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Effects and Dose-Response Relationships of Motor Imagery Practice on Strength Development in Healthy Adult Populations: a Systematic Review and Meta-analysis.

Effects and Dose-Response Relationships of Motor Imagery Practice on Strength Development in Healthy Adult Population

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Abstract

Background Motor imagery (MI), a mental simulation of a movement without overt muscle contraction, has been largely used to improve general motor tasks. However, the effects of MI practice on maximal voluntary strength (MVS) remain equivocal.

Objectives The aim of this meta-analysis was to: (1) estimate whether MI practice intervention can meaningfully improve MVS in healthy adults; (2) compare the effects of MI practice on MVS with its combination with physical practice (MI-C), and with physical practice (PP) training alone; (3) investigate the dose-response relationships of MI practice.

Data Sources and Study Eligibility Seven electronic databases were searched up to April 2017. Initially 717 studies were identified, however, after evaluation of the study characteristics, data from 13 articles involving 370 participants were extracted. The meta-analysis was completed on MVS as the primary parameter. In addition, parameters associated with training volume, training intensity, and time spent training, were used to investigate dose-response relationships.

Results MI practice moderately improved MVS. When compared to conventional PP, effects were of small benefit in favour of PP. MI-C when compared to PP showed unclear effects. MI practice produced moderate effects in both upper and lower extremities on MVS. Cortical representation area of the involved muscles did not modify the effects. Meta-regression analysis revealed that: (a) a training period of four weeks, (b) a frequency of three times per week, (c) two to three sets per single session, (d) 25 repetitions per single set, and (e) session duration of 15 minutes, were associated with enhanced improvements in muscle strength following MI practice. Similar dose-response relationships were observed following MI and PP.

Conclusions The present meta-analysis demonstrates that compared to a no-exercise control group of healthy adults, MI practice increases MVS, but less than PP. These findings suggest that MI practice could be considered as a substitutional or additional training tool to preserve muscle function when athletes are not exposed to maximal training intensities.

Key Points:

- Motor imagery practice is an effective method for maximal strength development in healthy adults, while there is no convincing evidence that the combination of motor imagery and physical practice is more effective than conventional strength training alone.
- The following variables were associated with enhanced strength: a training period of four weeks, a training frequency of three sessions per week, a training volume of two to three sets, 25 repetitions per set and sustained contractions of five seconds.
- Cortical representation of the involved muscle has minor modulating power, suggesting that both large and small cortically represented muscles can almost equally benefit from motor imagery practice.

1 Introduction

To improve the motor performance in athletes, sport psychologists are using several techniques designed to increase physical and mental activation without execution of overt movement [1,2]. Those "psyching-up" techniques have been proven as beneficial tools for strength improvement among athletes [3] and non-athletes [1,2,4,5]. Currently, motor imagery (MI) represents one of the most widely used cognitive strategies designed to enhance physical performance for both sports-based [6] and therapeutic interventions [7,8]. For example, it contributes to rehabilitation of Parkinson's Disease patients [8–10], following immobilization [11], following stroke [7,12,13] and orthopaedic surgeries [14–16]. Imagery is the process which refers to all those quasi-sensory or quasi-perceptual experiences of which we are self-consciously aware, and which exist even in the absence of the stimulus conditions known to produce their genuine sensory and perceptual counterparts [17]. Imagery has different modalities like the visual (with internal or external perspectives), kinesthetic (based on somatosensory information normally generated during actual movement), auditory, olfactory, gustatory and tactile senses [6,18]. MI practitioners may use these modalities independently or combine them in order to enhance performance and/or to achieve different types of outcomes [19–22]. However, this review will only focus on motor imagery, which we defined as explicit mental simulation of a specific action without any corresponding motor output (e.g., overt motor execution) [23], hence requiring a representation of the body as the generator of acting forces, regardless of the modality used.

The efficiency of MI practice relies on the fact that MI and motor execution share common neural substrates [23,24], supporting the theory of functional equivalence [23,25,26]. Accordingly, functional equivalence relies on three facts: (i) that executed and imagined tasks are the same in duration [27]; (ii) both processes follow Fitts' law, that more difficult movements take more time to produce physically than do easier ones [28]; and (iii) subjective rating of the mental effort during the mentally simulated task correlates with the amount of force which is needed for the task execution [29].

Accordingly, an early review published in 1983 dealing with the effects of MI practice included 60 studies and yielded 146 effects sizes (ESs) in total. The authors concluded that MI could enhance performance for motor, strength, cognitive, self-paced and reactive tasks (ES = 0.48) [30]. However, the effects of MI practice on strength tasks were trivial (ES = 0.20) [30]. More promising results were reported in a recent literature review [1] in which the effects of various cognitive strategies (i.e., imagery, goal setting, self-talk, preparatory arousal, and free choice) on strength performance were investigated. The authors concluded that imagery is reliably associated with increased strength performance (results ranged from 63 to 74 %) [1], which agree with the results of Scholefield and colleagues [31]. However, although the authors reported positive alterations after MI practice, none of the six included studies reported a minimal clinical important difference in strength gains [31]. Another recent review [32], which aimed to investigate the effects of MI on muscular strength in healthy and patient populations, concluded that MI in combination with physical practice (PP), is more efficient than PP training only on strength. Further, Slimani and colleagues [32] reported the advantageous effects for muscular strength development of internal imagery (range from 2.6 to 136.3%) compared to external imagery (range from 4.8 to 23.2%). Nonetheless, a recent meta-analysis [33], based on only four studies that yielded 6 ESs, reported that MI practice alone does not enhance strength gains in healthy adults (ES = - 0.10; 95 % CI – - 1.46 to 1.24; $p < 0.001$). However, Manochio and colleagues' [33] meta-analysis needs to be replicated, given the variability across the small number of the studies included, because it is possible the meta-analysis was underpowered [34]. Also, a number of relevant studies were not included, but have been included in this review. One recent review aimed to identify the specific characteristics of successful MI training sessions (MITS) within five disciplines: education, medicine, music, psychology and sports [35]. On average, the study intervention lasted 34 days, with participants practicing MI a mean three times per week for 17 minutes, with 34 MI trials. The average total MI time was 178 minutes including 13 MITS. However, the authors reported that only seven of the total 141 interventions involved strength focussed activities [35]. In addition, strength-focused MI interventions were investigated in healthy participants aged between 20 to 39 years old only.

Several methodological issues limit all the aforementioned reviews. For example, the majority of the reviews in this area included studies that evaluated the effects of various interventions on general motor tasks [1,30,36], or included small numbers of studies [31,33]. Also, since the first review on this topic [30] a number of experimental studies investigating MI effectiveness have been published, but despite these new additions many questions still remain unclear and unanswered. For example, data are scarce on the magnitude of the effects following MI practice and/or MI combined with PP training (MI-C), compared with PP only. Nonetheless, although it is known that the imagery perspective used [32,37] and the participant skill level [38,39] might moderate the effects, less thoroughly analysed are the dose-response relationships of quantitative training variables (i.e., training volume, duration, frequency, numbers of sets and repetitions) [30,35,36], and especially qualitative ones (i.e., trained muscle, type and intensity of contraction).

Based on the functional equivalence theory [40], we hypothesized that both MI practice and PP training effectiveness will be modified by common variables used in conventional strength training [CST] (i.e., training volume, type and intensity of the contraction, time spent in training, trained muscles) [41–43]. Therefore, the current meta-analysis aims to provide an evidence-based synthesis of the currently published research and addresses the following questions: (i) In healthy adult populations does MI practice enhance strength performance compared to no-exercise controls?; (ii) Is MI or MI-C practice superior to PP training? (iii) How is the MI-performance relationship modified by training volume, training type, intensity of the contraction, time spent in training, and muscles trained? Accordingly, the answers to these questions will enable evidence-based optimization of MI practice, and consequently lead to proper program prescription designed to achieve the best results.

2 Methods

2.1 Search Strategy

This systematic review and meta-analysis was undertaken in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement guidelines [44]. Thus, a systematic search of the research literature published in peer-reviewed journals was conducted for randomized controlled trials (RCTs) studying the effects of motor imagery practice on strength performance in populations of healthy adults. To carry out this review, English and German language literature searches of the PubMed, ERIC, DOAJ, Web of Science, SPORTDiscus, Google Scholar, and ScienceDirect databases were conducted from January 2016 up to April 2017. Electronic databases were searched using the following keywords: “motor imagery training”, “movement imagery”, “mental practice”, “mental simulation”, “cognitive training”, “strength”, “force”, “performance”, “effects”, “improvement”, and “healthy adults”. The reference lists of each included article were also scanned to identify additional relevant studies.

2.2 Inclusion and Exclusion Criteria

In accordance with the PICOS approach [45] inclusion criteria were selected by (a) *Population:* studies recruiting as participants male and female healthy adults in any age category (b) *Intervention:* MI practice interventions were required to be a minimum of 1 week in duration (more than 3 training sessions) and include at least one control group and/or another experimental PP group. For preliminary analysis the control groups included were those without any treatment; (c) *Comparison:* maximal muscle voluntary strength (MVS) was compared across the (c1) intervention type (i.e., MI practice vs. no–exercise controls, PP vs. no–exercise controls, PP vs. MI practice, and MI-C vs. PP alone), (c2) the body regions trained (upper vs. lower limbs), (c3) the type of contraction (isometric vs. dynamic), (c4) the muscle groups trained (larger vs. smaller cortical representation area/CRA), (c5) the degree of control of muscle activity during MI sessions (controlled or not controlled), and (c6) the presence or absence of encouragement during MVS testing; (d) *Outcome(s):* MVS; (e) *Study Design:* RCTs published in peer-reviewed journals.

Studies were excluded according to the following criteria: (a) studies written in languages other than English and German; (b) non-randomized, uncontrolled studies; (c) studies that sampled unhealthy populations; (d) studies where data about dose-response relationship variables were not reported; (e) studies from which we could not extract enough information to calculate effect sizes or include them in the analysis.

2.3 Screening Strategy

Two independent reviewers (AP and UM) performed the literature search, along with study identification, screening, quality assessment and data extraction. First, the titles were initially screened by the reviewers during the electronic searches to assess the papers' suitability, and all papers beyond the scope of this meta-analysis were excluded. Second, the abstracts were assessed using predetermined inclusion and exclusion criteria. Third, the full texts of the remaining papers that met the inclusion criteria were retrieved and included in the ongoing procedure and reviewed by the two reviewers to reach a final decision on inclusion in the meta-analysis. Finally, the reference lists from the retrieved manuscripts were also examined for any other potentially eligible papers. Any disagreements between the reviewers were resolved by consensus or arbitration through a third reviewer (RP). If the full text of any paper was not available, the corresponding author was contacted by mail or ResearchGate. The study selection process as described above is illustrated in Fig. 1.

****** Figure 1 near here******

2.4 Data Extraction

The Cochrane Consumers and Communication Review Group's data extraction protocol was used to extract the participant information, including sex, age, sample size, training status, description of the intervention, study design and study outcomes [46]. This extraction was undertaken by one author (AP), while a second author (UM) checked the extracted data for accuracy and completeness. Disagreements were resolved by consensus or by a third reviewer (RP). Reviewers were not blinded to authors, institutions or manuscript journals. In those studies, where the data were shown in figures or graphs, either the corresponding author was contacted to get the numerical data to enable analysis or the Web Plot Digitizer software (Version 3.10, Austin, TX, USA) was used to extract the necessary data.

2.5 Quality Assessment

The Physiotherapy Evidence Database (PEDro) scale was used to assess the methodological quality of the included studies [47]. The quality assessment score was interpreted using the following 10-point scale: ≤ 3 points was considered as poor quality, 4–5 points as moderate quality and 6–10 points as high quality. The PEDro scale consists of 11 items designed for rating the methodological quality. Each satisfied item contributes 1 point to the overall PEDro score (range 0–10 points). Item 1 was not included as part of the study quality rating for this review, because it pertains to external validity which was beyond the scope of the current review questions. The quality assessment was conducted by one author (AP).

2.6 Statistical Analyses

The meta-analyses were performed using Comprehensive Meta-analysis software (Version 3.0, Biostat Inc., Englewood, NJ, USA). The mean differences and 95% confidence intervals (CIs) were calculated for the included studies. The I^2 measure was used to examine between-study variability; values of 25, 50 and 75 % represent low, moderate and high statistical heterogeneity, respectively [48]. Although the heterogeneity of the effects in the present meta-analysis ranged from 0% to 48% (see Results section), it was decided to apply a random-effects model of meta-analysis in all comparisons, to determine the pooled effect of motor imagery practice on measures of MVS. To test the robustness of these analyses, a fixed-effects model for major comparisons was calculated and reported. The ESs were calculated using the following formula (Eq. 1):

$$\mathrm{ES} = \frac{\text{Raw Mean Change}_1 - \text{Raw Mean Change}_2}{\mathrm{SD}_{Post-Pooled}}$$

SD $_{Post\text{-}Pooled}$ was calculated using the following formula (Eq. 2):

$$\mathrm{SD}_{postpooled} = \sqrt{\frac{(\mathrm{N}_1 - 1) * \mathrm{SD}_1^2 + (\mathrm{N}_2 - 1) * \mathrm{SD}_2^2}{\mathrm{N}_1 + \mathrm{N}_2 - 2}}$$

If two or more studies reported the same training variable (e.g., training volume, intensity, time spent in training), random effect meta-analysis was performed over the studies, and presented as filled squares in the dose–response relationship figures of the “Results“ section. Each unfilled symbol illustrates the ES per single study, while circles and triangles represents the isometric (i.e., maximal voluntary isometric contraction (MViC)) and the dynamic (submaximal intensity) types of contraction used in the training settings.

Furthermore, a random effects meta-regression was performed to examine whether the effects of MI on MVS were moderated by different training variables. Training variables were grouped according to: training volume (i.e., period, frequency, number of sets per exercise, number of repetitions per set; number of repetitions per single session, number of repetitions per study); training intensity (i.e., maximal or submaximal, duration of imagined contraction in other words time under tension (TUT)); and time spent in training (total training duration per study, total training duration per week, duration of single training session). If exercise progression was realized over the course of the intervention or if training variables were reported, the average of these variables was calculated. For sub-group analysis, only protocols with same value for the variable of interest were selected and averaged.

To improve the generalizability and the external validity of the present findings, we combined the results from all the included studies that examined muscle strength based on both one-repetition maximum (1RM) dynamic contractions and/or MViC tests. In addition to the meta-regression, dose–response relationships were calculated independently using the effect size of characteristics of each training variable.

The chance of the true effect being trivial, beneficial or harmful was interpreted using the following scale: 25–75 % (possibly); 75–95 % (likely); 95–99.5 % (very likely); and 99.5 % (most likely), according to a previous approach developed by Hopkins [49]. The publication bias was assessed by examining the asymmetry of the funnel plots using Egger's test, and a significant publication bias was considered if the $p < 0.10$. The magnitude of the MI practice effects on strength performance were interpreted as changes using the following criteria: trivial (< 0.20), small (0.21–0.60), moderate (0.61–1.20), large (1.21–2.00), very large (2.01–4.00) and extremely large (> 4.00) [49].

3 Results

The Egger's test was performed to provide statistical evidence of funnel plot asymmetry (Fig 2.) and the results indicated publication bias for all analyses ($p < 0.10$).

****** Figure 2 near here******

3.1 Study Selection

A total of 717 articles were identified by the literature search (Fig. 1.). Following the removal of duplicates and the elimination of articles based on title and abstract screening, 60 studies remained. An evaluation of the remaining 60 studies was conducted independently by two researchers. Following the final screening process, 13 studies were included in the systematic review and meta-analysis.

****** Table 1 near here******

3.2 Study characteristics

After the computerized literature search, 13 eligible articles were found (Table 1). Table 1 presents details of each included study regarding sample, measures, results and additional comments. The pooled sample size of the 13 studies yielded 370 participants, where the typical sample size of the individual studies ranged from 8 to 15 subjects per group (Mean = 10 subjects). All of the selected studies except one [50] included a non exercise, non-imagery control group. Nine studies included an additional physical practice group, involving maximum isometric contractions [51–55], submaximal isometric contractions [56], moderate to high intensity dynamic contractions [57,58], or low intensity (as fast as possible) dynamic contractions [59]. Three further studies included a combination of MI and PP practice [50,56,58], thus enabling its comparison with PP only. Regarding the MI practice itself, almost all the included studies investigated the effects of traditional MI practice, while one [58] additionally studied the effects of another modified type of MI practice, called Physical, Environment, Task, Timing, Learning, Emotion and Perspective (PETTLEP), that relies on the functional equivalence approach to imagery. The PETTLEP intervention was designed according to the important dimensions involved in imagery [60].

The 13 eligible studies varied in sense of duration, trained muscle, training frequency, volume, intensity (Table 2), and other methodological items (e.g., control for muscle activity during MI sessions, method of outcome measurement assessment, and the researchers' approach regarding the MVS protocol itself). The most common duration of intervention was four weeks and was applied in eight studies [50–54,59,61,62], while the remaining five studies were one [63], two [57], three [55], six [58] and twelve [56] weeks in durations. Additionally, the 13 eligible studies varied regarding the trained muscle group. More specifically: extensor muscles of the knee joint [50,59,63], dorsal [54] and plantar flexors of ankle joint [62], flexors of the hip joint [57], pectoral and arm extensor muscles (e.g., bench press exercise) [50,53], flexors of the elbow joint [56,58,61], hand flexors [55] and abductors of the little finger of the hand [51,52]. The most common training frequencies were three to five sessions per week (mean ± SD, 4.08 ± 1.24). The number of sets per one training session ranged from one to four (mean ± SD, 2.42 ± 1.00), while the repetitions per set ranged from 2 to 25 (mean ± SD, 13.64 ± 7.89). The overall training volume, presented as total number of repetitions per individual study (total repetitions per set x number of sets x training session per study) [64], ranged from 120 to 3000 (mean ± SD, 646.36 ± 839.77). However, four studies [55,56,61,62] had considerably higher volumes than others with 450 [55], 1000 [61,62] and 3000 [56]. In nine studies the intensity of the MI practice in regard to the imagined movement was set to 100% of maximal voluntary contraction (MVC) [51–56,61–63], since the tasks were to imagine a MViC. In the remaining studies [50,57,58] the intensity was submaximal and varied from 70 to 95 %. In these submaximal studies, participants imagined dynamic contractions. Finally in one study the participants imagined maximal explosive isometric contractions [59]. Across all studies MVS was measured by either the 1RM test [50,57,58] or the MViC strength test.

****** Table 2 near here******

Previously it was shown that the MVS protocol assessment could influence the MVS results moderating participants' motivation levels [65]. To control the measurement of MVS, several criteria were previously proposed [65], including visual or verbal feedback, standardized verbal encouragement, rewards with repeated testing, elimination of subject-perceived submaximal efforts. All of these aim to promote true maximal voluntary efforts. At best, only two of the recommended criteria were fulfilled [59,61], or at least one [51,55], while nine other studies did not report any effort to control motivation [50,52–54,56–58,62,63]. Moreover, of all the initially included studies, seven controlled the muscle activity during the MI sessions: three studies used electromyography (EMG) [51,52,63]; one used dynamometry in combination with visual inspection [54]; and three studies used visual control only [53,59,61]. The remaining six studies did not report any control of muscle activity [50,55-58,62].

3.3 Participants' characteristics

The pooled sample size of the 13 studies was 370, with a mean age of 28.5 years (age range 18-83 years), where two studies examined the effects of MI practice on a population of older adults (mean age of 72.9 years) [55,56]. One study included females only [63], four studies included males [55,57,61,62], four studies used both males and females [53,54,56,59], while four studies did not report a gender [50–52,58]. Thus, none of the included studies reported sex specific effects. Regarding the training status of the participants, it can be noticed that all studies had involved untrained individuals, except one study that had included active individuals from various sports, both individual and team sports [57]. The participants had not previously been engaged before in any kind of structured motor imagery or cognitive practice interventions.

3.4 Methodological Quality

Overall, the included studies were of high quality, with PEDro scores of 6.00 (Table 3). All the checked studies failed to satisfy the following items: that allocation was concealed, blinding for all subjects and blinding of therapist and/or assessors. Also, all of the included studies received points for the following items: randomized allocation to groups, baseline indicators, measures of at least one key outcome was obtained from more than 85 % of the subjects, all subjects received the treatment or control condition, and statistical comparison between groups and point measures.

****** Table 3 near here******

3.5 Overall findings

3.5.1 Effects of Motor Imagery Practice on Maximal Voluntary Strength

Eleven studies reported a favorable effect of MI on the upper and lower extremity muscles (Fig. 3A). Compared to no-exercise controls, the effect of MI was most likely moderately beneficial for MVS (ES = 0.72; 95 % CI 0.42 – 1.02). An almost identical effect was observed when a fixed-effect model was used (ES = 0.71; 95 % CI 0.45 – 0.97). The statistical heterogeneity of the effects was small (I^2 = 21.34 %). For the upper and lower extremities, we determined a likely moderate beneficial effect (ES = 0.54; 95 % CI 0.16 - 0.91; I^2 = 11.95 %,) and a likely moderate beneficial effect (ES = 0.95; 95 % CI 0.51 - 1.39; I^2 = 16.45 %), respectively. With respect to the type of contraction, a moderate ES was seen after applying isometric contraction (ES = 0.92, 95% CI 0.55 – 1.30, most likely moderate beneficial), compared to small ES in dynamic (ES = 0.35; 95% CI -0.10 – 0.79, likely beneficial). Moderate ES was observed when muscles with larger CRA were trained (ES = 0.76; 95% CI 0.21 – 1.31, very likely beneficial), and smaller areas (ES = 0.69; 95% CI 0.39 – 0.99, very likely beneficial). When the muscle activity during MI sessions was controlled, the effect was likely moderately beneficial (ES = 0.87; 95 % CI 0.41 - 1.32; I^2 = 36.79 %), compared to a small, very likely beneficial effect of non-controlled conditions (ES = 0.58; 95 % CI 0.2 - 0.97; I^2 = 0.00 %). In addition, for both encouragement (ES = 0.74; 95 % CI 0.26 - 1.20; I^2 = 0.00 %) and non-encouragement (ES = 0.72; 95 % CI 0.31 - 1.13; I^2 = 39.52 %), the conditional results were similar, that is the effect was found to be very likely moderate. Moreover, MI effects were also observed in contralateral (i.e., non-trained limb), as well as in non-trained movements during strength tasks. Therefore, following MI practice one study observed contralateral effects of up to a 10.45% strength increase on average ($P < 0.005$) [51], while in the PP group an increase of 14.43% was observed ($P < 0.02$), without a significant difference between the groups [51]. Furthermore, positive alterations ($P < 0.05$) were also observed for the non-trained strength task (i.e., the increase in fifth digit flexion force after abduction was imagined [51], or when the knee flexion strength after extension was imagined [59]).

****** Figure 3 near here******

Eight studies examined the effects of both PP and MI practice models on the measure of muscle strength (Fig. 3B). The observed I^2 value of 0 % (Q = 7.21, *df* = 8, p = 0.51) is indicative of non-existent heterogeneity, which was not further sub-analyzed. The pooled effect for eight studies showed a likely small beneficial effect (ES

= 0.42; 95 % CI 0.11– 0.72) on MVS favoring PP. An identical effect was observed when the fixed-effect model was applied (ES = 0.42; 95 % CI 0.11 – 0.72).

Three studies examined the effects of both MI-C and PP models separately on the measures of muscle strength. An I^2 value of 0 % (Q = 0.74, *df* = 3, p = 0.83) is indicative of non-existent heterogeneity, which was not further sub-analyzed (Fig. 3C). The pooled effect across the three ESs was trivial and clinically unclear (ES = 0.05; 95 % CI 0.40 – 0.49), slightly, but not significantly favoring MI-C. An identical effect was observed when the fixed-effect model was applied (ES = 0.05; 95 % CI 0.40 – 0.49).

3.5.2 Effects of Physical Practice on Maximal Voluntary Strength

All nine studies that included an analysis of PP on upper and lower extremity muscles reported favourable effects. The current analysis, as displayed in Figure 3D, shows that the pooled effect of PP, when compared with controls, was most likely moderately beneficial on MVS (ES = 1.05; 95 % CI 0.57 – 1.53). A somewhat lower effect was observed when the fixed-effect model was applied (ES = 0.97; 95 % CI 0.64 – 1.30). The statistical heterogeneity of the effects was moderate (I^2 = 51.62 %). We determined a most likely moderately beneficial effect (ES = 1.18; 95 % CI 0.52 - 1.83; I^2 = 60.39 %), and a very likely moderately beneficial effect (ES = 0.83; 95 % CI 0.10 - 1.55; I^2 = 39.54 %) for the upper and lower extremities, respectively. With respect to the type of contraction, large ES was seen after applying the isometric contraction (ES = 1.40; 95% CI 0.83 – 1.98, most likely beneficial), compared to the small ES in dynamic model (ES = 0.43; 95% CI -0.09 – 0.95, likely beneficial). A noticeably large ES was observed when muscles with larger CRA (ES = 1.6; 95% CI 0.98 – 2.23, most likely beneficial) were trained compared to moderate ES in smaller areas (ES = 0.79; 95% CI 0.26 – 1.32, very likely beneficial). Furthermore, for both the encouragement (ES = 1.08; 95 % CI 0.12- 2.04; I^2 = 64.41 %) and non-encouragement conditions (ES = 0.89; 95 % CI 0.28-1.49; I^2 = 48.15 %), the conditional results were almost similar, that is, very likely moderate effects were observed, slightly favoring the encouragement condition.

3.6 Dose-Response Relationship of Motor Imagery Effects on Maximal Voluntary Strength

3.6.1 Meta-Regression Analysis for Training Variables of Maximal Voluntary Strength Following Motor Imagery Practice

Table 4 shows the results of the meta-regression for the three subcategories of variables: training intensity, training volume, and training duration. In the subcategory of training intensity, only the type of contraction predicted the effect of MI practice (p = 0.05). Concerning the training volume, both the number of repetitions per one training session (p = 0.01), and per study (p = 0.05), predicted the effects of MI on MVS. On the other hand, the number of repetitions per set showed a trend that was nearly significant (p = 0.08). In the subcategory of training duration, the only predictor for the explanation of effects of MI on MVS was the duration of the single training session (p = 0.04).

****** Table 4 near here******

3.6.2 Different Training Variables Effects on Maximal Voluntary Strength Following Motor Imagery Practice

In addition to the meta-regression, dose–response relationships were calculated independently using the effect size of the characteristics of each training variable (Table 5). On average, the training intensity of the imagined contraction was classified as maximal (100 % of MViC) and submaximal (less than 100 % MViC or 1RM). Moderate ES was seen after a maximal contraction was used (ES = 0.92; 95% CI 0.55 – 1.30, most likely beneficial), while submaximal contraction showed small ES (ES = 0.30; -0.09 – 0.79, likely beneficial). Furthermore, on average the TUT for isometric contraction only was 6.8 s (range = 5-15 s). The mean effect size for TUT was most likely moderately beneficial 0.92 (95 % CI 0.55 – 1.30; df = 7; I^2 = 22.55 %). The largest improvements were associated with a five second contraction duration (mean ES= 1.05; 95% CI 0.57 – 1.52; df = 5), and similar gains were observed for longer than 5 s of sustained contractions (ES = 0.80; 95% CI -0.11 – 1.71; df = 0).

On average, the training period in 11 studies lasted 3.8 weeks. The pooled effect was most likely moderately beneficial 0.72 (95 % CI 0.42– 1.02; I^2 = 21.34 %). The largest mean effect (ES = 0.88; 95% CI 0.43 – 1.34) was associated with a period of four weeks training; the most frequent period assessed (7 studies, Table 5).

****** Table 5 near here******

The training frequency averaged 3.8 sessions per week and yielded a mean effect of 0.72 (95 % CI 0.42 – 1.02; *df* = 11; I^2 = 21.34 %), which was most likely moderately beneficial. Based on two studies, the largest improvements in MVS were observed after three training sessions per week (ES = 1.22, Table 5).

Regarding the number of sets per one training session, 2.4 sets were performed on average which gave a most likely moderately beneficial effect of 0.72 (95 % CI 0.42– 1.02; *df* = 11; I^2 = 21.34 %). Two to three sets per one session resulted in the largest improvements in MVS (mean ES = 0.90; 95% CI 0.49 – 1.31; *df* = 7).

Overall, in ten studies, the number of repetitions averaged 12.2 per one set (with a range of 2 to 25 repetitions), 25.9 per single session (with a range of 8 to 50 repetitions), and 395.4 repetitions per study (range of 120 to 1000 repetitions). The mean ES for the average number of repetitions was most likely moderately beneficial (ES = 0.70; 95 % CI 0.37– 1.02; *df* = 11; I^2 = 26.54 %). More specifically, 25 repetitions per single set (ES = 1.18; 95% CI 0.56 – 1.81; *df* = 1) resulted in the largest improvements in MVS (Table 5). The dose – response relationship for the number of repetitions per single set are shown in Figure 4A. Fifty repetitions per single training session (ES = 1.18; 95% CI 0.56 – 1.81; *df* = 1) resulted in the largest improvements in MVS. The dose – response relationship for the number of repetitions per single training session are presented in Figure 4B, and when between 30 and 32 repetitions per single sessions were used, the effect was 1.07, thus only slightly lower compared than to when the highest number of repetitions was applied. In addition, 1000 repetitions per study (ES = 1.18; 95% CI 0.56 – 1.81; *df* = 1) resulted in the largest improvements in MVS. The dose – response relationship for the number of repetitions per study are displayed in Figure 4C.

Regarding all duration variables, the mean ES was most likely moderately beneficial on MVS (ES = 0.72; 95 % CI 0.42– 1.02; I^2 = 21.34 %; *df* = 11, p = 0.23). The longest time spent in training per study was 300 minutes and thus revealed the largest improvements (ES = 1.07; 95% CI 0.37 – 1.77; *df* = 1), which was slightly larger in comparison with 80 to 100 minutes spent in training (ES = 1.03; 95% CI 0.37 – 1.69; *df* = 1). Regarding the duration of the training per week, the largest effect was found between 60 and 80 minutes of training per week (ES = 0.99; 95% CI 0.55 – 1.43; *df* = 3). On average, for the studies examined, the most frequent duration of a single session was 15 minutes (ES = 1.04; 95% CI 0.54 – 1.54; *df* = 4), and the dose response for duration of a single training session is presented in Figure 4D. It shows that prolonging the duration to 20 minutes did show comparable results as with a 15 minutes session duration.

****** Figure 4 near here******

4 Discussion

This study presents a quantitative evaluation of MI practice for MVS improvements in healthy adult populations. The present results showed that MI practice elicits moderate improvements in muscle strength (Fig. 3A). However, when directly compared with PP, the results favour PP (Fig. 3B). When MI-C, that is MI in combination with PP, was compared with PP only, the effect was trivial and probably only due to three clinically unclear studies. There was very low to moderate heterogeneity of the effects within each meta-analysis, suggesting that all trials likely examined the same population effect [34]. Moreover, the sensitivity analysis using both random and fixed-effects models did not yield considerably different mean effects or CIs, suggesting that the results of the meta-analysis were robust. Further, a meta-regression analysis showed that the number of repetitions per single session, the repetitions for the whole study, along with the duration of the single training session, and maximal isometric versus submaximal dynamic contraction, significantly predicted the effects of MI on MVS.

4.1 Effects of MI Practice on Maximal Voluntary Strength

Taken together previous reviews yielded equivocal conclusions regarding the effects of MI practice on the measures of MVS [30–33,36]. However, using meta-analytic procedures and conforming to the standards required of a systematic review, we found improvements of MVS in healthy adults' population following MI practice, that on average ranged from 5 to 30 % for the 13 included studies. Hence, by examining the potential moderators and knowing that these studies varied regarding the training variables (Table 2), our results suggest that diverse forms of MI practice have the potential to improve the maximal muscle strength. These findings are consistent with the results of a previous review [31] where the relative increase in strength varied from 12.6 to 35 %. More interestingly, the MI effects were also observed in the contralateral or the non-trained limb, as well as in non-trained movements during a strength task. It was shown that following MI practice, the contralateral effects were on average up to 10.45% of strength increase, while in the PP group the increase was 14.43% without a significant difference between the groups [51]. Similar contralateral limb effects following CST were shown elsewhere [66–68]. Furthermore, significant positive alterations were observed upon a non-trained strength task (i.e., when imagining the increase in the fifth digit flexion force after abduction, or the knee flexion strength after extension) [51,59]. The underlying mechanisms of the observed strength gains might be explained in alteration on both central and peripheral level, which will be discussed in the next paragraphs.

The short term positive effects of MI (that ranged from one to six weeks) not associated with morphological changes (e.g., muscle hypertrophy), can likely be attributed to psychological and neurophysiological factors [39,50,51,69]. In the early years of research in this field, Richardson [70] suggested that motivation may be partially responsible for the observed gains. Thus, in order to control or eliminate the influence of motivation, Feltz and Landers [30] proposed the use of a no-exercise group. Accordingly, some studies reported a non-significant increase in MVS (ranging from 1.7 to 5.5 %) for the control groups [51,53,55,57,58,61], suggesting that motivation was constant. Moreover, the observed non-significant gains in controls may be ascribed to the learning effect of the trained tasks [71,72]. However, the learning effect is difficult to argue because of the ease and simplicity of the strength tasks, which took only a few trials of practice to be performed correctly [69,73]. After three pre-training test sessions were performed, instead of the usual one, Ranganathan and colleagues [69] showed that both motivational and learning factors were not likely the significant determinants of the strength gains. In addition, the control group, whose individuals maintained their strength level throughout the course of the whole study, showed that a learning effect was likely trivial [69]. Further, previously it was shown that the MVS protocol assessment could influence test results by mitigating the participants' motivation level [65]. We noticed similar strength gains after both encouragement and non-encouragement protocols in the included studies, and therefore, the underlying mechanisms of MI practice might be predominantly influenced by neurophysiological factors, rather than psychological aspects. Consequently, in respect to the studies' durations (that ranged from one to six weeks), the MI might encourage that the strength can be enhanced in the absence of structural muscle changes (e.g., muscle hypertrophy) [51]. The muscle hypertrophy following CST is a well-known phenomenon [74], where increase in muscle size is shown to occur just after 8 to 10 weeks of training [74–76]. Another aspect to take into account is that the appearance of the contralateral limb effect following MI practice, might reflect neural components of adaptations in the absence of real movement and muscle hypertrophy [51]. Due to the advent in technology, including neuroimaging and other brain activity measuring techniques, particularly functional magnetic resonance imaging and electroencephalography, the last two decades have been populated with studies investigating neurological mechanisms of MI practice. The findings from such studies lend support to MI's effectiveness related to motor performance improvement [24,40,77–81].

Currently, the underlying mechanisms of MI practice might be explained by both central and peripheral factors [18,82]. First, the central explanation relies on the fact that MI can stimulate several brain regions which are known to play a role during actual movements [83,84], including the primary motor cortex [24,85–87]. Accordingly, prolonged MI practice leads to brain reorganization; that is brain plasticity [88,89], which represents the intrinsic property of the human brain and its primary mechanism of learning and development [88], including motor-skill learning and cognitive motor actions [90]. Second, the peripheral mechanism supposes that MI may result in excitability of the spinal motor neurons [91–93], further contributing to greater neural impulse output to agonist muscles [56], and thus increasing muscular activity [14,51,61,69]. Consequently, this might lead to better synchronisation of the fibers and inhibition at the level of antagonist muscle activation [61], thus improving MVS [61,81,94]. A recent comprehensive review of Ruffino et al [18] presented a potential model of neural adaptations in the learning process following MI practice, confirming aforementioned spinal and supraspinal factors as underlying mechanisms. However, of importance is to note that the methodological considerations (e.g., experimental set-up, measurement equipment and the technique used, the task imagined, the imagery modality used, the imagery ability and the skill level of the studied subjects), might influence the strength, or even the existence of both central and peripheral responses (for review see [18,83,84,95,96]).

Generally, the functional equivalence principle [23,25] is based on the theory that imagery enhances performance, because of the similar neurophysiological processes that underlie both imagery and actual movement [26,97], and has found its support elsewhere [24,80,98–100]. More precisely, during both motor execution and MI tasks, acute differences were shown in the supplementary motor area (SMA), the premotor cortex (PMC) and the primary motor cortex (M1one) movement, when compared to resting conditions. This suggested that imagining the motor task, and its actual execution, do share similar neural patterns [80]. Further, longitudinal studies involving the learning of a novel task [81], showed that MI practice can improve muscular abilities such as strength and power. Besides these performance improvements by MI practice could modify movement-related cortical potentials (MRCP) comparable to those observed following PP [81]. Thus, suggesting a central role of MI practice similar to those showed during execution of motor tasks [39,69,89,101,102].

However, despite that similar neural patterns have been found previously, and identical dose-response relationships were confirmed in the present review (Table 5.), a difference was observed; namely smaller effects in performance following mental simulation tasks (e.g., MI practice) when compared to motor executed tasks [51–54,59,62]. Therefore, in absence of such structural changes, the central mechanism (i.e., neural circuits controlling the motor action) also can be used to argue favouring effects in strength gains following PP, when compared to the MI practice group. Accordingly, the lack of somatosensory feedback [98,103] during MI due to restriction of overt movement execution, contributes to inhibition of the posterior cerebellum and the SMA [80,103,104]. As such these inhibitions play key roles in motor output suppression, and consequently, lead to less activation of M1one [24,104,105] and thus, lower both electromechanical muscle output and performance enhancement [69]. A study by Ranganthan and colleagues [69] may extend our understanding of the central mechanism's role following MI practice, where the gains of MVS were followed by a significant increase of MRCP. This was previously shown to correlate highly with muscular activity and the level of the expressed force [102]. Furthermore, the authors observed that the MRCP amplitudes were always higher for the MVC tasks than for the mental MVC tasks, thus providing evidence of crucial central mechanisms following the imagined task.

Despite the preceding evidence on the similarities between imagined and actual movement, there are several important facts that should be pointed out. First, when comparing training outcomes between MI and PP regimes, one must consider the fact that the PP training could almost always maximally activate - assuming training involves MVC- not only the muscle, but also the neural circuits controlling the motor action. Therefore, PP optimally trains both the central and the peripheral systems [106,107]. Second, although similar neural networks underlie both the imagined and the actual movement execution, they are not strictly identical, which might be influenced by the nature of the MI practice that requires inhibition of the efferent sensorimotor output [26,104]. Third, for MI training, difficulties of optimally performing the task (people have different abilities to accurately perform the MI task), could lead to suboptimal activation (and training) of the control network [19,95,108,109]. The extent to which a given subject can optimally activate the motor control network during MI training, may determine both the training outcome and the variability between participants and studies.

In contrary to both practice models alone (MI and PP), its combination (MI-C) was found to elicit greater cerebral activity in motor related brain regions [76,100]. Hence, both symptomatic [14,94,110,111] and asymptomatic (i.e., healthy population) [47,58] experienced greater benefits compared to PP alone. However, the present results indicate that those improvements are trivial (ES = 0.05) compared to PP alone. These trivial results are likely due to the initially higher performance level of the included subjects (i.e., generally healthy population) from the three analysed studies. Furthermore, Jiang et al. [112] compared the level of mental effort i.e., high mental effort (HME) vs. low mental effort (LME) with a no-training control group (CON), during a low-intensity (30% MVC) muscle exercise training program (6 weeks, 15 min/day, 5 days/week). They reported that HME for elbow flexion contractions, combined with a low (30% maximal) level of physical elbow flexion exercise, can significantly increase elbow flexion strength. But those trained with a LME combined with the same low level of physical elbow flexion exercise, and those in the CON group, did not increase elbow flexion in healthy young individuals. Thus, Jiang et al. [56] reported that at the end of the 12-week training in healthy elderly subjects, CST (high-intensity physical exercise) and HME significantly increased the elbow flexion strength, compared to the CON group (-6%), with no significant difference between CST and HME groups. The amount of increase in MRCP in the HME group was significantly greater than that in CST and CON groups [56]. These results suggest that high mental effort training combined with low-intensity physical exercise is an effective method for voluntary muscle strengthening in healthy population and might be useful for those individuals who have difficulties in participating in high-intensity exercise training. Therefore, when maximal intensity of PP is limited, incorporating MI practice may help trainees to optimally train their system, and may yield better training effects.

Two studies [50,58] different by design concerning the trained muscles (biceps brachii vs pectoralis major and quadriceps), report slightly greater effects (ES = 0.17; 0.15 and 0.31) favouring the combination of the two models (MI and PP) over PP only. Accordingly, Lebon et al. [50] used imagery practice in addition to CST during the rest periods in between the individual sets. Thus, one might assume that the overall active time spent in training might have influenced the effects of the combined mode, compared to PP only. Wright et al. [58], however mitigated this assumption by using consecutive sets of both models (one PP set followed by one MI set), compared to two sets of PP training. This resulted in equal time spent in training and similar effects in strength gains (ES = 0.17), parallel to the study of Lebon et al. (ES = 0.15 and 0.31) [50]. The authors suggest that the greater results following a combination of the two models were influenced by enhancing the technical execution of the movement, the individual intrinsic motivation [70], and maybe the cerebral reorganization [89]. Thus, of importance seems to be: driving the motor units to a higher intensity [101], and/or leading to the recruitment of motor units that remain otherwise inactive, rather than the overall time spent in training [50]. In summary, compared with CST, MI has less beneficial effects, which suggests that PP will remain the most efficient method for strength increase, while MI can be used as additional, or sometimes even as a substitutional tool, in the same manner. Regarding the combined effect of MI and PP, more research is necessary to draw strong evidence about its likely beneficial effect compared to CST.

Despite the substantial effect of MI on muscle strength, the present results indicate there was still considerable variation among the studies in the magnitude of adaptations. This may be ascribed to various methodological issues. Accordingly, the magnitude of the response varies between the body regions (upper vs. lower limbs), the muscle groups, the type and/or intensity of the contractions, and the existence of the muscle activity control during the MI practice session. Previous adapations to MI practice were shown to be specific, as training induced changes in MVS that differ between the exercise practiced [50], and/or distal and proximal muscles [69]. Furthermore the variation could be modified by the type and the intensity of the imagined contraction [113]. Different musculature was investigated among the analysed studies. We assumed, based on the observed discrepancies and the outcomes among them, as well as on previous findings [31,69], that this can have a possible influence on the results of the MI practice. It is known that distal and proximal muscles differ in many aspects [114]. For example, the size of the CRA [115], the firing rate scheme (both recruitment and decruitment), and the modulation of the discharge rate to the gradation of muscle force can be different [116]. For example, distal muscles (e.g., m. oponens policis) have a significantly greater excitability of cortical area compared to the proximal muscles (m. biceps brachii) [117]. To what extent those features might modulate the outcomes following MI practice with respect to MVS, however, has been poorly investigated. To our knowledge, only one study [69] was performed with that aim. It showed that distal muscles (m. abductor digiti minimi) experience larger improvement in MVS strength, compared to proximal muscles (m. biceps brachii), 35 % vs 13.5 %, respectively following 12 weeks of training (15 min per day, 5 days per week). Furthermore, the study showed greater potential for an increase of the descending command to the target muscle favouring large vs. small CRA muscles [69], which might alter muscular activity and thus the level of expressed force [102]. However the authors [69] ascribed these favouring effects of distal muscles simply to the training status of the involved muscles [118], rather than to the neurophysiological features. Thus, it is well-known that untrained individuals have a greater starting potential to increase their strength compared to trained ones [118], due to lower levels of initial strength [119], as well as to maximal voluntary activation (MVA) level [120]. Therefore, an individual probably seldom contracts intentionally the intrinsic muscles of the hand like the little finger abductor [69] or thumb adductor muscles [121]. These muscles have a lower MVA level compared to the proximal muscles (e.g., biceps brachii) [121]. Consequently, there may have been more potential for increasing the voluntary activation in the intrinsic finger muscles, which might lead to greater force exertion following strength training. However, a study by Lebon and colleagues [50] showed that MI practice in addition to CST significantly modulates the effect of only the lower limb muscles (i.e., leg extensors), compared to the upper limb muscles (i.e., pectoral and arm adductors). This is in accordance with our findings, where we observed that the lower body parts experienced greater strength gains compared to the upper ones. Unfortunately, the previously discussed causal link between individual muscle MVA (i.e., its trainability level and the MI practice effect), cannot argue for the observed discrepancies in the results of Lebon' study, due to the many varieties of sports in which the participants were engaged, and their randomised control and experimental grouping, respectively. To summarise, with respect to the CRA of the involved muscles, this review does not suggest a strong conclusion. And although we showed a minor influence on the training outcomes, we cannot ascribe it only to CRA, but should mention as an important factor the trainability status (i.e., muscular fitness level) of the involved muscles. However, contrary to previous findings on this particular topic [31], we suggest that both large and small CRA muscles might almost equally benefit from MI practice.

Considering the MI practice principle that only mental rehearsal must be performed, without overt movement execution, both brain and muscle activity during MI session should be provided, otherwise it might confound the interpretation of the results [31]. However, probably due to the high costs, time consumption, and the complexity of the recording set-up, there is no research that directly measured the brain activity during MI practice sessions over prolonged periods of time. In those shorter-term studies where muscle activity was monitored, greater strength gains were observed [51,52,54,59,61,63], suggesting that the supervised muscle activity might lead to consciously greater focus on mental simulation of the movements.

4.2 Dose – Response Relationship of MI Practice to Increase Muscle Strength

In the previous section we established a moderate effect of the MI practice on MVS in healthy adults. The present meta-regression identified the training variables that moderated the changes in strength following MI practice. Further, based on the additional analyses, the dose-response relationships were presented for each variable independently (Table 5), i.e., of the six "Training Volume" variables, the ones that were significant predictors of the effects of MI on MVS: the number of repetitions, both per single training session and for the whole study.

Based on seven studies, the most frequent period of four weeks yielded a moderate effect (ES = 0.88). However, when compared to one week period (ES = 0.96), and three weeks (ES = 0.80) in duration, the most frequent period lead to respectively, a somewhat lower (compared with one week) and larger (compared with three weeks) effect. This suggests that MI practice might be a suitable intervention for strength increase in healthy adults after only performing a few sessions [63]. To support our findings, a study of Reiser et al. [53] observed the largest improvement in strength after the first week of MI practice. And although the increase in strength was linear throughout the next four weeks, it suggests that the nervous system exhibits a rapid modulation to adapt to new mental demands [86,122,123].

In contrast to the meta-regression, the dose-response relationship analysis revealed considerably different effects regarding the weekly frequency and the number of sets during a single MI session. This was reflected as an inverted U shape. Thus, three sessions of MI practice per week produced a substantially larger effect on MVS (ES = 1.22), compared to the protocols where two (ES = 0.42), or five sessions (ES = 0.72) per week were performed. One rare study conducted by Wakefield and Smith [124] aimed to investigate the influence of different frequencies of MI, and indicated that although the training programs delivered at least once per week can be beneficial, practicing imagery more frequently can be more effective [124]. Based on the average frequency used across the studies and the additional analysis of the dose-response relationships, the current review suggests an optimal three sessions per week as a starting point for those who want to benefit from MI practice. More frequent practice would not lead to greater strength gains in periods fewer than six weeks in duration. Considering "the number of sets", notably greater effects were found with two to three sets (ES = 0.90) compared to the training protocols where one (ES = 0.46), or four sets (ES = 0.37) were performed. A similar trend reflected as an inverted U shape was observed following CST [125,126]. Hence the largest effect was observed during protocols that applied three and two sets per session [125,126]. Since changes on structural level are lacking for short period of CST [74–76], our data suggests that similar neural mechanisms might underlie short-term effects [26,40,99]. In summary, positive effects of both practice models should be expected regardless of single or multiple sets used. Where two to three sets should be recommended when designing a MI practice program.

Regarding "the number of repetitions per set" variable, its effect on strength gains following the MI practice was nearly significant, whereas both the derived variables (i.e., the total number of repetitions per single session and per whole study) significantly predicted the effect in strength gains. Additional dose-response analysis supports the meta-regression data, where the largest effects were found after the use of the greatest number of repetitions. When planning a MI practice program this observation underlines the importance of considering the right training volume, rather than the total number of repetitions per set only. Bearing in mind that only a few studies investigated the MI ability of participants [52,53,55,58,61], and only two studies used participants' MI ability as inclusion criteria [52,53], an overall greater number of mentally simulated trials was probably needed to induce positive alterations following MI practice. The need for greater number of simulated trials was most likely influenced by the initial lower ability of the subjects to visualize and kinaesthetically feel the task. The imagery ability may have had a significant impact upon its effectiveness, because it is likely that someone who cannot clearly imagine performing a motor task will not benefit much from MI practice [19,108].

Moreover, previous experience [38], as well as an internal versus external perspective of the imagined task [39], elicit greater brain activity of motor related areas during a MI session [38]. Consequently, those alterations on the cortical level lead to greater descending command of the involved muscles, improving its motor unit recruitment and activation, finally improving the muscle mechanical output following MI practice. Furthermore, our data suggest that both the type and the intensity of the imagined contraction have a large influence on the MI practice outcomes. Considerably larger strength gains were observed when MViC compared to submaximal dynamic contractions was investigated. This was also confirmed by the meta-regression analysis (Table 4.). To support our findings, a larger muscular activity (in elbow flexors) during imaging a heavy lift, compared to the light lifting task and the isometric type of contraction compared to the light dynamic type of contractions were found [113]. Moreover, the authors observed the mirroring effect when comparing imagined and executed contractions regarding both types and intensities [113]. In overt execution of motor task the MVA level was found to be moderated by the type of muscle contraction when maximal effort was used [127]. More precisely, for the use of three different MVC types of quadriceps muscle it was found that the MVA levels during eccentric and concentric contractions were 88.3 and 89.7%, respectively, and were significantly lower with respect to maximal isometric contractions (95.2%) [127]. Consequently, it leads to improvement in MVS by 10.8, 15.3 and 34.1%, following eccentric, concentric or isometric type of training, respectively [73]. In accordance with our results, another recent meta-analysis [128] showed that high training loads (≥ 65% 1RM) lead to notably greater strength gains compared to low loads training (≤ 60% 1RM). Hence, similar to overt movement execution [73], the type, along with the intensity of the imagined contractions, plays an important role in the magnitude of the MI intervention. This might be linked to the previously discussed greater descending command to the muscle, when maximal mental and/or physical effort is produced [102,112].

Along with the mechanical stress induced by the training intensity (% of 1RM), metabolic stress results in increase of muscle size and strength [129,130]. Accordingly, TUT is a variable which should be controlled during the training [131], because its manipulation induces different responses of the neuromuscular system [132]. How the neuromuscular system operates and to what extent TUT might affect the strength gains following MI practice, was until now not investigated. Expressed as the time of sustained contraction during imagined or executed MViC, the TUT showed an insignificant effect on the strength gains. Comparable large effect was observed following MI practice using both the 5 and 10 seconds of sustained contraction. These observations probably reflect that subjects were mainly untrained individuals. Thus, 5 to 10 seconds of sustained contraction in less than six weeks period of resistance training, were adequate to induce the optimal neuromuscular adaptation and the greatest strength gains. One study, which aimed to investigate the differences between short intermittent contractions (3s with 2s rest), versus long continuous isometric contraction (30 s with one minute rest in between sets), found that both groups increased their MVC after six weeks of training [133], although not significantly compared to baseline. However, following 14 weeks of training, both groups significantly increased the strength compared to baseline. Regarding strength gains, the longer contractions were shown to be more beneficial compared to the short isometric contractions. Thus, due to the greater metabolic changes elicited following long isometric contraction training, the sustained contraction larger than 5 seconds might be the most beneficial, when training longer than six weeks is planned. Only hypothetically, increasing the time of contraction following the first few weeks of training might be applicable for either mental or CST, knowing that training periodization leads to optimal and continuous adaptations of both the neural and structural components [43,134,135].

Regarding “the Time spent in training” variable, only the duration of the single training session was shown to be a significant predictor of strength gains following the MI practice. The regression curve showed a slightly inverse U shape. Hence, our results suggest that moderate time spent in training, of around 15 minutes, is an optimal framework to induce the most benefits from MI. This finding is similar to those of the previous reviews that suggested that the optimal duration of mental practice was 20 minutes on average [35,36]. In addition it was mentioned that longer duration may decrease the motivation and thus can trigger negative effects like focus reduction and advent of boredom [36]. To support the shorter periods of MI practice, another study aimed to investigate effectiveness of single practice session when 100 imagined movements were performed, and found that the participants experienced subjective feelings of mental fatigue following the protocol [136]. This was accompanied by an increased duration of both the actual and the imagined movements. Thus, the observed decline in performance suggests that the session of prolonged duration should not be performed to help avoid mental fatigue, which could worsen the performance of the motor task. However, an integration of one actual movement on every ten imagined, might delay an advent of mental fatigue [136], and this should be considered carefully when designing a MI practice programme, especially since it is easily implemented.

4.3 Limitations of the Present Review

Some limitations of this systematic review must be outlined. One limitation might be the overall variability of the included studies with the training design, making it difficult to reach firm conclusions on some issues. There were limitations in the external validity as well: almost all the participants included were untrained and healthy. Therefore, no comparison could be made between trained and untrained, as well as between healthy and symptomatic individuals. In addition, it was not feasible to use chronological age as a moderator variable, as only two studies included older adults. Given the number of studies resulting from the search, we were not able to assess interactions effects among the moderating variables. Finally, the publication bias results indicated the presence of bias. It is possible that some studies may have not been published, due to null or negative results, reducing the general positive effect of MI practice on strength.

5 Conclusion

The present meta-analysis demonstrates that MI practice has most likely moderate beneficial effects on MVS development, compared to a no exercise control group. However, when compared to a physical practice group, we found likely small beneficial effects, favouring physical practice. There is no strong evidence that the combination of both practices has greater effect than PP only. The dose-response relationship analysis showed that the number of repetitions per single session (50 repetitions), and during the whole study (1000 repetitions), the intensity and/or the type of the imagined contractions (MViC), along with a single training session duration (15 minutes), all can significantly modify the effects of MI practice on muscle strength in healthy adults.

To summarize, our finding suggest that CST will remain the most efficient method of strength development. However, MI practice should be considered as substitutional or additional training tool to preserve muscle function when athletes are not exposed to maximal training intensities. Hypothetically MI might also apply in patients' rehabilitation planning as well, when motor execution is constrained or impaired. Moreover, we propose a thorough and proper MI practice design, regarding a multitude of training variables. Our results provide guidance for strength and conditioning coaches, as well as physiotherapists, to get the most out of the mental simulation practice for their clients.

Compliance with Ethical Standards

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Conflicts of Interest

Armin Paravlic, Mammer Slimani, David Tod, Uros Marusic, Zoran Milanovic and Rado Pisot declare that they have no conflict of interest relevant to the content of this review.

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Table 1 Systematic overview of the included studies in the meta-analysis with their characteristics and relevant outcomes

Study	Population			Trained movement; measurement equipment	Outcome measures	Results	Additional comments
	Sex; Age (years) [mean ± SD]	Training status	Sample size	Trained muscle	Outcome measure		
Cornwall et al. [63]	F; 21 - 25 yr.	Untrained	MI (n =12) CON (n = 12)	Knee extension; isokinetic dynamometer.	MVC Isometric	MI: 12.6% ↑* CON: 0.89% ↓	- No MI ability assessment - No specific instructions concerning how to practice - EMG was used to monitor MI practice
Yue and Cole [51]	ND; 21 - 29 yr.	Untrained	MI (n = 10) PP (n = 8) CON (n = 9)	Abduction of little finger of the hand	MVC Isometric	MI: 22.03 % ↑** PP: 29.75 % ↑** CON: 3.7 % ↑	- No MI ability assessment - Imagery modality is not defined - 80% of training session monitored by EMG - Left hand
Smith et al. [52]	ND; 29.33 ± 8.72 yr.	Untreined	MI (n = 8) PP (n = 8) CON (n = 8)	Right hand, (fifth digit); Isometric dynamometer	MVC Isometric	MI: 23.2 % ↑* PP: 53.3 % ↑** CON: 5.3% ↓	- MI ability assessed by MIQ-R - Kinesthetic MI approach was used - EMG was used to monitor MI practice
Reiser et al [53]	M and F; 23.9 ± 1.8 yr.	Untrained	MI (n = 11) PP (n = 12) CON (n = 11)	Pectoral and arm extensor muscles Isometric Bench press	MVC Isometric	MI: 5 % ↑** PP: 13.9 % ↑** CON: 1.7 % ↑	- MI ability was assessed by MIQ - Internal MI was used in MI group - Muscle activation was visually monitored
Sidaway and Trzaska [54]	M and F; 19 – 26 yr.	Untrained	MI (n = 10) PP (n = 10) CON (n = 10)	Ankle dorsiflexion Isokinetic dynamometer	MVC Isometric	MI: 17.13 % ↑* PP: 23.28 % ↑* CON: 1.77 % ↓	- No MI ability assessment - Kinesthetic MI approach was used - Muscle activation was monitored by dynamometer and visually
Shackell and Standing [57]	M; 18 - 24 yr.	Trained	MI (n = 10) PP (n = 10) CON (n = 10)	Hip flexors Hip flexor machine-dynamic movement	MVC Dynamic	MI: 23.7 ↑** PP: 28.2 % ↑** CON: 3.5 % ↑	- No MI ability assessment - Kinesthetic MI approach was used - No control of muscle activity during MI practice

Wright and Smith [58]	ND; 20.74 ± 3.71 yr.	Untrained	Mip (n = 10) MI (n = 10) PP (n = 10) MIco (n = 10) CON (n = 10)	Upper limb, not defined which, or maybe both were trained; Bicep curl machine	MVC Dynamic	MIp: 23.2 % ↑* MI: 13.7 % ↑ PP: 26.5 % ↑* Mico: 28 % ↑* CON: 5.1 % ↑	- MI ability assessed by MIQ-R - Kinesthetic MI approach was used In MI group, while MIp used PETTLEP model - The CON completed a placebo task (reading some literature related to body building)
Lebon et al. [50]	ND 19.75 ± 1.72 yr.	Untrained	Mico (n = 9) CPP (n = 10)	Bench press Leg press	MVC dynamic	Mico: BP 9 % ↑** LP 26.2 % ↑** CPP: BP 12.2 % ↓** LP 21.2 ↑**	- MI ability assessed by MIQ-R - Kinaesthetic MI aproach from internal perspective was used
Bahari et al. [61]	M; 22.5 ± 1.36 yr.	Untrained	MI (n = 8) CON (n = 8)	Right hand; elbow flexion; isometric dynamometer	MVC Isometric	MI: 30% ↑* CON: 5.5 % ↑	- MI ability was assessed by MIQ - Internal MI approach was used - Muscle activity was visualy monitored during MI practice
Ruiter et al. [59]	M and F; 18 - 24 yr.	Untraned	MI (n = 10) PP (n = 9) CON (n = 10)	Leg extensors; Isometric torque;	MVC Isometric	MI: 9.3 % ↑* PP: 6.6 % ↑* CON: 5.4 % ↓	- MI ability was assessed by SIAM internal perspective was used - MI sessions were guided by script reading - EMG was used to monitor MI practice
Darvishi et al. [55]	M; (70.93 yr)	Untrained	MI (n = 10) PP (n = 10) CON (n = 10)	Hand flexors, Isometric dynamometer	MVC Isometric	MI: 11.2 % ↑* PP: 25 % ↑** CON: 2.82 % ↑	- Mi ability was assessed by VVIQ and VMIQ - No specific instructions concerning how to practice
Niazi et al. [62]	M; 22.4 ± 1.25 yr.	Untrained	MI (n = 15) CON (n = 15)	Plantar flexors; Isometric dynamometer	MVC Isometric	MI: 13.4 % ↑* CON: 0.5 % ↓	- MI ability was not assessed - Internal MI perspective was used
Jiang et al. [56]	M and F; 75 ± 7.9 yr.	NR	MET (n = 10) PP (n = 10) CON (n = 7)	Elbow flexion; Isometric dynamometer	MVC Isometric	MET: 13.83 % ↑** PP: 17.58 % ↑** CON: 3.28 ↓	- MI ability was not assessed - Internal MI perspective was used

BP bench press, *CON* controls, *EMG* Electromyography, *F* females, *IMI* Internal Motor Imagery, *LP* leg press exercise, *M* males, *MI* motor imagery, *MIp* motor imagery based on PETTLEP (Physical, Environment, Task, Timing, Emotion, Perspective) method, *MVC* Maximal Voluntary Contraction, *MIQ* Motor Imagery Questionnaire, *MIQ – R* Motor Imagery Questionnaire – Revised, *ND* not defined, *SIAM* Sport Imagery Ability Measure, *VMIQ* The Vividness of Movement Imagery Questionnaire, *VVIQ* Vividness of Visual Imagery Questionnaire;

↑ indicates increase, ↑* indicates significant increase $p<0.05$, ↑** indicates significant increase $p<0.01$, ↓ indicates decrease

Table 2 Training variables

Study name	Study duration (weeks)	Weekly frequency	Duration of one TS (min)	NSTS	NRS	Type of contraction	TNRS	TTST (min)	CRA (L/S)	ES
Cornwall et al. [63]	1	4	20	3	NR	Isometric	NR	80	S	0.96
Yue and Cole [51]	4	5	7	1	15	Isometric	300	140	L	0.44
Smith et al. [52]	4	2	12	2	10	Isometric	160	96	L	1.15
Reiser et al. [53]	4	5	8	4	8	Isometric	160	190	S	0.15
Sidaway and Trzaska [54]	4	3	15	3	10	Isometric	360	180	S	2.06
Shackell and Standing [57]	2	5	15	4	10	Dynamic	320	150	S	0.64
Wright and Smith [58]	6	2	10	2	25	Dynamic	240	120	S	0.14*
Bahari et al. [61]	4	5	15	2	10	Isometric	1000	300	S	1.46
Ruiter et al. [59]	4	3	15	1	10	Dynamic	120	180	S	0.33
Darvishi et al. [55]	3	5	20	3	25	Isometric	450	300	L	0.8
Niazi et al. [62]	4	5	15	2	2	Isometric	1000	240	S	1.05
Jiang et al. [56]	12	5	15	2	25	Isometric	3000	900	S	1.93

CRA Cortical Representation Area of the muscle, *ES* effect size, *L* large**,** *N* number, *NRS* Number of Repetitions per Set, *NSTS* Number of Sets per Training session, *S* small, *TNRS* Total Number of Repetitions per Study, *TS* training session, *TTST* Total Time Spent in Training, * averaged effects of two ESs from same study

Table 3 Quality assessment of the included studies

Study	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Criterion 5	Criterion 6	Criterion 7	Criterion 8	Criterion 9	Criterion 10	Criterion 11	Total
Cornwall et al. [63]	/	1	0	1	0	0	0	1	1	1	1	6
Yue and Cole [51]	/	1	0	1	0	0	0	1	1	1	1	6
Smith et al. [52]	/	1	0	1	0	0	0	1	1	1	1	6
Reiser et al. [53]	/	1	0	1	0	0	0	1	1	1	1	6
Sidaway and Trzaska [54]	/	1	0	1	0	0	0	1	1	1	1	6
Shackell and Standing [57]	/	1	0	1	0	0	0	1	1	1	1	6
Wright and Smith [58]	/	1	0	1	0	0	0	1	1	1	1	6
Lebon et al. [50]	/	1	0	1	0	0	0	1	1	1	1	6
Bahari et al. [61]	/	1	0	1	0	0	0	1	1	1	1	6
Ruiter et al. [59]	/	1	0	1	0	0	0	1	1	1	1	6
Darvishi et al. [55]	/	1	0	1	0	0	0	1	1	1	1	6
Niazi et al. [62]	/	1	0	1	0	0	0	1	1	1	1	6
Jiang et al. [56]	/	1	0	1	0	0	0	1	1	1	1	6

Criterion 1 eligibility criteria were specified, *Criterion 2* subjects were randomly allocated to groups, *Criterion 3* allocation was concealed, *Criterion 4* the groups were similar at baseline regarding the most important prognostic indicators, *Criterion 5* there was blinding of all subjects, *Criterion 6* there was blinding of all therapists who administered the therapy, *Criterion 7* there was blinding of all assessors who measured at least one key outcome, *Criterion 8* measures of at least one key outcome were obtained from more than 85 % of the subjects initially allocated to groups, *Criterion 9* all subjects for whom outcome measures were available received the treatment or control condition as allocated, *Criterion 10* the results of between-group statistical comparisons are reported for at least one key outcome, *Criterion 11* the study provides both point measures and measures of variability for at least one key outcome.

Table 4 Meta regression for the training variables of different subscales to predict the MI effects on maximal voluntary strength

	Coefficient	Standard error	95 % lower CI	95 % upper CI	Z value	P value
Training intensity						
Maximal (MViC)®	0.5595	0.2812	0.0083	1.1106	1.99	**0.05**
Time under tension (sec)¥	-0.0543	0.0474	-0.1473	0.0387	-1.14	0.25
Training volume						
Training period (weeks)	-0.1366	0.105	-0.3424	0.0692	-1.3	0.19
Training frequency (per week)	0.0618	0.1232	-0.1797	0.3033	0.5	0.61
Number of sets (per training)	0.0101	0.1748	-0.3325	0.3526	0.06	0.95
Number of repetitions (per set)	0.038	0.0219	-0.0049	0.0808	1.74	0.08
Number of repetitions per single session	0.0237	0.01	0.004	0.0433	2.36	**0.01**
Number of repetitions (per study)	0.0009	0.0005	0	0.0019	1.95	**0.05**
Time spent in training						
Total training duration per study (min)	0.0023	0.0022	-0.0021	0.0066	1.02	0.31
Total training duration per week (min)	0.00859	0.00571	-0.0026	0.01978	1.50	0.13
Duration of single training session (min)	0.06686	0.03222	0.00371	0.1300	2.07	**0.04**

® - dichotomus variable (dynamic contraction i.e., less than 100% 1RM or MVC was used as reference group)
¥ - time under tension was calculated only for MViC contraction (100% intensity)

Table 5 Training variables with the largest mean effect on maximal voluntary strength

Training variables	Motor imagery vs. no-exercise controls	
	Highest value	Effect size (CIs)
Training period [weeks]	4	0.88 (0.43 – 1.34)
Training frequency [per week]	3	1.22 (-0.32 – 2.75)
Number of sets [per training]	2-3	0.90 (0.49 – 1.31)
Number of repetitions [per set]	25	1.18 (0.56 – 1.81)
Number of repetitions [per single session]	50	1.18 (0.56 – 1.81)
Number of repetitions [per study]	1000	1.18 (0.56 – 1.81)
Training intensity (% of 1RM or MViC)	100	0.92 (0.55 – 1.30)
Time under tension [s] ¥	5	1.05 (0.57 – 1.52)
Total training duration per study [min]	300	1.07 (0.37 – 1.77)
Total training duration per week [min]	60-80	0.99 (0.55 – 1.43)
Duration of one training session [min]	15	1.04 (0.54 – 1.54)

The content of this table is based on the individual training variables with no respect for interaction between training variables; Cis - Confidence intervals, 1RM - one-repetition maximum, MVC - maximum voluntary contraction, ¥ - time under tension was calculated only for MViC contraction (100% intensity)

Figure Legends

Fig. 1 Flow diagram of the study selection process.

Fig. 2 Funnel plot of the standard differences in means vs standard errors.
The aggregated standard difference in means is the random effects mean effect size weighted by the degrees of freedom

Fig. 3 Effects of (A) motor imagery (MI) practice *vs.* no-exercise control; (B) MI vs. physical practice (PP); (C) MI combined with PP vs. PP only; (D) PP vs. no-exercise control - on maximal muscle strength.
ES effect size, *Std diff* standardized difference, *CI* confidence interval

Fig. 4 Dose-response relationship for (A) the number of repetitions per single set; (B) the number of repetitions per single training session; (C) the number of repetitions per study; (D) the duration of single training session - and effect on the maximal strength measure following motor imagery practice. Each *unfilled symbol* illustrates the SMD per single study. The *filled black squares* represent the mean SMD of all studies for the assigned value. *Circles* and *triangles* symbolize imagined maximal isometric contractions and the dynamic contractions during practice, respectively.