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Research

Physiotherapists report improved understanding of and attitude toward the cognitive, psychological and social dimensions of chronic low back pain after Cognitive Functional Therapy training: a qualitative study

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KEY WORDS

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ABSTRACT

Question: What are physiotherapists' perspectives on managing the cognitive, psychological and social dimensions of chronic low back pain after intensive biopsychosocial training? **Design:** Qualitative study design using semi-structured interviews to explore physiotherapists' perceptions of their identification and treatment of the biopsychosocial dimensions of chronic low back pain after intensive Cognitive Functional Therapy (CFT) training. **Participants:** Thirteen qualified physiotherapists from four countries who had received specific CFT training. The training involved supervised implementation of CFT in clinical practice with patients. Interviews were audio-recorded and transcribed verbatim. An interpretive descriptive analysis was performed using a qualitative software package. **Results:** Four main themes emerged from the data: self-reported changes in understanding and attitudes; self-reported changes in professional practice; altered scope of practice; and increased confidence and satisfaction. Participants described increased understanding of the nature of pain, the role of patient beliefs, and a new appreciation of the therapeutic alliance. Changes in practice included use of new assessments, changes in communication, and adoption of a functional approach. Since undertaking CFT training, participants described a greater awareness of their role and scope of practice as clinicians in identifying and addressing these factors. **Conclusion:** Physiotherapists expressed confidence in their capacity and skill set to manage the biopsychosocial dimensions of chronic low back pain after CFT training, and identified a clear role for including these skills within the physiotherapy profession. Despite this, further clinical trials are needed to justify the time and cost of training, so that intensive CFT training may be made more readily accessible to clinicians, which to date has not been the case. **[Synnott A, O'Keeffe M, Bunzli S, Dankaerts W, O'Sullivan P, Robinson K, O'Sullivan K (2016) Physiotherapists report improved understanding of and attitude toward the cognitive, psychological and social dimensions of chronic low back pain after Cognitive Functional Therapy training: a qualitative study. *Journal of Physiotherapy* 62: 215–221]**

Introduction

Chronic low back pain is a costly and debilitating musculoskeletal disorder that imposes a significant burden on both the person and society.[1,2] The societal and other costs of chronic low back pain are such that establishing an efficacious management approach to chronic low back pain is a healthcare priority.[3,4]

Chronic low back pain is no longer considered a purely structural, anatomical or biomechanical disorder of the lumbar spine. Instead, there is strong evidence that chronic low back pain is associated with a complex interaction of factors across the biopsychosocial spectrum. These not only involve structural or biomechanical factors, but also cognitive (eg, unhelpful beliefs, catastrophising, maladaptive coping strategies, low self-efficacy), psychological (eg, fear, anxiety, depression) and social (eg, work and family issues) factors.[5] Whilst the presence of cognitive, psychological and social factors are regarded as predictors of poor prognosis, when targeted effectively, these factors are considered important mediators for improved patient outcomes.[6–8] This is on the basis of trials showing that successful outcomes, even after a purely physical intervention, are often mediated by changes in cognitive and psychological factors (eg, fear, catastrophising, self-efficacy, beliefs), not changes in physical factors (eg, posture, muscle thickness), which are often the main targets for treatment.[9,10]

Consequently, chronic low back pain treatment guidelines[11,12] generally acknowledge a shift toward a biopsychosocial management approach. In this approach, the cognitive, psychological and social dimensions of chronic low back pain are considered in addition to the physical and pathoanatomical dimensions of pain.[13,14]

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The available research indicates that physiotherapists theoretically endorse the proposed biopsychosocial approach to treatment, yet very few are adopting this approach in clinical practice, despite training in cognitive behavioural principles.[12,15] A recent systematic review[16] found that physiotherapists lacked confidence in their ability to identify, communicate about and manage cognitive, psychological and social dimensions of chronic low back pain in practice. Physiotherapists reported feeling that neither their initial training nor currently available professional development equipped them to successfully deal with these factors in practice. The physiotherapists emphasised a need for training on integrating these factors into patient management.

A growing body of research is exploring the impact of training directed at altering physiotherapists' ability to manage cognitive, psychological and social factors in chronic low back pain.[17–19] It remains unclear whether such training equips physiotherapists with the requisite skill set to appropriately target these factors in practice.[18]

Few treatment approaches in the domain of physiotherapy explicitly integrate cognitive, psychological and social factors in the management of chronic low back pain. Cognitive Functional Therapy (CFT) is a novel, multidimensional, patient-centred intervention that directly explores and manages cognitive, psychological and social factors deemed to be barriers to recovery in chronic low back pain.[5,20] The CFT approach centres on the retraining of maladaptive movement patterns, reconceptualising patient pain beliefs, and addressing any relevant cognitive, psychological, social or lifestyle factors.[20] Training in CFT aims to equip physiotherapists with the required skills through training workshops that place an emphasis on practical experimentation and demonstration with live patients.[5]

Quantitative research has established that patient outcomes improve with CFT delivered by trained physiotherapists.[5,21] However, physiotherapists' experiences after completing such training have not yet been qualitatively explored. It is important to establish such perspectives because, while CFT may be beneficial to patients, if therapists are unwilling or unconfident to administer it, it may not be an approach that is incorporated regularly, effectively, or with ease in the clinical setting.

Therefore, the study question for this qualitative study was:

> What are physiotherapists' perspectives on treating the biopsychosocial dimensions of chronic low back pain after receiving intensive biopsychosocial training?

Methodology

Study design

A qualitative, interpretive description design was chosen.[22] Interpretive description is a non-categorical methodological approach that was developed purposely to provide healthcare practitioners with a conducive framework for exploring clinically occurring phenomena in healthcare.[23] Interpretive description allows exploration of complex experiential clinical phenomena[23] and provides direction in the creation of an interpretative account using techniques of reflective, critical examination.[22,24] An interpretive description design was deemed compatible with the objectives of this study because the theoretical standpoint of this design centres on the ability of interpretive description to provide generalisable insights into the current clinical practices of healthcare practitioners, which may aid in guiding future clinical approaches.[24] Due to the individual experiences of physiotherapists in their management of chronic low back pain, semi-structured interviews were employed. The authors are clinical and research physiotherapists with an interest in biopsychosocial models of pain. Authors KOS, POS and WD acted in the capacity of CFT trainers and mentors of the physiotherapist participants in this study.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist guided the reporting of this study.[25] To ensure that the questions had a valid and meaningful theoretical scaffolding, the questioning route or topic guide for this study was generated based on a literature review of research articles in the area.[24] The route was then refined by discussion within the research team to ensure the questions, content and structure were suitably open-ended, neutral and sensitive.[26]

Participants

CFT trainers (inclusive of authors KOS, POS and WD) (www.pain-ed.com) nominated physiotherapists whom they deemed competent in the delivery of CFT, after training, and email addresses for individual contacts were provided. A recruitment email containing an information leaflet and consent form was emailed to potential participants. Fourteen physiotherapists were invited to participate.

Participants represented a purposive sample of English-speaking physiotherapists who had completed CFT training. All participants had received CFT training from CFT trainers (www.pain-ed.com) (inclusive of authors KOS, POS and WD). Training included both workshop attendance, in which they observed CFT trainers assessing and treating live patients, and supervision of clinical practice. All participants had participated in at least two CFT workshops (average of nine workshops completed to date, average duration of 12 hours), and were supervised by CFT trainers for at least four sessions of clinical practice with patients. The key criterion for inclusion was that a CFT trainer had observed the participant assessing and treating multiple patients and deemed that the participant was competent in the administration of CFT.

Data collection

Semi-structured telephone and Skype interviews were completed by a researcher (AS) who was unknown to the participants and was guided by a flexible question route. The questioning route covered: changes in practice as a result of CFT training; the participant's confidence and competence in identifying, discussing and addressing cognitive, psychological and social factors with patients; and the participant's confidence in establishing a strong patient-therapist alliance. Interviews lasted from 45 minutes to 1 hour in length. Interviews were recorded using computer audio software[a] and audio taped with a voice recorder.

During the interviews the researcher took notes, as needed, and statements of relevance and contextual field notes were written verbatim. This aided in the identification of the point of data saturation, as it was evident when no new material or concepts arose.[27] Data saturation was achieved after the completion of 11 interviews, with 13 conducted in total.

At the conclusion of each interview, the researcher debriefed the participant on the main content of the interview, and time was permitted for any additional commentary to facilitate the emergence of new unanticipated information.[26]

Data analysis

Interviews were transcribed verbatim. Specialist qualitative research software[b] was used to aid in sorting the data.[28] Three transcripts were randomly selected and initial inductive codes were formed individually by three authors (AS, KOS and MOK). The three initial code lists were then amalgamated and a comprehensive code list was finalised, in view of the codes most representative of the dataset informed by background reading related to the research question. The finalised code list was then applied to all transcripts by AS.

Coded data were categorised using the qualitative research software and – through a process of repetitive interpretation, synthesising and theorising – themes were identified.[22] Transcripts were then re-read several times and the selected themes were finalised based on consensus discussion between AS, KOS and MOK. The software aided in determining the intensity and