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Research / Araştırma

Validity and Reliability of the Turkish Version of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17"

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ABSTRACT

Validity and reliability of the Turkish version of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17"

Objective: This study aimed to assess the validity and reliability of the Turkish version of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17".

Method: Study group consisted of 36 patients, who have been treated in a child psychiatry unit and diagnosed with agoraphobia, and 100 healthy volunteers who have been secondary and highschool students. For the assessment, the Screen for Childhood Anxiety and Related Emotional Disorders (SCARED) was used along with the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17".

Results: Regarding reliability analyses, Cronbach's alpha internal consistency coefficient was calculated as 0.929. Test-retest correlation coefficient was 0.566. For concurrent validity, the measure showed a high correlation with the SCARED. In ROC analysis, area under ROC curve was calculated as 0.934.

Conclusion: It was concluded that Turkish version of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17" could be used as a valid and reliable tool both in clinical practice and for research purposes.

Keywords: DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17", reliability, validity

ÖZET

DSM-5 Agorafobi Şiddet Ölçeği Çocuk Formunun Türkçe güvenilirliği ve geçerliliği

Amaç: Bu çalışmada DSM-5 Agorafobi Şiddet Ölçeği Çocuk Formunun Türkçe sürümünün güvenilirliği ve geçerliliğinin değerlendirmesi amaçlanmıştır.

Yöntem: Araştırma grupları çocuk psikiyatri kliniğinde tedavi gören ve agorafobi tanısı alan 36 hasta ile ortaokul ve lise öğrencilerinden oluşan 100 sağlıklı gönüllüden oluşmaktadır. Değerlendirmede Agorafobi Şiddet Ölçeği Çocuk Formunun yanı sıra Çocukluk Çağı Anksiyete Tarama Ölçeği kullanılmıştır.

Bulgular: Güvenilirlik analizlerinde Cronbach alfa iç tutarlılık katsayısı 0.929'dur. Test- yeniden test bağıntı katsayısı r=0.566 olarak hesaplanmıştır. Birlikte geçerlilikte Çocukluk Çağı Anksiyete Tarama Ölçeği ile yüksek düzeyde bağıntı göstermiştir. ROC analizinde eğri altında kalan alan 0.934'dür.

Sonuç: Agorafobi Şiddet Ölçeği Çocuk Formunun Türkçe sürümünün hem klinik uygulamada hem araştırmalarda güvenilir ve geçerli biçimde kullanılabileceği gösterilmiştir.

Anahtar kelimeler: DSM-5 Agorafobi Şiddet Ölçeği, güvenilirlik, geçerlilik

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INTRODUCTION

Agoraphobia is an anxiety disorder characterized by significant fear and anxiety about multiple situations in which one thinks that escape might be difficult or help might not be available in the event that panic-like symptoms or other incapacitating symptoms appear. The situations causing agoraphobia are effectively avoided; either a companion is needed or the situation is endured with intense fear and anxiety.

The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. This fear and anxiety are disproportionate to the real danger posed by the agoraphobia sources and to the social and cultural context (1).

Approximately 1.7% of adolescents and adults are diagnosed with agoraphobia each year (1). In a study, performed in a clinical sample of children and adolescents, consisting of 280 consecutive admissions, agoraphobia rate was found as 5.7% based on DSM-IV; and the mean age of onset of agoraphobia was 7.2 years (2). In another clinical sample, it was reported that agoraphobia was diagnosed in 15% of the sample (3). In the studies conducted in the community sample, it has been reported at varying rates of 3.5% to 12.3% (4,5).

Agoraphobia has been associated with impairment in daily functioning and other psychiatric disorders such as depression, substance abuse, and suicidality when it is left untreated. The earlier the psychopathology starts, the more resistant symptoms and the further deterioration in functioning it causes. Therefore early detection and treatment of agoraphobia started in childhood is important (6-9). In our country, there is no specific self-report measure that can evaluate agoraphobia severity in children and that could be used in monitoring.

DSM, the most commonly used system in the categorization of psychiatric illnesses and disorders, published and periodically renewed by the American Psychiatric Association, has been released as the fifth edition (1). In this edition, changes have been made to the diagnostic criteria for agoraphobia. The category of "agoraphobia without history of panic disorder" has been added. In the new case, agoraphobia is not a syndrome anymore, it is defined as a disorder that could be solely coded–with or without panic disorder (1). With the release of the DSM-5 in 2013, new measures adapted to the DSM-5 criteria have been proposed for both determining the severity of the illnesses and also monitoring the progress (10).

"Severity Measure for Agoraphobia—Child Age 11–17" is a 10-item measure assessing the severity of agoraphobia symptoms in children and adolescents aged 11-17. It has been designed to be used in the initial assessment and treatment process of children and adolescents diagnosed with (or having symptoms of) agoraphobia (10). The first 5 items of the scale are related to the anxiety and fear when the object or situation is faced, and the second 5 deal with the avoidance behavior against the object or situation. It has been found valid and reliable in a study conducted in a community sample of 8-13 year old children in the Netherlands (11).

The purpose of this study is to evaluate the reliability and validity of the Turkish version of the "Severity Measure for Agoraphobia—Child Age 11–17".

METHOD

In order to perform the adaptation study of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17" to the Turkish language, at first, permission was obtained by HYB Publishing and Boylam Psychiatric Institution, which possess the rights of translation and publishing of DSM-5. The translation of the scale was conducted by two pediatric psychiatrists, working in the field of child and adolescent mental health, and an adult psychiatrist working in the field of mental health. After it has become an agreed text with regard to the congruence of meaning, language use, cultural and conceptual appropriateness, and orthographic rules, it was translated back into English by an adult psychiatrist. Back-translation was compared with the original measure and was checked whether it met the original concepts. Once it was approved, the scale's text was composed.

Sample Group

The patients being followed at Celal Bayar University Pediatric Psychiatry Outpatient Clinic and healthy volunteers formed the study sample.

School children composed the community sample representing the low-risk group in psychiatric terms. In order to have an adequate sample size for the statistics,

the number of subjects in the sample group should be at least 5-10 times of the number of items in the measure (12). For this purpose, the number of healthy students was determined as 100. In the control group, the inclusion criteria were; being at the ages of 11-17, not meeting any mental or physical illness diagnosis criteria, and having cognitive competence to perform the study guideline.

The clinical sample representing the higher psychiatric risk group consisted of 36 adolescents aged between 11 and 17 years that admitted to the Department of Child Psychiatry of the Celal Bayar University Faculty of Medicine and were diagnosed with agoraphobia. The diagnoses of the patient group based on the DSM-5 diagnostic criteria were made via clinical interview. Admission criteria for the study include being at ages of 11–17, meeting the agoraphobia diagnostic criteria according to the DSM-5, and having the mental capacity to perform the study guideline. Exclusion criteria were having a physical or neurological disease that requires continuous treatment.

Written consent was obtained from all the children and their parents who participated in the study. The ethical committee approval of the study was obtained from the Celal Bayar University Faculty of Medicine Clinical Investigations Evaluation Committee.

Measures

The DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17": It is a 10 item measure. It provides an assessment on a five-point Likert type scale (0=Never; 1=Occasionally; 2=Half of the time; 3=Most of the time, and 4=All of the time). The subject is asked to rate the severity of the agoraphobia symptoms within the last 7 days. The total score ranges from 0 to 40, with a higher score indicating greater agoraphobia severity (10).

The Screen for Childhood Anxiety and Related Disorders (SCARED): It has been developed by Birmaher et al. (13), for the purpose of screening childhood anxiety disorders. Turkish validity and reliability study of the SCARED was made by Çakmakçı (14), and it has a parent and a child form. SCARED consists of 41 items and a score of 25 is considered to serve as a warning sign for anxiety disorder. The scale also includes somatic/panic, generalized anxiety, separation anxiety, social phobia and school phobia subscales (14).

Statistical Analyses

The methods used to determine the psychometric characteristics of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17" are as follow:

In the statistical evaluation, at first, to ensure there are no differences between the study groups from a clinical or a socio-demographic perspective, t-test was applied to numerical variables and Chi-square test to categorical variables. Pearson correlation test was used to determine the level and the direction of the relationship between the numerical variables. A correlation power of 0.4 was considered as low level, 0.4 to 0.69 moderate level, 0.7 and above was considered as the high level of correlation. A p value of <0.05 was considered statistically significant in all analyses.

In the reliability analysis of the measure, the Cronbach's alpha internal consistency coefficient was calculated. Values between 0.00-0.40 were considered as 'not reliable', values between 0.40-0.60 'barely reliable', values between 0.60-0.80 'moderately reliable', and values between 0.80-1.00 were considered as 'highly reliable'.

In the reliability analyses of the measure, the test-retest consistency coefficients were calculated.

In the study, 42 healthy volunteers were administered the "Severity Measure for Agoraphobia—Child Age 11–17" a second time two weeks after the first administration and the test-retest correlation coefficients were used to establish the consistency of the test over the time.

For the construct validity of the scale, the data from all the study groups were used to set both an exploratory and a confirmatory factor analysis. Exploratory factor analysis was executed in accordance

with the Principal Component Analysis procedure, using Varimax Orthogonal Rotation and considering factors whose eigenvalues were greater than 1. The factors with factor loadings of 0.4 and above were taken into consideration. Exploratory factor structure was compared with the scale's original dimensional structure. In the case of the confirmatory factor structure, during the assessment of model suitability and the data's consistency model, different types of "goodness-of-fit" indexes were used (root mean square error of approximation [RMSE] and comparative fit index [CFI]).

In terms of concurrent validity, the correlation between "Severity Measure for Agoraphobia—Child Age 11–17" and Screen For Childhood Anxiety and Related Emotional Disorders was examined.

The ability to distinguish between community and clinical samples was shown by the ROC (Receiver Operating Characteristic) Curve. The area under the ROC curve is 0.9 and above indicates that the measure is well distinguished, while the range of 0.8-0.9 is considered as acceptable.

RESULTS

The study was conducted on 36 patients who admitted to the Celal Bayar University Child Psychiatry outpatient clinic and were diagnosed with agoraphobia, and 100 healthy volunteers. All subjects with agoraphobia had a comorbid diagnosis as well. Comorbid diagnoses were panic disorder (n=28), separation anxiety disorder (n=10), social anxiety disorder (n=8), specific phobia (n=4), generalized anxiety disorder (n=3), and attention deficit hyperactivity disorder (n=3). The socio-demographic and clinical characteristics of the study groups are shown in Table 1.

Reliability Analyses

The Cronbach's alpha internal consistency coefficient of the "Severity Measure for Agoraphobia—Child Age 11–17" was 0.929. The Cronbach's alpha coefficient for each item is shown in Table 2. Item-total score correlation coefficients ranged 0.488-0.783 (Table 2). In the test-retest, data of the 42 volunteers

Table 1: Socio-demographic characteristics of the study groups

	Agoraphobia Group n=36		Control Group n=100	
	Mean	**SD**	**Mean**	**SD**
Age (year)	14.9	1.6	15.7	1.1
	n	**%**	**n**	**%**
Sex				
Female	23	63.9	42	42.0
Male	13	36.1	58	58.0
Academic Status				
Attending School	36	100	100	100
Not Attending School	0	0	0	0
Disease Duaration				
Newly Diagnosed	11	30.6		
1-6 months	25	69.4		
>6 months	0	0		
Medication				
Antideppressant	25	69.4		
Antipsychotic	5	13.8		
Benzodiazepin	3	8.3		
	Mean	**SD**	**Mean**	**SD**
Scores of the Applied Measure				
Severity Measure for Agoraphobia—Child Age 11–17	18.8	6.6	4.0	6.0
Screen for Childhood Anxiety and Related Emotional Disorders	44.9	12.1	21.8	13.9

SD: Standard deviation

Table 2: Item-total score correlation coefficients, Cronbach's alpha coefficients, and factor loading of the items of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17"

Scale Item	Item-Total score coefficient	Cronbach's alpha coefficient	Factor 1	Factor 2
Agoraphobia 1	0.783	0.919	0.709	
Agoraphobia 2	0.783	0.919	0.812	
Agoraphobia 3	0.772	0.920	0.682	
Agoraphobia 4	0.774	0.920	0.753	
Agoraphobia 5	0.740	0.921	0.845	
Agoraphobia 6	0.718	0.923		0.886
Agoraphobia 7	0.735	0.922		0.907
Agoraphobia 8	0.734	0.922		0.731
Agoraphobia 9	0.711	0.923		0.737
Agoraphobia 10	0.488	0.933	0.666	

Table 3: Two factor confirmatory factor analysis results of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17"

Fit test	Fit values of the DSM-5 Severity Measure for Agoraphobia—Child Age 11–17
CFI*	0.927
RMSEA**	0.128

*CFI: Comperative Fit Index, **RMSEA: Root Mean Square Error of Approximation

were appropriate for evaluation and the correlation coefficient between the two-week applications was found as r=0.566 (p<0.0001).

Validity Analyses

In order to demonstrate construct validity, exploratory factor analysis was applied to the "Severity Measure for Agoraphobia—Child Age 11–17". In the Kaiser-Meyer-Olkin analysis, performed before the exploratory factor analysis to evaluate the adequacy of the sample size, the coefficient was obtained as 0.893. Chi-square was calculated as 1029.753 in the Bartlett Test (p<0.0001). It indicates that the size of the sample group is suitable for factor analysis. Factor analysis yielded two factors with the eigenvalue greater than 1 (Table 2). Eigenvalue of the first factor is 6.137, accounting for 61.4% of the total variance. The first 5 items and the 10th item of the scale loaded on the first factor. These are the items related to fear and anxiety about the situation. The second factor has an eigenvalue of 1,106 and accounts for 11.1% of the total variance. Sixth, 7th, 8th, and 9th items loaded on the second factor. These items contain questions about the avoidance behavior. The factor loadings are given in Table 2.

The distribution of the sample group was examined in the confirmatory factor analysis performed to reveal the scale's construct validity. In the confirmatory factor analysis for the model constructed to fit the scale's bi-dimensional structure, CFI and RMSEA values were calculated as 0.927 and 0.128, respectively (Table 3).

In the ROC analysis of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17" involving the agoraphobia group and the control group, the area under the ROC curve was found to be 0.934.

Since the SCARED does not comprise an agoraphobia subscale, in the concurrent validity analysis of the "Severity Measure for Agoraphobia—Child Age 11–17" and the SCARED, the correlation between total scale scores was examined. The correlation coefficient was found as r=0.681 p<0.0001.

DISCUSSION

In this study, the adaptation, reliability and validity of the Turkish version of the DSM-5 "Severity Measure for Agoraphobia—Child Age 11–17" were investigated and the Turkish version was proven to be applicable.

Since it is an assessment of the homogeneity of the items used in the measure, having a high internal consistency reliability coefficient is important. In psychometric evaluations, the closer the Cronbach's alpha coefficient is to 1, the more reliable the measure

is accepted (15). In the original development study of the measure, the Cronbach's alpha coefficient in the adult age group was found to be 0.89 in the community sample and 0.98 in the clinical sample (16). Cronbach's alpha coefficient was 0.84 in the reliability study conducted in the child age group (11). In our study, the internal consistency Cronbach's alpha coefficient of the measure was 0.929 which is high; and proves that the construct of the measure represents the whole suitably. It is desirable for the item-total score correlation coefficient to be over 0.2 for each item (15). The item-total score correlation coefficients were also found at a high level, proving that the measure's construct is reliable. One of the methods used in reliability analysis is to determine whether the person who answered the measure can respond to the measure in the same way when the application is repeated. The correlation coefficient evaluated for this purpose is expected to show a positive and high correlation (17). The test-retest correlation coefficient applied after two weeks is r=0.566. It is high and statistically significant. When all these findings are taken into consideration, it is concluded that the measure can be reliably used.

Correlation with the SCARED was examined in the concurrent validity analysis. In a study performed with the original measure, correlation with the subscales of the SCARED was analyzed and the correlation coefficients were found between 0.31-0.49 (11). Whereas, in our study, it was highly correlated (r=0.681) with the total scale score of SCARED which was statistically significant. The concurrent validity of the measure also supports that the measure can be used validly.

In our study, two factors were obtained in factor analysis. It is not compatible with the original one-factor structure of the scale (11,18). The first 5 items consisted in the scale are related to the fear and the anxiety arising from the encountered situation and the second 5 items are related to the avoidance of these situations. Although the 2-factor structure found in our study is different from the original structure, it is consistent with the context of the scale. Confirmatory factor analysis result also supports 2 factor structure (CFI=0.927). The RMSEA value was found to be 0.128, indicating that the error rate is above the acceptable level. It is considered that the error rate was above the acceptable value due to the fact that all cases constituting the clinical sample had co-morbid diagnosis, and that 69.4% of the cases had to continue treatment and were partly symptomatic cases.

The first limitation of this study is the fact that the number of symptomatic patients is relatively low and all of the subjects had a co-morbid diagnosis. Another limitation of the study is that in the control group a structured clinical interview was not used for diagnostic evaluation. In addition, age and gender differences between the patient group and the control group should be taken into consideration when evaluating the differences in comparative analysis in terms of scale items. It was possible to perform all statistical analyzes completely with the used sample size. The strength of the study is that the sample group represents the patients, so the clinical usability of the measure was demonstrated.

Both the concurrent validity and the construct validity of the measure support that the measure can be used validly.

Contributions category	**Authors name**
Development of study idea	O.A., E.K., S.Y.S., H.O.E.
Methodological design of the study	O.A., E.K., S.Y.S., D.E., N.S.C., D.K., M.O., H.O.E.
Data acquisition and process	M.O., D.E., N.S.C., D.K.
Data analysis and interpretation	O.A., S.Y.S., H.O.E.
Literature review	M.O., D.E., N.S.C., D.K.
Manuscript writing	O.A., S.Y.S., H.O.E.
Manuscript review and revisation	O.A., E.K., S.Y.S., D.E., H.O.E., N.S.C., D.K., M.O.

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