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Providing a new transdiagnostic emotion-focused pain treatment in a clinical context: therapists' experiences of facilitators and barriers

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ABSTRACT

Providing new psychological treatments in clinical settings requires implementation strategies adapted to the organizational context. This study explored how licensed psychologists experienced their context when providing a new transdiagnostic psychological treatment, “the hybrid treatment”, to treat comorbid pain and emotional problems in a clinical setting. We aimed to identify which contextual factors the therapists experienced as facilitating or hindering, to gain a better understanding of important considerations when planning a future implementation strategy. Contextual factors were identified using the Consolidated Framework of Implementation Research (CFIR) in data collection and analysis. Data were collected through semi-structured interviews ($N = 9$). Thematic analysis resulted in the identification of five main influencing factors: Perception of the intervention's adaptability, prioritization of the patient's needs, leadership engagement, structure for collaboration, and therapists' professional engagement. The results highlight the importance of ensuring a clearly stated mandate for the key individuals involved. The findings may guide future implementation of new psychological treatments into regular care, to enhance facilitators and overcome barriers.

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Pain is one of the major health concerns in the general population. About 20% of adults in Europe suffer from chronic pain conditions, with moderate-to-severe pain intensity of at least 6 month duration (Mills et al., 2019). In addition to individual suffering, there are considerable societal costs in terms of sick leave and loss of work productivity (Leadley et al., 2012). The development of chronic pain is a complex process in which psychological, biological, and social aspects interact (Cohen et al., 2021) and psychological interventions such as cognitive behavioral therapy (CBT) are

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important components in treatment and rehabilitation efforts for patients with chronic pain (Williams et al., 2012). Comorbidity with emotional problems such as anxiety and depression is common and associated with greater impairment than pain alone (Velly & Mohit, 2018) and pain patients with comorbid emotional problems have been pointed out as a particularly vulnerable group, in need of more effective treatments (Mills et al., 2019).

A multiprofessional approach is recommended for rehabilitation of pain patients with comorbidities (Gerdle et al., 2022; Scascighini et al., 2008). However, the accessibility to interdisciplinary pain treatments varies due to economic, geographic, and organizational factors (Eklund et al., 2021; Gatchel & Okifuji, 2006; Nyberg et al., 2011). Furthermore, available pain treatments have on average small to moderate effect sizes that have not improved over time (McCracken, 2023; Morley et al., 2013). Hence, new treatment strategies for patients with pain and emotional problems are needed within both primary and specialized care.

One promising and pragmatic way of dealing with comorbid pain is to offer treatments targeting psychological mechanisms that are relevant for both pain and emotional disturbances, i.e. a *transdiagnostic* approach (Linton, 2013). Targeting processes of change, rather than diagnosis-specific symptoms, has received increased focus within psychological treatment research and chronic pain is no exception (McCracken, 2023). Emotional dysregulation and avoidance of movement are examples of such mechanisms for pain patients, however, traditional pain rehabilitation focuses on pain management and interventions targeting emotion regulation are seldom as extensive as for psychiatric conditions (Linton & Fruzzetti, 2014). Consequently, our research group has developed an emotion-focused exposure treatment for pain patients, hereby referred to as the “hybrid treatment” (Boersma et al., 2019; Linton, 2013). It is a psychological treatment based on cognitive behavior therapy (CBT) that integrates emotion regulation strategies from dialectical behavior therapy (Koerner, 2012) with exposure methods based on the fear and avoidance model (Vlaeyen et al., 2016). A detailed description of the treatment is described elsewhere (Södermark, 2023). The hybrid treatment has shown to be effective in a feasibility study and a subsequent randomized controlled trial (Boersma et al., 2019; Linton & Fruzzetti, 2014), and its broad and transdiagnostic focus makes the treatment suitable for both primary and specialized care settings. Still, there is a lack of knowledge of how well it fits into regular care and how it should best be implemented.

Implementing a new treatment into regular care is challenging and the importance of overcoming this gap has been pointed out in many areas including the pain field (Chambers, 2018). Factors influencing implementation occur at multiple levels, including individual, organizational, intervention, and system levels and the complexity implies that an implementation strategy must be adapted to the current intervention and to the organizational context (Damschroder et al., 2009; Grol & Grimshaw, 2003). A recent systematic review of barriers and facilitators of evidence-based psychotherapies for chronic pain concludes that most studies focus on patient-level factors, stating a need for future research to explore how provider and system-level factors influence the use of these treatments in a clinical context (Goldsmith et al., 2023). To our knowledge, only one study has examined contextual factors from the therapists’ perspective when implementing a new psychological treatment. This study recognized the importance of tailored treatments, however therapists’ ability to be

flexible in their treatment approach was significantly limited by system-level barriers (Carroll et al., 2021). Thus, the review indicated a significant gap of knowledge about contextual factors affecting implementation of psychological treatments for pain at the provider and system levels.

The aim of this study is to apply a broad scope on contextual factors, as defined by Damschroder et al. (2009). The Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009), is used to identify barriers and facilitators of providing the hybrid treatment in a clinical context, in order to address contextual factors that might influence a future implementation process. The CFIR has been applied in a wide variety of studies (Kirk et al., 2016), however, the use in pain research is rare and the heterogeneity in how implementation frameworks are applied makes the comparison of studies difficult (de la Vega et al., 2024).

The current study aims to explore which contextual factors the therapists experience as facilitating or as barriers when providing the new transdiagnostic psychological treatment, “the hybrid treatment”, in their clinical settings.

Method

Setting

This study is part of an effectiveness project (Clinical Trials registration number NCT05082922), which aims to implement and evaluate the effectiveness of the transdiagnostic, emotion-focused “hybrid” treatment model in clinical care in Sweden. The project involves therapists from primary and specialized health care all over Sweden, working with the treatment of comorbid pain and in the early phases of implementing the hybrid treatment model in their respective clinics. Key individuals for a future implementation are the therapist’s providing treatment, and hence therapists who were actively engaged in identifying, assessing, or providing the hybrid treatment were the population of interest for this study.

Participants

Fourteen therapists who were involved in the overarching effectiveness project and hence either identifying and assessing patients, or providing the hybrid treatment, were contacted in the end of March 2022 via e-mail with information about this study and asked to participate. Out of those, 10 agreed while 4 did not respond despite reminders. One of the therapists was a colleague of the first author and was, therefore, not included in this study but participated in a pilot interview to test the interview guide. The included therapists ($N=9$) were all licensed psychologists working with psychological treatment for patients with chronic pain in primary or specialized care. They had basic CBT training and specific knowledge of the hybrid treatment and worked in clinics in both urban and rural areas all over Sweden. See Table 1 for a detailed description of the participants. At the time of the interview, all nine of the therapists had experience with attempting to identify suitable patients, seven of them had experience with assessing patients, and five of them had experience with providing the treatment.

Table 1. Overview of the therapists' demographic characteristics and inclusion of patients.

Therapist	Participated in present study	Interview length	Care level	Years in profession	Initiated treatment of patients in the effectiveness study
T1	Yes	30 min	Specialized	4	Yes
T2	Yes	37 min	Primary	12	Yes
T3	Yes	35 min	Specialized	12	Yes
T4	Yes	44 min	Specialized	24	Yes
T5	Yes	65 min	Primary	25	Yes
T6	Yes	32 min	Specialized	12	No
T7	Yes	31 min	Specialized	2	Yes
T8	Yes	20 min	Primary	1	No
T9	Yes	35 min	Specialized	12	Yes
T10	No. Used in pilot interview	34 min	Specialized	5	Yes
T11	No	–	Specialized	–	Yes
T12	No	–	Primary	–	Yes
T13	No	–	Specialized	–	No
T14	No	–	Primary	–	No

Data collection

The therapists were interviewed using semi-structured interviews with questions that covered areas of importance for implementation as proposed by The Consolidated Framework for Implementation Research (CFIR). The CFIR is a comprehensive framework which categorizes influential factors for implementation into five domains, representing different levels in the organization including individual, organizational, intervention, and system levels (Damschroder et al., 2009). Its broad scope is an asset for considering facilitators and barriers to implementation which entails a need to adapt it to the specific context (Safaeinili et al., 2019). The domain *intervention characteristics* aims to describe the need for adapting an intervention to a new context. *Outer setting* focus on the structural and political context, *inner setting* on organizational culture and the social context within which the implementation process will take place. *Characteristics of individuals* describes the significance of individuals involved, and *the implementation process* focuses on the active change process. Each domain is divided into constructs, which provide a more detailed description of the content (Damschroder et al., 2009). In this study, we proceed from four of the CFIR domains: intervention characteristics, outer setting, inner setting, and characteristics of individuals, to get a broad base and to cover all conceivable aspects related to the aim of the study. The process domain was excluded since it describes characteristics relevant at a later stage of an implementation process. The reporting of the findings follows the recommendations by Tong et al. (2007).

The interview guide was created using the CFIR website interview guide (<https://cfirguide.org/>) which contains suggested questions from all constructs within each of the four CFIR domains. The questions related to the aim of the study were selected and adapted to the specific context (see Appendix). General follow-up questions were used when needed to clarify answers (for example: “can you elaborate/be more specific?” or “how did you handle that?”). An initial pilot interview was done with one of the therapists, to be able to test the interview guide and revise the interview questions if necessary. This resulted in specifying questions related to the therapists' motivation to provide the hybrid treatment in their clinic.

All interviews were held between April and May 2022. They were conducted by the author KL, who is a licensed psychologist with experience from pain treatment within specialized care. KL obtained knowledge of the hybrid treatment through the same University course as some of the participating therapists. The interviews lasted between 20 and 65 min (see [Table 1](#)), were held digitally via Zoom and recorded. The recordings were thereafter stored on a safe server according to the data protection policy at Örebro University.

Data analysis

All interviews were transcribed verbatim and personal information was removed to anonymize the data. The thematic analysis was performed in a six-step process by the author KL, with guidance of the co-authors SB, MW, and EBB, according to Braun and Clarke (2006). In the initial step in the analysis, KL read all transcripts twice, to become familiar with the data. In the second step, initial codes were developed and labeled based on the domains and constructs of the CFIR framework. The co-authors SB and MW reviewed the labeled categories. The categories were then merged into more overarching themes by KL and reviewed again by the other authors (SB, MW, and EBB). Lastly, the themes were named to reflect the content of each theme. The analysis process was dynamic and went back and forth between codes and themes, categorizing codes to find patterns and formulate the final themes. Hence, author KL performed the coding and authors KL, SB, EBB, and MW were all active and reflexive collaborators in the analysis. See [Table 2](#) for excerpts from the analysis procedure. Quotes were initially translated into English by KL and reviewed by co-author MW. In the analysis, “the therapist” refers to all psychologists included in the study. When the answers differed between therapists in primary and specialized care, this was highlighted. The presented quotations have been translated to English and edited to increase readability, but without changing neither the colloquial language used by the interviewees nor the content.

Ethical considerations

The overarching effectiveness evaluation, not part of this manuscript and not yet published, was approved by the Swedish Ethical Review Authority (Dnr. 200042). Since this study does not contain sensitive personal data as defined in article 9.1 in the EU data protection regulation (The Swedish Parliament, 2003), it does not fall under the Ethical Review Act and, therefore, no ethical approval was deemed needed. All participants gave their written informed consent and the procedure followed ethical guidelines.

Results

The results are presented in five themes, which show the therapists’ experiences of providing the hybrid treatment, and facilitators and barriers related to each theme. See [Table 3](#) for an overview of the results.

Table 2. Excerpts from the analysis procedure. Examples of identified codes, corresponding CFIR constructs, and identified themes.

CFIR Domain	Codes with initial interpretation of facilitators (F) and barriers (B)	Corresponding CFIR constructs	Final Themes
Intervention Characteristics	Problematizes assessment of suitable patients for treatment (B) Adapts treatment when necessary (F) Problematize manual adherence (F/B) Addresses adaptations required based on patient's needs (B/F)	Adaptability Knowledge and beliefs about the intervention Compatibility	Therapists' perception of possible adaptations of the treatment manual
Outer Setting	Lack of clarity regarding the manual's flexibility (B) Management express need for treatment (F) Addresses co-morbidity and need for treatment (F) Internal communication on benefits with treatment (F) Internal discussion on how to treat complexity in pain patients (F) Psychological treatment for pain patients not a priority (B)	Patient needs and resources Implementation climate Networks & Communications	Therapists' view of available resources and prioritization of patients' needs
Inner Setting	Management trust in therapists' competence (F) Evaluation of quality/treatment significance relied on therapists (F/B) Openness among colleagues about the treatment (F) Ability to try/develop new working methods (F) Difficult to argue that other therapists should use the treatment (B)	Culture Leadership engagement Learning Climate	Leadership engagement and the therapists' autonomy
Inner Setting	The manual in line with current working methods (F) Challenge to complete treatment within time frame (B) Lack of meetings for the purpose of collaboration (B) Therapists independently set up treatments (F) Distribution of patients done by other profession (B)	Compatibility Culture	The treatment's compatibility with existing workflows and degree of cooperation with other key individuals
Characteristics of Individuals	Disseminated treatment information through emails, meetings and/or lectures (F) Skill development/learn the method as incentive to participate (F) Unsure of how to provide parts of the treatment (B) Uncertainty about desired way of working after study (B) Uncertainty of future role in implementing the treatment (B)	Networks & Communications Organizational Incentives & Rewards Knowledge and Beliefs about the Intervention Self-efficacy	Therapists' professional engagement

For definitions of the constructs see Damschroder et al. (2009).

Intervention characteristics

Therapists' perception of possible adaptation of the treatment manual

The participants brought up adaptability of the intervention as the main factor influencing the assessment and the treatment of patients. The therapists had different views of how much the treatment could be adapted to the patient's needs. Some of the therapists felt free to adapt and use the treatment manual quite flexibly, while others described an insecurity about its adaptability. One of the therapists described the dilemma: *"What exactly is the manual? Like this—these parts . . . should all parts be included? Is that the manual then? Or can you jump and skip certain parts? Is that still the manual?"* (T3)

The question of suitability to patients was problematized more frequently during assessment among the therapists with a more restrained view of the manual's adaptability. Those who had a more flexible approach to the treatment manual, on the other hand, tended to identify eligible patients for the treatment to a larger extent.

Table 3. Overview of the CFIR domains; themes related to experiences of providing the hybrid treatment, including identifying, assessing, and treating patients; and facilitators of and barriers to this procedure.

CFIR domain and construct	Theme	Facilitators	Barriers
Intervention characteristics	Therapists' perception of possible adaptations of the treatment manual	Therapists who adapted the manual when needed described the structure as helpful throughout treatment	Therapists who were uncertain about adherence to the manual raised concerns whether the manual would meet the patient's treatment needs
Outer setting	Therapists' view of available resources and prioritization of patients' needs	A clearly stated need for a psychological treatment for pain patients facilitated the ability to identify patients in need of treatment	Lack of resources was a reason why pain patients' needs for psychological treatment were not prioritized, which affected the conditions for identifying eligible patients
Inner setting	Leadership engagement and the therapists' autonomy	The therapists' experience of a supportive leadership Managing their own time allowed the therapists to engage in the procedure Involvement of other key individuals helped to identify patients	Lack of presence and support from managers limited therapists' ability to identify suitable patients and to influence other key individuals Therapists' lack of mandate to influence colleagues' choice of treatment influenced their view of their role in a future implementation process
Inner setting	The treatment's compatibility with existing workflows and degree of cooperation with other key individuals	Compatibility with structures for existing treatments was facilitating for providing the treatment Existing structure for collaboration facilitated the identification and distribution of patients	The conditions of identifying patients depended on others than the therapist Lack of structure and time for cooperation were a barrier for identifying and distributing patients
Characteristics of Individuals	Therapists' professional engagement	The therapists' engagement in disseminating information about the intervention facilitated the conditions of identifying suitable patients Incentives to participate, related to competence development, enhanced therapists' engagement	Therapists' uncertainty regarding knowledge and beliefs about the intervention affected their view of their role in a future implementation process

Those who expressed uncertainty about the adaptability of the manual raised the ethical aspect of following the patient's needs rather than the manual's phases. One therapist also problematized the difference between following a manual and adaptations that are required, based on the patient's needs.

Outer setting

Therapists' view of available resources and prioritization of patients' needs

The therapists in primary care described a need for any psychological pain treatment to offer their patients, while therapists in specialized care rather recognized the need for a specific pain treatment targeting emotion regulation skills. Pain patients were acknowledged as a prioritized patient group at all the clinics. However, the priority of offering

them psychological treatment, as an alternative to only medical treatment, differed between primary care clinics. One therapist mentioned that management saw the treatment as an opportunity to save resources for the physicians, which facilitated the process of finding patients eligible for treatment:

They (the management) probably thought that more treatment was needed for people with long-term pain. That we haven't had a standardized treatment method like this, so then it was probably up to each therapist and different therapists have come and gone and so on. . . . And maybe mostly also such cases that the physicians are dealing with, that are quite difficult. . . . so they saw immediately that this could really add to the primary care clinic. (T2)

One of the therapists from a primary care clinic, who was not able to identify any eligible patients for the treatment, brought up priorities and lack of resources as a barrier. Due to lack of resources, patients with chronic illness were generally not prioritized and the management estimated that pain patients could be taken care of by other professions than psychologists. Therefore, psychological treatment for this group of patients was not a priority.

We have a big shortage of physicians so . . . we don't prioritize chronic patients. (T8)

It's not just me who can work with pain, it's also physicians and physiotherapists who can work with it. And therefore, I prefer to work with those that the others can't work with. (T8)

In comparison, one of the therapists, who did include several patients, brought up available resources as a facilitator for identifying pain patients in need of the treatment:

We have a lot of physicians actually. . . . right now. There are plenty of physicians there. They seem to thrive. . . . I have good contact with them, and they have respect for what I do as well. So that is a good foundation. (T5)

Inner setting

Leadership engagement and the therapists' autonomy

All therapists felt that the management had confidence in them in their professional roles. Most therapists described that the management fully relied on their evaluation of quality and research evidence of interventions. Furthermore, the therapists described that they independently planned and evaluated their treatments. The reason specified was that their managers often lacked knowledge about psychological treatment for pain and about the therapists' work in general. As one therapist described: *"It is probably also an advantage that they have an unawareness, I have been given a great deal of freedom. . . ."* (T7)

Most therapists described a working climate characterized by learning and development. They expressed an openness for trying new methods in the organization and they felt valued in change processes. This experience was related to the perception of the management being positive and encouraging about development of competence and skills. Nevertheless, several therapists described the role of their managers as rather passive. The issue that mainly had been raised with the management prior to participation in the project, was making sure to have time to participate and carry out treatments within the project. The therapists who clearly communicated a need for time also included more patients, than the therapists who did not have this type of discussion or

agreement with their managers. When asked about management participation, one of the therapists responded: *“So I just made sure that there is time for what is needed. It was nothing special.”* (T1)

Management having a peripheral role was described as a freedom but was also problematized as a lack of support throughout the procedure.

I still think our boss has been cool about this. She may not have supported us that much, and given us any support in this process, more like this free rein. To design our own work. (T9)

Therefore, I have a fairly high degree of freedom to... I’m allowed to, based on my own judgment, how much time and how many [patients] I can bring in then. (T5)

One concern that was raised was that it tended to rely on the individual therapist to disseminate information about this new treatment. However, the therapists did not feel that they had a mandate to introduce the treatment to other therapists at their clinic. Therefore, if there was no interest from other therapists in learning the treatment, no one felt that they had the mandate to drive a future implementation process. One therapist exemplified:

No, it’s not like, it won’t be like “do you also want to?” “Are you going to take this course?” “Do you want to work based on or with this method?” It’s not that kind of discussion. (T3)

A couple of therapists, working in specialized care, gave examples of colleagues who were satisfied with the treatments they currently offered, and therefore, had low motivation to learn and implement a new treatment: *“I can imagine that there is a curiosity, but perhaps not entirely obvious to let go of the methods you have...”* (T1)

In the long term, the lack of leadership involvement was raised as a concern for fidelity and an increased risk of not being able to sustain the treatment over time in the organization.

Although the managers’ role tended to be negligible in several organizations, some of the therapists received support from other individuals in leading positions, such as a physician in charge of research or a physician with a medical responsibility at the unit. This support was a facilitator for identifying eligible patients and helpful in disseminating information about the treatment.

The manager, she was not very involved. It was a bit more my thing and the medically responsible physician. He is also interested in pain and things like that. (T8)

The treatment’s compatibility with existing working methods

Most of the therapists did not need to make any changes in the existing workflows in their organization, which was a facilitator for the ability to provide the new treatment. Even if minor changes were necessary, it was not seen as a barrier, due to the therapists’ control over planning their treatments.

A more prominent factor compared to compatibility with existing workflows, was whether the conditions of identifying patients in need of the treatment depended on other key individuals within the organization, such as a physician or a nurse. When that was the case, the structure for cooperating with these individuals played a significant role. Most therapists within specialized care described a system where they could choose appropriate patients from a waiting list, while the therapists from primary care more

often were dependent on another profession to identify the right patients. The therapists in primary care, who identified eligible patients, described an existing structure for cooperation, such as a weekly meeting where they distributed the patients together. The therapists who did not manage to identify any patients described few opportunities to collaborate with others, due to organizational obstacles or because their meetings had a more practical focus rather than a cooperative one.

So absolutely, there is like a desire for it, but then... due to quite large organizational obstacles, which always stand in the way of all... all change anyway. So much desire but also like this... how do you get it to work with, like the physician's schedules when they are on call at the hospital and can only work so and so many hours, how do you get a collaboration where we meet. So, on that level. (T3)

When someone from another profession, e.g. a physician or a nurse, was involved in the planning and distribution of the pain patient's care, they needed to have knowledge of the new treatment and at the same time know the relevant criteria for identifying patients suitable for the treatment. However, the interest in learning more about the treatment varied due to other priorities. One therapist, who did not identify any eligible patients, described the dilemma: *"Now we try to teach them as much as possible so that they [the nurses] find the right patients for us at all... and then pain patients are not the ones who need to come in the first place."* (T8)

Characteristics of individuals

Therapists' professional engagement

All therapists perceived themselves as key individuals in disseminating information about the new treatment within the organization. They initiated meetings and educated colleagues about the intervention. However, some of the therapists were more eager to engage in dissemination than others. Some of them initially entered the research project as part of their specialist training. They could include the initial course as part of their specialist qualifications, and they got an opportunity to write an essay within the project: clear incentives for engagement. Other therapists mentioned their own driving force to develop their competence in the field. One therapist described: *"I thought it would be like a skill development in a way for me as well... taking on patients that I probably wouldn't have approached at all..."* (T5)

One therapist, who identified and treated several pain patients, described actively involving key individuals in the organization by informing the management, the physicians, and the therapist colleagues, and educating colleagues about psychological treatment for pain. The therapist also described continuous informal communication with colleagues: *"People know that I work with the hybrid treatment, I say that all the time so... 'I can take this one in the hybrid' or 'can this patient be a hybrid for you?' That's what they say."* (T5)

However, not all therapists were as confident about their role as key individuals, spreading the word to their colleagues about the intervention or leading a future implementation process forward. Some expressed uncertainty about the desired way of working and being a part of leading the continued implementation forward. This was partly

linked to an uncertainty regarding the application of the manual. Moreover, some therapists related their insecurity to lack of training. One therapist described:

It takes a will, I think. . . Or an enthusiast. And I don't know if I will feel that this is how I want to work. But I probably don't know the method well enough or have sort of not gotten a good enough grasp of okay, how will this work for my patients? (T4)

Some therapists expressed a specific doubt about the treatment component “exposure for movement” and whether it would be relevant for all pain patients. These doubts affected the therapists’ view of their role as key individuals in the implementation process forward, as described below:

So, I find it rather difficult to say that I would like to specifically pursue the issue of hybrid treatment [. . .] To lecture about this and at the same time struggle quite a lot with. . . Yes, but how do you actually think about this part? And how has this part actually worked? That it also makes it a little more difficult to present it to others as something that we should really use in our clinic. (T3)

In summary, the identified facilitators and barriers were linked to different parts of the procedure of identifying, assessing, and treating pain patients. Perceived adaptability affected the whole procedure, i.e. identification of eligible patients, as well as the assessment and treatment of patients. The prioritization of pain patients, a structure for collaboration and therapists’ engagement facilitated the identification of eligible patients, and leadership engagement was a key facilitating factor through the whole procedure. In addition, it emerged in the analysis of the data that lack of leadership support and uncertainty regarding knowledge and beliefs about the intervention were barriers for the therapists’ view of their role in a future implementation process.

Discussion

The aim of this study was to explore therapists’ experiences of contextual factors that may facilitate or act as barriers in the identification, assessment, and treatment of eligible patients when providing a new transdiagnostic psychological pain treatment in a clinical setting. While other dimensions from the outer setting and other stakeholders will have impact on a future implementation process, the focus of this study was the therapists’ experiences. The results relate to different levels of the organization, including individual, intervention, and organizational levels, which is consistent with the CFIR framework (Damschroder et al., 2009). The therapists’ experiences were related to the perceived adaptability of the intervention, their role as key individuals, the organization’s culture, and leadership, and prioritization and structure within the organization. The results relating to these four factors are further elaborated below.

Perceived adaptability

The therapists’ perception of the adaptability of the intervention varied. The structure of the treatment facilitated the use of it for some therapists, while others reported feeling constrained. Similar differences in perception of adaptability have been noted in other studies (Ringle et al., 2015), and the results are in line with studies showing that therapists

tend to perceive that manual-based treatments fail to acknowledge the patients' complexity related to their problems and needs (Taylor & Chang, 2008). Furthermore, it is well documented that there is no one-size-fits-all intervention for pain patients (Gilpin et al., 2017). However, these studies focus on either the therapist's perception of a treatment manual during treatment or the effect on treatment outcome for the patients. Our findings show that the perceived adaptability also affect the selection of eligible patients, i.e. which patients the therapists perceive to be suitable for the treatment and to what extent they feel that the treatment fits the pain patients' needs. The hybrid treatment manual is designed to be adaptable, yet findings suggest a need for clarification and support regarding the degree of flexibility when providing the treatment.

Therapists' role as key individuals

The findings show that identifying key individuals in the organization is crucial. However, the desire to take on this role appears to be influenced by potential barriers such as uncertainty related to knowledge and beliefs about the intervention and lack of leadership support. This implies that both confidence in the treatment's adaptability and sufficient knowledge of the intervention facilitates the therapists' engagement in having a key role in a future implementation. The need for professional training, and the costs of such training, has proved to be important to consider when implementing new treatments (Crome et al., 2017). Our findings show that it may not only be important for the therapists' skill development regarding the intervention, it may also function as a facilitator for taking on a key role in the implementation which emphasizes the importance of continued education and supervision for the therapists over time.

Leadership and culture of the organization

Internal leadership support appeared as a key factor for sustained use of the hybrid treatment. This is consistent with previous research showing that internal support and committed leaders with a key role in the process are crucial for a successful implementation (Edmunds et al., 2013; Taylor & Chang, 2008). However, the leadership is influenced by the organizational culture, for instance regarding the degree of autonomy for individual therapists. In CFIR, the definition of culture is described based on the Competing Values Framework (Quinn & Rohrbaugh, 1983). The model differentiates *team cultures*, i.e. cultures with high internal flexibility vs. *hierarchical culture*, i.e. cultures with a more formalized and structured control. This is relevant for understanding the results, since one facilitating factor was when therapists experienced that the management had confidence in their professional judgement. However, the perceived support did not necessarily include a mandate to lead the change process and involve colleagues when needed, making it a possible barrier for further implementation. Based on these cultural aspects, implementation of new psychological interventions should preferably be anchored at management level in the organization.

Prioritization and structure within the organization

Finally, prioritization of pain patients' needs and structures for collaboration appeared as other key factors for successful implementation. However, the conditions differed somewhat between primary and specialized care. In primary care, the prioritization of pain patients was not as unitary as in specialized care, and the management had different perceptions of how providing a psychological treatment for pain patients would affect resources. The perception of seeing the treatment as an alternative that may save time for other professions, rather than a supplement that makes the pain patient's care more comprehensive, influenced the management's prioritization, which in turn affected the therapists' conditions for finding eligible patients for the treatment. Furthermore, within primary care clinics, the therapists more often depended on other professional groups to identify patients for the treatment, making a collaborative structure essential. These circumstances may entail different kinds of barriers in primary care compared to specialized care, which suggests a need to adapt the key individual role to the organizational context for the implementation process to be successful.

Methodological considerations

The study has a few important methodological considerations worth lifting. First, the authors all have experience from treatment and treatment development in the pain field. This was a valuable competence in the analysis of the data but could conceivably imply that the authors are biased. Moreover, the therapists who were interviewed were aware that the first author, who conducted the interviews, had several years of experience from a specialized pain rehabilitation unit. It is reasonable to assume that the relationship between the interviewer and the interviewee was affected by factors such as differences in experience, which may have inhibited them in their responses. However, the results indicate that they were able to problematize the use of the treatment in their clinical setting. The authors did not use specific aids to improve reflexivity during this process, such as notes during the interviews or in the transcription phase. Nevertheless, we argue that the collaboration among the authors in the analysis phase promoted reflexivity and aided a nuanced interpretation of the data. Moreover, the first author's background and knowledge of the area of chronic pain treatment have most likely impacted on her ability to ask well-informed follow-up questions improving the quality of the data material.

Second, the participants were therapists who had initiated contact with the project's research group on their own initiative, which suggests an expressed interest in participating in the study. This implies a potential selection bias, which may affect the transferability of the results. Yet, their experiences were in line with previous research in this field. The first author, who conducted the interviews and was the main responsible for coding and analyses, attended the same digital University course as some of the participating therapists. This prior understanding and relation to the participating therapists may induce a potential social response bias. Another potential source of bias was the first author's prior understanding of the treatment and experience of specialist care for pain patients. This may have influenced the interpretation and understanding of the data. However, using CFIR throughout the research process enhances the dependability of the findings, through

emphasizing the overall picture. It also facilitates structured comparison of the results to previous findings. On the other hand, using a framework, however extensive, may increase the risk of disregarding data that is not part of the framework. Moreover, gaining an overall understanding of the CFIR domains was challenging due to the wide variety of constructs included in the domains, as well as the fact that there is an overlap in definitions that allows for different interpretations of how to apply the constructs.

Finally, an important limitation is the lack of member checking during the analysis phase. Involving the interviewees and returning the results to them to check for resonance with their experiences would have been a way to improve the credibility and confirmability of the results. However, we argue that the collected and multifaceted experience within the group of authors has decreased the risk of the results being flawed. Moreover, since the results were in many parts in line with previous findings, we are confident enough that the findings are useful and transferable to other settings. In sum, there were indeed limitations to the study, but we argue for the validity of our findings despite these limitations.

Clinical implications

The findings show that leadership support is essential to secure resources and empower key individuals to make the necessary decisions to facilitate a future implementation. A potential barrier for therapists to engage as key individuals is insufficient knowledge of the intervention, which emphasizes the importance of therapists being comfortable with the treatment protocol and its adaptability and suggests a need for continued training and supervision of therapists over time. Management, or key individuals with a mandate, need to establish that there are organizational structures such as compatible workflows and structure for collaboration that facilitate the use of the intervention.

Recommendations for future research

The current study identified contextual factors experienced as facilitating or as barriers when providing a new transdiagnostic psychological treatment, “the hybrid treatment”, in a clinical setting. These factors can be used as a starting point for further implementation studies with the aim of creating implementation strategies tailored to the organizational context. However, due to our perspective of therapists’ experiences, our findings are limited to their perspective, hence more research is required to understand facilitators and barriers of outer setting aspects such as how other external stakeholders influence the possibilities of implementing a new psychological treatment in regular care.

Conclusions

This study contributes to previous literature on implementing psychological interventions for pain patients in regular care by exploring facilitators and barriers across multiple levels of systems and organizations. The results may assist in identifying factors that could influence a future implementation of a new treatment in regular care, emphasizing a coherent implementation strategy, suited for the organizational context. The findings

specifically indicate a need for committed leadership and key individuals with competence and mandate to both support and communicate with other stakeholders. The willingness to engage in such a key role seems to depend on the therapists' knowledge and beliefs about the intervention's adaptability and treatment content. Future implementation of new treatments in regular care should preferably consider these factors to enhance facilitators and overcome barriers when designing an organizationally tailored implementation strategy.

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Data availability statement

The data is not publicly available due to content that could compromise the privacy of the study participants. Inquiries about access may be sent to Örebro University, School of Behavioral, Social, and Legal Sciences, Center for Health and Medical Psychology (CHAMP), Fakultetsgatan 1, 701 82 Örebro.

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Appendix. Interview guide

Informed consent to participate in the study (is recorded): Have you read the information letter about the study, and do you understand what it entails to participate? That personal information will be collected and handled according to GDPR. That participation is voluntary and that you can end participation at any time, without explanation.

Demographic information:

Years in profession?

Gender?

Type of av organization (primary- or specialist care)?

CFIR Constructs:	Core questions:	Follow-up questions:
Intervention Source (Internal/external) Evidence Strength & Quality	Describe the background of your/ your organization's participation in the project regarding implementation of the hybrid treatment?	– How and by whom was the decision made to implement the hybrid treatment in your clinic? – Was the treatment's evidence/validity/quality an important variable regarding the decision to participate? – Which other reasons/arguments were raised?
Networks & Communications Readiness for Implementation Leadership Engagement Access to Knowledge & Information	Which role has your boss/ management played in you being able to take part in the hybrid project?	– Can you describe how closely you work with management or other relevant interested parties that may enable implementation? – Do you experience that you have support from management throughout the process? – Which degree of cooperation/authorization has been necessary to participate in the study? – Are there examples of barriers that management has contributed to?
Intervention Complexity Design Quality & Packaging Intervention Source (external—research project) Readiness for implementation Access to Knowledge & Information	How has the treatment's set-up and/or the support you have received from the hybrid project influenced the conditions for implementation?	– How do you feel that the support that has been given in the form of education/supervision/ workshops has influenced the conditions for participating in the study? - Has anything been missing? - How do you experience the availability of support from the hybrid project? – Anything else regarding the procedure surrounding the treatment that you think has had an influence? – What are the pros and cons you can see with implementation as part of a study?
Patient Needs & Resources Implementation Climate Tension for Change Knowledge & Beliefs about the Intervention	How well is your clinic's task in line with the hybrid treatment?	– Are pain patients a prioritized patient group in your clinic? – Is pain treatment a prioritized need for the patients you meet? – Which factors (barriers or facilitators) do you see affecting the conditions for the organization in prioritizing pain patients' needs for pain treatment in general or the hybrid treatment specifically? – How do you view the need for the hybrid treatment in your clinic? Is it a prioritized need? Why/why not? – How well does the treatment match the patient's needs? – Do you see other external factors, such as the clinic's goals or guidelines, that influence the conditions to use the hybrid treatment in your patient work?
	Specifically for pain clinics:	

(Continued)

(Continued).

CFIR Constructs:	Core questions:	Follow-up questions:
External Policies & Incentives Implementation Climate Goals & Feedback Organizational Incentives & Rewards	How would you describe the organizational preconditions for implementing the hybrid treatment in your clinic?	– How well does the intervention match the existing working processes? – Did ways of working need to look differently when using the hybrid treatment? – Did the hybrid treatment's scope, or the steps included, influence the possibilities of implementation? – <i>If needed, clarify regarding the study's influence on implementation:</i> Are the described adaptations of ways of working connected to the participation in the study or the use of the hybrid treatment generally? – If work has been adapted, has management been involved/done anything to enable participation in the study? Which changes, in your opinion, have to be made to implement the hybrid treatment "for real" in the organization?
Structural Characteristics Networks & Communications Readiness for implementation Leadership Engagement Culture Implementation Climate Tension for Change Compatibility Relative Priority Organizational Incentives & Rewards Goals & Feedback Learning Climate Self-efficacy Other Personal Attributes	How does the clinic's "implementation climate" influence? To what extend is there space for learning and how is this rewarded at your workplace?	– How do you think that the culture (values and assumptions influencing the organization) in your organization influence the preconditions for implementation? – To what extend do you experience that you have space, in terms of time, to test new ways of working in order to develop in your work? – Do you have the time and/or energy to think about how things at work could be developed or changed? (stress level) – What makes you want to use and implement the hybrid treatment in your organization? Does it positively influence you or your work situation in any way? – Are there other ongoing prioritized activities in your organization that risk influencing the implementation of the hybrid treatment? Finally, besides what you've raised, – Do you see anything else that may have obstructed or promoted the implementation of the hybrid treatment in your organization?