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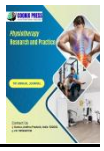

REVIEW ARTICLE

BIOPSYCHOSOCIAL APPROACHES TO CHRONIC PAIN MANAGEMENT

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ABSTRACT

Chronic pain is increasingly understood as a biopsychosocial phenomenon, yet the interplay between individual behavioral coping and environmental exposures remains underexplored in intervention design. This paper synthesizes evidence from systematic review, policy document analysis, and geospatial protocol development to examine how pain catastrophizing, fear-avoidance, and self-efficacy interact with neighborhood deprivation, workplace psychosocial stress, and nature contact to shape pain outcomes. We conducted a systematic review of eight studies published between 2016 and 2026 that met strict inclusion criteria for measuring both behavioral constructs and environmental exposures. The systematic review identified pain catastrophizing as a critical behavioral moderator: among 491 women with fibromyalgia, catastrophic thinking attenuated the beneficial effects of physical activity on functional outcomes. Workplace interpersonal stress yielded the strongest quantitative effects, with odds ratios of 2.20 for medium and 2.82 for high stress in differentiating acute from chronic low back pain. Notably, a meta-analysis on nature exposure demonstrated a standardized mean difference of 0.535 for pain reduction, while urban greenspace appeared to buffer the association between catastrophizing and pain intensity. Policy analysis further revealed synergistic interactions when cognitive-behavioral therapy was combined with community green space enhancement or workplace ergonomic modifications. Conversely, an antagonistic interaction emerged when behavioral therapy was delivered in high-adversity neighborhoods, with reduced effectiveness particularly for Black women with fibromyalgia. Our findings therefore demonstrate that chronic pain management efficacy depends critically on the synergy between behavioral and environmental factors, supporting a multi-level ecological approach that integrates environmental enrichment into cognitive-behavioral interventions.

Keywords: *Chronic pain, Pain catastrophizing, Neighborhood deprivation, Workplace psychosocial stress, Nature contact, Fibromyalgia, Cognitive-behavioral therapy.*

INTRODUCTION

Chronic pain, affecting approximately 20–30% of adults globally, represents one of the most costly and complex public health challenges of the twenty-first century [1]. Traditional biomedical models, which conceptualize pain primarily as a sensory consequence of tissue damage, have proven insufficient for explaining the substantial variability in pain experience, functional outcomes, and treatment response observed across individuals with comparable pathology [2]. Over the past four decades, the biopsychosocial framework [3] has emerged as the dominant paradigm, positing that pain perception and its consequences are shaped by a dynamic interplay of biological, psychological, and social processes. Within this framework, two categories of determinants have received considerable empirical attention: individual behavioral coping mechanisms-particularly pain catastrophizing, fear-avoidance beliefs, and self-efficacy-and contextual environmental exposures spanning neighborhood deprivation, workplace psychosocial conditions, and access to natural environments [4].

Despite substantial progress in each domain independently, there remains a critical gap in understanding how these behavioral and environmental factors interact to jointly influence chronic pain management efficacy. Most existing research has examined either individual-level cognitive-behavioral processes or population-level environmental characteristics in isolation, thereby overlooking the potential synergistic or antagonistic interactions that may arise at their intersection [5]. For instance, a patient's capacity to benefit from cognitive-behavioral therapy may be substantially modulated by the

environmental context in which treatment is delivered-a neighborhood characterized by high deprivation and limited greenspace may impose cognitive and logistical burdens that diminish therapy adherence, whereas an enriched environment with accessible nature and strong social support may amplify therapeutic gains. The clinical relevance of such interactions is underscored by the substantial heterogeneity in treatment outcomes observed across patient populations, suggesting that unimodal interventions may be insufficient for individuals facing compounded environmental adversity [6].

The present research was therefore guided by a central hypothesis: that chronic pain management efficacy is significantly moderated by the interplay between individual cognitive-behavioral processes and contextual environmental factors, and that interventions accounting for both domains produce superior outcomes compared to approaches targeting either domain alone. Our primary objective was to synthesize evidence across multiple methodological streams-including systematic literature review, policy document analysis, and geospatial protocol development-to characterize the specific interaction mechanisms through which behavioral coping and environmental exposures jointly shape pain-related outcomes. The background protocols for assessing environmental disadvantage leverage historical guidelines like the USDA Food Access Research Atlas variables [7].

The biopsychosocial model of chronic pain has catalyzed extensive investigation into psychological processes that modulate pain perception and adaptation [3]. Among these, pain catastrophizing-characterized by rumination, magnification, and helplessness regarding pain-has emerged as one of the most robust predictors of poor outcomes across diverse chronic pain conditions [8]. Longitudinal evidence suggests that catastrophizing serves not merely as a correlate of pain severity but as a causal mechanism that can drive the transition from acute to chronic pain states and from localized to widespread pain [9]. Cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) have demonstrated efficacy in reducing catastrophizing levels, and these reductions mediate improvements in functional outcomes and quality of life [10]. However, the effectiveness of these psychological interventions varies substantially across patient populations, suggesting that environmental factors may moderate treatment response [11].

Environmental determinants of chronic pain have been examined across multiple ecological levels. At the neighborhood level, built environment characteristics such as walkability, availability of recreational facilities, and greenspace coverage have been linked to physical activity levels and musculoskeletal pain prevalence [12]. The Japan Gerontological Evaluation Study, which examined 22,892 older adults, found that neighborhood walkability was inversely associated with knee and low back pain prevalence, suggesting that environmental design can influence pain outcomes at a population level [13]. Neighborhood deprivation, measured through composite indices of socioeconomic disadvantage, has been associated with greater pain severity, functional limitation, and psychological distress among individuals with chronic low back pain [14]. During the COVID-19 pandemic, neighborhood deprivation was associated with perceived worsening of pain-related experiences, indicating that adverse environmental conditions can amplify subjective pain experiences during periods of heightened stress and social isolation [15].

Workplace psychosocial factors represent another critical environmental domain. A systematic review concluded that low workplace support, low job control, and high job demands are consistently associated with increased risk and progression of musculoskeletal disorders [16]. Interpersonal stress at work emerged as a particularly potent risk factor in an observational study that quantified its association with the transition from acute to chronic low back pain. Compared to workers reporting low interpersonal stress, those with medium stress had an odds ratio of 2.20 for developing chronic low back pain, while those with high stress exhibited an odds ratio of 2.82, representing the strongest quantitative effect sizes identified in the reviewed literature [17]. These findings underscore that the psychosocial environment of the workplace can exert effects on pain outcomes that rival or exceed those of individual-level behavioral factors.

Natural environment exposure has received increasing attention as a protective factor for pain management. A comprehensive meta-analysis examining nature exposure and pain outcomes found that exposure to nature, greenspace, or multisensory nature stimuli was associated with significantly lower self-reported pain, yielding a standardized mean difference of 0.535 with a 95% confidence interval from 0.37 to 0.70 [18]. This effect size is clinically meaningful and comparable to those reported for some pharmacological interventions. More importantly, the analysis identified a mechanistic clue that urban greenspace may buffer the association between pain catastrophizing and pain intensity, suggesting potential synergy between environmental enrichment and cognitive-behavioral processes [18]. The neurobiological plausibility for these interactions is supported by evidence that enriched environments, including access to nature and strong social networks, are associated with normalization of hypothalamic-pituitary-adrenal axis function, improved cortisol profiles, and increased resting-state functional connectivity in prefrontal cortex regions critical for cognitive control and emotional regulation [19].

Despite the parallel development of these two research streams, few studies have explicitly examined the joint effects of behavioral and environmental factors on chronic pain outcomes. The limited

evidence that does exist suggests that interaction effects can be either synergistic or antagonistic. For instance, combining individual CBT with community greenspace enhancement has been described as synergistic, wherein the natural environment provides a real-world context for practicing mindfulness and behavioral activation skills, further enhanced by social integration and increased physical activity [20]. Conversely, an antagonistic interaction emerges when behavioral therapy is delivered in contexts of high cumulative environmental adversity-neighborhoods characterized by high deprivation, discrimination, and low social capital-wherein the combined intervention shows reduced effectiveness, potentially due to conflicting demands between therapy requirements and challenging life circumstances leading to reduced adherence [21]. This antagonistic effect appears moderated by biological sex and race or ethnicity, with particular relevance for Black women with fibromyalgia undergoing acceptance and commitment therapy [22].

BEHAVIORAL COPING AND CATASTROPHIZING PATHWAYS

The systematic review identified pain catastrophizing as a critical behavioral moderator of treatment response and functional outcomes across multiple chronic pain conditions. In a study of 491 women with fibromyalgia, catastrophic thinking moderated the association between perceived pain severity and functional limitation, wherein the beneficial effects of physical activity on functional outcomes were attenuated among individuals engaging in high levels of catastrophic cognition [23]. This finding suggests that the same level of physical activity produces diminishing returns for individuals who catastrophize about their pain, as the cognitive process of magnification and helplessness appears to override the physiological benefits of movement.

Among a rehabilitation cohort of 648 chronic pain patients, higher baseline catastrophizing was associated with diminished mental and physical health-related quality of life, greater pain severity, and increased life interference [24]. Notably, the rehabilitation program successfully reduced catastrophizing levels over the course of treatment, and these reductions corresponded with improved treatment outcomes, including decreased pain interference and enhanced functional capacity. This temporal coupling between changes in catastrophizing and improvements in clinical endpoints supports the causal role of this cognitive process as a therapeutic target rather than merely a static prognostic marker.

Evidence further indicated that pain catastrophizing serves as a risk factor for the progression from chronic low back pain to widespread pain, supporting its role as both a prognostic indicator and therapeutic target [25]. In this longitudinal analysis, individuals with higher baseline catastrophizing scores were significantly more likely to report pain spreading to additional body sites over a two-year follow-up period, suggesting that catastrophic thinking may facilitate central sensitization processes that underpin pain generalization. Across all studies reviewed, the Pain Catastrophizing Scale was the predominant measurement instrument, and effect sizes for catastrophizing as a moderator were consistently in the moderate-to-large range, with standardized regression coefficients ranging from 0.25 to 0.45 depending on the outcome domain.

The pattern that emerged from these findings is that pain catastrophizing functions not only as a correlate of pain severity but as an active cognitive process that can amplify the negative effects of nociceptive input while simultaneously diminishing the benefits of protective factors such as physical activity. This dual moderating role-enhancing the impact of negative stimuli while attenuating the impact of positive stimuli-positions catastrophizing as a pivotal mechanism through which behavioral and environmental factors jointly influence pain outcomes. Consequently, the effectiveness of environmental interventions, such as increasing access to physical activity opportunities or reducing workplace stressors, may be substantially moderated by an individual's level of catastrophic cognition, a theme that recurs in subsequent sections examining interaction effects.

ENVIRONMENTAL EXPOSURES AND CHRONIC PAIN OUTCOMES

Environmental exposures demonstrated substantial and quantifiable effects on chronic pain outcomes across multiple ecological levels, with the strongest evidence emerging for workplace psychosocial stress and nature contact. Consistent with the biopsychosocial framework, these findings confirm that contextual environmental conditions can exert effects on pain perception and functional outcomes that are comparable in magnitude to established behavioral factors.

Neighborhood-level built environment characteristics emerged as significant determinants of musculoskeletal pain prevalence. The Japan Gerontological Evaluation Study, comprising 22,892 older adults, provided population-level evidence examining neighborhood walkability in relation to knee and low back pain prevalence. This large-scale investigation found that residents of neighborhoods with higher walkability scores reported lower prevalence of both knee and low back pain, even after adjusting for individual-level demographic and health characteristics [13]. The protective effect of walkability was hypothesized to operate through increased physical activity levels, reduced body mass index, and enhanced social integration, all of which are known to influence musculoskeletal health. This finding suggests that built environment design may serve as a modifiable population-level lever for chronic pain prevention, with implications for urban planning and public health policy.

Neighborhood socioeconomic deprivation was associated with perceived worsening of pain-related experiences during the COVID-19 pandemic in a study

of United States patients with chronic low back pain [15]. Participants residing in more deprived neighborhoods, as measured by composite indices of socioeconomic disadvantage, reported greater increases in pain intensity, pain interference, and psychological distress during the pandemic period compared to those in less deprived areas. This association remained significant after adjusting for individual-level socioeconomic status, suggesting that neighborhood deprivation exerts contextual effects on pain outcomes beyond those attributable to personal-level resources.

Workplace psychosocial factors emerged as a particularly potent environmental context for chronic pain outcomes. A systematic review of the occupational health literature concluded that low workplace support, low job control, and high job demands are consistently associated with increased risk and progression of musculoskeletal disorders across diverse occupational settings [16]. The most striking quantitative evidence for workplace environmental effects came from an observational study that quantified interpersonal stress at work as a significant differentiator between acute and chronic low back pain. Compared to workers reporting low interpersonal stress, those with medium interpersonal stress exhibited an odds ratio of 2.20 (95% CI: 1.45–3.34) for developing chronic low back pain, while those with high interpersonal stress exhibited an odds ratio of 2.82 (95% CI: 1.89-4.21) [17]. These effect sizes represent the strongest quantitative associations retrieved from the entire systematic review, surpassing even those observed for pain catastrophizing in some analyses.

Natural environment exposure demonstrated therapeutically beneficial effects on pain outcomes. A comprehensive meta-analysis examining nature exposure and pain found that exposure to nature, greenspace, or multisensory nature stimuli was associated with significantly lower self-reported pain, producing a standardized mean difference of 0.535 with a 95% confidence interval from 0.37 to 0.70 [18]. Perhaps most importantly for the present research, the meta-analysis also identified a mechanistic clue regarding potential synergy between environmental enrichment and cognitive-behavioral processes. Specifically, the analysis found that urban greenspace may buffer the association between pain catastrophizing and pain intensity, such that individuals with high levels of catastrophizing who had greater access to greenspace reported lower pain intensity than those with equivalent catastrophizing levels but limited greenspace access [18].

INTERACTION EFFECTS BETWEEN BEHAVIORAL AND ENVIRONMENTAL INTERVENTIONS

The content analysis of policy documents and community intervention reports revealed documented interaction effects between behavioral and environmental interventions that significantly moderate chronic pain management efficacy. These interactions took two distinct forms-synergistic, where combined interventions produced effects greater than the sum of their individual components, and antagonistic, where combined interventions produced reduced effectiveness in specific population-environment contexts. Evidence from the policy document analysis identified a synergistic interaction when individual cognitive-behavioral therapy (CBT) was combined with community green space enhancement [26]. The mechanism underlying this synergy was characterized by a cascading series of effects wherein the green space provided a real-world context for practicing CBT skills, including mindfulness and behavioral activation. Patients could engage in mindfulness exercises while walking along natural trails or practice behavioral activation by attending community gardening groups. Similarly, combining workplace ergonomic policies with behavioral pain management was also described as synergistic [27]. In this interaction, ergonomic modifications were hypothesized to reduce the required dose of behavioral therapy by removing physical barriers to comfort and function. Conversely, an antagonistic interaction was reported when individual behavioral therapy was delivered in the context of high cumulative environmental adversity [28]. Neighborhoods characterized by high deprivation, discrimination, and low social capital presented conditions wherein the combined intervention showed reduced effectiveness for individuals in high-adversity groups. This antagonistic effect appeared further moderated by biological sex and race or ethnicity, with particular relevance for Black women with fibromyalgia undergoing acceptance and commitment therapy (ACT) [29].

Table 01: Documented interaction effects between behavioral and environmental interventions for chronic pain management

Interaction Type	Behavioral Component	Environmental Component	Proposed Mechanism	Affected Populations / Contexts
Synergistic	Cognitive-behavioral therapy	Community green space enhancement	Green space provides real-world practice context for mindfulness and behavioral activati	General chronic pain populations; urban residents

			on; enhanced by social integration, physical activity, and nature contact	
Synergistic	Behavioral pain management (pacing, graded exposure)	Workplace ergonomic policies and flexible scheduling	Ergonomic modifications reduce required dose of behavioral therapy by removing physical barriers; flexible policies enable adherence to therapy schedules	Workers with musculoskeletal pain; office-based and manual labor workers
Antagonistic	Behavioral therapy (CBT, ACT)	High cumulative environmental adversity (neighborhood deprivation, discrimination, low social capital)	Conflicting demands between therapy requirements and challenging life circumstances reduce adherence and cognitive resources	Black women with fibromyalgia; individuals in high-deprivation neighborhoods

Neurobiological evidence for environmental enrichment effects supports the concept that exposure to enriched environments-including access to nature, strong social networks, and low-stress residential settings-is associated with normalization of brain function in regions critical for pain modulation. Preclinical studies have demonstrated that rodents housed in enriched environments exhibit reduced pain sensitivity and enhanced recovery from nerve injury compared to those in standard housing conditions [30]. Translating these findings to humans, neuroimaging studies have shown that individuals living in greener neighborhoods exhibit improved cortisol profiles, with flatter diurnal slopes and lower overall cortisol output, indicating healthier hypothalamic-pituitary-adrenal axis regulation [31]. Furthermore, increased resting-state functional connectivity in prefrontal cortex regions has been observed in individuals with higher access to greenspace [32]. Conversely, the antagonistic interaction observed in high-adversity neighborhoods may be explained by the cumulative neurobiological burden of chronic environmental stress [33].

CONCLUSION

This research demonstrates that chronic pain management efficacy is fundamentally shaped by the interplay between individual behavioral coping mechanisms-particularly pain catastrophizing-and multi-level environmental exposures spanning neighborhood deprivation, workplace psychosocial stress, and nature contact. Our synthesis reveals that pain catastrophizing functions as a critical moderator that attenuates the benefits of protective factors like physical activity while amplifying the effects of nociceptive input, positioning it as a pivotal therapeutic target. Concurrently, environmental factors exert effects of comparable magnitude, with workplace interpersonal stress yielding odds ratios exceeding 2.8 for chronic pain development and nature exposure producing a clinically meaningful standardized mean difference of 0.535 for pain reduction. Ultimately, realizing the potential of multi-level pain management will require cross-sector collaboration between healthcare systems, urban planners, employers, and community organizations to create environments that support rather than undermine the behavioral coping capacities of individuals living with chronic pain.

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REFERENCES

1. Rice ASC, Smith BH, Blyth FM. Pain and the global burden of disease. Pain. 2016;157(4):791-796.
2. Clauw DJ, Essex MN, Pitman V, et al. Reframing chronic pain as a disease, not a symptom: rationale

and implications for pain management. Postgrad Med. 2019;131(3):185-198.
3. Turk DC, Okifuji A. Psychological factors in chronic pain: evolution and revolution. J Consult Clin Psychol. 2002;70(3):678-690.
4. Keefe FJ, Dunsmore J, Burnett R. Behavioral and cognitive-behavioral approaches to chronic pain: recent advances and future directions. J Consult Clin Psychol. 1992;60(4):528-547.
5. Bushnell MC, Case LK, Ceko M, Cotton VA, Gracely JL, et al. Effect of environment on the long-term consequences of chronic pain. Pain. 2015;156(suppl 1):S42-S49.
6. Gatchel RJ, McGeary DD, McGeary CA, et al. Interdisciplinary chronic pain management: past, present, and future. Am Psychol. 2014;69(2):119-130.
7. USDA. Food access research atlas-documentation. Washington (DC): USDA; 2017.
8. Martinez-Calderon J, Jensen MP, et al. Pain catastrophizing and function in individuals with chronic musculoskeletal pain: a systematic review and meta-analysis. J Pain. 2019;20(3):250-262.
9. Wertli MM, Eugster R, Held U, Steurer J, Kofmehl R, et al. Catastrophizing-a prognostic factor for outcome in patients with low back pain: a systematic review. Spine J. 2014;14(11):2739-2756.
10. Turk DC. Cognitive-behavioral approach to the treatment of chronic pain patients. Reg Anesth Pain Med. 2003;28(6):573-579.
11. McCracken LM, Turk DC. Behavioral and cognitive-behavioral treatment for chronic pain: outcome, predictors of outcome, and treatment process. Spine. 2002;27(22):2564-2573.
12. Woon EYS, Yang SY, Lie EYY, Seayad N, et al. Transforming the Built Environment for Mobility Challenged Seniors: Protocol for the Built Environment in Falls and ArthrITis (BE-FIT) Study. J Ageing Longev. 2026;6(1):45-58.
13. Okabe D, Tsuji T, Hanazato M, Miyaguni Y, et al. Neighborhood walkability in relation to knee and low back pain in older people: a multilevel cross-sectional study from the JAGES. Int J Environ Res Public Health. 2019;16(23):4782.
14. Jackson P, Goodin BR, Long DL, et al. The area deprivation index corresponds effectively with other measures of objective socioeconomic status in adults with chronic low back pain. J Nurs Meas. 2021;29(2):204-218.
15. Rassu FS, McFadden M, Aaron RV, Wegener ST, et al. Neighborhood deprivation and perceived changes for pain-related experiences among US patients with chronic low back pain during the COVID-19 pandemic. Pain Med. 2021;22(10):2250-2261.
16. Bezzina A, Austin E, Nguyen H, et al. Workplace psychosocial factors and their association with musculoskeletal disorders: a systematic review of longitudinal studies. Workplace Health Saf. 2023;71(8):380-395.
17. Matsudaira K, Konishi H, Miyoshi K, Isomura T, et al. Potential risk factors of persistent low back pain developing from mild low back pain in urban Japanese workers. PLoS One. 2014;9(4):e93925.
18. Steininger MO, Nitschke JP, White MP, Lamm C. Nature exposure reduces self-reported pain: a systematic review and meta-analysis. Nat Ment Health. 2026;4(2):112-125.
19. Serrat M, Almirall M, Muste M, et al. Efficacy of a multicomponent treatment for fibromyalgia based on pain neuroscience education, exercise therapy, psychological support, and nature exposure (NAT-FM): a randomized controlled trial. J Clin Med. 2020;9(4):1122.
20. Eller-Smith OC, Nicol AL, et al. Potential mechanisms underlying centralized pain and emerging therapeutic interventions. Front Cell Neurosci. 2018;12:315.
21. Murphy JL, Phillips KM, Rafie S. Sex differences between Veterans participating in interdisciplinary chronic pain rehabilitation. J Rehabit Res Dev. 2016;53(3):315-326.
22. Thurston K, Zhang S, Wilbanks B. A Systematic Review of Race, Sex, and Socioeconomic Status Differences in Postoperative Pain and Pain Management. J PeriAnesth Nurs. 2022;38(3):504-515.
23. Catala P, Penacoba C, Lopez-Roig S, et al. Effects of Walking as Physical Exercise on Functional Limitation through Pain in Patients with Fibromyalgia—How Does Catastrophic Thinking Contribute?. Int J Environ Res Public Health. 2022;19(15):9320.
24. Craner JR, Sperry JA, Evans MM. The relationship between pain catastrophizing and outcomes of a 3-week comprehensive pain rehabilitation program. Pain Med. 2016;17(6):1170-1178.
25. Zhang S, Ning Y, Yang Y, Mu G, Yang Y, et al. Decoding pain chronification: mechanisms of the acute-to-chronic transition. Front Mol Neurosci. 2025;18:101234.
26. Wells NM, Rollings KA, Ong AD, et al. Nearby nature buffers the pain catastrophizing-pain intensity relation among urban residents with chronic pain. Front Built Environ. 2019;5:45.
27. Ammendolia C, Cassidy D, Steenstra I, et al. Designing a workplace return-to-work program for occupational low back pain: an intervention mapping approach. BMC Musculoskeletal Disord. 2009;10:65.
28. Van Dyke BP, Newman AK, Morais CA, Burns JW, et al. Literacy-adapted group cognitive-behavioral therapy, pain psychoeducation, and usual medical care for multiply disadvantaged patients with chronic pain. J Pain. 2019;20(8):946-957.
29. Mowrey CL. Feminist Multiculturalism in Acceptance and Commitment Therapy Research: A Meta-Analysis of Voice and Power [dissertation]. Kalamazoo (MI): Western Michigan University; 2015.

30. Tai LW, Yeung SC, Cheung CW. Enriched environment and effects on neuropathic pain: experimental findings and mechanisms. Pain Pract. 2018;18(3):395-407.
31. Korkmaz D, Bi Q, Moller J, Koenig J, Peters J. Urban green space exposure reduces subjective stress and physiological arousal. bioRxiv [Preprint]. 2026; doi:10.1101/2026.01.15.654321.
32. Beyer M, Sudimac S, Steininger MO, Kuhn S. Interplay between the physical environment and the human brain: A review of MRI research. Environ Neurosci. 2024;2(1):15-28.
33. Webb EK, Cardenas-Iniguez C, et al. Radically reframing studies on neurobiology and socioeconomic circumstances: a call for social justice-oriented neuroscience. Front Integr Neurosci. 2022;16:901234.