Psychiatry Research 259 (2018) 68–76

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Can the Perceived Barriers to Psychological Treatment Scale be used to investigate treatment barriers among females with disordered and non-disordered eating behaviours?

Natasha T. Innes[a], Bonnie A. Clough[a,b], Jamin J. Day[b], Leanne M. Casey[a,*]

[a] School of Applied Psychology, Griffith University, Menzies Health Institute Queensland, Australia
[b] School of Psychology and Counselling, Institute for Resilient Regions, University of Southern Queensland, Australia

ARTICLE INFO

Keywords:
Barriers to care
Barriers to treatment
Eating disorder
Help-seeking
Treatment engagement

ABSTRACT

There is a lack of psychometrically sound instruments to assess treatment barriers among individuals with disordered eating behaviours. This study examined the factor structure and psychometric properties of the Perceived Barriers to Psychological Treatment scale (PBPT; Mohr et al., 2010) among a sample of individuals with disordered eating behaviours. Participants were 708 females aged 14 years and older who completed an online survey. The sample was randomly divided in two for the conduct of exploratory (EFA) and confirmatory (CFA) factor analyses. EFA suggested a seven-factor structure retaining 24 of the original 27 items (variance explained = 60%, $\alpha = 0.91$). Factors were stigma, participation restrictions, negative evaluation of treatment, lack of motivation, emotional concerns, access restrictions, and time constraints. To assess clinical sensitivity, we conducted a secondary EFA utilising only clinical cases from this sample, which supported the solution but suggested retaining 25 of the original 27 items (variance explained = 58%, $\alpha = 0.89$). The 25-item, seven-factor solution was further supported by CFA with an independent sample. Construct validity was also supported. The study suggests that the instrument will provide clinicians and researchers with a valid and reliable method of assessing treatment barriers in disordered eating samples.

1. Introduction

Engagement with treatment services is problematic in disordered eating populations, in terms of help-seeking, dropout, and relapse prevention strategies (Guarda, 2008; Mahon, 2000). The proportion of individuals with a clinical eating disorder who access treatment in a single year is considerably less (19–36%) than the proportion of individuals suffering other types of mental health problems (35–41%; Cachelin and Striegel-Moore, 2006; Hart et al., 2011; Vanheusden et al., 2008). In addition, treatment for an eating disorder is sought an average of 10–15 years after the onset of their illness compared to an average 8.2 year delay in those with mood or anxiety disorders (Oakley Browne et al., 2006; Thompson et al., 2004). There is a need to improve help-seeking in this population, and for that help-seeking to occur earlier in the disorder progression, including when symptoms are sub-clinical.

Failure to engage in treatment may be understood in terms of barriers to care (Hart et al., 2011; Innes et al., 2016). Instruments that systematically assess barriers to accessing specialised mental health services are important to understanding the specific factors that prevent individuals accessing and/or receiving treatment. A systematic review of the measurement of barriers to care among disordered eating populations identified shame/ stigma, poor mental health literacy, perceived need for treatment, unhelpful past treatment experiences, fear of change, low motivation, service restrictions, and cost as being key barriers inhibiting engagement with services (Innes et al., 2016). However, it was also revealed that there are very few psychometrically sound and appropriate scale-based instruments to adequately measure treatment barriers (Innes et al., 2016). Methods to date have primarily used qualitative or checklist methods (e.g., Cachelin et al., 2001; Evans et al., 2011; Hepworth and Paxton, 2007; Meyer, 2001), which do not allow for standardised investigations or comparisons across individuals or populations. Furthermore, the only scale-based instrument available in the area of eating disorders (Cachelin et al., 2006) does not enable the relative influence of each barrier to be assessed and lacks any data on the psychometric properties of the instrument (Innes et al., 2016).

Within the broader treatment literature, the Perceived Barriers to Psychological Treatment (PBPT) scale (Mohr et al., 2010) has been widely used and has demonstrated sound psychometric properties for the accurate and comprehensive assessment of treatment barriers. It

* Correspondence to: School of Applied Psychology, Griffith University, Mt Gravatt Campus, Queensland 4122, Australia.
E-mail address: l.casey@griffith.edu.au (L.M. Casey).

http://dx.doi.org/10.1016/j.psychres.2017.09.070
Received 25 July 2016; Received in revised form 1 August 2017; Accepted 24 September 2017
Available online 28 September 2017

was designed to measure barriers toward attending weekly counselling or therapy for emotional or health (e.g. smoking cessation) problems. The PBPT has previously been used to assess treatment barriers (such as cost, stigma, availability of services, etc.) in areas such as the treatment of depression (e.g. Casey et al., 2014) and among a Veteran's sample with mixed mental health needs (Pfeiffer et al., 2016). However, to the authors' knowledge (and according to citing articles of the PBPT), the scale has yet to be used or validated for individuals with eating, weight, or body shape concerns. The purpose of the current study was to examine the psychometric properties of the PBPT among females with a range of eating behaviours and symptoms.

1.1. The PBPT

The PBPT (Mohr et al., 2010) has demonstrated excellent psychometric properties in assessing barriers specifically toward psychological treatment. This is particularly important given that rates of psychotherapy attendance for a range of mental health problems have declined over the past 40 years, despite a corresponding increase in receiving treatment for a mental health disorder (Mackenzie et al., 2014). This finding reflects a shift towards pharmacological interventions with general practitioners becoming an increasingly preferred professional source of help (Mackenzie et al., 2014; Olfson and Marcus, 2010; Reavley et al., 2011). Such findings are of particular concern in the area of eating disorders given the demonstrated efficacy of cognitive behavioural treatment for Bulimia Nervosa (BN) and Binge-Eating Disorder (BED) over and above pharmacological interventions (Fairburn and Harrison, 2003; Grilo et al., 2005). There is also a lack of evidence for the efficacy of pharmacological approaches in the treatment of Anorexia Nervosa (AN) (Zhu and Walsh, 2002).

Another important attribute of the PBPT is that it enables assessment of the degree of difficulty that each individual barrier may cause, allowing greater information to be gathered about barriers than by checklist approaches. Lastly, individuals can complete the PBPT at any stage of the help-seeking process and regardless of treatment history or type of mental health problem. For these reasons, the PBPT may prove useful in the assessment of treatment barriers in eating disorder populations.

1.2. The current study

The aim of this study was to test the utility of the PBPT for face-to-face psychological treatments for weight, shape, and eating behaviours in a mixed sample, inclusive of those meeting criteria for a clinical diagnosis of eating disorder, and those with concerns around their eating behaviours. The recruitment strategy employed was specifically designed so that women in the sample were similar on the presence of these concerns, regardless of whether or not they met clinical criteria. This approach is consistent with a continuum view of psychopathology and disordered eating (Ahmed et al., 2012; Garner et al., 1983; Gleaves et al., 2000) rather than categorical, and allowed for the scale to be tested in a sample representing a range of eating and weight concerns, not just among those with concerns of pathological level. This approach is also consistent with previous sampling approaches in the help-seeking and barriers literature (e.g., Fairburn, 2008; Gulliver et al., 2010; Mackenzie et al., 2007), and the original PBPT development study (Mohr et al., 2010). Furthermore, although the current study utilised a cross sectional design, longitudinally it is not uncommon for individuals with eating disorders to shift between clinical, subclinical, and non-clinical symptomology (Herzog et al., 1999). As such, although clinical status was used to describe the sample and allow judgment on representativeness, it was not intended for use in the analytical approach. The sample was however limited to females, due to the disproportionate representation of females across all categories of eating disorders and the resulting difficulty in recruiting an adequate sample size of males (Andersen and Holman, 1997; Wright et al., 2009). We examined the structural validity of the scale, as modified to focus on psychological barriers to treatment for concerns around eating behaviours, as well as explored construct validity through assessing convergent and divergent validity. In addition, the internal consistency of the PBPT was examined. Finally, as the PBPT allows for the examination of the relative influence of barriers to treatment, an explorative comparison of barriers (between identified subscales) was also planned.

Construct validity was tested by comparing the PBPT to items on the General Help Seeking Questionnaire (GHSQ) relating to intentions to seek help from a mental health professional, via online treatment, and a global "I would not seek help" item. Our expectation was that intentions to seek help and perceived barriers to accessing treatment are related but discrete constructs. For many, intentions to seek help are likely to be inversely related to the number of perceived barriers. However, some may identify few barriers to accessing treatment but have no intention to seek help, while some may have a strong intention to seek help but feel there are currently too many barriers to doing so. Therefore, we expect only a small to moderate correlation, suggesting discriminant validity of the PBPT and supporting the notion that PBPT responses reflect barriers to treatment as discrete from intentions to seek help.

Assessment of depression is also important when examining possible treatment barriers, as depression is co-morbid in nearly 50% of individuals with eating disorders (Sullivan, 1995). Further, depression has also been identified as a barrier to treatment seeking (Mohr et al., 2006), which may influence ratings of other perceived barriers. To test whether ratings on the PBPT could be discriminated from severity of depressive symptoms, the relationship between treatment barriers (PBPT scores) and depressive symptoms were examined using scores from the Patient Health Questionnaire (PHQ-2).

2. Method

2.1. Participants

The study was conducted as an online survey and was advertised through information websites and forums regarding eating behaviours, among undergraduate university students, and at local exercise centres. The survey description was targeted at individuals who had shape, weight, and/or eating concerns, but was not restricted to individuals with an eating disorder, but was limited to females. Further, the age was restricted to females who were 14 years or older, which allowed for participation without parental consent.

The survey was accessed by 901 individuals, with 78.6% (n = 708) of respondents completing the survey and 193 incomplete responses removed prior to analyses. The final sample comprised 708 females, ranging between the ages of 14 and 63 years (M = 21.79; SD = 7.05). Participants were predominantly Caucasian (n =576, 81.36%), single (n = 563, 79.52%), students (n = 530, 74.86%) or working (n = 135, 19.07%), and living in metropolitan areas (n = 564, 79.66%). Of the retained responses, 288 (40.7%) were sourced from the local community, 278 (39.3%) were recruited through the host university, and 142 (20.1%) were international respondents.

Based on the Questionnaire for Eating Disorder Diagnoses (Q-EDD) scores, most respondents in the analysed sample (n = 381, 53.81%) were in the clinical range for an eating disorder, 95 (13.42%) were in the subclinical range, and 232 (32.77%) were in the non-clinical range. Of those in the clinical range, subcategories were: AN (20.11%), BN (34.32%), BED (3.22%), and Other Specified Feeding or Eating Disorder (OSFED, 42.36%). Although the clinical and sub-clinical groups were over-represented in the current sample (when compared to typical community sampling), it was deemed this was likely the result of the targeted recruitment strategy utilised. That is, the recruitment specifically called for females with shape, weight, or eating concerns, and as such, these individuals were more likely to self-select into the study than those without such concerns. As such, a distinction should also be