



## Cognitive Functional Therapy

- Mary O’Keeffe, PT, PhD: School of Public Health, Physiotherapy and Sports Science, University College Dublin, Belfield, Dublin, Ireland.
- Prof Peter O’Sullivan, PT, PhD: Curtin School of Allied Health, Curtin University, Perth, WA, Australia.

### What is it?

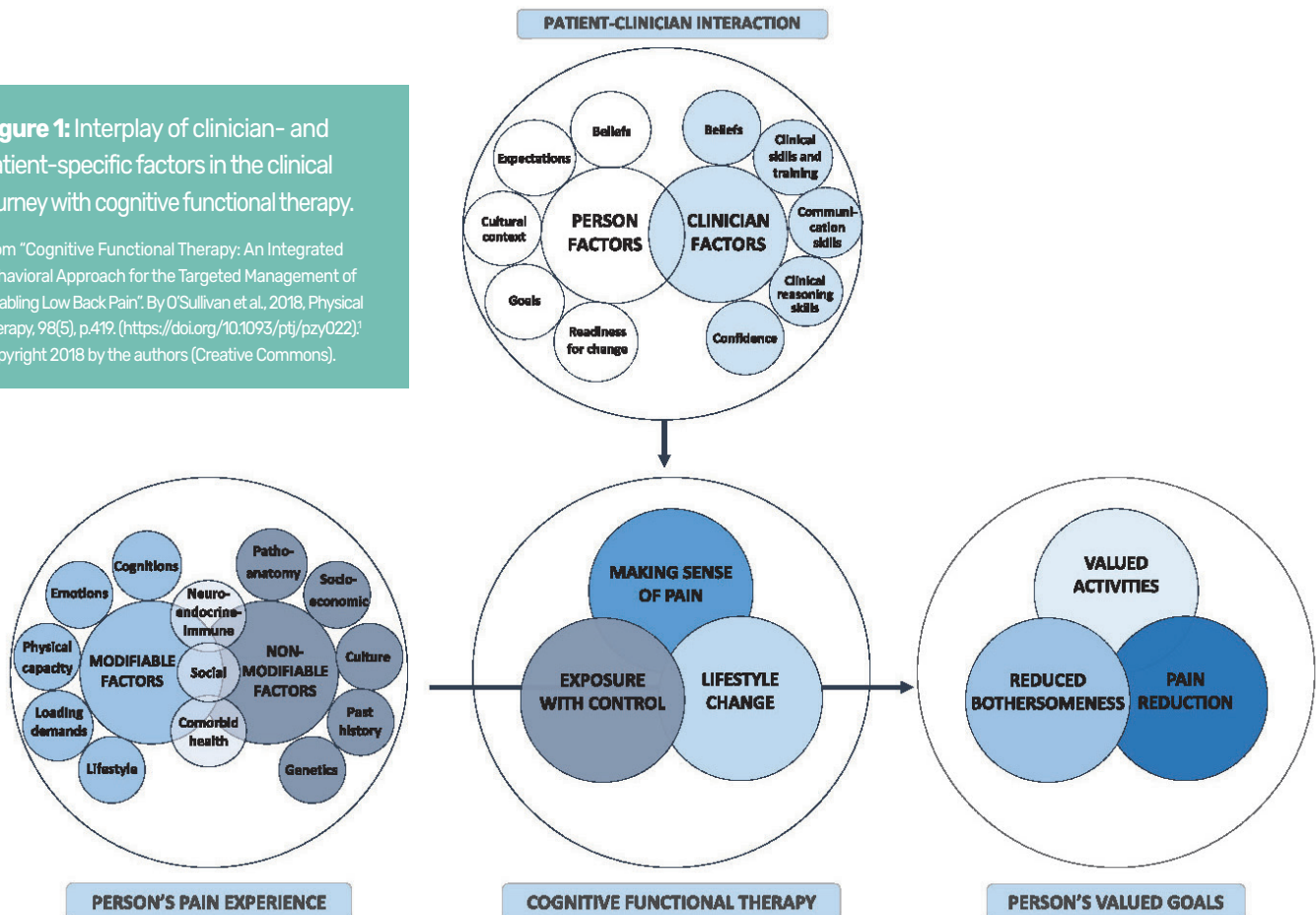
Cognitive Functional Therapy (CFT) is a person-centred, biopsychosocial approach to treating patients with chronic musculoskeletal pain when serious pathology is excluded.<sup>1,2</sup> It was originally developed for and tested in people with chronic low back pain but has broad application for people with other musculoskeletal pain problems (e.g. neck, knee, hip, shoulder, multisite pain). With CFT the clinician partners with the patient to identify and address

their individual biopsychosocial barriers to recovery, coaching the patient to self-manage their condition and reach their goals. CFT has evolved in the context of evidence-based daily clinical practice, guided by systematic research over the past 20 years and informed by people living with chronic musculoskeletal pain.

A flexible multi-dimensional clinical reasoning process underpins CFT (Figure 1).

**Figure 1:** Interplay of clinician- and patient-specific factors in the clinical journey with cognitive functional therapy.

From "Cognitive Functional Therapy: An Integrated Behavioral Approach for the Targeted Management of Disabling Low Back Pain". By O’Sullivan et al., 2018, Physical Therapy, 98(5), p.419. (<https://doi.org/10.1093/ptj/pzy022>). Copyright 2018 by the authors (Creative Commons).



First the clinician takes time to listen to the patient story, exploring: their pain journey and concerns, their understanding of their pain, the pattern of their pain (what aggravates and eases it), the impact pain has on all aspects of their life, their emotional responses to their pain and body perceptions, social context and general health. Their short and long term goals as well as expectations for care are identified.

During the physical examination the clinician observes the patients primary functional concerns that are pain provocative, feared or avoided. Their pain beliefs, emotions, pain experience as well as any sympathetic responses and protective behaviours are explored during this process. A series of guided behavioural experiments are then performed where the patient's sympathetic responses and protective behaviours are controlled while they engage in painful, feared and avoided tasks (in a graduated manner). During this process the patient's ability to control their pain and normalise their functional behaviours are assessed, and where possible their expectations (e.g. its dangerous to move) are violated (e.g. its safe to move).

At the end of this process the clinician in partnership with the patient maps the different elements of the CFT intervention targeting the key individual biopsychosocial barriers to recovery identified during the interview and physical examination.

Three Key Elements of CFT:

- 1. Making Sense of Pain:** Helping people understand their pain from a biopsychosocial perspective, through their own story and experiences. This includes patient-specific reassurance, reframing and goal setting (mapping out a plan for their recovery). Pain exacerbation plans are developed identifying helpful ways for them to respond to pain flares. Patient specific resources are shared.
- 2. Exposure with Control:** Teaching body relaxation, awareness and control integrated with gradual exposure to painful, feared or avoided functional tasks that are valued by the patient. These new learnt behaviours are practiced daily and are immediately and integrated into their valued activities aligned to their goals in a graduated manner.
- 3. Lifestyle Coaching:** Including paced physical activity base on their preference, healthy sleep and dietary habits, stress management strategies, social engagement and work.

Cognitive functional therapy involves an initial 60 minute consultation and 30-45 minute follow-ups, with up to seven to eight sessions over three months, starting weekly and gradually reducing in frequency as the patient develops confidence to self-manage and reach their goals. Booster sessions are provided if the patient loses confidence in their self-management strategies (eg. during a pain-flare-up).

## Evidence for CFT

A 2023 systematic review<sup>3</sup> of 15 CFT trials for chronic low back pain showed mixed results for pain intensity, disability, and secondary outcomes. Of the 15 trials included, 9 were ongoing, 1 was terminated, and five provided data that could be meta-analysed. All trials were rated high risk of bias and had different comparison groups. The review concluded with very low certainty for the effectiveness of CFT compared to manual therapy plus core exercises (2 studies, n = 265) for reducing pain intensity (mean difference: -1.02/10, 95% confidence interval: -14.75, 12.70) and disability (mean difference: -6.95/100, 95% confidence interval: -58.58, 44.68), and called for higher-quality studies.

Four trials have been published since this review, and a new review is underway.<sup>4</sup>

Since the publication of the 2023 review, the largest and highest quality clinical trial (RESTORE) including 492 people with CLBP, was published in *The Lancet*.<sup>5</sup> In this trial CFT was compared to the patient's "usual care". The primary clinical outcome was activity limitation at 13 weeks, self-reported by participants using the 24-point Roland Morris Disability Questionnaire. CFT was more effective than usual care (mean difference -4.6/24 [95% CI -5.9 to -3.4] for activity limitation at 13 weeks. Effect sizes were similar at 52 weeks. The treatment was as safe as usual care and was also cost-effective. It saved more than A\$5,000 per person over a year, largely due to increased participation at work.

## Training in CFT

Training clinicians to competently deliver CFT involves a tiered training process involving a series of workshops over a period of 5-6 months. This involves:

1. A knowledge workshop, including watching a CFT expert examine and treat a person with CLBP.
2. Skills training, including case-based active role-play of patient centred communication, behavioural experiments and CFT management of people with a range of CLBP presentations.
3. Direct mentoring in small groups while each clinician examines and treats people with chronic and disabling LBP. Importantly, clinicians are trained to a formalised competency standard. Several qualitative papers have been published on clinicians' experience with the training.<sup>6-8</sup>

To date all clinical trials have been conducted in people with chronic low back pain, however researchers are in the early stages of applying it to other musculoskeletal pain disorders, such as osteoarthritis.<sup>9-10</sup>

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