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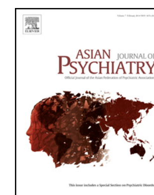

Psychometric properties of translated outcome measures of cognitive behavioural therapy for psychosis in the Chinese context

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ABSTRACT

Objectives: Growing evidence supporting the use of Cognitive Behavioural Therapy (CBT) to improve outcomes in patients with psychosis has largely originated from American and European countries, its applicability and effectiveness in Chinese patients with psychosis is still under-explored. However, the lack of stable and reliable outcome measures to evaluate the effectiveness of CBT for patients with psychosis hinders further development of psychological intervention in patients with psychosis in the Chinese context. The present study therefore aims to translate selected outcomes measures developed in American and European countries to measure the effectiveness of CBT for psychosis into Chinese and evaluate their psychometric properties.

Methods: Thirty-three patients with residual psychotic symptoms were recruited in the Department of Psychiatry, Kowloon Hospital, Hong Kong. Participants were asked to complete a set of self-reported questionnaires twice with an interval of a week, including Beliefs About Voices Questionnaire-Revised (BAVQ-R), Beck Cognitive Insight Scale (BCIS) and Southampton Mindfulness Questionnaire (SMQ).

Results: The results found that the Chinese versions of BAVQ-R, BCIS and SMQ had excellent test-retest reliability with good to acceptable internal reliability.

Conclusions: Generally, all three translated outcome measures were found to be stable and reliable, and were ready for evaluating the effectiveness of cognitive therapy for psychosis in the Chinese population. Further discussions on scoring and interpretations of the Chinese version of SMQ were made.

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1. Introduction

Cognitive models of schizophrenia have developed from a vulnerability-stress model (Zubin and Spring, 1977). It postulates that the development of psychotic symptoms such as delusion and hallucination is a result of interaction of biological vulnerability and stress. Once the symptoms have developed, patients' dysfunctional appraisal towards their experiences, cognitive inflexibility as well as maladaptive coping strategies may lead to symptom exacerbation and maintenance (Chadwick and Birchwood, 1994; Garety et al., 2005, 2001). Based on the above, changing patients' dysfunctional appraisals and behavioural responses towards psychotic experiences is understood as a way to lessen their symptoms' severity and the associated distress level, and is also regarded as the cornerstone of cognitive behavioural therapy (Hagen and Turkington, 2011). Since the last century, evidences ranging from a single case study (Beck, 1952), empirical studies (Chadwick and Birchwood, 1994; Chadwick and Lowe, 1990) to randomized controlled trials (Haddock et al., 2009; Kuipers et al., 1998, 1997; Sensky et al., 2000) have indicated the effectiveness of using cognitive behavioural therapy for patients with psychosis. Since most of the efficacy and effectiveness studies have been completed in American and European countries, the applicability and effectiveness of cognitive behavioural therapy for psychosis (CBTp) in the Chinese context is still questionable. Although Ng et al. (2003) reported a series of case studies to show the effectiveness of using CBT to reduce severity of psychotic symptoms and distress among patients with resistant delusion, it has still been difficult to conclude that CBT for psychosis is effective, and to support a widespread adoption in clinical practice without rigorous local research. In order to facilitate such development of CBT for psychosis in the Chinese context, having reliable and relevant assessment tools seems important and

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essential. In Ng et al.'s study, the only objective measure used was the Brief Psychiatric Rating Scale to measure the severity of psychotic symptoms, whereas the core elements of change process such as beliefs towards psychotic experiences, awareness of cognitive process and ways to react to the abnormal experiences underlying CBT for psychosis were under-evaluated. Moreover, limited local studies have been conducted to translate or examine related instruments measuring the abovementioned change process in CBT for psychosis except a study in Taiwan which translated the Beck Cognitive Insight Scale into Taiwanese and examined its' psychometric properties (Kao and Liu, 2010). The aims of the present study therefore are twofold. First, selecting and translating three self-report measures which address the change process underlying CBTp into Chinese, they are: (1) Beliefs about voices scale-revised (BAVQ-R) which measures people's beliefs towards auditory hallucination, and their emotional and behavioural reactions to them (Chadwick et al., 2000); (2) Beck Cognitive Insight Scale (BCIS) measuring people's capacity and willingness to observe their mental process and consider alternative explanations, as well as their overconfidence in making interpretations on their experiences (Beck et al., 2004), (3) Southampton Mindfulness Scale which assesses people's relationship with distressing beliefs and images (Chadwick et al., 2008). Second, evaluating the psychometric properties of the Chinese versions of BAVQ-R, BCIS and SMQ in preparing for future effectiveness studies of CBTp in the Chinese context.

2. Method

2.1. Instruments

2.1.1. The Beliefs about Voices Questionnaire-Revised (BAVQ-R; Chadwick et al., 2000)

This is a 35-item self-report questionnaire designed to assess key beliefs and responses people have related to their voice(s). The scale comprises three subscales relating to the beliefs about voices: (1) malevolence (e.g. "my voice is evil"); (2) benevolence (e.g. "My voice wants to help me") and omnipotence (e.g. "My voice is very powerful"). Two additional subscales of (1) resistance (e.g. "My voice frightened me, I try and have to stop it") and (2) engagement (e.g. "My voice made me feel calm, I seek the advice of my voice") are included to measure people's behavioural and emotional responses to the voices. All responses are rated on a 4-point scale: disagree (0); unsure (1); agree slightly (2) and agree (3). The range of score for the subscales of malevolence, benevolence and omnipotence is 0–18, a higher score represents a stronger belief in each area. The range of score for the subscale of resistance is 0–27, people with a higher score have more resistance to the voices. People with a higher score for the subscale of engagement (range 0–24) engage more with the voices. The scale was found to be a reliable measure and sensitive to individual difference. The mean Cronbach's α for the five subscales was 0.86 (range 0.74–0.88) (Chadwick et al., 2000).

2.1.2. Beck Cognitive Insight Scale (BCIS; Beck et al. (2004))

This is a 15-item self-report questionnaire measuring patients' capacity and willingness to observe their mental productions and to consider alternative explanations, as well as their overconfidence in the validity of their beliefs. The scale comprises 2 subscales: self-reflectiveness (e.g. "I have jumped to conclusions too fast") and self-certainty (e.g. "My interpretations of my experiences are definitely right"). A composite index of the BCIS reflecting cognitive insight is calculated by subtracting the score from the self-certainty scale from that of the self-reflectiveness scale. Patients are asked to rate how much they agree with the statement in the questionnaire. All responses are rated on a 4-point scale ranging from 0 (do not agree at all) to 3 (agree completely), and the total range of score is −18 to 27, the higher the score, the better the cognitive insight. The scale demonstrated good convergent, discriminant, and constructive validity (Beck et al., 2004). The Cronbach's α for the subscales of self-reflectiveness and self-certainty were 0.68 and 0.60, respectively (Beck et al., 2004).

2.1.3. Southampton Mindfulness Questionnaire (SMQ; Chadwick et al., 2008)

This is a 16-item self-report questionnaire assessing relationship with distressing thoughts and images. The SMQ can be understood as a single factor structure consisting four related bipolar constructs: (1) decentred awareness of cognitions as mental events versus being lost in reacting to them; (2) allowing attention to remain with difficult cognitions versus experiential avoidance; (3) accepting difficult thoughts/images and oneself versus judging cognitions and self, and (4) letting difficult cognitions pass without reacting versus rumination/worry. All responses are scored on a 7-point Likert scale, ranged from strongly disagree (0) to strongly agree (6), yielding a total range of score of 0–96 (i.e. a higher score indicates being more mindful towards distressing thoughts and images). Amongst items, eight items are framed positively, eight negatively. The SMQ was found to be internally reliable ($\alpha = 0.85$) with adequate concurrent and discriminant validity (Chadwick et al., 2008).

2.2. Translation

Permission was granted from the original authors to translate the three scales. The repeated forward-backward translation procedure was used to translate the BAVQ-R, BCIS and SMQ from English to Chinese. A professional translator with a background of psychology studies was hired to translate the questionnaires into Chinese. An expert group consisting of a clinical psychologist and 2 psychiatrists with experiences in working with patients with psychosis was formed to discuss the translated questionnaires and to resolve any inconsistencies arisen. An independent clinical psychologist then translated the questionnaires back into English and sent them back to the original authors for further revision, the expert group reviewed the revision and discussed a few inconsistencies raised by the original authors and revised them accordingly, which led to the present finalized version.

2.3. Participants

Participants were recruited from the Outpatient, Inpatient and Day-patients psychiatric service in the Department of Psychiatry, Kowloon Hospital, Hong Kong. Participants who met DSM IV diagnostic criteria for schizophrenia; currently experienced residual hallucinations and delusions, had stabilized for medication for at least 6 months and were aged between 16 and 60 would be invited to participate in the study. Patients who had a history of substance abuse, were mentally retarded and illiterate would be excluded from the study. All eligible participants would be interviewed by an independent psychiatrist to assess their ability to give informed consent, and who failed to give informed consent would be excluded from the study. All participants would be briefed about the purpose and procedure of the study, and would also be reminded that they had the rights to freely withdraw from the study anytime.

2.4. Clinical measures

2.4.1. Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987)

The scale has been widely used to assess the symptom of psychosis (Kay et al., 1987) and was used to assess participants'

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