



## Knowledge Attitude and Practice Towards Patients with Chronic Low Back Pain Among the Physiotherapist Clinical Practice at Dhaka City - A Cross Sectional Study

Nafisa Tahera<sup>1\*</sup>, Shamema Bari<sup>2</sup>, Mohd Harun-Or-Rashid<sup>3</sup>, Abul Hasnat Mohiuddin<sup>4</sup> and Bijoya Sarkar<sup>5</sup>

<sup>1</sup>Senior Physiotherapist and OPD Head - Hasnat's Physiotherapy Lalmatia, Dhaka, Bangladesh

<sup>2</sup>Junior Consultant (Physiotherapy) - Hasnat's Physiotherapy Lalmatia, Dhaka, Bangladesh

<sup>3</sup>Consultant (Physiotherapy), New Life Trauma Centre, Rampura, Dhaka, Bangladesh

<sup>4</sup>Assistant Professor and Head of Physiotherapy Department, Dhaka College of Medical and Technology, Mohammadpur, Dhaka, Bangladesh

<sup>5</sup>Physiotherapist, Gono Shasthaya Medical College Hospital, Mirzanagar, Savar, Dhaka, Bangladesh

\*Corresponding Author: Nafisa Tahera, Senior Physiotherapist and OPD Head - Hasnat's Physiotherapy Lalmatia, Dhaka, Bangladesh.

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### Abstract

**Introduction:** Low back pain is one of the top foremost causes of disability worldwide. Most cases of acute low back pain progress to chronic low back pain when recuperation takes more than three months. This is due to psychosocial factors, brain structural change and also the neurochemical changes which lead to change in the central mechanism of the brain. The management approach of chronic low back pain has evolved from the biomedical to the biopsychosocial come up to in order to consider the psychosocial factors during assessment and management of patients with chronic low back pain. The multidisciplinary team and biopsychosocial draw near are currently recommended in managing patients with chronic low back pain in order to gain best possible results for patients. Their knowledge of the neurophysiology of pain and their attitudes and practice about patients with pain is equally important in influential the appropriate approach in the management of patients with chronic low back pain.

**Objective:** The objective of this study was to evaluate Knowledge, attitude and practice towards patients with chronic low back pain among the physiotherapist clinical practice in Dhaka city of Bangladesh.

**Methodology:** Cross sectional research with 105 participants among the target population of this study is male and female enthusiastically grace with presence in Dhaka city of Bangladesh. On the other hand the study population was those congregation inclusion/exclusion criteria and KAP study of chronic low back pain. Data was collected through a well structured NPQ for knowledge and HC-PAIRS for attitude and practice questionnaire prepared by the interviewer and approved by the examination board. Baseline information was collected through interviewer-administered questionnaire through face to face interview. Data were numerically coded and captured in Excel, using an SPSS 16.0 version.

**Results:** The study found that The youngest participants in this study were 25 years old and oldest participants were 50 years old. In this study, Gender showed that Male and female participant quotient was identical. Male 95.2% (n = 100) and Female 4.8% (n = 5). In this study Highest level of Education completed showed that HSC participants were highest rate that was 39% (n = 41). In this study income status of the participants showed that 10000-20000 BDT participants were highest rate that was 55.2% (n = 58). Have you ever been instructed or received information on low back pain and its contributing factors? This study showed that that yes participants were highest rate that was 59% (n = 62) and no participants were 41% (n = 43). Accepting your pain may facilitate recovery from low back pain this study showed that strongly agree participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1). Flexion combined with compressive force to the lumbar spine, e.g. in lifting heavy objects poses the risk of developing low back pain This study showed that strongly agree participants.

**Conclusion:** This study highlighted that many patients with LBP in Dhaka city are not sufficiently knowledgeable about LBP and hold unconstructive attitudes and beliefs regarding their LBP. Even though no delineation was made between the knowledge, attitude and beliefs of patients living with chronic against repeated LBP, it can be accomplished that providing education to the patients regarding their LBP and especially pain neuroscience education may augment their knowledge regarding LBP. Therefore, LBP management approaches in Dhaka city should include education programmes aimed at sanction patients with knowledge regarding LBP, its contributing factors as well as changing their negative attitudes and beliefs about their pain. Patients' sympathetic of the cause and nature of their pain may augment the accomplishment of treatment goals. The biomedical and biopsychosocial treatment orientations of physiotherapists in Dhaka city were relatively low. The most recurrent treatment strategies used by physiotherapists for Non specific chronic low back pain were home exercises and patient education. However, some passive and traditional treatments which are not optional by clinical practice guidelines for the management of LBP persist to be used repeatedly by physiotherapists in Dhaka city in Bangladesh. This study has confirmed that physiotherapists' pain attitudes and beliefs are appreciably associated with treatment selection when managing individuals with NSCLBP. Further research through which to better understand and make possible the implementation of best evidence-based practice and clinical practice with the consideration of the biopsychosocial model in universities' curricula is a priority, particularly in countries in which the biopsychosocial model is rarely measured in the healthcare and education/university systems.

**Keywords:** Low Back Pain; Knowledge; Attitudes; Practice; Physiotherapist

## Introduction

Low back pain is one of the top foremost causes of disability worldwide [10]. The majority suitcases of discriminating low back pain evolution toward chronic low back pain whilst recuperation acquire supplementary three months. This is due to psychosocial factors, brain structural change and also the neurochemical changes which lead to change in the central mechanism of the brain [15]. The psychosocial factors include anxiety, stress, recovery expectation, summarization, depression and fear evasion behavior [13]. The executive come within reach of persistent low back pain has go forward commencement the biomedical to the biopsychosocial come up to in order to regard as the psychosocial aspects during appraisal and supervision of patients through chronic low back pain [9]. The multidisciplinary squad and biopsychosocial depict near

are at this time suggested in supervision patients with chronic low back pain in categorize to expand greatest probable consequences intended for patients [12]. However, there is unfortunate completion of the biopsychosocial come up to by healthcare supplier due to the negative attitudes of health care providers, their associate of the neurophysiology tenderness, biomedical factors, and their patient acumen [3]. Attitudes and practice about invariable low back pain among health care contributor engage in recreation aim operative responsibility in the preference of come close to for the management of patients with continual low back pain [8]. Education of the neurophysiology of pain has been efficient in uneven the attitudes and practice of health care providers more absolutely as a result guarantee accomplishment in achievement of the biopsychosocial move toward [6]. Professional physiotherapists of Thera-

peutic Sciences are uncovered to the clinical surroundings, where they are predictable to supervise patients with chronic low back pain. Their knowledge of the neurophysiology of pain and their attitudes and practice about patients with pain is evenly significant in influential the suitable approach in the management of patients with chronic low back pain.

Most population-based studies on the occurrence of LBP were conducted in the urbanized countries and little in sequence is available in developing countries, particularly in Bangladesh and Africa [1]. Moreover, minimal dissimilarity of prevalence of LBP between developed and developing world has been established, with a life time occurrence of 28% to 74% among Africans, which is most likely to increase in the next ten years [2]. South Africa alone has 63% of life width LBP incidence in general [4]. Thus, despite of geographical location, LBP has been indicating as one of the most important causes of disability in the general population [5]. LBP can affect anybody adults and adolescents, working and non-working populations, educated or non-educated groups [7].

In the UK, despite enhanced diagnostic procedures and superiority of care, LBP is regarded as a encumber on the health care system [16]. In Africa, LBP is a growing difficulty, accompany by strict financial consequences in African countries [16]. For illustration, in the year 2000, South Africa alone, spent a probable cost of about 20 million USD as compensation due to LBP cases [14] claims that about 80% of the South African work force suffers from various degrees of incapacity due to LBP at some point in their working life. In other African countries such as Rwanda and Uganda, LBP is also irritating health problem, imposing a severe economic saddle to the governments due to its high charge of supervision [11].

Knowing about these factors will contribute to the improvement of therapeutic strategies and, thereafter, a better treatment outcome. The existing literature has shown that factors such as the beliefs and attitudes of physiotherapists towards NSCLBP have an influence on clinical practice [17,18]. In addition, physiotherapists' clinical reasoning and treatment decision making are influenced by personal and working environment constraints [19]. Another important aspect is that the pain attitudes and beliefs of physiotherapists towards NSCLBP in Saudi Arabia (SA) have not been investigated previously. This is critical for physiotherapy practice since LBP is the most common condition of musculoskeletal pain

in SA among construction workers, schoolteachers and healthcare professionals [20-22].

### **Problem statement**

The health care providers' echelon of knowledge of neurophysiology of pain are reported to influence their attitudes and practice towards patients with chronic low back pain, which then affects their assessment and treatment approach to the patients. This level of knowledge is found to differ across Physiotherapy professions due to a number of factors i.e. curriculums and number of years of experience. In South Africa, the level of knowledge of pain was assessed among practicing physiotherapists only which was reported to be poor [5]. However, no research regarding this has been done among the physiotherapist in Dhaka City of Bangladesh. The Physiotherapist Practicing at Dhaka city in Bangladesh cooperates with patients with chronic low back pain during their clinical period. However, their level of knowledge, attitudes and practice towards patients with chronic low back pain, and how these are associated with each other are mysterious.

### **Significance of research**

Physiotherapist who practicing at Dhaka city are exposed to clinical work, which involves assessing and managing patients with chronic low back pain. The Physiotherapist's attitudes and Practice are critical in the choice of approach to be used in managing such patients. Therefore, it is vital to appreciate the Physiotherapists' level of knowledge and attitudes and practice towards patients with chronic low back pain in order to inform if there is a latent require for an intrusion.

### **Materials and Methods**

#### **Study objectives**

##### **General objective**

The objective of this study was to appraise Knowledge, attitude and practice towards patients with chronic low back pain surrounded by the physiotherapist clinical practice in Dhaka city of Bangladesh.

##### **Specific objectives**

- To find out the demographic uniqueness of physiotherapist's in Dhaka city.
- To find out the level of knowledge of neurophysiology of pain among physiotherapist's in Dhaka city.

- To determine the attitudes and practice towards patients with chronic low back pain among the physiotherapist's in Dhaka city.
- To determine the correspondence between knowledge of pain and attitude and practice of physiotherapist's towards patients with chronic low back pain and their relationship with demographic details.

### Study design

This study was demeanor use cross sectional study under a quantitative study design. Cross sectional study design were desire to meet the study aim as an effective way to collect data.

### Study period

It was started with etiquette development and completed with concluding report submission of this study epoch was from July 2011 to December 2011.

### Place of the study

The setting for this study was demeanor at physiotherapist's practicing in Dhaka corporation area for the study.

### Study population

The study population was age 25 to 50 years living in Dhaka City areas in Bangladesh.

### Sample size

P = Prevalence of Physiotherapist's knowledge, attitude and practice of chronic LBP (total (percentage) of the total population)

$$p = 20.5\% \text{ (Population census-2006)}$$

$$q = 1-p$$

$$q = 1-.20.5$$

$$= 0.80$$

$$d = \text{Acceptable margin of error (.05)}$$

Actual sample size was

$$(n) = Z^2 pq/d^2$$

$$= (1.96)^2 \times 0.5 \times 0.5 / (0.05)^2$$

$$= 3.84 \times 0.25 / 0.0025$$

$$= 384$$

But as the study carry out as a part of academic research project and there were some restraint, so that 105 were taken as the sample of this study from physiotherapists at Dhaka corporation area for the study.

### Sampling technique

Samples were selected used convenience sampling method.

### Data collection and management

Data was composed during a well controlled NPQ for knowledge and HC-PAIRS for attitude and practice questionnaire equipped by the interviewer and accepted by the examination board. Baseline in sequence was serene through interviewer-administered questionnaire through face to face interrogate.

### Data collection procedure

During data compilation, the researcher engagement the participants' office at a convenient time (assurance not to obstruct with their studies), to explain the rationale of the research and to tempt them to take part in the study. Three self-administered questionnaires were given to the participants to entire in hard copy. The first questionnaire was incarcerate demographic details; the second questionnaire was NPQ, which measured the level of knowledge of the neurophysiology of pain; and the third questionnaire was the HC-PAIRS, which deliberate the attitudes and practice towards patients with chronic low back pain. The participants were invited to drop the completed questionnaires in a sealed box. The data collection was completed within a three months epoch.

### Conduction of the study, quality control and monitoring

The data was collected from chosen areas by me. The collected data was checked and verified by the investigator at the end of the work every day. Any imprecision and variation was corrected in the next working day.

### Data presentation

Data was presented by tables, Bar chart and Pi chart.

### Selection criteria

Inclusion criteria

- Physiotherapists' were include age 25-50 living in Dhaka city.
- Willing to participate

Exclusion criteria

- None.

Data processing

Data processing involves

- Categorization of the data
- Coding
- Summarizing the data
- Categorizing to detect the errors and to maintain consistency and validity

Data analysis

Data were scrutinized Statistical Package for the Social Science (SPSS) version 16.0. Microsoft office Excel 2010 was used to adorn the bar graph and pie charts. The results of this study were consisted of quantitative data. By this study a lot of in sequence was composed.

Ethics and other permissions

Ethical concerned (including plagiarism, data fabrication, double publication) have been completely pragmatic by the authors.

Limitations of the study

This study used HC-PAIRS questionnaire to appraise the echelon of attitudes and practice towards patients with chronic low back pain. Its validity and reliability have been ingrained among health professionals, but not established among physiotherapists. This questionnaire does not have a definition of the authentic scores that signify unconstructive or positive attitudes towards patients with chronic low back pain. Therefore, in this study, the elucidation of attitudes was made based on the accessible evidence. Additionally, being a cross-sectional study, the elucidation of results was scarce in terms of association between variables. There may be other demographic details that were not captured in the demographic questionnaire, which could manipulate the level of knowledge; attitudes and practice towards patients with chronic low back pain i.e. qualities type and socioeconomic status of the physiotherapists.

Results

Age of the participants

Distribution of respondents by their age (n = 105)

Among 105 respondents, highest proportion 41.9% (n = 44) of respondent’s age was between 25 years and lowest proportion

| Age   | Frequency | (Percentage) % |
|-------|-----------|----------------|
| 25    | 44        | 41.9           |
| 28    | 21        | 20.0           |
| 32    | 18        | 17.1           |
| 40    | 12        | 11.4           |
| 50    | 10        | 9.5            |
| Total | 105       | 100.0          |

Table 1: Age of participant.

9.5% (n = 10) of respondents, age was between 50 years (Table 1).

Gender of the participants (n = 105)

This figure showed that Male and female participant amount

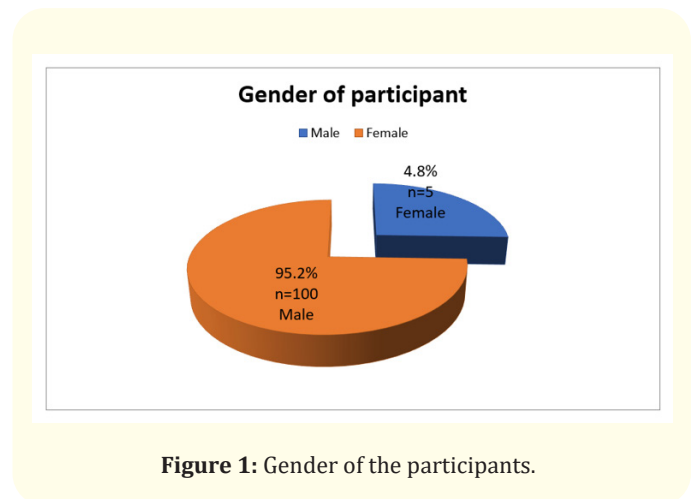


Figure 1: Gender of the participants.

was identical. Male 95.2% (n = 100) and Female 4.8% (n = 5) (Figure 1).

Education completed of the participant (n = 105)

This figure showed that HSC participants were highest rate that was 39% (n = 41). SSC participant were second highest rate that was 30.5% (n = 32) and graduate Participants were 26.7% (n = 28) and masters were 3.8% (n = 4) (Figure 2).

Distribution of respondents income status (n = 105)

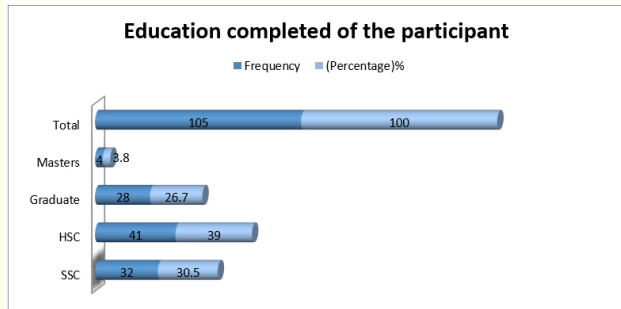


Figure 2: Education completed of the participants.

This table showed that 10000-20000 BDT participants were highest rate that was 55.2% (n = 58). Low participants between

| Income          | Frequency | (Percentage) % |
|-----------------|-----------|----------------|
| 10000-20000 BDT | 58        | 55.2           |
| 21000-30000 BDT | 27        | 25.7           |
| 31000-40000 BDT | 16        | 15.2           |
| 41000-50000 BDT | 4         | 3.8            |
| Total           | 105       | 100.0          |

Table 2: Distribution of Respondent's income status.

41000 BDT to 50000 BDT were rate that was 3.8% (n = 4) (Table 2).

**Distribution of respondents occupations (n = 105)**

This figure showed that house wife participants were highest

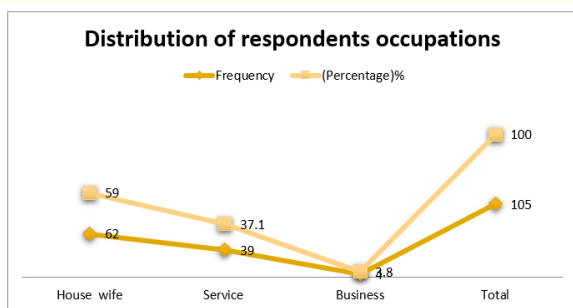


Figure 3: Occupation of the participants.

rate that was 59.6% (n = 62). Service participants were second highest rate that was 37.1% (n = 39) and business participants were 3.8% (n = 4) (Figure 3).

**Have you ever been instructed or received information on low back pain and its contributing factors? (n = 105)**

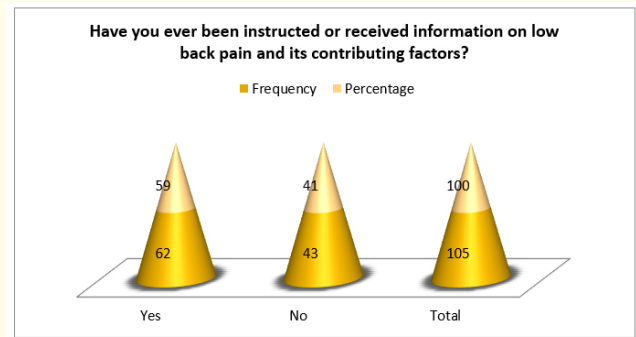


Figure 4: Have you ever been instructed or received information on low back pain and its contributing factors?.

This figure showed that showed that yes participants were highest rate that was 59% (n = 62) and no participants were 41% (n = 43) (Figure 4).

**Where did you receive the information? (n = 105)**

This table showed that at school participants were highest rate

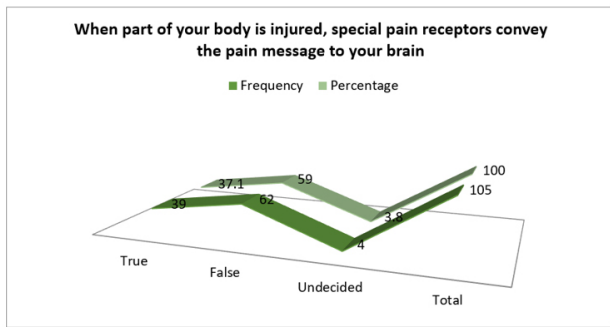
|                          | Frequency | (Percentage) % |
|--------------------------|-----------|----------------|
| At school                | 36        | 34.3           |
| From the doctor          | 33        | 31.4           |
| From the Physiotherapist | 22        | 21.0           |
| From the Internet        | 14        | 13.3           |
| Total                    | 105       | 100.0          |

Table 3: Where did you receive the information?.

that was 34.3% (n = 36) and from the doctor participants were second highest rate that was 31.4% (n = 33) and from the physiotherapist were 21% (n = 22) with from the internet participants were 13.3% (n = 14) (Table 3).

**When part of your body is injured, special pain receptors con-**

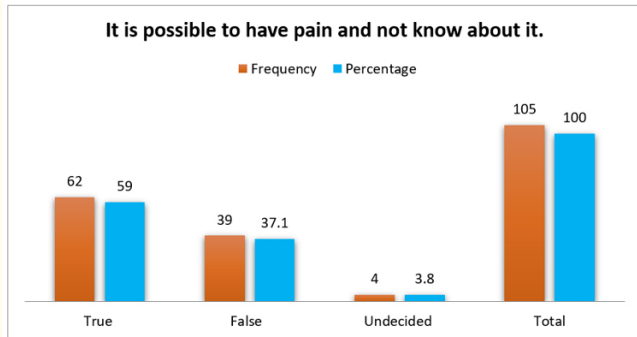




**Figure 5:** When part of your body is injured, special pain receptors convey the pain message to your brain.

**vey the pain message to your brain (n = 105)**

This figure showed that false participants were highest rate that was 59% (n = 62). True participants were second highest rate that was 37.1% (n = 39) and undecided participants were 3.8% (n = 4) (Figure 5).



**Figure 6:** It is possible to have pain and not know about it.

**It is possible to have pain and not know about it (n = 105)**

This figure showed that true participants were highest rate that was 59% (n = 62). False participants were second highest rate that was 37.1% (n = 39) and undecided participants were 3.8% (n = 4) (Figure 6).

|                            | Frequency | Percentage |
|----------------------------|-----------|------------|
| Strongly agree             | 51        | 48.6       |
| Agree                      | 47        | 44.8       |
| Neither agree nor disagree | 6         | 5.7        |
| Disagree                   | 1         | 1.0        |
| Total                      | 105       | 100.0      |

**Table 4:** Accepting your pain may facilitate recovery from low back pain.

**Accepting your pain may facilitate recovery from low back pain (n = 105)**

This table showed that strongly agree participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1) (Table 4).

|                            | Frequency | Percentage |
|----------------------------|-----------|------------|
| Strongly agree             | 47        | 44.8       |
| Agree                      | 6         | 5.7        |
| Neither agree nor disagree | 51        | 48.6       |
| Disagree                   | 1         | 1.0        |
| Total                      | 105       | 100.0      |

**Table 5:** Because of your low back pain, you should abandon your life duties, and should not do any physical activities as you may cause more damage.

**Because of your low back pain, you should abandon your life duties, and should not do any physical activities as you may cause more damage (n = 105)**

This table showed that neither agree nor disagree participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1) (Table 5).

**Repetitive heavy lifting causes/worsens low back pain (n = 105)**

This table showed that don't know participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1) (Table 6).

|                | Frequency | Percentage |
|----------------|-----------|------------|
| Strongly agree | 47        | 44.8       |
| Agree          | 6         | 5.7        |
| Don't know     | 51        | 48.6       |
| Disagree       | 1         | 1.0        |
| Total          | 105       | 100.0      |

**Table 6:** Repetitive heavy lifting causes/worsens low back pain.

|                | Frequency | Percentage |
|----------------|-----------|------------|
| Strongly agree | 51        | 48.6       |
| Agree          | 6         | 5.7        |
| Don't know     | 1         | 1.0        |
| Disagree       | 47        | 44.8       |
| Total          | 105       | 100.0      |

**Table 7:** Flexion combined with compressive force to the lumbar spine, e.g. in lifting heavy objects poses the risk of developing low back pain.

**Flexion combined with compressive force to the lumbar spine, e.g. in lifting heavy objects poses the risk of developing low back pain (n = 105)**

This table showed that strongly agree participants were highest rate that was 48.6% (n = 51) and lowest don't know were 1% (n = 1) (Table 7).

**Relationship between knowledge and practice among participants**

As it is stated prior, the study institute that 105 participants had

| Knowledge Variable Attitudes /practice | PK** (%) | CK*** (%) | Chi-square test (p = value)       |
|--|----------|-----------|-----------------------------------|
| Positive practice                      | 97.1     | 91.2      | $\chi^2 = 4.33, df (1), p = 0.04$ |
| Negative practice                      | 2.9      | 8.8       |                                   |
| Totals                                 | 100      | 100       |                                   |

**Table a**

- \*Significant at level of 5%
- \*\*Partially Knowledgeable
- \*\*\*Completely Knowledgeable
- df = Degree of freedom.

knowledge in at least one of the six questions which was aiming to categorize the general knowledge of the participants on the course and causes of LBP in general. Consequently, the attempt was made to discover if the knowledge of the participants had any association with their attitudes and practice on their LBP. The Chi-square test explained a momentous relationship between knowledge of the participants and their attitudes and beliefs on LBP (p = 0.04).

**Association between knowledge and selected variables**

The cross tabulation was implement to find out if there was any associations between the knowledge of the participants and the selected variables. The variables included gender, age levels of the participants.

| Characteristic      | Completely knowledgeable | Partially knowledgeable | Chi-square statistic (p-value)  |
|---------------------|--------------------------|-------------------------|---------------------------------|
| Gender (n = 105)    | (%)                      | (%)                     | $\chi^2 (1^*) = 1.44, p = 0.23$ |
| Male                | 4.8                      | 93.8                    |                                 |
| Female              | 95.2                     | 89                      |                                 |
| Education completed |                          |                         | $\chi^2 (3^*) = 1.27, p = 0.74$ |
| SSC                 | 6.1                      | 30.5                    |                                 |
| HSC                 | 9.2                      | 39.0                    |                                 |
| Graduate            | 11.8                     | 26.7                    |                                 |
| Masters             | 14.3                     | 3.8                     |                                 |

**Table 8:** Association between knowledge and selected variables.

p = p-value, at 5% level of significance

\*degrees of freedom

No noteworthy associations were found between the knowledge of the participants and the selected variables. Chi- square tests did not expose any momentous association between source of the information and the knowledge (p = 0.07). There were also no significant associations between knowledge of the participants and other variables such as gender (p = 0.23), age (p = 0.83) (see Table: 8 below).



## Discussion

The endeavor of this study were to the intention of this study was to appraise Knowledge, attitude and practice towards patients with chronic low back pain among the physiotherapist clinical practice in Dhaka city of Bangladesh. Though the study populations were those convention inclusion/exclusion criteria and KAP study at chronic low back pain among the physiotherapist clinical practice in Dhaka city of Bangladesh. Total number of embelishment was one hundred five for quantitative study with aged (25-50) years living in Dhaka city were selected for this study was careful as research population. The study found that most of the participants were above 25 years. The youngest contestants in this study were 25 years and oldest participants were 50 years. McGrath CMF. Et. Al., (2008) performed a cross-sectional study for these purpose 78 patients (mean age  $57.8 \pm 11.9$  years, 55 women and 23 men) were randomly selected for inclusion in the study. Another result has been reported by Siti Noor khairina S., Sakinah H. (2014) who concluded that the mean age was  $\pm 62.1$  and their age range was 30-50 years. So above two studies, mean age was not similar to this study. In this study, Gender demonstrated that Male and female participant proportion was indistinguishable. Male 95.2% (n = 100) and Female 4.8% (n = 5) and Majority of the participants were males n = 100 (95.2%). Many studies done on LBP patients show that females dominate in terms of enrolment at the study (Duke., *et al.* 2013; Ferreira., *et al.* 2004; Kennedy., *et al.* 2014; Ryan., *et al.* 2010). The studies have found that gender gap could be influenced by both cognitive and non-cognitive factors. In this study Highest level of Education completed showed that HSC participants were highest rate that was 39% (n = 41). SSC participant were rate that was 30.5% (n = 32). Another result has been Videman., *et al.* (2005), graduate participants had a low back pain prevalence increase from 34% to 82%. However, this is contrary to what was found among other HSC participants who were followed for a period of 20 months (Klaber Moffett., *et al.* 1993). In this study income categories of the contestants illustrated that 10000-20000 BDT participants were uppermost rate that was 55.2% (n = 58). Bushnell CD and Goldstain LB, 2010 showed his research maximum income level were higher participants was highest ratio. So this study was some prophecy regarding economic significance of those continents wise. In this study occupation status of the participants showed that house wife were highest rate that was 59.6% (n = 62).

In this study, the physiotherapists got an overall NPQ-mean score of 6.0(SD 1.9) out of 12, which indicate an average knowledge of the neurophysiology of pain. Have you ever been teach or conventional in sequence on low back pain and its causal aspects? This study showed that that yes contestants were uppermost rate that was 59% (n = 62) and no accomplices were 41% (n = 43). Where did you receive the information? This study showed that at school participants were highest rate that was 34.3% (n = 36). Adillón., *et al.* 2015 of his study showed school participants were highest ratio. So this two study were similar. When part of your body is injured, special pain receptors convey the pain message to your brain this study showed that false participants were highest rate that was 59% (n = 62). True participants were second highest rate that was 37.1% (n = 39) and undecided participants were 3.8% (n = 4). Ryan., *et al.* (2010) of his study showed true participants were 89%. It is possible to have pain and not know about it this study showed that true participants were highest rate that was 59% (n = 62). False participants were second highest rate that was 37.1% (n = 39) and undecided participants were 3.8% (n = 4). Watt-Watson., *et al.* 2004 of her study showed were false highest ratio. Accepting your pain may smooth the progress of recuperation from low back pain this study showed that strongly agree contestants were uppermost rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1). Alshami and Albahrani, 2015 showed her study agree were highest ratio. Because of your low back pain, you should abandon your life duties, and should not do any physical activities as you may cause more damage This study showed that neither agree nor disagree participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1). Briggs., *et al.* 2013 showed of study strappingly agree were highest ratio. Repetitive heavy lifting causes/worsens low back pain This study showed that don't know participants were highest rate that was 48.6% (n = 51) and lowest disagree were 1% (n = 1). Morris., *et al.* 2012; study showed were agree participants highest ratio. Flexion mutual with compressive compel to the lumbar spine, e.g. in lifting heavy objects poses the risk of developing low back pain This study showed that strongly agree participants were highest rate that was 48.6% (n = 51) and lowest don't know were 1% (n = 1). Briggs., *et al.* 2013 showed off his study don't know highest ratio. Relationship between knowledge and practice among participants the attempt was made to explore if the knowledge of the participants had any association with their attitudes and practice on their LBP. The Chi-square test showed a significant relationship between knowledge

of the participants and their attitudes and beliefs on LBP ( $p = 0.04$ ). Association between knowledge and selected variables the cross tabulation was performed to find out if there was any associations between the knowledge of the participants and the selected variables. The variables included gender, age levels of the participants. No significant associations were found between the knowledge of the participants and the selected variables. Chi-square tests did not reveal any significant association between source of the information and the knowledge ( $p = 0.07$ ). There was also no significant associations between knowledge of the participants and other variables such as gender ( $p = 0.23$ ), age ( $p = 0.83$ ).

### Conclusion

This study tinted that many patients with LBP in Dhaka city are not sufficiently knowledgeable about LBP and hold negative attitudes and beliefs regarding their LBP. Even though no delineation was made between the knowledge, attitude and beliefs of patients living with chronic against repeated LBP, it can be accomplished that as long as education to the patients regarding their LBP and especially pain neuroscience education may enhance their knowledge regarding LBP. Therefore, LBP management approaches in Dhaka city should include education programmes aimed at sanction patients with knowledge regarding LBP, its contributing factors as well as changing their negative attitudes and beliefs about their pain. Patients' sympathetic of the cause and nature of their pain may augment the attainment of treatment goals.

The biomedical and biopsychosocial treatment orientations of physiotherapists in Dhaka city were relatively low. The most frequent treatment approaches used by physiotherapists for Non specific chronic low back pain were home exercises and patient education. However, some passive and traditional treatments which are not recommended by clinical practice guidelines for the management of LBP continue to be used frequently by physiotherapists in Dhaka city in Bangladesh. This study has confirmed that physiotherapists' pain attitudes and beliefs are significantly associated with treatment selection when managing individuals with NSCLBP. Further research through which to better understand and facilitate the implementation of best evidence-based practice and clinical practice with the deliberation of the biopsychosocial model in universities' curricula is precedence, particularly in countries in which the biopsychosocial representation is rarely considered in the healthcare and education/university systems.

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### Conflict of Interest

None.

### Author's Contributions

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