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Short communication

Becoming an eCoach: Training therapists in online cognitive-behavioral therapy for chronic pain

Jessy A. Terpstra[a,*], Rosalie van der Vaart[a,1], Saskia Spillekom-van Koulil[b], Arno van Dam[c], Judith G.M. Rosmalen[d,1], Hans Knoop[e,1], Henriët van Middendorp[a], Andrea W.M. Evers[a,f,1]

[a] Institute of Psychology, Health, Medical and Neuropsychology Unit, Leiden University, Wassenaarseweg 52, PO Box 9555, 2300 RB, Leiden, The Netherlands
[b] Radboud University Medical Center Nijmegen, Department of Medical Psychology Nijmegen, PO Box 9101, 6500 HB, The Netherlands
[c] Tilburg University, Tilburg School of Social and Behavioral Sciences, PO Box 90153, 5000 LE, Tranzo, Tilburg, The Netherlands
[d] University of Groningen, University Medical Center Groningen, Departments of Psychiatry and Internal Medicine, PO Box 30001, 9700 RB, Groningen, The Netherlands
[e] Academic Medical Center, Department of Medical Psychology, PO Box 22660, 1100 DD, Amsterdam, The Netherlands
[f] Leiden University Medical Center, Department of Psychiatry, PO Box 9600, 2300 RC, Leiden, The Netherlands

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ABSTRACT

Objective: Online cognitive-behavioral therapy (iCBT) is effective in supporting patients' self-management. Since iCBT differs from face-to-face CBT on several levels, proper training of therapists is essential. This paper describes the development and evaluation of a therapist training based on theoretical domains that are known to influence implementation behavior, for an iCBT for chronic pain.
Methods: The training consists of 1.5 days and covers the implementation domains "knowledge", "skills", "motivation", and "organization", by focusing on the therapy's rationale, iCBT skills, and implementation strategies. Using an evaluation questionnaire, implementation determinants (therapist characteristics, e-health attitude, and implementation domains) and iCBT acceptance were assessed among participants after training.
Results: Twenty-two therapists participated, who generally showed positive e-health attitudes, positive implementation expectations, and high iCBT acceptance. Organizational aspects (e.g., policy regarding iCBT implementation) were rated neutrally.
Conclusions: An iCBT therapist training was developed and initial evaluations among participants showed favorable implementation intentions.
Practice implications: Therapists' positive training evaluations are promising regarding the dissemination of iCBT in daily practice. Organizational support is vital and needs to be attended to when selecting organizations for iCBT implementation.

1. Introduction

Internet-based cognitive-behavioral therapy (iCBT) is an important tool to support patients' self-management. It empowers them by increasing their knowledge, skills, and confidence to manage their condition [1]. Previous research on iCBT for patients with chronic somatic conditions has shown positive results on psychological and physical functioning, as well as on the impact of the conditions on daily life [2–4]. This internet-based mode of delivery provides flexibility regarding time and location for both patients and therapists, and therefore increases the availability of therapists [1]. Therapist contact remains important in internet-based therapy, since it has been found that guided iCBT appears more effective in supporting behavior change than iCBT without

Abbreviations: iCBT, internet-based cognitive-behavioral therapy; TDF, Theoretical Domains Framework; DIBQ, Determinants of Implementation Behavior Questionnaire; HR-QoL, health-related quality of life; MREC, Medical Research Ethics Committee; LUMC, Leiden University Medical Center; IBM SPSS Statistics 23, International Business Machines Corporation Statistical Package for the Social Science 23.

* Corresponding author.
E-mail addresses: j.a.terpstra@fsw.leidenuniv.nl (J.A. Terpstra), r.van.der.vaart@fsw.leidenuniv.nl (R. van der Vaart), Saskia.Spillekom-vanKoulil@radboudumc.nl (S. Spillekom-van Koulil), a.vandam@uvt.nl (A. van Dam), j.g.m.rosmalen@umcg.nl (J.G.M. Rosmalen), hans.knoop@amc.uva.nl (H. Knoop), h.van.middendorp@fsw.leidenuniv.nl (H. van Middendorp), a.evers@fsw.leidenuniv.nl (A.W.M. Evers).

[1] Master Your Symptoms Consortium.

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those attributes [5]. However, the implementation of iCBT is challenging [6]. A significant factor for successful iCBT implementation entails the skills of therapists, which include deciding when to use iCBT and motivating patients using written feedback. Training therapists in applying these skills could therefore be valuable to enhance implementation.

This paper describes the development and evaluation of a theory-based therapist training regarding an iCBT for chronic pain. To develop our training, a framework by Huijg et al. [7], based on the Theoretical Domains Framework (TDF [8]), was used. This framework consists of domains that reflect potential determinants of implementation behavior for health-related interventions, such as knowledge of the intervention, skills to deliver it, and motivation to deliver it. Huijg et al. subsequently developed a measurement instrument, the Determinants of Implementation Behavior Questionnaire (DIBQ [7]) and a shorter version of it as a checklist [9, p.175], to assess implementation behavior in healthcare professionals. The checklist [9, p.175] was adopted to evaluate the effectiveness of the therapist training and to assess implementation expectations of trained therapists. Additionally, the Technology Acceptance Model (TAM [10,11]) was used to evaluate the acceptance of iCBT amongst the trained therapists, since a vital factor associated with implementation of online therapy is acceptance of its technology by the foreseen user. TAM is one of the most influential user acceptance models, based on the Theory of Reasoned Action (TRA [12]). It postulates that *perceived ease of use* and *perceived usefulness* of a new technology are essential determinants of users' *behavioral intention* to use it. Subsequently, behavioral intention predicts actual use of the technology. The present paper provides an explorative overview of the implementation expectations and iCBT acceptance of therapists after our training and summarizes implications for clinical practice.

2. Methods

2.1. Participants and procedure

Thirteen mental healthcare institutions across the Netherlands expressed interest to implement the iCBT for chronic pain. Participating therapists had a minimum of a clinical master's degree in psychology, with the exception of one master student who was about to complete the degree. The participating therapists received an information letter before the training, including the aims of the intervention and the content of the therapist training.

In this study, a descriptive design was applied, using an explorative evaluation questionnaire to gather data. The study has been granted an exemption from requiring ethics approval by the Medical Research Ethics Committee of Leiden University Medical Center.

2.2. iCBT for chronic pain

The iCBT for chronic pain "Master Your Pain" (presented in Fig. 1) was designed to provide chronic pain patients with an easily accessible online program, in which maladaptive coping strategies are adjusted in order to improve health-related quality of life.

2.3. iCBT therapist training

The therapist training (outlined in Fig. 2) was developed to offer a comprehensive training in the iCBT for chronic pain to therapists who are experienced in treating chronic pain patients.

2.4. Instruments

In order to evaluate the therapist training and assess iCBT acceptance, participants were asked to fill out the evaluation questionnaire (summarized in Table 1) right after completion of the second training day.

2.5. Data analysis

The Statistical Package for the Social Sciences 23 (IBM SPSS Statistics 23) was used to perform analyses. Descriptive statistics were applied to describe the study sample (demographics, their attitudes towards e-health, internet experience, and work experience), their implementation expectations, and their iCBT

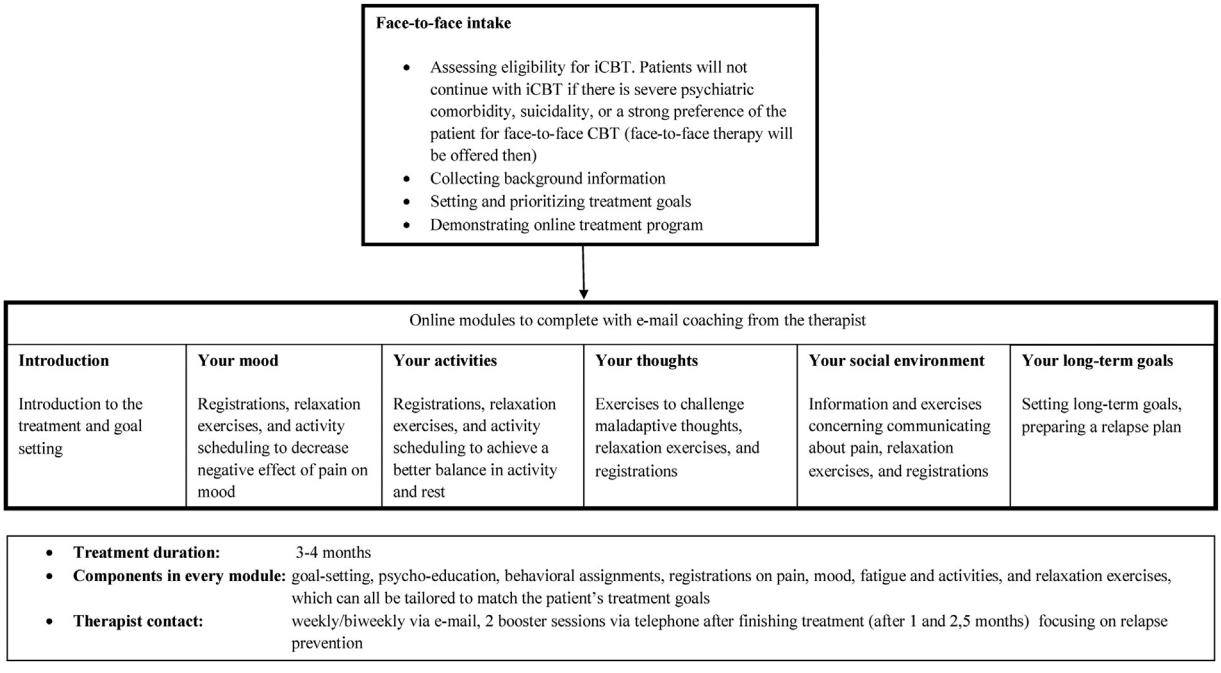

Fig. 1. Flow chart of iCBT "Master Your Pain".

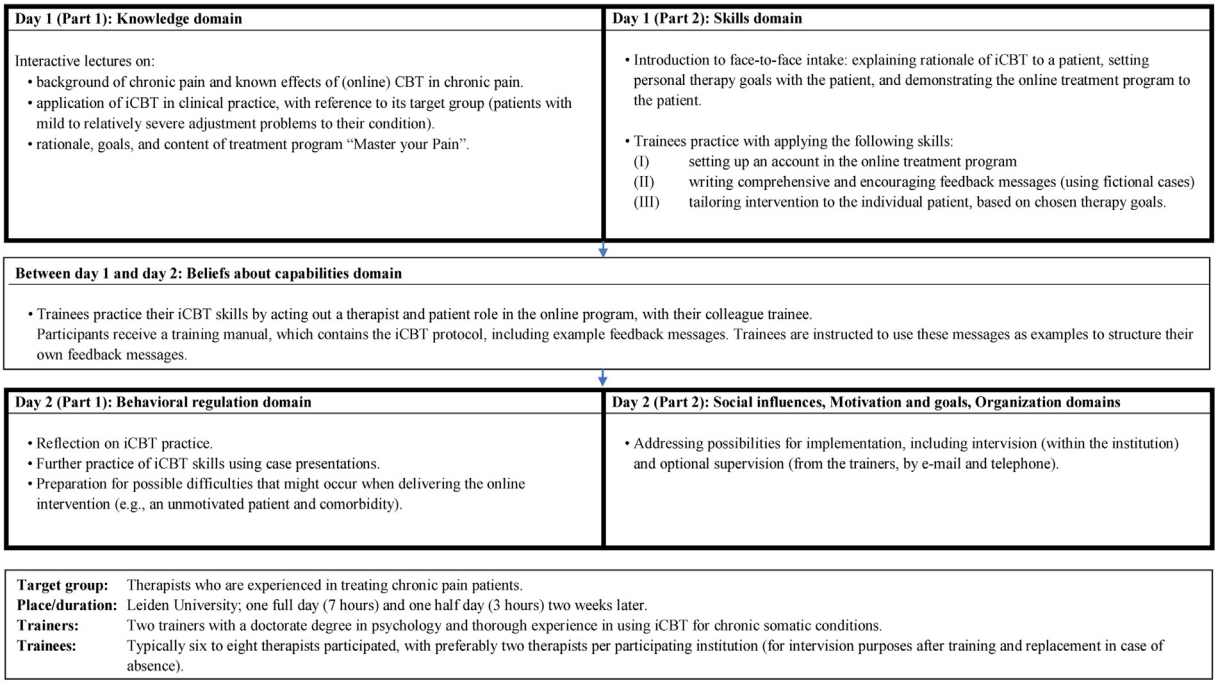

Fig. 2. Overview of the iCBT therapist training of "Master Your Pain".

Table 1
Content Evaluation Questionnaire iCBT Therapist Training.

Part	Measured construct	Description	Example items
I	background information about the healthcare professional	Ten questions on age, sex, healthcare specialism, number of working years, experience with psychological (chronic pain) treatments.	"How many protocolized treatments have you completed?"; "How many chronic pain patients have you treated?".
II.	internet experience	Four questions on the frequency of internet use, perceived internet skills level, and range of activities executed via the internet.	"How often do you use the internet?"; "What activities do you execute via the internet?"
III	participants' attitudes towards e-health	Short version of the E-health questionnaire [13]: eighteen questions scored on a 5-point Likert scale, ranging from 1 (*completely disagree*) to 5 (*completely agree*), with an acceptable overall internal consistency ($\alpha = .76$).	"E-health promotes patients' self-management"; "E-health undermines therapists' creativity"; "The flexibility that e-health offers to the patient is positive for treatment".
IV	Evaluation of implementation expectations after training	Fifteen questions, based on an implementation domains checklist ([9] p.175). The questions comprised implementation domains (e.g., *Knowledge* and *Skills*) as discussed by Huijg [9]. All domains were measured with 1 item that was scored on a 5-point Likert scale, ranging from 1 (*completely disagree*) to 5 (*completely agree*).	"I have sufficient skills to deliver the iCBT following the guidelines"; "I have sufficient knowledge to deliver the iCBT following the guidelines".
V	iCBT acceptance	Four questions based on the TAM [10], evaluating the perceived usefulness and the perceived ease of use of the online treatment, and the intention to use the iCBT program. One question was added to measure the perceived usefulness of the therapist training. All questions were scored on a 5-point Likert scale, ranging from 1 (*completely disagree*) to 5 (*completely agree*).	"I find the iCBT useful"; "I intend to use the iCBT whenever it suits a patient's complaints".

acceptance. Missing data were deleted pairwise, thereby preserving more data in a small data set than after listwise deletion. Pairwise deletion was applied after checking that data were missing completely at random (MCAR), using Little's MCAR procedure [14].

3. Results

3.1. Study sample

A total of 23 therapists were trained and filled out the evaluation questionnaire. One participant had a high number of missing data (19%) and was therefore excluded from the data analysis, which makes a total *N* of 22. Overall, a low 1% of items (12 items) were missing from the dataset, of which the greater part (11 out of 12 items) were rated "not applicable". A non-significant Little's MCAR test [14], $\chi 2$ (272, $N = 22$) = 44.31, $p = 1.000$, showed that the data were missing completely at random. The therapist characteristics are listed in Table 2. The therapists generally had positive e-health attitudes ($M = 3.72$, $SD = 0.93$, on a 5-point scale; data not shown in table). They indicated agreement with items such as "E- health promotes patients' self-management" ($M = 4.27$, $SD = 0.63$) and indicated disagreement with items such as "E-health undermines therapists' creativity" ($M = 2.18$, $SD = 0.80$).

3.2. Implementation expectations and iCBT acceptance after training

Therapists had mostly positive implementation expectations after training (see Table 3), with respondents agreeing with

Table 2
Background information about the 22 participating healthcare professionals and their work experience

Characteristics (*n* in case of missings)		Healthcare professionals *N* (percentages)
Sex		
	Female	18 (81.8)
Age (M, SD) Professional background[a]		42.9 (9.1)
	Healthcare psychologist	10 (45.5)
	Clinical psychologist	5 (22.7)
	Other ([Basic] psychologist, MSc Health Psychology student, psychologist NIP[b])	5 (22.7)
	Psychotherapist	2 (9.1)
	Psychiatric nurse practitioner	1 (4.5)
	Psychiatrist	1 (4.5)
Number of working years as a therapist (*n* = 21)		
	≤9	5 (23.8)
	10–19	9 (42.9)
	≥20	7 (33.3)
Estimated total number of completed protocolized treatments (*n* = 17)		
	≤ 50	4 (23.5)
	51–100	5 (29.4)
	>100	8 (47.1)
Estimated total number of treated chronic pain patients		
	≤ 50	13 (59.1)
	51–100	4 (18.2)
	>100	5 (22.7)

[a] Multiple types of specialisms can be registered simultaneously.
[b] Psychologists with a master's degree and work experience can become a member of the Netherlands Institute of Psychologists (NIP), a professional association of psychologists in The Netherlands.

Table 3
Implementation domains in the iCBT evaluation after the therapist training with M, SD, and Range (theoretical range: 1–5).

Implementation domain[a]	Item (*n* in case of missings)	*M*	*SD*	Range
Knowledge	I have sufficient knowledge to deliver the iCBT following the guidelines	4.00	0.54	3–5
Skills	I have sufficient skills to deliver the iCBT following the guidelines	3.91	0.75	2–5
Innovation	It is possible to tailor the iCBT to participants' individual characteristics and needs (i.e., it is not a straightjacket) (*n* = 21)	3.90	0.63	3–5
Motivation and goals	I am motivated to deliver the iCBT following the guidelines	4.64	0.49	4–5
Beliefs about consequences	A (suspected) consequence of delivering the iCBT following the guidelines is that a patient will be hindered less by his/her pain	4.25	0.55	3–5
Beliefs about capabilities	I am confident that I can deliver the iCBT following the guidelines, even when I encounter barriers (e.g., limited time, unmotivated patient)	3.82	0.59	3–5
Emotions and optimism	I feel good when I deliver the iCBT following the guidelines (e.g., comfortable, calm, relaxed, cheerful, elated) (*n* = 19)	3.89	0.57	3–5
Behavioral regulation	I have clear plans of how I will deliver the iCBT following the guidelines	3.23	0.81	2–5
Memory	I can easily remember what I need to do to deliver the iCBT following the guidelines	3.45	0.67	2–4
Socio-political context	Delivering the iCBT is a free choice for me (i.e., it is not imposed by others)	4.36	0.85	2–5
Social/professional role and identity	I believe that as an online therapist, it is my job to keep the patient motivated for the treatment through my messages	4.50	0.51	4–5
Organization	In my organization, formal arrangements are made with regard to the delivery of the iCBT (i.e., policy, work plans, etc.) (*n* = 18)	3.28	1.07	1–5
Social influences	I can count on sufficient support with regard to delivering the iCBT (e.g., from colleagues, management, others involved) (*n* = 21)	4.05	0.81	2–5
Participants	In my organization, there is (I suspect) a sufficient influx of patients for the iCBT	3.18	0.85	2–5
Innovation strategy	I would like to have more training to deliver the iCBT following the guidelines	1.95	0.79	1–4

[a] All domains were measured with 5-point Likert scale items with scores 1 (*completely disagree*), 2 (*disagree*), 3 (*neutral*), 4 (*agree*), and 5 (*completely agree*).

statements indicating sufficient acquirement of skills ($M = 3.91$, $SD = 0.75$), knowledge ($M = 4.00$, $SD = 0.54$), and motivation ($M = 4.64$, $SD = 0.49$) to deliver the iCBT following protocol. Organizational aspects, such as the presence of formal arrangements within the organization regarding delivering the iCBT and an expected sufficient influx of patients for the iCBT, were rated neutrally ($M = 3.28$, $SD = 1.07$ and $M = 3.18$, $SD = 0.85$, respectively).

Overall, respondents experienced the therapist training as useful ($M = 4.43$, $SD = 0.51$; see Table 4). Regarding iCBT acceptance, respondents mostly perceived the iCBT as useful ($M = 4.43$,

Table 4
Perceived Usefulness, Ease of Use, and Intention to use iCBT.

Usefulness, ease of use, and intention items[a] (*n* in case of missings)	*M*	*SD*	Range
I find the iCBT useful (*n* = 21)	4.43	0.51	4–5
The iCBT program is easy to use	3.95	0.65	2–5
I intend to use the iCBT whenever it suits a patient's complaints	4.77	0.43	4–5
I find the iCBT therapist training useful	4.55	0.51	4–5

[a] All items were measured on a 5-point Likert scale with scores 1 (*completely disagree*), 2 (*disagree*), 3 (*neutral*), 4 (*agree*), and 5 (*completely agree*).

SD = 0.51) and easy to use (*M* = 3.95, *SD* = 0.65). Moreover, they expressed the intention to use the iCBT whenever it would suit a patient's complaints (*M* = 4.77, *SD* = 0.43).

4. Discussion and conclusion

4.1. Discussion

In the present study, a theory-based therapist training in iCBT was outlined and preliminary implications for implementation behavior were examined. Overall, therapists had positive attitudes and intentions regarding adoption of the iCBT after training. Moreover, they indicated to have acquired sufficient skills, knowledge, and motivation to implement the intervention in daily practice. Beidas and Kendall emphasize in their review on therapist trainings [15] that trainings must use active learning strategies, such as practice possibilities, to impact therapist behavior change. Our therapist training incorporated several active learning strategies, with practice opportunities in iCBT skills during the training and between the two training sessions. Additional supervision in the form of e-learning modules or an online communication forum could be useful to further support the therapists with the implementation of the intervention [16].

Organizational aspects of implementation were rated neutrally by the trained therapists, which may point to insufficient knowledge or influence on these factors to rate them. The importance of organizational aspects in treatment implementation is highlighted in several studies [e.g., 15–17]. For instance, Zazzalli et al. [17] have suggested that for implementation it is important that the intervention fit the organization's mission, the organization has sufficient means to implement the intervention, and patient referrals are facilitated. These measures are likely to be outside of the scope of integration in a therapist training, yet appear critical factors to attend to when selecting organizations for therapist trainings and iCBT implementation.

To our knowledge, this is the first study in which a theory-based face-to-face therapist training in iCBT was described and evaluated. However, some limitations have to be considered. Firstly, the sample size was small. Therefore, the findings cannot be generalized based on this study alone. Moreover, certain psychometric properties of the evaluation questionnaire (e.g., factor structure) could not meaningfully be calculated due to the small sample size. The evaluation questionnaire needs to be further validated in larger samples. Thirdly, only self-report was used to assess implementation factors. Adding methods to measure implementation factors more objectively, such as an in vivo skill assessment, could yield more information on levels of iCBT competency achieved through the training and inform training techniques.

4.2. Conclusion

To conclude, therapists' positive implementation expectations and high iCBT acceptance after training are promising with regard to the dissemination of iCBT in clinical practice. Future research should focus on relations between iCBT therapist trainings and treatment implementation rates, using follow-up measurements to investigate actual implementation and potential barriers.

4.3. Practice implications

Organizational support is vital for implementation and needs to be targeted using a holistic implementation approach. As well as training therapists, creating an open atmosphere among managers and colleagues is important to ensure that the new intervention becomes part of the regular treatment options.

Authors' contributions

RV, SS, and AE made substantial contributions to the conception and design of the training and the study, and the acquisition of data. RV and SS acted as trainers in the iCBT therapist training. AD made the E-health attitude questionnaire available for evaluation of the iCBT therapist training. JT subsequently analyzed and interpreted data regarding the evaluation scores of the therapist training and was a major contributor in writing the manuscript. RV, SS,AD, JR, HK, HM, and AE revised the manuscript critically for important intellectual content. All authors read and approved the final manuscript.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Ethics approval and consent to participate

The study has been granted an exemption from requiring ethics approval by the Medical Research Ethics Committee (MREC) of Leiden University Medical Center (LUMC). I confirm all personal identifiers have been removed so the persons described are not identifiable and cannot be identified through the details of the story.

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