.

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