



# Continuum beliefs about psychotic symptoms are a valid, unidimensional construct: Construction and validation of a revised continuum beliefs questionnaire



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## ABSTRACT

Growing evidence supports a continuum model of psychosis, with mild psychotic symptoms being frequently experienced by the general population. Moreover, believing in the continuum model correlates with less stigmatization of schizophrenia. This study explores whether continuum beliefs are a valid construct and develops a continuum beliefs scale. First, expert-generated items were reduced to a candidate scale (study 1,  $n=95$ ). One-dimensionality was tested using confirmatory factor analysis (study 2,  $n=363$ ). Convergent validity was tested with a previous continuum beliefs scale, essentialist beliefs, and stigmatization (study 2), while self-reported psychotic experiences (i.e. frequency and conviction) served to test discriminant validity (study 3,  $n=229$ ). A nine item questionnaire that assesses continuum beliefs about schizophrenia symptoms showed acceptable to good psychometric values, high correlations with a previous continuum beliefs scale and small correlations with essentialist beliefs, stereotypes, and desired social distance. No correlations with psychotic experiences were found. Thus, continuum beliefs can be considered a valid construct. The construed CBQ-R asks about symptoms rather than the abstract category "schizophrenia", which may increase understandability of the scale. Validation confirms previous studies and highlights the difference between continuum beliefs and personal psychotic experiences.

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## 1. Introduction

In early psychopathological theory, psychotic symptoms were depicted as being qualitatively different from normal experiences and thus not accessible by means of rational interpretation (Jaspers, 1913). Delusions within schizophrenia, for example, were commonly seen as an expression of a fundamentally different kind of existence, the "schizophrenic existence" (Kunz, 1931). Jaspers (1913) inferred that delusions constitute a "completely alien mode of experience" that "is impossible [...] to be understood in its [individual] genesis". Even to this day, some researchers continue to stress the alleged otherness of psychotic symptoms and infer them to be uncorrectable by interpersonal interaction of any kind, including psychotherapy (Moldzio, 2004). Thus, the perceived otherness of persons with a diagnosis of schizophrenia has played a prominent role from the beginning of its existence in the early 20th century.

Contemporary research, however, demonstrates that qualitative differences between people with schizophrenia and the rest of

society may not exist in the proposed form: It has been shown that as much as 10% of the population report to experience delusions more frequently than the average patient with schizophrenia (Van Os et al., 2009). Similarly, about 16% of population samples report to have experienced mild verbal hallucinations. Of importance, these people neither feel distressed by their experiences, nor do they meet criteria of functional impairment because of them (Stefanis et al., 2002; van Os et al., 2009). Thus, beliefs into the qualitative difference of schizophrenia appear to be grossly inaccurate. A conceptualization of schizophrenia as an artificial category without strict borders, devised to describe a range of extreme values within a continuum of human experiences, is more valid (Rössler, 2013).

Link and Phelan (2001) conceptualized the separation between "us" and "them" as one integral part of stigmatization. In line with this, research on mental illness stigma showed that the origin of stigmatization can be thought of as observation and subsequent labeling of differences between groups (Angermeyer and Schulze, 2001). Given the history of highlighting the perceived otherness of people with schizophrenia, categorization may play a dominant role in the social perception of schizophrenia and uniquely

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contribute to discrimination and self-stigma. As a potential remedy, the continuum model of psychosis has been used to educate patients about schizophrenia and subsequently reduce misconceptions and related distress (McGovern and Turkington, 2001; Kingdon and Turkington, 2004). Only recently, however, have researchers turned their attention towards the “belief” in (or agreement with) a continuum model itself as a variable of interest. Schomerus et al. (2013) measured continuum beliefs with one item following a case vignette depicting a person with schizophrenia (“Basically we are all sometimes like this person. It’s just a question of how pronounced this state is”, rated on a 5 point Likert scale) in their initial study as well as its successor (Angermeyer et al., 2014). Wiesjahn et al. (2014) went one step further and developed a 16 item “Continuum Beliefs Questionnaire” to measure agreement with a continuum view.

All of the aforementioned studies found self-reported continuum beliefs to correlate with fewer stereotypes and less discrimination of people with schizophrenia. However, the measurement of continuum beliefs leaves room for improvement. In the continuum beliefs questionnaire used by Wiesjahn et al. (2014) the item-scale correlations were low for the majority of the questionnaire’s items. A likely reason for this is that the content of the scale tapped into a variety of aspects that diverge from the central premise of continuity. For example, a subset of items compared schizophrenia symptoms with symptoms of other disorders (e.g., “it is easier to empathize with anxiety problems than with delusions”). Other items focused on the multidimensionality of symptoms (e.g., frequency and distress: “many people experience psychotic symptoms without feeling distressed”). Thus, while the emerging research on continuum beliefs shows promising results, we have yet to demonstrate that continuum beliefs are a valid construct and we still lack a psychometrically valid way to measure them.

This study aims to construe and validate a continuum beliefs questionnaire and to show that continuum beliefs about schizophrenia are a unidimensional construct. We adopted a three-step approach: In a first step, a surplus of items was generated and presented to a first group of participants. Based on the results of this first test and the participants’ feedback, we selected the items for our revised Continuum Beliefs Questionnaire (CBQ-R). In a second step, the CBQ-R was presented to a large population sample alongside various other measures of stigmatization. Based on this data, we tested one-dimensionality of the CBQ-R with confirmatory factor analysis and explored the convergent validity of the CBQ-R. A third population sample was then recruited to test the association of continuum beliefs and self-reported psychotic symptoms as an additional aspect of discriminant validity.

## 2. Study 1 – Item selection for a revised continuum beliefs questionnaire

### 2.1. Methods

#### 2.1.1. Materials

A list of candidate items for the CBQ-R was developed by the authors and a group of four clinical and research experts in the field of schizophrenia.

Item generation was formally guided by two rules in order to optimize the item content with respect to the construct of continuum beliefs and to avoid tapping into related topics (e.g., a diathesis-stress model of psychosis). In order to be included, items had to describe the continuum or discreteness of psychosis with respect to etiology, prevalence or (treatment) consequence. Furthermore, they had to deal with either schizophrenia itself or certain symptoms of schizophrenia. Thus, we secured that

**Table 1**  
Sample characteristics for the three studies.

	Study 1	Study 2	Study 3
Sample size	95	363	229
Female	49.5%	65.3%	61.6%
Age in years: M (SD)	26.37 (9.50)	27.4 (9.13)	37.3 (15.1)
<b>Education level</b>			
≤ Secondary education	17.8%	7.7%	3.5%
Completed apprenticeship	9.5%	10.2%	13.1%
University entrance diploma (Abitur)	48.4%	44.1%	31.9%
Graduated from university	24.2%	38.0%	49.9%
<b>Occupation</b>			
Student (school)	17.9%	8.6%	3.1%
Student (university)	48.4%	47.1%	31.9%
Employed/self-employed	48.4%	32.2%	48.5%
Unemployed	3.2%	4.1%	2.6%
Retired	–	4.1%	5.2%
<b>Previous knowledge</b>			
(former) Psychology student	11.6%	14.0%	19.7%
(former) Medical student	8.4%	7.4%	3.5%
Had contact to people with mental disorders	33.7%	51.8%	21.0%

generated items only reflect the core idea of continuum beliefs (i.e., the qualitative difference vs. continual nature of schizophrenia with respect to normal cognition and behavior) and that the content of comparisons is restricted to what a lay person may understand (e.g., no comparisons with other psychiatric patients, no inclusion of symptom dimension distinctions).

#### 2.1.2. Participants

Ninety-five participants were recruited via facebook advertisement and met the inclusion criterion of being at least 18 years old. Sample characteristics are shown in Table 1.

#### 2.1.3. Procedure

An online study was designed using QuestBack EFS Survey 10.3 (formerly Unipark; QuestBack GmbH, 2014). Cookies were used to prevent repeated participation by the same person.

At the beginning of the study, participants were welcomed and the study was described as a survey on “opinions and attitudes on schizophrenia”. Afterwards, conditions of participation were outlined and the participants gave informed consent. Following this, demographic data was assessed. Next, all items of the continuum beliefs item list were presented in randomized order. Participants had to indicate their agreement with each item on a Likert scale ranging from 1 (“fully disagree”) to 5 (“fully agree”). After completion of the item list, participants were given the chance to comment on specific items and to add a general comment on the questionnaire. Finally, participants were debriefed and thanked for their participation. The completion of the study took 10 min on average. There was no monetary incentive or other compensation for participation.

#### 2.1.4. Strategy for data analysis

All analyses were carried out with R 3.1.1 (R Core Team, 2014). To maximize the internal consistency of the final scale, item selection was based on corrected item-scale correlations of all items. Kline (1986) proposed a minimum sample size of 200 to reliably compute point estimates of item-scale correlations. Furthermore, an item-scale correlation of  $r_{it}=0.20$  is described as a threshold for item exclusion, while  $r_{it} \geq 0.30$  is the lower end of the optimal range for internally consistent item-scale correlations. In order to

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