Body awareness therapies in medical and health-related conditions: a scoping review

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Abstract

Introduction: Body awareness (BA) therapies are interventions with a focus on the internal subjective experience of the body. The theory behind BA therapies states that physical, emotional and social strain affect the whole body and therefore the respiration, posture, balance, muscular tension, movements, body awareness and flexibility. There is evidence for positive effects of BA therapies in various pathologies. With this scoping review we intend to explore the different forms of BA therapies, and their effectiveness on specific medical and health-related conditions

Methods: We conducted a scoping review of randomized clinical trials (RCTs) and systematic reviews/meta-analyses with RCTs the different BA therapies and their effect on medical and health-related conditions. Yoga, tai chi, eastern therapies and Mindfulness-Based(-Stress-Reduction) therapies were excluded, because of the large amount of studies already existing for these therapies

Results: The search resulted in an overview of different BA therapies; basic body awareness therapy (BBAT), (Norwegian) psychomotor (physio)therapy (NPMP), dance-movement therapy, Alexander technique and Feldenkrais Method. These therapies showed some effectiveness in psychological, musculoskeletal, neurodegenerative, disorders, pain and quality of life. Nonetheless, we noted a lack of RCTs, with clear therapy protocols, large sample sizes and long-term results; possible targets for future research.

Conclusion: BA therapies are multimodal interventions that already showed some significant effectiveness in clinical settings. Still, future research is needed to make conclusion for the clinical practice.

1.Introduction

Body awareness (BA) therapies are interventions with a focus on the internal subjective experience of the body, the awareness of how the body is used. A holistic approach is used in these interventions in which all movement characteristics and focus on breathing, postural balance and awareness are involved. These approaches are therefore centered around the patient's individual resources. (1)

The theory behind BA therapies states that physical, emotional and social strain affect the whole body and therefore the respiration, posture, balance, muscular tension, movements, body awareness and flexibility. (2)

There is evidence for positive effects of BA therapies in various pathologies, quality of life. These interventions are for instance applied across Europe in centers for rehabilitation with the aim to improve patients' movement and functional ability when affected by pathology, aging or environmental factors. (1)

Pain, for instance, is best represented by a biopsychological model. To be clinically effective and cost efficient, treatment options should be focused on holistic approaches for a multimodal pain management. Mindfulness has been proven to be an important factor in these approaches but requires considerable cognitive and linguistic skills. Furthermore, pain is situated in the body, there is a chance that physical suffering won't be validated enough. Working with the body instead, could be a better therapeutic solution.(3)

BA therapies could also be effective interventions for patients with mental health problems. Firstly, because these patients, by focusing on physical activities, could be pulled out of their immersion in their own world. And secondly, it is usually easier to establish contact with these patients by using therapies, as communication on a non-verbal level could be more understandable and easier for these patients.(4)

With this scoping review we intend to explore the different forms of BA therapies, and their effectiveness on specific medical and health-related conditions. The target is to research the studies that have been conducted on this subject, and present the evidence. Finally, we aim to identify evidence gaps and give recommendations for future research.

2.Methodology

In January 2023 we conducted a search of randomized controlled trials (RCTs), systematic reviews and meta-analyses with randomized controlled trials in Pubmed, Embase, Web Of Science Core Collection, Cochrane, Pedro, Sportdiscus and PsychArticles. Addendum 1 shows an overview of the search terms used in the different databases.

The inclusion criteria consisted of:

- Population: adults with medical or health-related symptoms/disorders/quality of life, both genders
- Intervention: body awareness therapy, conducted by a certified, professional
- Control: treatment as usual, waiting list, other therapy
- Languages: English, Dutch
- Randomized controlled trials or systematic reviews with RCTs

The exclusion criteria were:

- Population: age < 18 years
- Intervention: yoga, tai chi, eastern body awareness therapies, Mindfulness-Based-stress-reduction (MBSR) therapies
- No limit on the publication date
- Conference abstracts

We decided to exclude yoga, tai chi, MB(SR) therapies, because of the great amount of research that already exists for these therapies. Therefore, we made the choice to put the focus on the other less known body awareness therapies.

The first search yielded 9701 articles, after deduplication 6769 articles. After title and abstract screening, 213 full texts were studied. Hereby also looking for relevant articles in the reference list. Ultimately 22 articles were included. This process is presented in a PRISMA flowchart in addendum 2. Endnote was used as a reference library and Rayann for the screening of the articles.

Data extraction happened structured following the PICOS- method, and can be found in table 1.

3.Findings and discussion

In our search we identified several different body awareness therapies applied in a couple medical and health-related disorders. An overview of these RCTs is presented in table 1.

3.1. Basic Body Awareness Therapy

3.1.1. Systematic review with RCTs

Vancampfort et al. conducted a systematic review and meta-analysis of RCTs to study the efficacy of basic body awareness therapy (BBAT) on functional outcomes and quality of life (QoL) in patients. Patients with mental health problems, long-lasting musculoskeletal disorders, psychosomatic and chronic pain and neurological disorders were included as these are believed to be the most important indications for BBAT.(5)

BBAT interventions as defined by the International Association of Teachers in Basic Body Awareness Therapy (IATBBAT) and supervised by BBAT physiotherapists (certified via the IATBBAT) were included. The aim of BBAT is to promote more functional movement quality, wellbeing and health, by integrating postural stability, free breathing and mental awareness into movements. Movements consist of exercises such as lying, sitting, standing, walking, relational movements, use of the voice and massage.(5)

Eventually eight RCT met the inclusion criteria and were selected. A RCT by Olsen et al. studied BBAT in hip osteoarthritis. Nordbrandt et al. conducted a study of BBAT in trauma-affected refugees. The effectiveness of BBAT was furthermore studied for fibromyalgia by Bravo et al., idiopathic scoliosis by Yagci et al., chronic whiplash associated disorders by Seferiadis et al., major depression by Danielsson et al., eating disorders by Catalan-Matamoros et al. and in psychiatric outpatient care by Gyllenstein et al. (5) The RCTs are summarized in table 1.

The results compared to non-active control conditions showed no significant benefits for BBAT in these patients. Concerning the global functional outcomes and QoL, active control conditions were superior to BBAT. Furthermore, it is important to note that 20% of people with depression reported more emotional distress/anxiety following BBAT. For now, there should be caution for the application of BBAT, more RCTs and qualitative research is needed. (5)

3.2. Psychomotor therapies

3.2.1. Psychomotor therapy for schizophrenia

In patients with schizophrenia the senses of individuality, unity and autonomy, which are essential to the personality, are impaired. Furthermore, there is a loss in physical perception and motor activity in these patients. The body is believed to be an anchor for the personality; in patients with schizophrenia, that support is lost. (4)

Hátlová et al. conducted a randomized controlled double-blind study with 142 in-patients with schizophrenia from the Psychiatric hospital Prague, Bohnice. The aim was to study the effectiveness of psychomotor therapy on the mental health of these patients.(4)

The control group followed the routine program (pharmacotherapy, memory training twice a week and free time daily). The intervention group also underwent the routine program, in addition with a psychomotor therapy program. The therapy had a duration of 45 minutes, 3 times a week, during 14 weeks. It consisted of non-contact and simple gymnastic exercises aiming to body awareness, importance was given to precision in movement and the positive emotional experience when the movement was mastered. (4)

The evaluate the effect of the PMT, the Brief Psychiatric Rating Scale (BPRS) was administered pre-and post-intervention. This scale consists of five factors; anxiety/depression (ANDP), anergy (ANER), thought disturbance (THOT), activation (ACTV), hostility/suspiciousness (HOST). The results showed significant differences for all the five factors in the intervention group. In the control group, no significant differences were found. Following these positive results, implementation of this psychomotor therapy in routine programs for schizophrenic patients could be considered. (4)

3.2.2. A brief body and movement-oriented intervention for eating disorders

In people with an eating disorder (ED) aggressiveness is often directed to the self, using self-destructive behaviors stemming from an inhibited anger expression. In psychomotor therapy (PMT)- a body and movement-oriented therapy- body awareness and physical activities are used to increase the understanding of emotions and expression skills.(6)

Boerhout et al. conducted a two-arm randomized RCT of a brief body and movement-oriented intervention with the aim to study the effect of the intervention on aggression regulation and eating disorder pathology in individuals with an ED. Forty women from the outpatient department for ED of Lentis Psychiatric Institute Groningen, who met DSM-IV criteria for anorexia nervosa, bulimia nervosa or ED not otherwise specified (including binge eating disorder) enrolled in the study. They were randomized to the intervention (aggression regulation + supportive contact) or the control group (supportive contact). (6)

The intervention was led by a psychomotor therapist and consisted of six one-hour sessions in which different body and movement-oriented strategies were used to unlock functional anger expression. During these exercises different props such as sticks, boxing gloves, balls

ropes…were used. Where some props, a boxing bag for instance, represented a bully at school, a nosy parent and the ED. The supportive contact, once in 1 or 2 weeks consisted of consultations with a psychiatrist, psychotherapist, specialized nurse practitioner or dietician. (6)

For the measures, twenty-nine patients eventually filled in questionnaires at pre-intervention and post-intervention; the self-expression and control scale (SECS) and the eating disorder examination-self-report questionnaire (EDE-Q). For this trial the focus was mainly on the 'Anger In' (efforts to hide anger) and 'Anger Out' (outwardly directed anger) subscales of the SECS (based on the pilot study from Boerhout & Van der Weele in 2007).(6)

There was a significant difference in the Anger In subscale of the SECS ($p < 0.03$) and EDE-Q total ($p < 0.02$) for the patients of the intervention group compared to the control group. No significant difference was found in the Anger Out subscale of the SECS ($p < 0.21$). The intervention thus led to a decrease of anger internalization and reduction in ED-related psychopathology, making it a possible worthy add-on treatment for patients with ED. (6)

Another RCT of the brief body and movement-oriented intervention by Boerhout et al. was conducted, this time at two locations; PsyQ Center for ED in Groningen, part of Lentis Psychiatric Institute and Amarum Center for ED in Zutphen. Patients were randomly assigned to treatment-as-usual (TAU) plus the intervention (n= 38) or to TAU only (n= 32). TAU was a multidisciplinary group treatment (using principles of cognitive behavioral therapy), 3-5 days a week. The SECS Anger In showed also this time a significant difference ($p< 0.001$) between the two groups. Although a decrease in EDE-Q was noted in both groups, the difference was not significant. A possible explanation for this result could have been the extensive therapeutic schedule for both groups. (7)

3.2.3. Norwegian psychomotor physiotherapy for musculoskeletal pain

Longlasting musculoskeletal disorders are caused by multiple factors. Patients with these conditions therefore need a treatment that includes physical, psychological and social aspects. These aspect are found in Norwegian psychomotor physiotherapy (NPMP).(8)

Dragesund et al. completed a single-blinded RCT to study the effect of NPMP musculoskeletal pain and/or pain located to the neck and shoulders compared to cognitive patient education combined with active individualized physiotherapy (COPE-PT). A total of 128 patients were randomized to the intervention group (NPMP) or the control group that consists of COPE-PT. The study took place in physiotherapy clinics, the interventions where led by experienced and NPMP physiotherapists. (8)

For the outcome measures the Numeric Pain Rating Scale (NPRS) was used, with additional questionnaires; Norwegian Function Assessment Scale (NFAS), Hopkins Symptoms Checklist (HSCL-25), Örebro Musculoskeletal Pain Questionnaire short form (ÖMPQ-SF), Bergen Insomnia Scale (BIS), Tampa Scale of Kinesiophobia (TSK), Subjective Health Complaints Inventory (SHC) and The Short Form-12 (SF-12), using the mental (MSC) and physical (PSC) subdomains. Also physical tests were used; Global Body Examination-Flexibility (GBE-6), Back Performance Scale (BPS), a high lift test, Biering–

Sørensentest, a dynamic sit-up test and 18 tender points from the American College of Rheumatology (ACR) of fibromyalgia. (8)

COPE-PT showed a significant difference; at 3 months for pain, anxiety and depression, quality of life- physical dimension, risk profile, fear of movement, at 6 months for anxiety, depression, sleep, and at 12 months for anxiety, depression, sleep and quality of life-physical dimension. In conclusion: COPE-PT gives more improvement in these outcomes then NPMP.(8)

3.2.4. Psychomotor physical therapy on health-related quality of life

With the use of massage, therapeutic reflection and body awareness through grounding exercises and relaxation training during NPMP, changes in affected functions are facilitated. (2)

Bergland et al. conducted a RCT including 105 participants, who were randomly assigned to an intervention group (NPMP) and a control group (no intervention). The aim of this RCT was to study the effect of NPMP on health-related quality of life (HRQOL), pain, coping, self-esteem, and social support. NPMP was given once a week during 6 months by NPMP specialized physiotherapists. Becoming aware of how the body and mind interact by normalizing respiration and muscular control was the target during this NPMP intervention. This, with the use of massage, relaxation and movement trainings. (2)

HRQOL was measured with the Short Form 36 Health Survey (SF-36). The Numeric Pain Rating Scale (NPRS) was used to evaluate pain. Coping was assessed with the 7-item coping scale. Self-worth and attitudes towards the self were measured with the Rosenberg Self-Esteem Scale. And the Oslo-3 Social Support Scale has been used for the social support measurements. (2)

The participant of NPMP- group showed a significant improvement in SF-36 scores. Between the two groups there was a significant difference in physical functioning, bodily pain, general health, mental health, social functioning and vitality. With Cohen’s d effect sizes ranging from 0.9 for vitality to 0.3 for role physical and median of 0.6 for role emotional. Self-esteem and pain measures, also showed significant differences in favor of NPMP.(2)

3.3. Dance movement therapies

3.3.1. Systematic review with RCTs

Dance movement therapy as defined by the American Dance Therapy Association (ADTA) aims to the integration of the emotional, social, cognitive and physical of the patient by the use of movement so that an improvement of health and well-being is achieved.(9)

Koch et al. conducted a meta-analysis of the effects of dance movement therapy (DMT) on health-related and psychological outcomes. The DMT interventions showed significant effects for cognitive skills and quality of life. But not for motor skills, therefore affirming the mainly psychotherapeutic use of DMT. (9)

3.3.2. Dance movement therapy for psychophysiological effects in mild dementia

DMT stimulates brain areas that are important for memory, executive function and motor skills, thereby activating networks associated with spatial memory, which are impaired in dementia. (10)

Rainbow et al. conducted a RCT with 204 patients to assess the effect of DMT on psychophysiological effects in older adults with mild dementia. Patients were included from psychogeriatric outpatient departments and community centers in Hong Kong and randomized into DMT group, exercise group or waitlist control group. The duration of the DMT intervention was 1 hour and given twice a week during 12 weeks. The main factors of the DMT sessions were simple dance group, movement games, improvisational dance movement, and movement interactions with group members.(10)

For the measurement of the outcome several scales were used; de Jong Fierveld Loneliness Scale, Geriatric Depression Scale, 11-point Visual Analogue mood Scale, instrumental activities of daily living (IADL) scale, 12- item Neuropsychiatric Inventory, and severity of symptoms (apathy, hallucination, agitation) on 4-point scale. Furthermore, the Fuld Object Memory Evaluation, Digit Span test of the Wechsler Adult Intelligence Scale, trail making test and saliva samples were used to evaluate the effect.(10)

Compared to the waitlist control, DMT showed a decrease in depression ($p< 0.01$), loneliness ($p<0.01$) and negative mood ($p< 0.02$), and better IADL ($p< 0.01$) and neuroendocrine functioning. This study shows that DMT could be incorporated in programs for older patients early psychosocial support.(10)

3.3.3. A short-term dance movement therapy for patients with breast cancer

Ho RT et al. conducted a RCT to examine the effects of a short-term dance movement therapy in patients with breast cancer undergoing radiotherapy. A total of 139 patients were included and randomly assigned to the DMT intervention (1.5 hour, twice a week during three weeks) or a waitlist control group. (11)

For the measures different scales were used; Perceived Stress Scale, Hospital Anxiety and Depression Scale, Brief Fatigue Inventory, Pittsburgh Sleep Quality Index and Functional Assessment of Cancer Therapy-Breast Scale. (11)

Compared to the control group, significant differences on stress, pain severity and pain interference were seen after DMT intervention.(11)

3.4. Alexander technique

3.4.1. systematic review with RCTs

The focus of Alexander Technique (AT) is the diminishment of self-damaging postural and movement habits and modification of habitual reactions to stimuli, including pain and stress for instance. AT teachers use verbal explanation and manual contact to help the patients to experience another movement coordination that is more effortless.(12)

Woodman et al. reviewed the effectiveness of AT on medical and health-related conditions. In this review 3 RCTs were included; two on chronic low back pain and one on Parkinson's disease. (12)

The measure results following the AT therapy showed significant long-term reductions in back pain and incapacity caused by chronic back pain and an improved ability to perform daily activities in patients with Parkinson.(12)

3.4.2. Alexander Technique for neck pain

MacPherson et al performed a three-group RCT to study the effectiveness of a AT on neck pain. The recruitment out of thirty-three general practices resulted in 517 patients. Eventually patients were randomly assigned to an AT group (20 lessons of thirty minutes) with usual care, acupuncture group (12 fifty minutes sessions) with usual care, and usual care (medications, visits to physical therapists and other health care professionals).(13)

Outcomes were measured with the Northwick Park Questionnaire (NPQ) score, pain intensity score by text message, Short Form 12-version 2 (SF-12v2) and Chronic Pain Self-Efficacy Scale. The results showed a significant decrease in the NPQ score for the AT ($p< 0.01$), and also a significant improvement of self-efficacy ($p< 0.001$).(13)

3.5. Feldenkrais Method

3.5.1. Systematic review with RCTs

The aim of Feldenkrais Method (FM) is to enhance personal self-knowledge through conscious movements. In this treatment two modalities are used. In the “Awareness through movement” (ATM) modality, the therapists guide the patient verbally into postures and movements and inquire about the bodily sensations that the patient experiences. In the other modality “Functional integration” passive and soft mobilizations are conducted to re-educate movements and improve proprioception. (14)

Berland et al. conducted a systematic review and meta-analysis of RCTs of the effects of Feldenkrais Method as a physiotherapy tool. (14)

The RCTs showed positive effects of FM for several patients. Most trials showed a significant improvement in gait, balance, mobility and quality of life in elder people. In patients with cervical, dorsal or shoulder pain, a significant improvement in pain, functional balance and perceived exertion was noted. For subjects with chronic lower back pain, FM improved the pain, disability, quality of life and interoceptive awareness. For patients with multiple sclerosis, an enhancement of functional capacity was observed. And for patients with Parkinson’s disease, the trial showed significant effects on quality of life and functional tests. (14)

3.6. Overview of the RCTs

Author, year	Participants	Intervention	Control	Outcome
Olsen 2022 (15)	101 patients with hip osteoarthritis	BBAT (n= 51) 70 min, 1 session /week, 12 weeks	PE (n= 50) 3.5h, 1 seminar /month	No significant differences
Nordbrandt 2020 (16)	318 refugees with PTSD	BBAT (n= 105) 60 min, 1 session/week, 20 weeks	TAU, interdisciplinary treatment (n= 104) with medical doctor (10 sessions) and psychologist (16 sessions); aerobic and resistance training (n= 109)	No significant differences
Bravo 2019 (17)	39 patients with fibromyalgia	BBAT (n= 19), 60 min, 2 sessions/week, 5 weeks	TAU (n= 20)	Significant decrease ($p< 0.037$) in severe pain on VAS

Yagci 2018 (18)	20 patients with idiopathic scoliosis	BBAT (n= 10), 60 min, 2 sessions/week, 10 weeks added to TAU	TAU (n= 10) 60 min exercises 2 sessions/week, home exercises 5 sessions/week + brace intervention (volunteers) 10 weeks	No significant differences
Seferiadis 2016 (19)	113 patients with whiplash associated disorders	BBAT (n= 56), 90min, 2 sessions/week, 10 weeks added to TAU	TAU (n= 57) 90 min exercises 2 sessions/week 10 weeks	Significant in SF-36 physical functioning (p< 0.032)
Danielsson 2014 (20)	62 patients with depression	BBAT (n= 22) 60min, 1 session/week, 2 weeks, 2 group sessions/week, 8 weeks 10 weeks	Control 1 60min, 1 session/week, 2 weeks, 2 group sessions/week, 8 weeks 10 weeks Control 2 one advice session + TAU	Significant difference in MADRS, better VO2max
Catalan-Matamoros 2011(21)	22 patients with eating disorders	BBAT (n= 14), 60min, 1 session/week, 2 weeks, 60-90min 2 sessions/week, 5 weeks + TAU	TAU (n=8)	Significant reduction in EDI total score score (p< 0.015), improvement in SF-36 mental health (p< 0.002)
Gyllensten 2009 (22)	60 patients with mood disorder, somatoform disorder or personality disorder	BBAT (n= 30), 12 sessions/week	TAU (n=30)	No significant improvements
Hatlova 2020 (4)	142 patients with schizophrenia	Psychomotor therapy (n= 82) 3 sessions/week,	TUA (n=60) pharmacotherapy, memory training twice a week and	Significant improvements for all subscales of the BPRS

		14 weeks + TUA	free time daily	
Boerhout 2016 (6)	40 patients with eating disorder	Body and (= 20) movement -oriented therapy + TUA	TUA (=20) Supportive contact 1/1-2week	Significant difference in the Anger In subscale of the SECS (p <0.03) and EDE-Q total (p <0.02)
Boerhout 2017 (7)	60 patients with eating disorder	Body and (= 38) movement -oriented therapy + TUA	TUA (n= 32) multidisciplinary group treatment (using principles of cognitive behavioral therapy), 3-5 days a week	Significant difference in the Anger In subscale of the SECS (p <0.001)
Dragesund 2021 (8)	128 patients with musculoskeletal pain and/or pain located to the neck and shoulders	NPMP (=64) 60min 1session/week 3-6 months	COPE-PT (=64) 30 min 1session/Week	Significant difference for COPE-PT; at 3 months for pain, anxiety and depression, quality of life- physical dimension, risk profile, fear of movement, at 6 months for anxiety, depression, sleep, and at 12 months for anxiety, depression, sleep and quality of life-physical dimension
Bergland 2018 (2)	105 patients recruited by physiotherapists	NPMP (=55) 1 session/week 6 months	Control (=50) no intervention	significant difference in physical functioning, bodily pain, general health, mental health, social functioning and vitality, also significant differences in Self-esteem and pain measures
Ho RT 2016 (19)	139 patients withbreast cancer undergoing radiotherapy	Short-term dance movement therapy 1.5 hour, twice a week during three weeks	Waitlist control	significant differences on stress, pain severity and pain interference
MacPherson 2015 (21)	517 patients with neck pain	AT treatments (n=172) 30 minutes 20 lessons	acupuncture group (12 fifty minutes sessions) with usual care, and usual care (medications, visits to physical therapists and other health care professionals)	Significant decrease in the NPQ score for the AT (p< 0.01), and significant improvement of self-efficacy (p< 0.001)

Table 1. Description of the discussed RCTs

4.Conclusion

In this scoping review different BA therapy modalities were found; basic body awareness therapy, (Norwegian) psychomotor (physio)therapy, dance movement therapies, Alexander technique, Feldenkrais Method.

Significant effectiveness of these interventions on several medical and health-related conditions such as psychological, musculoskeletal, neurodegenerative symptoms and disorders, pain, quality of life, functional outcomes where found.

The definition of BA therapy is heterogeneous across the articles, as well as the descriptions of the different BA therapies. During the research it has been noted that clear, specific protocols for the therapies were missing. Furthermore, the qualification of professional, experienced therapists for these specific interventions, was not always easy to assess.

A number of studies for these therapies have been conducted, but in general there was a lack of randomized controlled trials. Moreover, it has been clear that the existent RCT often contained a small sample size. More RCTs for the BA therapies should be conducted, with larger sample sizes.

Note: the limitations of this scoping review exist in the lack of screening of information in grey literature. Furthermore, the screening was conducted by one person, increasing the risk of selection bias.

Furthermore, patients in DMT trials were mostly female. Future studies of DMT therapies should aim to include more men.

For the measures (self-rated) scales and questionnaires were often used. And because of the type of interventions, conducting blinded studies is not evident. Future studies should critically assess these aspects.

Finally, a lack of studies on the long-term effect of BA therapies was noticed. Important data for making conclusions for the future clinical implications of these BA therapies.

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Addendi

Addendum 1. Search terms

PUBMED	"Mind-Body Therapies"[Mesh:NoExp] OR "Dance Therapy"[Mesh] OR "dance therap*"[tiab] OR "Mind-Body Relations, Metaphysical"[Mesh] OR "body awareness therap*"[tiab] OR "psychomotor therap*"[tiab] OR "psycho-motor therap*" [tiab] OR "mind body therap*"[tiab] OR "body mind therap*"[tiab] OR "mind body relation*"[tiab] OR "body mind relation*"[tiab] OR "mind body techniqu*"[tiab] OR "body mind techniqu*"[tiab] OR "body mind walk*"[tiab] OR "mind body walk*"[tiab]
Embase	'body awareness therapy'/exp OR 'dance therapy'/exp OR 'dance therap*':ti,ab,kw OR 'body awareness therap*':ti,ab,kw OR 'psychomotor therap*':ti,ab,kw OR 'psycho-motor therap*':ti,ab,kw OR 'mind body therap*':ti,ab,kw OR 'body mind therap*':ti,ab,kw OR 'mind body techniqu*':ti,ab,kw OR 'body mind techniqu*':ti,ab,kw OR 'mind body relation*':ti,ab,kw OR 'body mind relation*':ti,ab,kw OR 'mind body walk*':ti,ab,kw OR 'body mind walk*':ti,ab,kw
Web of Science core collection	Science Citation Index Expanded (SCI-EXPANDED)--1955-present Social Sciences Citation Index (SSCI)--1956-present Arts & Humanities Citation Index (AHCI)--1975-present Conference Proceedings Citation Index – Science (CPCI-S)--1990-present Conference Proceedings Citation Index – Social Science & Humanities (CPCI-SSH)--1990-present Book Citation Index – Science (BKCI-S)--2005-present

	Book Citation Index – Social Sciences & Humanities (BKCI-SSH)--2005-present Emerging Sources Citation Index (ESCI)--2018-present TS=("dance therap*" OR "body awareness therap*" OR "psychomotor therap*" OR "psycho-motor therap*" OR "mind body therap*" OR "body mind therap*" OR "mind body techniqu*" OR "body mind techniqu*" OR "mind body relation*" OR "body mind relation*" OR "mind body walk*" OR "body mind walk*")
Cochrane trials	#1: [mh ^"Mind-Body Therapies"] OR [mh "Dance Therapy"] OR [mh "Mind-Body Relations, Metaphysical"] #2: (("dance" NEXT therap*) OR ("body awareness" NEXT therap*) OR ("psychomotor" NEXT therap*) OR ("psycho-motor" NEXT therap*) OR ("mind body" NEXT therap*) OR ("body mind" NEXT therap*) OR ("mind body" NEXT relation*) OR ("body mind" NEXT relation*) OR ("mind body" NEXT techniqu*) OR ("body mind" NEXT techniqu*) OR ("body mind" NEXT walk*) OR ("mind body" NEXT walk*)):ti,ab,kw
Pedro	body awareness therap*, basic body awareness therap*, dance therap* 23:15, mind body therap*, body mind therap*, psychomotor therap*, psycho-motor therap*, mind body relation*, body mind relation*, mind body techniqu*, body mind techniqu*, , body mind walk*, OR mind body walk*
Sportdiscus	DE "MIND-body walking" OR DE "MIND & body therapies" OR DE "DANCE therapy" AB ("Dance Therap*" OR "Body Awareness Therap*" OR "Psychomotor Therap*" OR

	"Psycho-Motor Therap*" OR "Mind*Body Therap*" OR "Body*Mind Therap*" OR "Mind*Body Relation*" OR "Body*Mind Relation*" OR "Mind*Body Techniqu*" OR "Body*Mind Techniqu*" OR "Body*Mind Walk*" OR "Mind*Body Walk*") OR TI ("Dance Therap*" OR "Body Awareness Therap*" OR "Psychomotor Therap*" OR "Psycho-Motor therap*" OR "Mind*Body Therap*" OR "Body*Mind Therap*" OR "Mind*Body Relation*" OR "Body*Mind Relation*" OR "Mind*Body Techniqu*" OR "Body*Mind Techniqu*" OR "Body*Mind Walk*" OR "Mind*Body Walk*") OR KW ("Dance Therap*" OR "Body Awareness Therap*" OR "Psychomotor Therap*" OR “Psycho-Motor therap*” OR "Mind*Body Therap*" OR "Body*Mind Therap*" OR "Mind*Body Relation*" OR "Body*Mind Relation*" OR "Mind*Body Techniqu*" OR "Body*Mind Techniqu*" OR "Body*Mind Walk*" OR "Mind*Body Walk*")
Psycharticles	MAINSUBJECT.EXACT(“Mind Body Therapy”) OR MAINSUBJECT.EXACT("Dance Therapy") OR AB,TI,IF("body awareness therap*" OR "psychomotor therap*" OR "psycho-motor therap*" OR "dance therap*" OR "mind*body therap*" OR "body*mind therap*" OR "mind*body relation*" OR "body*mind relation*" OR "mind*body techniqu*" OR "body*mind techniqu*" OR "body*mind walk*" OR "mind*body walk*")

Addendum 2. PRISMA flow chart

