Psychological Assessment

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Expectations concerning barriers to children's psychosocial care seem to be major drivers when seeking help, but validated questionnaires measuring expectations are not available. Therefore, this study examined the psychometric properties of the parent and adolescent versions of the Barriers to Treatment Participation Scale–Expectancies (BTPS-exp), in terms of consistency, structure, parent–child agreement, and validity. The authors obtained data via questionnaires on 1,382 Dutch children aged 4–18 years (response rate 56.6%) enrolled in psychosocial care, and on 666 children (response rate 70.3%) from the community. Internal consistencies of the BTPS-exp total and subscales of both versions were good (lowest Cronbach's alpha = .85). Fit of the data with the assumed scale structure was acceptable. Correlation coefficients between the parent and adolescent scores were low (Pearson's r total scale = 0.25). Parents expecting multiple barriers was significantly more likely in non-Dutch ethnicity (odds ratio [*OR*] = 1.4; 95% confidence interval [CI] [1.1, 1.9]), in lower parental educational levels (primary education: *OR* = 3.0; 95% CI [1.5, 6.1]; lower-level secondary education: *OR* = 2.0; 95% CI [1.3, 3.1], both vs. university), in single parent families (1.3; 1.1–1.6), in case of child psychosocial problems (*OR* = 1.3; 95% CI [1.0, 1.5]) and in adolescents with psychosocial problems (*OR* = 2.1; 95% CI [1.4, 3.1]). Expecting multiple barriers did not affect the association between psychosocial problems and care enrollment. The authors conclude that the BTPS-exp has good psychometric properties regarding reliability and structure and is reasonably valid. Parents and adolescents have their own separate views, implying that it is valuable to assess both. Use of the scale might be helpful in providing direction to improve access to psychosocial care for children and adolescents.

Keywords: child, adolescent, psychosocial problems, expectations of barriers to care, health services accessibility

Children and adolescents with emotional and behavioral problems constitute approximately 7–24% of the total child population (Briggs-Gowan, Carter, Skuban, & Horwitz, 2001; Merikangas et al., 2010; Patel, Flisher, Hetrick, & McGorry, 2007; Tick, van der Ende, & Verhulst, 2007; Zwaanswijk, van Dijk, & Verheij, 2011). Timely and adequate intervention may prevent them from experiencing adverse consequences of psychosocial problems, such as current and future difficulties in daily functioning (Brugman, Reijneveld, Verhulst, & Verloove-Vanhorick, 2001; Kieling et al., 2011; Patel et al., 2007; Reijneveld, Brugman, Verhulst, & Verloove-Vanhorick, 2004). Only a minority, estimated as 23–38%, actually receive psychosocial care (Brugman et al., 2001; Jansen et al., 2013; Jörg et al., 2012; Kieling et al., 2011; Zwaanswijk et al., 2003; Zwaanswijk, van der Ende, et al., 2005a; Zwaanswijk, Verhaak, et al., 2005b). Barriers to care may be the main reason why not all of these children receive care. Estimates are that 35–61% of the parents experience barriers when accessing psychosocial care for their child (Girio-Herrera, Owens, & Langberg, 2013; Owens et al., 2002).

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In addition to barriers actually experienced when accessing care, parents' and children's expectations regarding such barriers may also play a critical role in seeking and utilizing psychosocial care for the child. In a review, Morrisey-Kane and Prinz concluded that positive expectations toward care, such as the expectation that the child's behavior is changeable or that treatment is effective, were of major importance for successful help-seeking and treatment of children's psychosocial problems (Morrissey-Kane & Prinz, 1999). The importance of expectations regarding barriers is also stressed in Andersen's health behavior model, in which expectations of barriers—as part of the beliefs patients hold—determine patients' need perception and their utilization of health services (Andersen, 1968, 1995, 2008).

To date, there are no reliable or valid measures available to assess expectations regarding barriers. This greatly limits the elaboration and the eventual remedying of barriers that prevent many parents and children from entering care and from participating in treatment after intake. The present study has evaluated a measure referred to as the Barriers to Treatment Participation Scale–Expectancies (BTPS-exp). The BTPS-exp is a modification of the Barriers to Treatment Participation Scale (BTPS), developed and validated by Kazdin and colleagues to measure actual barriers experienced during children's treatment (Kazdin, Holland, Crowley, & Breton, 1997). In the questionnaire, parents are instructed to imagine that they are seeking psychological help, counseling, or advice for the child (Murphy, 2005). The scale reflects both logistical and belief-based expectations of barriers by means of 44 items divided over four subscales: Stressors and Obstacles That Compete With Treatment, Treatment Demands and Issues, Perceived Irrelevance of Treatment, and Problematic Relationship With the Therapist (Girio-Herrera et al., 2013; Kazdin et al., 1997; Thornton & Calam, 2011).

The original retrospective BTPS items have been modified to prospective items. A prospective version enables to obtain insights into the opinions of parents and children in the community, during the various stages of the help-seeking process and the beginning of treatment. To address expectations at the beginning of treatment, use of a prospective version is critically important to prevent potential confounding by the degree of success in the treatment later on, for example, substantial symptom improvement could lead to the retrospective perception of less barriers. A means to reach this is to ask parents about their expectations of barriers before they actually are involved in care or expect to be so. Besides linguistic adaptations, this also requires a reconsideration of the topics covered by the various items because some topics may be difficult to imagine in advance of receiving care. Moreover, assessing expectations at the beginning of treatment is important to predict responses to treatment and therapeutic change. For example, addressing expectations regarding treatment relevance and therapist relationship early in the treatment process might decrease the high number of treatment drop-outs. These types of barriers are important predictors of premature treatment termination (De Haan, Boon, De Jong, Hoeve, & Vermeiren, 2013; De Haan, Boon, Vermeiren, Hoeve, & De Jong, 2015).

For young children, parents will be the sole informant, but for adolescents, they themselves are likely to be important informants as well and they are often decisive in seeking and participating in care (Raviv, Raviv, Vago-Gefen & Fink, 2009). For example, a recent study showed that many parents saw an urgent need for care for their adolescent children, but that the adolescents frequently refused to seek care (Jansen, Wiegersma, Ormel, Verhulst, Vollebergh & Reijneveld, 2013). Therefore, we created, in addition to the parent version, an adolescent version of the BTPS-exp, which previously had not been available for the original or the revised version.

To date, evidence for the validity of the BTPS-exp is lacking. To fill this gap, the aim of this study was to assess its psychometric properties in a Dutch sample of both children and adolescents, in care and in the community. Internal consistency, scale structure, parent-adolescent agreement, and validity were assessed. Addressing fundamental facets of the scale will open avenues of research for better understanding barriers and for procedures that might be used to surmount them.

Method

Study Design

We used data from the first measurement wave of a large prospective cohort study of Dutch children aged 4–18, called *TakeCare* (Nanninga, Jansen, Knorth, & Reijneveld, 2015; Verhage, Noordik, Knorth, & Reijneveld, 2014). TakeCare is conducted by the Collaborative Centre on Care for Children and Youth (C4Youth) and is designed to investigate the trajectories and outcomes of children receiving psychosocial care in a single Dutch region. The design was assessed by the Medical Ethical Committee of the University Medical Center Groningen and approved without requiring full assessment. Informed consent was obtained from all participating respondents.

Sample and Procedure

Between April 2011 and June 2013, parents/caregivers of children aged 4–18 years old, along with children aged 12 years and over, were invited to participate in either the care or the community sample of TakeCare (Nanninga, Jansen, Knorth, & Reijneveld, 2015; Verhage et al., 2014).

For the care sample, 2,664 children and their parents/caregivers were recruited via the main psychosocial care organizations for children in the northeast of the Netherlands, that is, preventive child health care, child and adolescent social care, and mental health care. In the Netherlands, children enter psychosocial care via either their general practitioner, the youth care office, or preventive child health care. The general practitioner and doctors and nurses in preventive child health care may provide light parenting support or refer to more specialized care, that is, either child and adolescent social care, which is primarily provided by child (social) workers, or mental health care, which is primarily provided by child psychologists and psychiatrists (Reijneveld et al., 2014).

Children with insufficient understanding of Dutch, living outside the northern region, or following special education because of intellectual disability were excluded (n = 223). Of the eligible 2,441 respondents, 1,382 participated, that is, either the child and/or the parent (response 56.6%). Differences between respondents and nonrespondents were small regarding age, gender, degree of urbanization, and psychosocial problems, with Cohen's effect sizes ranging from 0.01 (age) to 0.12 (degree of urbanization).

The community sample (n = 1,025) concerned a stratified random sample of schoolchildren, obtained via five primary

schools, two secondary schools, and one school for intermediate vocational education, recruited by taking into account the distribution of children across the study region according to age, gender, socioeconomic position, and degree of urbanization. Of these, 77 were excluded. Of the eligible 948 respondents, 666 participated (70.3%). Differences between respondents and nonrespondents were small in terms of age, gender, degree of urbanization, and psychosocial problems, with effect sizes ranging from 0.02 (psychosocial problems) to 0.08 (degree of urbanization).

Data were obtained from parents/caregivers and adolescents via Web based or paper questionnaires at the moment of entry into the study, which was, for the care sample, at the moment of the child's care enrollment. If required, we provided assistance in filling out the questionnaire.

Measures

Parents' and adolescents' expectations of barriers to care were measured with the BTPS-exp (Kazdin et al., 1997; Murphy, 2005), translated into Dutch (Guillemin, Bombardier, & Beaton, 1993). Three certified translators translated the questionnaire instructions, item content, and response options from English to Dutch. Next, three other certified translators translated the Dutch translations back into English, one translation each. Finally, three of the authors (DEMCJ/EJK/SAR) compared the resulting English versions to the original BTPS-exp, and discussed and resolved discrepancies. Item 14 was the only item not applicable and therefore not included in the adolescent version (see the Appendix).

Parents and adolescents were asked to "imagine that you were seeking psychological help, counseling or advice [for your child]" and asked to indicate to what extent they agreed with 44 and 43 items, respectively, on a 5-point Likert scale ranging from 1 (*totally disagree*) to 5 (*totally agree*). Mean scores were calculated for the total scale and subscales, when at least two thirds of the items were answered. The subscales were Stressors and Obstacles That Compete With Treatment (parents: 20 items; adolescents: 19 items), Treatment Demands and Issues (10 items), Perceived Irrelevance of Treatment (eight items), and Problematic Relationship With the Therapist (six items; see Appendix).

Child characteristics comprised age, gender, ethnicity, and psychosocial problems. *Ethnicity* was defined as either Dutch or non-Dutch (i.e., either the child and/or one of the parents was foreign-born). Psychosocial problems were measured using the total difficulties score of the Strengths and Difficulties Questionnaire, based on the past 6 months (Cronbach's alpha parent version = .74; adolescent version = .77; Crone, Vogels, Hoekstra, Treffers, & Reijneveld, 2008; Goodman, 1997; Muris, Meesters, & van den Berg, 2003; Van Widenfelt, Goedhart, Treffers, & Goodman, 2003). The score consists of 20 items describing positive and negative attributes of children for the following dimensions: emotional symptoms, conduct problems, hyperactivity/inattention, and peer problems. The scale was dichotomized into the "normal" range and the "borderline to abnormal," using the U.K. cut-off points (Crone et al., 2008; Goodman, 1997).

Family characteristics comprised parental educational level and family composition. Parental educational level was the highest educational level achieved by either one of the parents/caregivers (Centraal Bureau voor de Statistiek, 2006). Family composition was categorized as "biological two-parent family" or "other" (e.g., living with one parent, a foster family, or living in a residential care facility).

Psychosocial care enrollment was defined as enrollment of the child in any new type of care in one of the main psychosocial care organizations because of psychosocial problems.

Statistical Analyses

First, we described the background characteristics of the samples. Second, we determined the internal consistency of the total scale and subscales of the parent and adolescent versions of the BTPS-exp. A Cronbach's alpha $>.7$ was considered as good internal consistency. Next, we assessed whether the data fitted the assumed structure of the scale using a confirmatory factor analysis. We examined whether the data could be captured by the four subscales, and whether the four subscales were captured by a unique higher-order factor. A comparative fit index (CFI) and a Tucker–Lewis index (TLI) of >0.95, and the root mean square error of approximation (RMSEA) of <0.08 both were considered as indicating a reasonably good fit for the model (Browne & Cudeck, 1992; Hu & Bentler, 1999). Fourth, we assessed parent–adolescent agreement: Pearson correlation coefficients were calculated between parents' and adolescents' scores on the total scale and subscales.

Fifth, we assessed the criterion validity of the BTPS-exp by examining its relatedness to basic child and family background characteristics. We anticipated that some parents and adolescents would expect barriers more frequently, because they generally had more difficulties in navigating the health care system or because these children had psychosocial problems more often. For parents who have a child with psychosocial problems, or adolescents who have psychosocial problems themselves, the situation introduced in the BTPS-exp, that is, having (a child with) psychosocial problems, is real. It is likely that these parents and adolescents would expect more barriers as compared to participants who have to imagine the situation and speculate about it. Therefore, we expected the following characteristics to be associated with expecting multiple barriers on the total scale: non-Dutch ethnicity, low parental educational level, living in other than a two-parent family, and having (a child with) psychosocial problems (Brugman et al., 2001; De Wolff, Vogels, & Reijneveld, 2014; Paasche-Orlow & Wolf, 2007; Zeijl, Crone, Wiefferink, Keuzenkamp, & Reijneveld, 2005). The BTPS-exp total scale was dichotomized into expecting few barriers (parents: 1.00–1.98; adolescents: 1.00–2.63) and expecting multiple barriers (parents: 2.00–5.00; adolescents: 2.65–5.00) based on the 25% highest scores of the community sample (in comparison, the highest 25% scores in the care sample were 2.07–5.00 for parents and 2.51–5.00 for adolescents). We performed separate univariable and multivariable logistic regression analyses for the parent and adolescent versions, leading to odds ratios (*OR*s) and 95% confidence intervals (CIs).

Criterion validity was also assessed by examining whether expecting multiple barriers might cause children and adolescents with psychosocial problems and their parents to avoid seeking psychosocial care. We hypothesized that the association between children's psychosocial problems and care enrollment would become less strong, when controlled for the BTPS-exp and its interaction with psychosocial problems. We performed logistic regression analyses restricted to children with a Strengths and Difficulties Questionnaire score ≥ 10. A p value <0.05 was con-

sidered statistically significant (two-sided test). For the analyses on scale consistency and validity, we used SPSS version 20 and for the confirmatory factor analysis, Mplus version 7.1.

Results

Demographics

Of all children in the total sample, 60.5% were 4–11 years old, 51.1% were boys, and 84.8% were of Dutch ethnicity (parent information). Of the adolescents, 43.1% were boys and 87.9% were of Dutch ethnicity (adolescent information). Further characteristics of both samples are presented in Table 1.

Internal Consistency

The internal consistencies of the total scale and subscales of the parent and adolescent BTPS-exp were good, with the lowest Cronbach's alpha of 0.85 found for the parent subscale Perceived Irrelevance of Treatment (see Table 2). Examination of the consistencies without Item 28, accidentally missing in the questionnaire at first, did not yield different findings, except for a slightly lower α for the adolescent subscale Treatment Demands and Issues ($\alpha = .90$).

Scale Structure

Results on the model with the four subscales for the parent BTPS-exp showed a medium fit (CFI = 0.94, TLI = 0.94, RMSEA = 0.07, 95% CI [0.07, 0.07]). Two items had loadings <0.60 (Item 1 = 0.55, Item 36 = 0.47). Correlations coefficients between the four factors ranged from 0.52 to 0.79. A second-order one-factor solution showed a similar fit (CFI = 0.93, TLI = 0.93, RMSEA = 0.07, 95% CI [0.07, 0.08]).

Results for the model with four subscales for the adolescent BTPS-exp also showed a medium fit (CFI = 0.90, TLI = 0.90,

Table 1
Participants' Characteristics

Characteristics	Total sample		Care sample		Community sample	
	Parents (n = 1977)[a]	Adolescents (n = 733)	Parents (n = 1,331)	Adolescents (n = 453)	Parents (n = 646)	Adolescents (n = 280)
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Child characteristics						
Age						
4–11	1,196 (60.5)	—	828 (62.2)	—	368 (57.0)	—
12–19	781 (39.5)	733 (100)	503 (37.8)	453 (100)	278 (43.0)	280 (100)
Gender						
Male	1,010 (51.1)	316 (43.1)	720 (54.1)	200 (44.2)	290 (44.9)	116 (41.4)
Female	967 (48.9)	417 (56.9)	611 (45.9)	253 (55.8)	356 (55.1)	164 (58.6)
Ethnicity						
Dutch	1,677 (84.8)	582 (87.9)	1,099 (85.1)	349 (86.4)	578 (91.7)	233 (90.3)
Non-Dutch	244 (12.3)	80 (12.1)	192 (14.9)	55 (13.6)	52 (8.3)	25 (9.7)
Psychosocial problems						
Normal	1,103 (55.8)	427 (58.3)	527 (39.6)	206 (45.5)	576 (89.2)	221 (78.9)
Borderline	234 (11.8)	108 (14.7)	207 (15.6)	75 (16.6)	27 (4.2)	33 (11.8)
Abnormal	640 (32.4)	198 (27.0)	597 (44.9)	172 (38.0)	43 (6.7)	26 (9.3)
Family characteristics						
Parental educational level						
Primary education	44 (2.2)	12 (1.8)	41 (3.1)	11 (2.7)	3 (.5)	1 (.4)
Lower levels of secondary education	253 (12.9)	102 (15.4)	201 (15.2)	77 (19.1)	52 (8.1)	25 (9.7)
Higher levels of secondary education	1,009 (51.3)	325 (49.1)	694 (52.5)	206 (51.0)	315 (49.0)	119 (46.1)
Senior vocational education	482 (24.5)	159 (24.0)	280 (21.2)	81 (20.0)	202 (31.4)	78 (30.2)
University	178 (9.1)	64 (9.7)	107 (8.1)	29 (7.2)	71 (11.0)	35 (13.6)
Family composition						
Biological two-parent family	1,007 (51.0)	421 (57.4)	589 (44.4)	209 (46.1)	418 (64.8)	212 (75.7)
Other	966 (49.0)	312 (42.6)	739 (55.6)	244 (53.9)	227 (35.2)	68 (24.3)
Care-related characteristics						
Type of psychosocial care enrollment						
None	646 (32.7)	280 (38.2)	—	—	646 (100.0)	280 (100.0)
Preventive child health care	364 (18.4)	44 (6.0)	364 (27.3)	44 (9.7)	—	—
Child and adolescent social care	209 (10.6)	103 (14.1)	209 (15.7)	103 (22.7)	—	—
Child and adolescent mental health care	758 (38.3)	306 (41.8)	758 (57.0)	306 (67.6)	—	—
Expectations of barriers to care (M [SD])						
Barriers total (1–5)	1.68 (.56)	2.02 (.72)	1.69 (.56)	1.96 (.73)	1.65 (.55)	2.11 (.70)
Stressors and Obstacles That Compete With Treatment (1–5)	1.46 (.56)	1.87 (.77)	1.51 (.57)	1.85 (.78)	1.34 (.52)	1.91 (.76)
Treatment Demands and Issues (1–5)	1.81 (.77)	1.94 (.83)	1.84 (.76)	1.87 (.82)	1.74 (.78)	2.05 (.84)
Perceived Irrelevance of Treatment (1–5)	2.00 (.76)	2.37 (.95)	1.92 (.71)	2.22 (.96)	2.17 (.82)	2.62 (.88)
Problematic Relationship With the Therapist (1–5)	1.78 (.83)	2.05 (.94)	1.75 (.81)	2.02 (.94)	1.84 (.86)	2.09 (.93)

[a] Numbers do not always add up to N = 1,977 due to missing data.

Table 2
Internal Consistency (Cronbach's Alpha) of the Total and Subscale Scores on the BTPS-Exp Parent and Adolescent Versions

BTPS-exp scales	Parent version	Adolescent version
Total barriers	.95	.96
Stressors and Obstacles That Compete With Treatment	.92	.93
Treatment Demands and Issues	.89	.92
Perceived Irrelevance of Treatment	.85	.88
Problematic Relationship With the Therapist	.92	.91

Note. BTPS-exp = Barriers to Treatment Participation Scale–Expectancies.

RMSEA = 0.08, 95% CI [0.07, 0.08]), but slightly poorer compared to the parent BTPS-exp. One item had a loading <0.60 (Item 1 = 0.55). Correlation coefficients between the four factors ranged from 0.57 to 0.77. Again, a second-order one-factor solution gave exactly the same results.

Parent-Adolescent Agreement

The parent and adolescent BTPS-exp correlated significantly (see Table 4). Correlation coefficients were low, ranging from 0.16 (Pearson's *r*) for the subscale Stressors and Obstacles That Compete With Treatment to 0.29 for Perceived Irrelevance of Treatment.

Validity

Expecting multiple barriers was significantly more likely in children with non-Dutch ethnicity, psychosocial problems, lower parental educational level, and living in other than a biological two-parent family (see Table 3). For the adolescent BTPS-exp, expecting multiple barriers was only significantly associated with children's psychosocial problems, both univariable and adjusted (see Table 3).

The association between children's psychosocial problems and psychosocial care enrollment did not become less strong when controlling for the BTPS-exp and its interaction with psychosocial problems, for both the parents and adolescents (see Table 5).

Table 4
Pearson Correlations Between Parent BTPS-Exp and Adolescent BTPS-Exp Total and Subscale Scores

BTPS-exp scales	*N*	Pearson correlation
Total barriers	663	.25**
Stressors and Obstacles That Compete With Treatment	662	.16**
Treatment Demands and Issues	662	.25**
Perceived Irrelevance of Treatment	661	.29**
Problematic Relationship With the Therapist	665	.23**

Note. BTPS-exp = Barriers to Treatment Participation Scale–Expectancies.
** $p < .01$.

Discussion

In this study, we assessed the psychometric properties of the parent and adolescent versions of the BTPS-exp. Our findings showed that the internal consistencies of the total scale and the four subscales of both versions were good. Furthermore, the data fitted the assumed scale structure appropriately. Correlation coefficients between parent and adolescent scores were low. Regarding criterion validity, the BTPS-exp was, as assumed, associated with some child and family characteristics, but did not affect the association between children's psychosocial problems and care enrollment.

Interpretation and Fit With Other Studies

With this study, we are the first to assess the psychometric properties of the BTPS-exp parent and adolescent versions. Compared to other instruments, the BTPS-exp is the only instrument measuring the expectations of barriers of both parents and adolescents and is applicable in the community, in different stages of the help-seeking process, as well as at the beginning of treatment. Other instruments solely measure adolescents' beliefs regarding barriers, or measure barriers experienced by either children and

Table 3
Associations of Child and Family Characteristics With Parents' and Adolescents' Expectations of Multiple Barriers

	Parents		Adolescents	
Criterion	Crude *OR* [95% CI]	Full model *OR* [95% CI]	Crude *OR* [95% CI]	Full model *OR* [95% CI]
Child's age (12–19 vs. 4–11 years)	1.09 [.89, 1.33]	1.07 [.87, 1.32]	—	—
Child's gender (female vs. male)	.92 [.75, 1.12]	.90 [.73, 1.10]	1.03 [.72, 1.47]	.88 [.59, 1.30]
Child's ethnicity (non-Dutch vs. Dutch)	1.44 [1.08, 1.92]**	1.39 [1.03, 1.86]*	.93 [.51, 1.69]	.87 [.45, 1.68]
Child's psychosocial problems (borderline/abnormal vs. normal)	1.27 [1.04, 1.54]*	1.14 [.93, 1.41]	2.02 [1.41, 2.89]***	2.07 [1.39, 3.08]***
Parental educational level (reference: university)				
Primary education	3.03 [1.51, 6.06]**	2.49 [1.21, 5.13]*	.65 [.13, 3.32]	.55 [.10, 2.88]
Secondary, lower levels	1.98 [1.27, 3.09]**	1.83 [1.16, 2.89]*	.66 [.30, 1.44]	.57 [.26, 1.27]
Secondary, higher levels	1.45 [.99, 2.13]#	1.45 [.98, 2.14]#	.90 [.48, 1.70]	.79 [.41, 1.52]
Senior vocational	.98 [.64, 1.48]	.98 [.64, 1.50]	.77 [.38, 1.55]	.67 [.33, 1.37]
Family composition (other vs. biological two-parent family)	1.30 [1.06, 1.58]**	1.13 [.91, 1.40]	1.00 [.70, 1.44]	.92 [.61, 1.40]

Note. *OR* = odds ratio; CI = confidence interval.
# $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5
Association Between Children's Psychosocial Problems and Psychosocial Care Enrollment: Results on the Effect of Expecting Multiple Barriers[a,b]

	Psychosocial care enrollment					
	Parents[c]			Adolescents[d]		
	OR	95% CI	*p*	*OR*	95% CI	*p*
Model 1						
Child's psychosocial problems (10–40)	1.44	[1.32, 1.57]	<.001	1.36	[1.24, 1.50]	<.001
Model 2						
Child's psychosocial problems (10–40)	1.48	[1.32, 1.65]	<.001	1.36	[1.21, 1.53]	<.001
Expecting multiple barriers (vs. few)	1.45	[.12, 17.63]	.773	.16	[.01, 3.78]	.255
Child's psychosocial problems × Expecting multiple barriers	.96	[.79, 1.17]	.687	1.07	[.85, 1.33]	.575

Note. *OR* = odds ratio; CI = confidence interval.
[a] Children from the community sample, who had contact with psychosocial care in the past six months, were excluded for these analyses, because we lacked information on current psychosocial care enrollment. [b] Analyses including children with Strengths and Difficulties Questionnaire score <10 gave similar results (data not shown). [c] n = 1,161. [d] n = 408.

adolescents in need of psychosocial care and their parents, or by those in psychosocial care (Davidson & Fristad, 2006; Kazdin et al., 1997; Kuhl, Jarkon-Horlick, & Morrissey, 1997; Owens et al., 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003).

Compared to the original BTPS, the BTPS-exp showed higher Cronbach's alphas and better fit of the data to the scale structure (Kazdin et al., 1997). Scores of parents and adolescents on the BTPS-exp were correlated, though not strongly. Adolescents of both the community and the care samples scored higher on all scales of the BTPS-exp than their parents, that is, expected more barriers. This might be explained by adolescents' tendency to avoid interference of others, among them their parents but probably also psychosocial care professionals. Their developmental stage is characterized by a growth of autonomy and of self-directedness, and by a desire to solve problems on their own (Steinberg & Silverberg, 1986; Frank, Pirsch, & Wright, 1999; Raviv, Raviv, Vago-Gefen, & Fink, 2009). Ultimately, the adolescents are requested to talk about their personal problems during the treatment and not the parents. These findings also showed that each informant had his or her own unique information, which is in line with the level of parent–child agreement, when symptoms of psychopathology are evaluated (Achenbach, McConaughy, & Howell, 1987; De Los Reyes & Kazdin, 2005; Sourander, Helstelä, & Helenius, 1999).

Regarding criterion validity, the BTPS-exp parent version was associated, as assumed, with child and family background characteristics. The presence of child psychosocial problems was the only characteristic significantly associated with expecting multiple barriers in the BTPS-exp adolescent version. This might imply that the BTPS-exp does not cover all barriers of importance for some groups of adolescents, such as stigma attached to having psychosocial problems and care. Item 16 (see Appendix) of the BTPS-exp measures stigma to some extent, but this could be measured more extensively (Chandra & Minkovitz, 2006). Also, lack of parental support in seeking and using psychosocial care may become a barrier to care, since adolescents are still mainly dependent on their parents in attending care (Logan & King, 2001; Vogel, Wade, Wester, Larson, & Hackler, 2007).

Contrary to our assumption, the BTPS-exp did not affect the association between children's psychosocial problems and care enrollment. This most likely implies that the enrollment of children and adolescents in psychosocial care is more complex than we had assumed. This is supported by Andersen's Health Behavior Model and Brannan's model for children's mental health service utilization, which presents care utilization as the result of a complex interaction of factors, such as child emotional and behavioral challenges, stressful life events, families' resources and perceptions, caregiver strain, and service and system factors (Andersen, 1995; Brannan, Heflinger, & Foster, 2003).

Strengths and Limitations

A major strength of our study is the inclusion of children enrolled in psychosocial care as well as children from the community, its large sample size, extensive recruitment procedure, and successful actions to reduce missing data.

Potential selection bias may have affected the results of our study. However, we found only small differences between respondents and nonrespondents, which decreases the likelihood of bias. In addition, we lacked information on those who had opted out of the study, but it seems reasonable to assume that they resemble the nonresponders (Junghans, Feder, Hemingway, Timmis, & Jones, 2005). Finally, the BTPS-exp reflects some types of barrier expectations more than others. For example the type Stressors and Obstacles That Compete With Treatment has much more weight, that is, 20 items, than the type Problematic Relationship With the Therapist, which contains only six items. However, calculating the total score in the same way as the original BTPS enabled us to discriminate between those expecting few barriers and those expecting multiple barriers.

Implications

The BTPS-exp is reliable and reasonably valid, and is useful for detecting parents' and adolescents' expectations of barriers to psychosocial care for children and adolescents. The BTPS-exp might help to improve access to psychosocial care, as professionals with a gate keeping function, such as general practitioners, could already address and remedy barriers early in the help-seeking process. In addition, finding remedies for barriers at the beginning

of treatment could be beneficial for treatment responses and change, including treatment continuation. This study also showed that parents and adolescents have their own views of barriers, which argues for including both in evaluation of psychosocial care and for extra attention for adolescents, since in particular these expect barriers.

Our study has several implications for further research. First, research on whether a weight should be attached to the subscales in the calculation of the BTPS-exp total score is needed to better understand the validity of the BTPS-exp. Second, it should be examined whether the BTPS-exp, especially the adolescent version, must be expanded with other types of barriers such as stigma and lack of parental support. Third, research on the association between the BTPS-exp and psychosocial care enrollment in and treatment response to psychosocial care is needed on the role of barrier expectations in the care process and to also understand the validity of the BTPS-exp. Lastly, to facilitate wider use, the psychometric properties of the BTPS-exp need to be examined in other languages and cultures.

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(*Appendix follows*)

Appendix

Parent Version of the Barriers to Treatment Participation Scale–Expectancies (BTPS-exp)[a]

Imagine that you are seeking psychological help, counseling, or advice for your child. Below is a list of statements that some parents have about such help for children and adolescents. For each item, please check a box to indicate how much you agree with the statement.[b]

	Totally disagree	Somewhat disagree	Neutral	Somewhat agree	Totally agree
I. Stressors and Obstacles That Compete With Treatment					
1. We do not have transportation (car, truck, taxi) to travel to treatment	❑	❑	❑	❑	❑
2. My child is involved in other activities (sports, clubs, music lessons) that would make it hard to come to a session	❑	❑	❑	❑	❑
3. Scheduling appointment times for treatment would be difficult	❑	❑	❑	❑	❑
4. Treatment would conflict with other activities in which I am involved	❑	❑	❑	❑	❑
5. I experience too much stress in my life to participate in treatment	❑	❑	❑	❑	❑
6. My personal health problems or illness would stop me from getting treatment for him or her	❑	❑	❑	❑	❑
7. My child's health problems or illness will stop me from getting treatment for him or her	❑	❑	❑	❑	❑
8. Crises at home will get in the way	❑	❑	❑	❑	❑
9. Treatment will just add more stress to my life	❑	❑	❑	❑	❑
10. Bad weather will prevent us from coming to treatment	❑	❑	❑	❑	❑
11. My time is limited; I will not have time for the assigned work	❑	❑	❑	❑	❑
12. My child will never be home long enough to do the homework assigned	❑	❑	❑	❑	❑
13. Family health problems or illness in our home will stop me from getting treatment for my child	❑	❑	❑	❑	❑
14. Getting a babysitter so I can come to treatment with my child will be a problem[c]	❑	❑	❑	❑	❑
15. Parking at the treatment agency will stop me from getting treatment for my child	❑	❑	❑	❑	❑
16. Members of my family would stop me from getting treatment for my child or they would disagree with me about whether we should come to treatment at all	❑	❑	❑	❑	❑
17. I am too tired after work to go to sessions	❑	❑	❑	❑	❑
18. My job schedule is too hectic	❑	❑	❑	❑	❑
19. Treatment would take time away from spending time with my children	❑	❑	❑	❑	❑
20. I have trouble with other children at home, which would make it hard to come to treatment	❑	❑	❑	❑	❑
II. Treatment Demands and Issues					
21. My child will refuse to go to the sessions	❑	❑	❑	❑	❑
22. Treatment takes too long (too many weeks)	❑	❑	❑	❑	❑
23. Treatment will cost too much	❑	❑	❑	❑	❑
24. Billing will be a big hassle	❑	❑	❑	❑	❑
25. Information we get from treatment (handouts, referral information) will be confusing for me or my child	❑	❑	❑	❑	❑
26. My child will have trouble understanding treatment	❑	❑	❑	❑	❑
27. Treatment will be more work than I think	❑	❑	❑	❑	❑
28. The atmosphere at the clinic will make appointments uncomfortable	❑	❑	❑	❑	❑
29. I will not have a say in my child's treatment	❑	❑	❑	❑	❑
30. The work assigned to me as part of this treatment will be difficult	❑	❑	❑	❑	❑
III. Perceived Irrelevance of Treatment					
31. Treatment is not necessary	❑	❑	❑	❑	❑
32. Treatment won't be what I expect	❑	❑	❑	❑	❑
33. I will probably lose interest in coming to sessions	❑	❑	❑	❑	❑
34. Treatment will become less important as it goes on	❑	❑	❑	❑	❑
35. Treatment will not focus on my child's life and problems	❑	❑	❑	❑	❑
36. Treatment might "bring out" new or different problems in my child	❑	❑	❑	❑	❑
37. My child's behavior will improve on its own; treatment is not needed	❑	❑	❑	❑	❑

(*Appendix continues*)

Appendix (*continued*)

	Totally disagree	Somewhat disagree	Neutral	Somewhat agree	Totally agree
38. Treatment will not work	❑	❑	❑	❑	❑
IV. Problematic Relationship With the Therapist					
39. I worry that I won't have a good relationship with the therapist	❑	❑	❑	❑	❑
40. I will have to give too much personal information to the therapist	❑	❑	❑	❑	❑
41. The therapist won't be confident that treatment will work	❑	❑	❑	❑	❑
42. The therapist might question my ability to carry out treatment programs at home	❑	❑	❑	❑	❑
43. The therapist might not support me or my efforts	❑	❑	❑	❑	❑
44. The therapist will not call enough	❑	❑	❑	❑	❑

[a] Contact the corresponding author for the Dutch version of the BTPS-exp. [b] Instruction for the adolescent version was "Imagine that you are seeking psychological help, counseling, or advice. Below is a list of statements that some adolescents have about such help for adolescents. For each item, please check a box to indicate how much you agree with the statement." [c] Adolescent version: Item 14 was not applicable and therefore not included.

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