Reprint from The Review of DIABETIC STUDIES

The Review Of
DIABETIC
STUDIES OPEN ACCESS

Role Of Physical Therapy In Managing Chronic Lower Back Pain: Evidence-Based Practices

Alnour Theeb Awad Alruwaili[1], Afaf Jazzaa Mohammed Alanazi[2], Afrah Nahi alrowili[3], Rawan Jomah Aldowihi[4], Salam Mohammed alsharari[5], Halah Saad Mohammed Alrajraji[6], Samiyah Hail Ghazi Alkuwaykibi[7], Maha afet Alruwily[8], Dalal Nahi alrowili[9], Abdulaziz Khlowy Alrowily[10], Khalid Hail Hindi Alanazi[11], Hattan Saleh Albalawi[12]

[1] Specialist - Physiotherapy, Sowir General Hospital, Saudi Arabia - Skaka
[2] Specialist - Physiotherapy, Domat Aljandal General Hospital, Saudi Arabia - Skaka
[3] Specialist - Physiotherapy, Healthcare Center Qara, Saudi Arabia - Skaka
[4] Specialist - Physiotherapy, King Abdulaziz Specialist Hospital, Saudi Arabia - Skaka
[5] Specialist - Physiotherapy, Al-Mukhatat Healthcare Center, Sakakah, Saudi Arabia
[6] Specialist - Physiotherapy, Sowir General Hospital, Saudi Arabia - Skaka
[7] Specialist - Physiotherapy, Sowir General Hospital, Saudi Arabia - Skaka
[8] Specialist - Physiotherapy, King Abdulaziz Specialist Hospital, Saudi Arabia - Skaka
[9] Specialist - Physiotherapy, Healthcare Center Qara, Saudi Arabia - Skaka
[10] Senior Specialist - Physiotherapy, Sowir General Hospital, Saudi Arabia - Skaka
[11] Physical Therapist, Ministry of Health Branch, Arar, Specialist – Physiotherapy
[12] Physiotherapy Specialist, Duba General Hospital

Abstract:
Chronic lower back pain (CLBP) is a pervasive and complex condition necessitating a management shift from passive, pathoanatomical interventions to active, biopsychosocial strategies, with physical therapy serving as a cornerstone of evidence-based care. Contemporary practice integrates pain neuroscience education to reconceptualize pain, cognitive-behavioral principles to address fear-avoidance behaviors, and tailored therapeutic exercise to restore motor control, strength, and function. This holistic approach, which may be augmented by manual therapy as an adjunct and supported by modern paradigms like telerehabilitation, empowers patients through self-management, targeting the multifaceted interplay of physiological, psychological, and social factors that perpetuate chronicity. Ultimately, evidence-based physical therapy provides a sustainable, first-line pathway to reduce disability and improve quality of life by focusing on functional restoration and patient empowerment rather than mere pain elimination.

Keywords: chronic lower back pain, physical therapy, evidence-based practice, biopsychosocial model, pain neuroscience education, therapeutic exercise, motor control.

Introduction

Chronic lower back pain (CLBP), defined as pain persisting for 12 weeks or longer, represents one of the most pervasive, debilitating, and economically burdensome health conditions worldwide. It stands as the leading cause of years lived with disability globally, transcending geographic, cultural, and socioeconomic boundaries [1]. The personal toll is immense, often manifesting as severe functional limitations, reduced quality of life, sleep disturbances, and a heightened risk for psychological comorbidities such as depression and anxiety. From a societal perspective, the costs are staggering, encompassing direct medical expenditures, extensive losses in workforce productivity, and the long-term burden on social support and disability systems [2]. For decades, the management of CLBP was mired in a predominantly biomedical, pathoanatomical model. This paradigm focused intently on identifying a specific structural "lesion"—a herniated disc, a facet joint arthropathy, or spinal stenosis—as the definitive source of pain, with the corresponding treatment often being passive, invasive, or aimed solely at eradicating this presumed source. This approach frequently led to an overreliance on imaging, which poorly correlates with symptoms, and

interventions such as prolonged rest, opioid prescriptions, and surgery, outcomes of which have often been suboptimal or associated with significant risks and costs [3].

The evolution in understanding CLBP over the past two decades, however, has catalyzed a profound paradigm shift. Contemporary models now recognize CLBP not as a simple linear result of tissue damage, but as a complex, multidimensional experience arising from a dynamic interplay of biological, psychological, and social factors—the biopsychosocial model. This model acknowledges that while nociceptive input from lumbar structures is often a component, the persistence of pain is frequently mediated and maintained by alterations in the nervous system (central sensitization), maladaptive beliefs and behaviors (fear-avoidance, catastrophizing), emotional distress, and socio-contextual factors such as work environment and social support [4]. This reconceptualization has fundamentally altered therapeutic priorities, moving the focus from passive "cure" to active "management," from tissue-centric to person-centric care, and from mere pain suppression to the restoration of function and self-efficacy.

Within this modern framework, physical therapy (PT) has emerged not merely as a supportive adjunct but as a cornerstone of first-line, evidence-based management for CLBP. Modern physical therapy is a dynamic, patient-centered discipline that utilizes a comprehensive array of interventions informed by clinical reasoning and the best available research evidence. Its role is to address the multifaceted nature of CLBP by targeting impairments in body structure and function (e.g., mobility, strength, motor control), limitations in activities (e.g., bending, lifting, walking), and restrictions in participation (e.g., work, leisure, social roles) [5]. Crucially, contemporary physical therapy practice is grounded in active strategies that empower the patient. It moves beyond passive modalities to emphasize therapeutic exercise, education, and lifestyle modification, fostering the patient's own agency in their recovery process. This approach aligns perfectly with clinical practice guidelines from authoritative bodies worldwide, which consistently recommend non-pharmacological, non-invasive interventions, with exercise and education as core components, before considering pharmacological or surgical options [6].

The efficacy of physical therapy, however, is not universal; it is contingent upon its application being judicious, individualized, and rooted in evidence. "Evidence-based practice" in this context signifies the conscientious integration of three key elements: the best available research from clinically relevant scientific studies, the physical therapist's clinical expertise and judgment, and the patient's own values, preferences, and unique circumstances [7]. This tripartite foundation ensures that interventions are not applied in a standardized, one-size-fits-all manner but are tailored to address the specific drivers of pain and disability identified in each individual. For instance, the physical therapy approach for a patient with CLBP dominated by central sensitization and fear-avoidance behaviors will differ substantially from that for a patient whose primary issue is mechanical instability from profound core weakness. Therefore, the contemporary role of physical therapy in CLBP is that of a sophisticated, bio-psycho-socially informed service that employs a diagnostic process to subgroup patients and then applies a tailored, evidence-based package of care aimed at reducing pain, restoring function, and preventing recurrence, thereby enabling individuals to reclaim their lives from the grip of chronic pain [8].

Anatomical and Pathophysiological Underpinnings of Chronic Lower Back Pain

To appreciate the rationale behind physical therapy interventions, a foundational understanding of the relevant anatomy and the complex pathophysiology of CLBP is essential. The lumbar spine is an intricate mechanical structure designed for mobility, load-bearing, and protection of neural elements. Key anatomical contributors to pain include the intervertebral discs, which can generate pain through annular tears or chemical irritation; the facet (zygapophyseal) joints, susceptible to arthritic change and capsular strain; the sacroiliac joints; the muscles and their fascia; and the ligaments. Importantly, many of these structures are innervated and capable of being primary pain generators. However, the relationship between structural changes seen on imaging (e.g., disc degeneration, bulges) and the experience of pain is

notoriously weak, as many asymptomatic individuals exhibit such findings, underscoring the limitation of a purely pathoanatomical diagnosis [9].

The transition from acute to chronic pain involves complex neurophysiological processes. Peripheral sensitization occurs at the site of initial injury, where inflammatory mediators lower the activation threshold of nociceptors, making them more responsive. In a subset of individuals, this can lead to central sensitization, a phenomenon where the central nervous system (spinal cord and brain) undergoes maladaptive plasticity. In this state, the pain-processing neurons become hyperexcitable, leading to an amplified response to normal inputs (allodynia), an increased response to painful stimuli (hyperalgesia), and an expansion of the receptive field, where pain is perceived over a wider area than the original site [10]. This explains why in CLBP, pain may be disproportionate to provocation and may be referred or widespread.

Furthermore, the motor system is profoundly affected. Patients with CLBP often exhibit alterations in muscle function, including inhibition and atrophy of deep stabilizing muscles like the transversus abdominis and multifidus, coupled with increased activity and tension in more global, superficial muscles. This disruption of normal "core" stability and movement patterns is believed to contribute to pain persistence and recurrence by placing abnormal stresses on spinal structures [11]. Concurrently, psychological factors become deeply entwined with the pain experience. The Fear-Avoidance Model is a key conceptual framework, positing that catastrophic misinterpretation of pain can lead to fear of movement (kinesiophobia), resulting in avoidance of activity. This avoidance leads to physical deconditioning, disability, depression, and ironically, increased pain over time, creating a vicious cycle that perpetuates chronicity [12]. Thus, the pathophysiology of CLBP is a tapestry woven from threads of peripheral nociception, central neural dysregulation, impaired motor control, and potent cognitive-emotional influences, all of which must be considered in a comprehensive physical therapy assessment and treatment plan.

Comprehensive Assessment and Clinical Reasoning in Physical Therapy

The initial and perhaps most critical step in effective physical therapy management is a thorough, biopsychosocially-oriented assessment. This process extends far beyond identifying a painful structure; it seeks to construct a holistic clinical picture of the "person in pain." The assessment begins with a detailed subjective history, exploring the onset, behavior, and pattern of pain, its impact on daily activities, work, and sleep, and previous treatments and their outcomes. Crucially, the physical therapist will screen for "yellow flags"—psychosocial risk factors for chronicity such as unhelpful beliefs about pain (e.g., "My back is fragile"), fear-avoidance behaviors, catastrophizing, low mood, and problematic workplace or social dynamics [13]. This information is vital for risk stratification and tailoring intervention.

The objective physical examination is hypothesis-driven, based on the history. It includes observation of posture, movement patterns, and antalgic behaviors. A neurological screening assesses sensory, motor, and reflex function to rule out serious pathology like cauda equina syndrome or progressive radiculopathy. The examination of movement involves analyzing the quality, range, and pain response during functional tasks like forward bending, returning from flexion, and single-leg stance. Specific physical tests may be used to help differentially load tissues (e.g., joints, nerves) to inform clinical reasoning, though their diagnostic accuracy for specific structures is often modest [14]. The physical therapist also performs a detailed assessment of key physical impairments: muscle strength (particularly of the hip extensors/abductors and core), endurance, flexibility (notably of the hip flexors and hamstrings), and sensorimotor control. A critical component is the assessment of motor control, evaluating the timing and coordination of deep trunk muscles during limb movements or anticipated perturbations, which is often impaired in CLBP [15].

The synthesis of this data allows the physical therapist to subgroup the patient, a key concept in modern management. While no single classification system is universally definitive, common subgroups based on treatment response include:

1) **Motor Control Impairment:** Characterized by movement coordination deficits and specific directional movement impairments.
2) **Central Sensitization Dominant:** Featuring widespread pain, hypersensitivity, and pain disproportionate to examination findings.
3) **Physical Deconditioning:** Marked by generalized weakness, poor endurance, and fatigue.
4) **Neuropathic/Radicular:** Involving clear radicular pain patterns and neural tension signs. Many patients present with a mixed picture. This clinical reasoning process allows the therapist to move from a generic "back pain" diagnosis to a targeted management strategy, prioritizing interventions most likely to address the dominant contributing factors identified [16].

Core Evidence-Based Interventions in Physical Therapy Management

1. Patient Education and Cognitive Behavioral Approaches

Education is the bedrock upon which all other physical therapy interventions are built. Modern pain neuroscience education (PNE) aims to reconceptualize a patient's understanding of their pain. Instead of using biomechanical models of a "worn-out" or "slipped" disc, PNE uses metaphors and simple biology to explain concepts of central sensitization, the protective role of pain, and the disconnect between pain and tissue damage. By helping patients understand that their nervous system is in a heightened state of alarm, PNE can reduce threat, decrease catastrophizing, and increase engagement in movement and exercise [17]. This is integrated with principles of cognitive-behavioral therapy (CBT), where therapists work with patients to identify and challenge unhelpful pain-related thoughts and beliefs, gradually replace fear-avoidance behaviors with paced, goal-oriented activities (graded exposure), and develop self-management skills. This biopsychosocial educational approach has strong evidence for reducing disability and fear in CLBP [18].

2. Therapeutic Exercise: The Cornerstone of Intervention

Therapeutic exercise is arguably the most robustly supported intervention for CLBP, with a high level of evidence for its effectiveness in reducing pain and improving function. The specific prescription, however, must be individualized. For the Motor Control Impairment subgroup, the focus is on motor control training (often historically called "core stabilization"). This involves retraining the precise, low-load co-contraction of deep trunk muscles (transversus abdominis, multifidus, pelvic floor) to improve segmental control and coordination before integrating this control into functional and higher-load tasks [19]. For the Deconditioning subgroup, general aerobic conditioning (walking, cycling, swimming) and graded strength training (targeting trunk, hip, and leg muscles) are paramount. The evidence shows that any form of exercise is generally better than none, but programs that are supervised, progressive, and of sufficient duration tend to yield the best outcomes [20]. For patients with specific Directional Preferences (e.g., centralization of leg pain with extension movements), repeated movements or sustained postures as per the McKenzie Method can be highly effective in reducing symptoms and restoring function [21]. Flexibility exercises for tight muscles like the hip flexors or hamstrings are often used adjunctively but are rarely a standalone solution.

3. Manual Therapy and Hands-On Techniques

Manual therapy encompasses skilled, hands-on techniques including joint mobilization (rhythmic oscillatory movements within or at the limit of joint range) and manipulation (a high-velocity, low-amplitude thrust). The mechanisms are thought to be multifactorial, including neurophysiological effects (modulating pain processing through descending inhibitory pathways), biomechanical effects on joint mobility, and psychological effects (providing reassurance and reducing threat) [22]. While evidence suggests manual therapy can provide short-to-medium term reductions in pain and improvements in mobility, especially when combined with exercise, it is not recommended as a sole, long-term treatment.

Its optimal role is as an adjunct to facilitate movement and enable more effective participation in an active exercise program by initially reducing pain and stiffness [23].

4. Modalities and Adjunct Physical Agents

The use of electrophysical modalities like transcutaneous electrical nerve stimulation (TENS), ultrasound, or laser therapy is common. Their proposed mechanisms include pain gate theory (TENS) or tissue heating/repair. However, the overall evidence for their efficacy in CLBP, particularly for long-term outcomes, is generally weak to moderate. Current guidelines typically do not recommend their routine use due to lack of sustained benefit [24]. They may, however, have a very limited role as a short-term analgesic to facilitate participation in active therapy for some individuals. The focus of evidence-based care remains firmly on active, patient-performed interventions.

Addressing Psychological and Lifestyle Factors

As dictated by the biopsychosocial model, effective management must address psychosocial barriers to recovery. Physical therapists are trained to incorporate basic psychological strategies. Graded Activity and Graded Exposure are systematic behavioral approaches where functional or feared activities are broken down into achievable steps. The patient performs these activities based on pre-agreed quotas (time, repetitions) rather than pain, which helps break the pain-contingent activity cycle, builds confidence, and reduces fear [25]. Mindfulness and Acceptance-Based Strategies are also gaining traction. Techniques derived from Acceptance and Commitment Therapy (ACT) help patients develop psychological flexibility—to accept pain sensations as they are without futile struggle, while committing to actions aligned with their personal values (e.g., being a present parent, returning to work) [26]. Furthermore, physical therapists provide essential Lifestyle and Ergonomics Advice. This includes education on maintaining spinal hygiene during daily activities (lifting, sitting), optimizing the work environment, stress management techniques, and the importance of sleep hygiene and healthy nutrition, all of which can modulate the pain experience [27].

Modern Paradigms and Technological Advancements

The field continues to evolve with new evidence and technology. Telerehabilitation (TelePT)involves delivering assessment, monitoring, and intervention remotely via video conferencing and digital platforms. Its efficacy for CLBP is increasingly supported by research, offering improved access, convenience, and the ability to guide exercise in the patient's own environment, which may enhance carryover [28]. **Virtual Reality (VR)** is an emerging tool that uses immersive environments to distract from pain, reduce fear during movement, and provide engaging platforms for therapeutic exercise and graded exposure therapy, showing promising early results [29]. Additionally, the concept of Personalized or Precision Physical Therapy is gaining momentum. This involves using more advanced clinical prediction rules, and potentially biomarkers or genetic profiles, to better predict which patient will respond best to which specific type of exercise or manual therapy, moving treatment from subgrouping towards more truly individualized care [30].

Conclusion

Chronic lower back pain is a complex, multidimensional health challenge that defies simplistic, passive solutions. The contemporary role of physical therapy in its management is fundamentally aligned with the biopsychosocial model, positioning the physical therapist as an essential guide in the patient's journey from disability towards self-efficacy and restored function. Through a comprehensive assessment that considers physical impairments, neurophysiological mechanisms, and psychosocial contributors, physical therapists formulate an individualized, evidence-based plan of care. This plan strategically combines pain neuroscience education to reconceptualize pain, cognitive-behavioral strategies to address maladaptive thoughts and behaviors, and active, tailored exercise prescription—the cornerstone of intervention—to restore movement, strength, and confidence. Manual therapy may serve as a useful adjunct to facilitate this active process, while modalities play a minimal role. By also integrating lifestyle advice and embracing modern advancements like telerehabilitation, physical therapy delivers a holistic, patient-centered

approach. The overwhelming weight of evidence confirms that such a comprehensive, active, and psychologically informed physical therapy paradigm is not only a first-line recommendation but often the most effective and sustainable path to managing chronic lower back pain, empowering individuals to reclaim their lives and participate fully in the activities they value.

References:

1. Daly B, Thompsell A, Sharpling J et al. Evidence summary: the relationship between oral health and dementia. Br Dent J 2018; 223: 846-853.
2. Moody A, Cowley G, Fat L N, Mindell J S. Social inequalities in prevalence of diagnosed and undiagnosed diabetes and impaired glucose regulation in participants in the Health Surveys for England series. BMJ Open 2016.
3. Genco R J, Schifferle R E, Dunford R G, Falkner K L, Hsu W C, Balukjian J. Screening for diabetes mellitus in dental practices: A field trial. J Am Dent Assoc 2014; 145: 57-64.
4. Dietrich T, Webb I, Stenhouse L et al. Evidence summary: the relationship between oral and cardiovascular disease. Br Dent J 2017; 222: 381-385.
5. Chung R, Leung S-Y J, Abel S N et al. HIV screening in the dental setting in New York State. PLoS One 2020.
6. Riley B L, MacDonald J, Mansi O et al. Is reporting on interventions a weak link in understanding how and why they work? A preliminary exploration using community heart health exemplars. Implementat Sci 2008; 3: 27.
7. Friman G, Hultin M, Nilsson G H, Wårdh I. Medical screening in dental settings: a qualitative study of the views of authorities and organisations. BMC Res Notes 2015; 8: 580.
8. Wright D, Muirhead V, Weston-Price S, Fortune F. Type 2 diabetes risk screening in dental practice settings: a pilot study. Br Dent J 2014; 216: E15.
9. Yonel Z, Cerullo E, Kröger A T, Grey L J. Use of dental practices for the identification of adults with undiagnosed type 2 diabetes mellitus or non-diabetic hyperglycaemia: a systematic review. Diabet Med 2020; 37: 1443-1453.
10. NHS Digital. NHS Dental Statistics for England - 2019-20 Annual Report. 2020.
11. Bould K, Scott S E, Dunne S, Asimakopoulou K. Uptake of screening for type 2 diabetes risk in general dental practice; an exploratory study. Br Dent J 2017; 222: 293-296.
12. Feinstein-Winitzer R T, Pollack H A, Parish C L, Pereyra M R, Abel S N, Metsch L R. Insurer views on reimbursement of preventive services in the dental setting: results from a qualitative study. Am J Public Health 2014; 104: 881-887.
13. Care Quality Commission. Scope of registration: Regulated activities. Diagnostic and screening procedures. 2022.
14. Ungoed-Thomas J. GPs in England treat up to three times more patients than safety limit demands. The Observer (London) 2022 November 20.
15. Manger D, Walshaw M, Fitzgerald R et al. Evidence summary: the relationship between oral health and pulmonary disease. Br Dent J 2017; 222: 527-533.
16. Herrera D, Sanz M, Shapira L et al. Association between periodontal diseases and cardiovascular diseases, diabetes and respiratory diseases: Consensus report of the Joint Workshop by the European Federation of Periodontology (EFP) and the European arm of the World Organisation of Family Doctors (WONCA Europe). J Clin Periodontol 2023; 50: 819-841.
17. Gianos E, Jackson E A, Tejpal A et al. Oral health and atherosclerotic cardiovascular disease: A review. Am J Prev Cardiol 2021; 7: 100179.
18. Doble A, Bescos R, Witton R, Shivji S, Ayres R, Brookes Z. A Case-Finding Protocol for High Cardiovascular Risk in a Primary Care Dental School-Model with Integrated Care. Int J Environ Res Public Health 2023; 20: 4959.
19. Santella A J, Conway D I, Watt R G. The potential role of dentists in HIV screening. Br Dent J 2016; 220: 229-233.

20. Suarez-Durall P, Osborne M S, Enciso R, Melrose M D, Mulligan R. Results of offering oral rapid HIV screening within a dental school clinic. Spec Care Dentist 2019; 39: 188-200.
21. Nuredini G, Saunders A, Rajkumar C, Okorie M. Current status of white coat hypertension: where are we? Ther Adv Cardiovasc Dis 2020.
22. Coqueiro R S, Santos M C, Neto J S, Queiroz B M, Brügger N A, Barbosa A R. Validity of a portable glucose, total cholesterol, and triglycerides multi-analyser in adults. Biol Res Nurs 2014; 16: 288-294.
23. Hoffmann T C, Glasziou P P, Boutron I et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ 2014; 348: g1687.
24. Liau F L, Kok S-H, Lee J-J et al. Cardiovascular influence of dental anxiety during local anaesthesia for tooth extraction. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2008; 105: 16-26.
25. Public Health England. Making Every Contact Count (MECC): Consensus statement. 2016.
26. Abdulwahab M, Kamal M, Akbar A. Screening for High Blood Pressure at the Dentist's Office. Clin Cosmet Investig Dent 2022; 14: 79-85.
27. Creanor S, Millward B A, Demaine A et al. Patients' attitudes towards screening for diabetes and other medical conditions in the dental setting. Br Dent J 2014; 216: E2.
28. Ireland R S, Bowyer V, Ireland A, Sutcliffe P. The medical and dental attendance pattern of patients attending general dental practices in Warwickshire and their general health risk assessment. Br Dent J 2012; 212: E12.
29. NHS England. Building dental teams: Supporting the use of skill mix in NHS general dental practice - long guidance. 2023.
30. Kivimäki M, Strandberg T, Pentti J et al. Body-mass index and risk of obesity-related complex multimorbidity: an observational multicohort study. Lancet Diabetes Endocrinol 2022; 10: 253-263.