Title: Vertebral level specific modulation of paraspinal muscle activity based on vestibular

signals during walking.

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Key Points Summary

• Mediolateral stabilization of gait requires an estimate of the state of the body, which
is affected by vestibular afference.

• During gait, the heavy trunk segment is controlled by phasic paraspinal muscle
activity and in rodents the medial and lateral vestibulospinal tracts activate these
muscles.

• To gain insight in vestibulospinal connections in humans and their role in gait, we
recorded paraspinal surface EMG of cervical to lumbar paraspinal muscles, and
characterized coherence, gain and delay between EMG and electrical vestibular
stimulation, during slow walking.

• Vestibular stimulation caused phasic, vertebral level specific modulation of
paraspinal muscle activity at delays of around 40 milliseconds, which was mirrored
between left, lower and right, upper vertebral levels.

• Our results indicate that vestibular afference causes fast, synchronized, and spatially
co-ordinated responses of the paraspinal muscles along the trunk, that
simultaneously contribute to stabilizing the centre of mass trajectory and to keeping
the head upright.

Abstract

Evoking muscle responses by electrical vestibular stimulation (EVS) may help to understand

the contribution of the vestibular system to postural control. Although paraspinal muscles

play a role in postural stability, the vestibulo-muscular coupling of these muscles during

walking has rarely been studied. This study aimed to investigate how vestibular signals

affect paraspinal muscle activity at different vertebral levels during walking with preferred

and narrow step width. Sixteen healthy participants were recruited. Participants walked on

a treadmill for 8 minutes at 78 steps/min and 2.8 km/h, at two different step width, either

with or without EVS. Bipolar electromyography was recorded bilaterally from the paraspinal

muscles at eight vertebral levels from cervical to lumbar. Coherence, gain, and delay of EVS

and EMG responses were determined. Significant EVS-EMG coupling ($p<0.01$) was found at

ipsilateral and/or contralateral heel strikes. This coupling was mirrored between left and

right relative to the midline of the trunk and between the higher and lower vertebral levels,

i.e., a peak occurred at ipsilateral heel strike at lower levels, whereas it occurred at

contralateral heel strike at higher levels. EVS-EMG coupling only partially coincided with

peak muscle activity. EVS-EMG coherence slightly, but not significantly, increased when

walking with narrow steps. No significant differences were found in gain and phase between

the vertebral levels or step width conditions. In summary, vertebral level specific

modulation of paraspinal muscle activity based on vestibular signals might allow a fast,

synchronized, and spatially co-ordinated response along the trunk during walking.

Keywords: electrical vestibular stimulation, paraspinal muscles, balance control, gait

stability

Introduction

Stable walking, defined as "gait that does not lead to falls" (Bruijn *et al.*, 2013), is an effortless and seemingly simple task for healthy young adults. However, with the presence of disorder (e.g., low back pain, bilateral vestibular loss, etc.), aging, or external perturbations, the difficulty of the task becomes manifest (Mazaheri *et al.*, 2013; Sprenger *et al.*, 2017). To maintain stability, the centre of mass should be controlled relative to the base of support. Three mechanisms can contribute to the control of the centre of mass: modulation of foot placement, shifting the centre of pressure through ankle moments, and changing angular momentum such as through trunk rotation (known as counter-rotation) (Hof, 2007).

These mechanisms for stability are believed to be controlled using the error between efference copies and the actual state detected by sensory systems. The vestibular system, for instance, which encodes head motion, has been shown to contribute to gait stabilization (van Schooten *et al.*, 2011; Cullen, 2012; Magnani *et al.*, 2021). It has been reported that the medial vestibulospinal tract, commencing in the medial vestibular nucleus and then bilaterally extending through the cervical spinal cord into the medial longitudinal fasciculus, is involved in head stabilization (Wilson & Maeda, 1974; Fukushima *et al.*, 1979; Goldberg & Cullen, 2011; Forbes *et al.*, 2020)**.** Another descending brainstem pathway involved in stabilization is the lateral vestibulospinal tract, which originates in the lateral vestibular nucleus and projects ipsilaterally to axial motoneurons at all spinal levels (Grillner & Hongo, 1972; Fukushima *et al.*, 1979; Basaldella *et al.*, 2015). This pathway is required for the preservation of upright posture and for responding to postural perturbations (Markham, 1987; Dichgans & Diener, 1989; Murray *et al.*, 2018). The vestibulospinal reflex has been investigated experimentally by applying electrical vestibular stimulation (EVS). This stimulation activates the vestibular afferent nerve fibres without head movements and produces an illusion of moving the head (Goldberg *et al.*, 1982; Day, 1999; Kwan *et al.*, 2019). Consequently, muscle responses can be detected in balance related muscles while standing and walking (Ali *et al.*, 2003; Dakin *et al.*, 2010; Guillaud *et al.*, 2020; Magnani *et al.*,

2021). Studies have revealed that these muscle responses are frequency, task, and muscle

specific (Dakin *et al.*, 2010; Forbes *et al.*, 2013).

While the responses of lower limb muscles to vestibular stimulation during walking have

been extensively investigated (Forbes *et al.*, 2013; Magnani *et al.*, 2021), little attention has

been given to the trunk muscle responses to EVS, despite the fact that the upper body

represents approximately 50% of the total body mass (de Leva, 1996). In the study of gait,

most attention has been devoted to the control of the legs, whereas body parts above the

hips are commonly considered as a single rigid head-arm-trunk segment. However, in terms

of maintaining stability, the trunk may play a significant role, as even a tiny deviation from

the perfect upright position can produce a substantial destabilizing moment (Bruijn & van

Dieen, 2018). Additionally, the trunk may be crucial when employing the counter-rotation

mechanism for stabilization (Hof, 2007).

A narrow step width, which reduces the base of support, poses greater challenges to

stability and, as such, increases the demands on postural control (Arvin *et al.*, 2016;

Magnani *et al.*, 2023). A previous study demonstrated that vestibular contributions are

modulated by the stabilization demands of walking (Magnani *et al.*, 2021). This study

showed an increased coherence between EVS and ground reaction force during walking

with narrow steps but decreased EVS-ground reaction force coherence during walking with

wider steps. Though the coherence between EVS and EMG of lower limb muscles remained

unchanged or decreased, the EVS-EMG coherence increased in the paraspinal muscles at

the lumbar region when walking with a narrow step width (Magnani *et al.*, 2021). Overall,

these findings indicate the importance of coupling between vestibular signals and paraspinal

muscles in controlling stability during walking. However, while this previous study did look

at the paraspinal muscles, it only studied the paraspinal muscles at one vertebral level of

the trunk. It is therefore unknown if, and how, paraspinal muscles at other vertebral levels

are involved in the control of gait stability.

Our research question was: If and how do paraspinal muscles at different vertebral levels

respond to electrical vestibular stimulation throughout the gait cycle? Furthermore, we

tested if these vestibular contributions varied with step width. Based on previous studies

(Forbes *et al.*, 2013; Magnani *et al.*, 2021), we hypothesized that: 1) paraspinal muscle show

activity coherent with EVS at specific phases of the gait cycle, specifically at heel strike; 2)

the EVS-evoked muscles responses increase when walking with narrow step widths. To test

our hypotheses, we characterized the coherence, gain and delay of EMG-electrical

vestibular stimulation response in paraspinal muscle during walking with both preferred

step width and narrow step width. Paraspinal muscles from cervical to lumbar vertebral

levels were studied.

Methods

Ethical Approval

The study conformed to the standards set by the Declaration of Helsinki, except for

registration in a database. Procedures had been approved by the VU Amsterdam Research

Ethics Committee VCWE-2022-126.

Participants

Sixteen healthy participants (7 male, 9 female) between the ages of 19 and 29 years were

recruited (Age: 23.5 ± 3.4 years, height: 1.71 ± 0.07 m, weight: 64.5 ± 13.2 kg). Exclusion

criteria for participation included any diagnosed orthopaedic or neurological disorders, or

the use of medications that can cause dizziness. Participants were instructed not to engage

in intense physical exercise and to refrain from alcohol consumption 24 hours prior to the

experiment. Two participants were excluded during data analysis due to technical problems

in the signal synchronization between devices. The participants agreed to participate in the

study by signing an informed consent form.

Electrical Vestibular Stimulation

Continuous EVS was applied in a bipolar configuration. The EVS was delivered as an

analogue signal via a digital-to-analogue converter (National Instruments Corp., Austin, USA)

to an isolated constant-current stimulator (BIOPAC System Inc., Goleta, USA) that was

connected to carbon rubber electrodes (9 cm²). The two electrodes were coated with

electrode gel (SonoGel, Bad Camberg, Germany) and placed over the mastoid processes,

fixed tightly with hypoallergenic tapes and an elastic head band (Figure 1A).

All participants were exposed to the same zero-mean stochastic EVS signal, which was a

white noise generated in Matlab (2019a, The MathWorks, Natick, US) with a bandwidth

from 0 to 25 Hz, peak amplitude of ± 5.0 mA, root mean square of ~1.2 mA, and duration

of 8 minutes (Figure 1B & 1C). These signal characteristics were identical to those used

previously (Magnani *et al.*, 2021; Magnani *et al.*, 2023), in which measurable responses to

EVS in muscle activity, ground reaction force and foot placement were reported,

demonstrating the effectiveness of this EVS protocol.

Electromyography and Ground Reaction Force Measurement

Bipolar surface electromyography (EMG) was recorded by a 64-channel REFA amplifier

(TMSi, Oldenzaal, The Netherlands; CMRR: > 90 dB; Input impedance: > 100 MΩ; Gain:

26.55), bilaterally from the paraspinal muscles at 2048 samples/s using disposable self-

adhesive Ag/AgCl surface electrodes (Ambu blue sensor, Ballerup, Denmark). EMG was

recorded from paraspinal muscles at eight vertebral levels, including the seventh

cervical vertebra (C7), the third, fifth, seventh, nineth and twelfth thoracic vertebra (T3, T5,

T7, T9, T12) and the second and fourth lumbar vertebra (L2, L4). After shaving, lightly

abrading, and cleaning the skin with alcohol, electrodes were placed 2 to 3 cm lateral to the

mid-sagittal line, defined by the spinous processes (Figure 1A). A reference electrode was

placed over the bony part of the acromion process.

Ground reaction forces (GRF) were measured at a sampling rate of 1000 Hz by force plates,

which were built-in the split-belt treadmill (ForceLink b.v., Culemborg, the Netherlands). The

force plate data were used to identify heel-strike. Kinematic data were recorded using a 3D

motion capture system (Northern Digital Inc, Waterloo Ont, Canada), sampling at 50

samples/s, to calculate the step widths and the variability of head and thorax rotation.

Figure 1. Experimental Setup.

(A) The locations of the EVS electrodes (black squares) over the mastoid process, and paired

EMG electrodes (blue dots) over the paraspinal muscles at eight vertebral levels from top to

bottom: C7, T3, T5, T7, T9, T12, L2 and L4. EMG electrodes were placed 2 to 3 cm lateral to

the mid-sagittal line defined by the spinous processes. (B) Time series of the electrical

vestibular stimulation signal, zoomed in to a window of 5 seconds. (C) The power spectral

density of the electrical vestibular stimulation signal.

Protocol

Prior to the start of the experiment, participants were asked to walk on the dual-belt

treadmill at a speed of 2.8 km/h without EVS for 3 minutes to measure their preferred step

widths (PSW). For familiarization, participants were exposed to vestibular stimulation in a

three-minutes-walk at 2.8 km/h. In addition, they were instructed to time their steps to the

beat of a metronome at 78 steps/min.

For the experiment, participants walked on the dual-belt treadmill at 2.8 km/h with a

cadence of 78 steps/min for 8 minutes. Walking speed and cadence were chosen to

replicate the conditions of Magnani et al. (2021). The conditions were defined by the

presence of EVS (EVS and no-EVS), by the step width (preferred step width: PSW and narrow

step width: NSW) and by head orientation (facing forward and facing sideways). Participants

were instructed to face forward in all conditions except in head sideways condition. Data

from head sideways condition were not used in the current study. NSW was defined as 50%

of PSW. To impose step width, two lines were projected on the treadmill, symmetrical to its

midline. Participants were instructed to align the middle of their shoes with these lines and

to check the line with peripheral vision (Arvin *et al.*, 2016). The order of the conditions was

randomized for each participant. Throughout the conditions, participants received repeated

verbal instruction to maintain their cadence and step width. Before each condition,

participants were given sufficient time to rest, followed by 2 min walking without vestibular

stimulation before data collection, to avoid acclimatization and/or habituation effects.

Signal Analysis

The electromyography, force plate and vestibular stimulation signals were first synchronized

based on the trigger signals. Subsequently, EMG signals (2048 Hz) were resampled to 1000

Hz, aligned with the sampling rate of the force plate and EVS signals. Time instances of heel

strikes were calculated from force plate data from the characteristic "butterfly pattern" of

the centre of pressure (Roerdink *et al.*, 2008). To test if, and how well participants were able

to execute the task of controlling step widths and cadence, the mean step width of each

participant was calculated as the mediolateral distance between the second toe tip markers

during heel strikes. The cadence was calculated from the time between subsequent heel

strikes of the same leg.

To investigate the effects of EVS on stability control, the variability of head and thorax

rotation in the global coordinate system was calculated. The global coordinate system was

defined as positive y-axis forward, positive x laterally to the right, positive z-axis vertically

upward. Time series of thorax and head orientation were calculated using Euler

decomposition (y-x-z sequence). The variability of rotation was calculated as the standard

deviation of the orientation angle over gait cycles at each normalized time point,

subsequently averaged across the gait cycle for each participant.

The vestibular stimulation caused artifacts in the EMG signals, particularly when recording

from the cervical and upper thoracic region (Ali *et al.*, 2003). To assess how to remove these

artifacts, we compared the power spectral density of filtered EMG signals and the EVS-EMG

coherence after filtering with different cut-off frequencies (30, 40, 50, 60, 70, 80, 90, 100

and 110 Hz) (Forbes et al., 2013). In the end, the bipolar EMG signals were high-pass filtered

with a 6th order, Butterworth high-pass filter with a cut-off frequency of 100 Hz, in line with

previous literature (Blouin et al., 2011; Forbes et al., 2013). Filtered EMG signals were

rectified and normalized to the maximum amplitude of EMG from the averaged gait cycle in

the No-EVS-PSW condition for each vertebral level and participant.

Estimates of coherence, gain and phase were based on the continuous Morlet wavelet

decomposition (Blouin *et al.*, 2011). Before calculating the auto- and cross-spectra, EVS and

normalized EMG signals were first sectioned into strides based on the right heel strikes. To

avoid distortion in the coherence and gain calculation at either the beginning or the end of

the signals, each stride was padded with data from the previous (50%) and subsequent (50%)

strides. Time-frequency coherence, $Coh(\tau, f)$, was computed to measure the linear

relationship between the EVS and EMG signals across the frequencies considered as:

$$Coh(\tau, f) = \frac{\left| CSD_{xy}(\tau, f) \right|^2}{PSD_{xx}(\tau, f)\ PSD_{yy}(\tau, f)}$$

Where τ and f denote the stride time and frequency, $CSD_{xy}(\tau, f)$ refers to the time-

frequency cross-spectra between EVS and normalized EMG. $PSD_{xx}(\tau, f)$ and $PSD_{yy}(\tau, f)$

are the time-frequency auto-spectra of EVS and EMG, respectively. To account for the

variability of stride duration, time was normalized by resampling the CSD_{xy}, $PSD_{xx}(\tau, f)$

and $PSD_{yy}(\tau, f)$ to 1000 samples per stride cycle. Coherence, which is unitless, ranges from

0 to 1, with 0 indicating independence and 1 indicating a perfect linear relationship between

the two signals. Under the hypothesis that the stimulation signal and output signal are

independent, the distribution of coherence estimate can be written as (Zhan *et al.*, 2006):

$$P(R^2 \leq r) = 1 - (1 - r)^{K-1}, 0 \leq r \leq 1$$

where $P(R^2 \leq r)$ denotes the probability of coherence (R^2) less than the detection

threshold (r) and K is the number of strides for each participant. For a 99% confidence

interval, corresponding to $p < 0.01$, the threshold of coherence estimate is 0.015 with K as

300 strides, which was the minimum number of strides across all subjects.

To study the magnitude and timing of the output EMG relative to the input EVS, gain and

phase estimates were calculated from the frequency response function (FRF), defined as:

$$FRF(\tau, f) = \frac{CSD_{xy}(\tau, f)}{PSD_{xx}(\tau, f)}$$

Where $FRF(\tau, f)$ indicates the time-frequency frequency response function. The FRF is a

complex function, the modulus of which represents the gain (1/milliampere, mA^{-1}), and the

angle indicates the phase estimate (radian, rad). Since the gain and phase are not

interpretable when the coherence between input and output is weak, we only used the

phase and gain where the coherence reached its peak. The peak time-frequency coherence

was defined as follows: first, the non-significant coherence estimates were removed for

each participant and each vertebral level. The peak coherence was defined as the range of

frequencies and gait phases where the coherence was larger than 99% of the remaining

(significant) coherence estimates. Time-frequency phase estimates were then exacted from

the region of peak coherence and transformed into time lags (millisecond, ms).

Subsequently, the gain and delay were defined as the median of the gains and time lags

across the frequencies and gait phases at peak coherence for each vertebral level and each

participant. Gain and delay estimates from the left and right recording sites at the same

vertebral level were averaged.

Statistical Analysis

For the behavioural measures (i.e. step width, cadence, variability of head and thorax

rotations), repeated-measures ANOVAs with two factors: Step width (preferred step width

and narrow step width) × the Presence of EVS (with EVS and without EVS) were performed.

To test the difference in muscle activity, repeated-measures analysis of ANOVAs with two

factors: Step width (preferred step width and narrow step width) × the Presence of EVS

(with EVS and without EVS) was performed via one-dimensional Statistical Parametric

Mapping ((Pataky *et al.*, 2016)). To identify the most prominent effects of step width and

the electrical vestibular stimulation to muscle activity, significance was set as p value < 0.01.

As the coherence ranges from 0 to 1, the modified Fisher-Z transform was applied on

coherence before statistical analysis. For each participant, coherence exceeding 0.015, (i.e.,

p < 0.01), was defined as significant. To identify whether the paraspinal muscle responses

significantly differed between step widths we performed cluster-based permutation tests

(paired t-tests, 2000 permutations) on coherence in two step width conditions (Maris *et al.*,

2007). To identify whether there was habituation to the effects of EVS, we performed

cluster-based permutation tests (paired t-tests, 2000 permutations) on coherence in the

first 50 gait cycles versus the last 50 gait cycles in both step width conditions. To test the

differences in delays and gains, repeated-measures analysis of ANOVAs with two factors:

Vertebral level (eight vertebral levels) × Step width (preferred step width and narrow step

width) was performed. The assumption of sphericity for repeated-measures ANOVAs was

verified by Mauchly's Test (p > 0.05). Greenhouse-Geisser correction was applied when the

assumption of sphericity was rejected. A Bonferroni correction was applied for the post hoc

tests. Significance was set at $p < 0.05$ for the statistical tests. Statistical analyses were

performed in MATLAB (2019a, The MathWorks, Natick, US).

Results

Effects of EVS and Step Width on Gait Parameters

Although step width during walking with narrow step width (NSW) was not halved when

compared to walking with preferred step width (PSW), it was significantly smaller than

during walking with preferred step width (N = 14, $F_{(0.520, 6.760)}$ = 131.600, $p < 0.001$)

(Figure 2A). This difference was observed both when walking with EVS (N = 14, $p < 0.001$)

and without EVS (N = 14, $p < 0.001$), as confirmed by post hoc testing. EVS evoked a

significant increase in step width (N = 14, $F_{(0.520, 6.760)}$ = 8.176, $p = 0.013$) when walking

with preferred step width (N = 14, $p = 0.038$) and with narrow step width (N = 14, $p = 0.016$).

No significant interaction between Step width and the Presence of EVS was found (N =14, F

$_{(0.520, 6.760)}$ = 0.112, $p = 0.742$).

When walking without EVS, participants maintained their cadence as instructed (78

steps/min) with preferred step width (78.568 ± 1.202 steps/min) and narrow step width

(78.647 ± 1.400 steps/min). However, in both conditions, EVS evoked a significant increase

in cadence (N = 14, $F_{(0.592, 7.690)}$ = 11.043, $p = 0.005$) (Figure 2B). Post hoc testing

indicated that the difference was significant both when walking with preferred step width

(N = 14, $p = 0.011$) and with narrow step width (N = 14, $p = 0.010$). Step width (N =14, F

$_{(0.592, 7.690)}$ = 0.385, $p = 0.545$) and the Step width × the Presence of EVS interaction (N

=14, $F_{(0.592, 7.690)}$ = 1.438, $p = 0.314$) showed no significant effect on cadence.

Figure 2. (A) Step Width and (B) Cadence.

The X-axis indicate the step width conditions. The Y-axis represents the magnitude of step width (m) in panel A and cadence (steps/min) in panel B during walking with EVS (red box) and without EVS (blue box). Within each box, the central mark indicates the median, and the bottom and top edges indicate the 25th and 75th percentiles, respectively. The red '+' symbols represent the outliers, and the whiskers extend to the maximum and minimum values, excluding the outliers

Effects of EVS and Step Width on Posture Control

Step width and the Presence of EVS showed a significant interaction effect on the head rotation variability (N = 14, $F_{(0.849, 11.034)}$ = 6.127, p = 0.028), while step width had a significant main effect on the head rotation variability in roll as well (N =14, $F_{(0.849, 11.034)}$ = 7.724, p = 0.016), but no significant effect was evoked by EVS (N =14, $F_{(0.849, 11.034)}$ = 2.712, p = 0.124) (Figure 3A). Post hoc testing indicated that when walking without EVS, narrow step width caused a significant decline in head rotation variability (1.236 ± 0.362 degree) compared to preferred step width (1.488 ± 0.532 degree) (N = 14, p = 0.008). In addition, a significant decrease in head rotation variability in roll was evoked by EVS when walking with preferred step width (N = 14, p = 0.014).

In contrast, no significant effect of step width on thorax rotation variability in roll was found (N = 14, $F_{(0.481, 6.256)}$ = 0.877, p = 0.366) (Figure 3B). However, the presence of EVS (N = 14, $F_{(0.481, 6.256)}$ = 19.579, p < 0.001) and Step width × Presence of EVS interaction (N = 14, $F_{(0.481, 6.256)}$ = 6.948, p = 0.021) showed significant effects on thorax rotation variability in roll. Based on post hoc testing, the exposure to EVS evoked a significant increase in thorax rotation variability in roll both when walking with preferred step width (N = 14, p = 0.004) and with narrow step width (N = 14, p < 0.001). When walking without EVS, thorax rotation variability was significantly larger in walking with preferred step width than narrow step width (N = 14, p = 0.005).

 Figure 3. Variability of Head and Thorax Rotation in Two Step Width Conditions.

The X-axis indicate the step width conditions. The Y-axis represents the variability of head

rotation (degree) in panel A and thorax rotation (degree) in panel B during walking with EVS

(red box) and without EVS (blue box).Within each box, the centre mark indicates the median,

and the bottom and top edges indicate the 25th and 75th percentiles, respectively. The

whiskers extend to the maximum and minimum values, excluding the outliers.

Paraspinal Muscles Activity During Walking in Two Step Widths Conditions

Normalized muscle activity recorded from the paraspinal muscles at eight vertebral levels

(C7, T3, T5, T7, T9, T12, L2, L4, bilaterally) during walking with and without electrical

vestibular stimulation (EVS) with preferred step widths (PSW) and narrow step widths (NSW)

is illustrated in Figure 4. At higher vertebral levels, including C7, T3, T5, T7 and T9, peaks

occurred just after the contralateral heel strikes. At lower vertebral levels (T12, L2 and L4),

muscle activity demonstrated two peaks occurring just after both ipsilateral and

contralateral heel strikes.

Comparing the muscle activity in walking, the One-dimensional Statistical Parametric

Mapping based repeated-measures ANOVA with two factors: Step width (preferred step

width and narrow step width) × the Presence of EVS (with EVS and without EVS, featured

supra-threshold clusters for the main effect 'the Presence of EVS' at the lower vertebral

levels around ipsilateral heel strikes. For instance, at the left side of T12 at 47% gait cycles (p

= 0.010), at the right side of T12 from 96 to 98% (p = 0.008), at the left side of L2 from 44 to

47% (p = 0.005), etc (Table 1). And there was a smaller region with a significant effect of

'Step width' at the right L2 and L4 vertebral levels, e.g., at around 7% of gait cycles (L2: p =

0.009; L4: p = 0.010). No significant interactions of EVS and step width on muscle activity

were found.

A

Vertebral Level	Presence of EVS		Step Width	
	Phase (% gait cycles)	*p*-value	Phase (% gait cycles)	*p*-value
C7L	ns	ns	ns	ns
T3L	ns	ns	ns	ns
T5L	ns	ns	ns	ns
T7L	ns	ns	ns	ns
T9L	ns	ns	ns	ns
T12L	9%	0.009	ns	ns
	23~27%	0.003		
	47%	0.010		
L2L	29~31%	0.005	ns	ns
	44~47%	0.005		
L4L	6%	0.010	ns	ns
	8~12%	0.008		
	30~31%	0.009		
	39~48%	<0.001		
	60~62%	0.006		
	82~88%	<0.001		

B

Vertebral Level	Presence of EVS		Step Width	
	Phase (% gait cycles)	*p*-value	Phase (% gait cycles)	*p*-value
C7R	4~5 %	0.006	ns	ns
	56~58%	0.003		
	63%	0.010		
T3R	ns	ns	ns	ns
T5R	6%	0.010	ns	ns
T7R	49%	0.010	ns	ns
T9R	96%	0.010	ns	ns
T12R	58~60%	0.007	ns	ns
	66~68%	0.005		
	96~98%	0.008		
L2R	10~11%	0.007	7%	0.009
	16%	0.010		
	29%	0.010		
L4R	12~15%	0.005	4~6%	0.008
	22%	0.009	7%	0.010
	25%	0.009		
	27%	0.010		
	39~41%	0.008		
	58%	0.010		

Table 1. Summary of the effect of EVS and Step Width on Muscle Activity at Eight Vertebral Levels on the Left (A) and Right Side (B) Relative to the Midline of Trunk.
Results from the One-dimensional Statistical Parametric Mapping based repeated-measures two-ways ANOVAs. The *p*-value indicates the probability that a suprathreshold cluster of the same spatiotemporal extent could have resulted from a random field process of the same smoothness as the observed residuals.

 Figure 4. Paraspinal Muscle Activity Throughout the Gait Cycle.

Averaged EMG linear envelopes of paraspinal muscles at all investigated vertebral levels

during walking with EVS at preferred step width without EVS (Green), preferred step width

with EVS (Blue), narrow step width without EVS (Orange) and narrow step width with EVS

(Red). The X-axis indicates the time (normalized to gait cycle, starting at the right heel strike).

The Y-axis presents the amplitude of the normalized EMG. The lines and shadowed areas

represent the means and standard deviations across participants, respectively. The left and

right columns depict recorded sites at the left and right side relative to the midline of the

trunk. From top to bottom rows, the EMG of paraspinal muscles at eight vertebral levels are

displayed as: C7, T3, T5, T7, T9, T12, L2 and L4.

EVS-EMG Coherence During Walking with Preferred Step Width

Significant EVS-EMG coupling, defined as coherence over 0.015, was observed in all recorded sites when walking with preferred step width. But differences between vertebral levels as to when, and in which frequency band this coherence occurred were found (Figure 5).

Phase-specific EVS-EMG coherence was roughly mirrored in the left and right relative to the midline of trunk, i.e., phase shifted by about half a gait cycle. Cluster-based permutation paired t-test showed no significant differences between coherence on the left and right side when they were shifted by half a gait cycle.

At vertebral levels from T12 to L4, peak coherence occurred around the ipsilateral heel strikes. At T7 and T9, peak coherence occurred before both ipsilateral and contralateral heel strikes. At vertebral levels from T3 to T5, peak coherence occurred around the contralateral heel strikes. At C7 level, coupling between EVS and EMG was almost continuously present, without distinct peaks, albeit at an overall lower magnitude. Overall, the phase-specific responses at the higher and lower vertebral levels were also mirrored, such that at lower levels a peak occurred at ipsilateral heel strike, while at higher levels, it occurred at contralateral heel strike.

Additionally, responses occurred earlier in the gait cycle at the higher vertebral levels compared to the lower levels. The magnitude of coherence was higher at the lower vertebral levels. Peak coherence aligned with one of the peaks in muscle activity at the lower vertebral levels (i.e., ipsilateral heel strike), and with the only peak, at contralateral heel strikes, for the higher vertebral levels. Moreover, coherence calculated from the last 50 gait cycles was on average lower than those calculated from the first 50 gait cycles. However, this difference was not significant.

PSW

Figure 5. EVS-EMG Coherence Throughout the Gait Cycle During Walking with Preferred

Step Width.

Coherence between EVS and EMG of paraspinal muscles at C7, T3, T5, T7, T9, T12, L2 and L4

levels (from top to bottom) during walking with preferred step widths while exposed to EVS.

The left and right columns represent the recorded sites at the left and right side relative to

the mid-line of the trunk. The X-axis is the time (normalized to gait cycle, starting at the right

heel strike). The Y-axis is the frequency range (from 1Hz to 25 Hz). Coherence amplitude is

indicated by the colour bar. For illustrative purposes, only coherence above 0.015 are

presented.

EVS-EMG Coherence During Walking with Narrow Step Width

To address our hypothesis that the magnitude of coupling between EVS and EMG during

walking with narrow step width is larger than walking with preferred step width, the

differences in EVS-EMG coherence between walking with preferred step width (PSW) and

walking with narrow step width (NSW) were examined (Figure 6B).

At the majority of vertebral levels, during most of the phases in the gait cycle, EVS-EMG

coupling during walking with a narrow step width was slightly, but not significantly, higher

than that during walking with preferred step width (Figure 6A). The greatest differences

were observed at the instants around the peak coherence in normal walking. Interestingly,

at the L4 level on both sides, there was a decrease in coherence when walking with a

narrow step width, around the contralateral heel strikes, but again this was not significant.

Similar as when walking with preferred step width, a nonsignificant decreased coherence

was found in the last 50 gait cycles compared to the first 50 gait cycles.

Figure 6. EVS-EMG Coherence in NSW and Effects of Step Width.

(A) The coherence between EVS and EMG when walking with narrow step width (NSW); (B) The difference in coherence between walking with narrow step widths and preferred step width (NSW - PSW). Figures from top to bottom rows present the results at eight vertebral levels. The left or right columns represent the recorded sites at the left or right side relative to the mid-sagittal line of trunk. The X-axis is the time (normalized to gait cycle, starting at the right heel strike). The Y-axis is the frequency range (from 1Hz to 25 Hz). The magnitudes of coherence in NSW (A) and the difference of coherence between NSW and PSW (B) are indicated by the colour bar.

Gain and Delay Estimates Between EVS and EMG

No significant effects on gains of either Vertebral level (F (1.127, 30.429) = 1.641, p = 0.201),

Condition (F (0.161, 4.347) = 0.744, p = 0. 396), or their interaction (F (1.127, 30.429) = 1.736,

p = 0. 147) were found (Figure 7A).

After Greenhouse-Geisser correction, no significant effects on delays of Vertebral level (F

(2.415, 65.205) = 2.171, p = 0.087), Condition (F (0.161, 9.315) = 1.162, p = 0.291), or

Vertebral level x Condition interaction (F (2.415, 65.205) = 1.638, p = 0.177) were found

(Figure 7B).

Figure 7. Gain(A) and Delay (B) Estimates Between EVS and EMG

The Y-axis represents vertebral levels (C7, T3, T5, T7, T9, T12, L2 and L4). In panel A, the X-

axis represents the magnitude of the gain (mA^{-1}) between EVS and EMG during walking with

preferred (red box) and narrow step widths (blue box). In Panel B, the X-axis represents the

delay (ms) between EVS and EMG. Within each box, the central mark indicates the median,

and the bottom and top edges indicate the 25th and 75th percentiles, respectively. The red

'+' symbols represent the outliers, and the whiskers extend to the maximum and minimum

values, excluding the outliers.

Discussion

We used electrical vestibular stimulation (EVS) and EMG to investigate the coupling of vestibular afference to paraspinal muscles activity at different vertebral levels. The Presence of EVS induced a significant increase in muscle activity at the lower vertebral levels around ipsilateral heel strikes, while the Step Width evoked a significant increase at the right L2 and L4 vertebral levels. EVS evoked significant increase in both step width and cadence. Variability of thorax roll significantly increased when walking with EVS with both step width conditions, while the variability of head rotation significantly decreased during walking with EVS with preferred step width. Significant coherence between the input EVS signal and output paraspinal muscle EMG, from cervical to lumbar vertebral levels, was found at ipsilateral and/or contralateral heel strikes. This coupling between EVS and EMG was roughly mirrored between the left and right body sides, i.e., phase shifted about half a gait cycle. Between the higher and lower vertebral levels, the coupling was also mirrored, such that a peak coherence occurred at ipsilateral heel strike at lower vertebral levels, while at higher levels it occurred at contralateral heel strike. EVS-EMG coupling only partially coincided with the peak muscle activity. Small but non-significant increases were found in EVS-EMG coupling during walking with narrow step widths. A non-significant reduction in EVS-EMG coherence in the last 50 gait cycles compared to the first 50 gait cycles was found for walking with preferred and narrow step widths. Below, we discuss how these findings advance our understanding of the contribution of the vestibular system to the control of paraspinal muscles.

Attenuated EVS-EMG Coherence through Habituation

Non-significant attenuation in EVS-EMG coherence was found in both step width conditions. To ascertain that attenuation had no effects on our main findings, we compared the coherence in the two step width conditions in the first 50 gait cycles, which also showed no significant difference in EVS-EMG.

Attenuation in coherence over time is in line with the literature. For example, the gain

between sinusoidal EVS and centre of pressure movement declined over a five-minutes

standing trial (Balter *et al.*, 2004). Hannan et al. reported that in standing, the gain between

stochastic EVS to GRF decreased about 18% in the first 40 seconds, while over a one-hour

walking trial, the gain decreased by roughly 38% and the coherence decreased from 0.04 to

0.02 (Hannan *et al.*, 2021). Such a reduction in evoked responses has been attributed to

habituation (Balter *et al.*, 2004; Hannan *et al.*, 2021). It is believed that the nervous system

can down-weight the sensory cues offering irrelevant or erroneous information, and up-

weight alternative sources of sensory information, known as 'sensory reweighting' (Balter *et*

al., 2004; Hannan *et al.*, 2021). As a result, the induced response to an EVS stimulus will

decrease over time.

The Contribution of The Vestibular System to Paraspinal Muscle Activity

In line with previous study, muscle activity at the lower vertebral levels significantly

increased induced by both the presence of stimulation and the narrowing the step width

(Guillaud *et al.*, 2020; Magnani *et al.*, 2021). Similar to previous studies, paraspinal muscles

showed peak activity around both heel strikes at the lower vertebral levels (Ivanenko *et al.*,

2004; de Seze *et al.*, 2008; Guillaud *et al.*, 2020; Magnani *et al.*, 2021) and only a single peak

at contralateral heel strikes at the higher vertebral levels (Ivanenko *et al.*, 2006). However,

at the higher spinal levels, de Seze et al (2008) reported a double-peaked pattern with a

relatively smaller magnitude at ipsilateral heel strike. The difference in peak muscle activity

at higher vertebral levels could be attributed to the lower walking speed in our study (2.8

km/h) as compared to the study of de Seze et al (2008) at 5 km/h, since the trunk muscle

activity increases with walking speed (Callaghan *et al.*, 1999; Anders *et al.*, 2007).

At the higher vertebral levels, we found the EVS-EMG coupling partially aligned with the

only peak in EMG in the gait cycle at contralateral heel strike. At the lower vertebral levels,

we found that the peak EVS-EMG coupling partially aligned with the peak muscle activity at

ipsilateral heel strike. At the contralateral heel strike, no significant EVS-EMG coupling was

observed, in spite of the peak in muscle activity. This indicates that high motoneuron

excitability does not necessarily cause strong effects of vestibular input. Other studies also

reported that peak coherences do not always align with peak EMG for a range of muscles

(Dakin *et al.*, 2013; Forbes *et al.*, 2017; Magnani *et al.*, 2021). Partial alignment between

EVS-EMG coupling and muscle activity was demonstrated in the Gastrocnemius muscle

where the increase in coherence paralleled the increase in muscle activity but peaked

slightly earlier in the gait cycle than the muscle activity (Blouin *et al.*, 2011).

At the lumbar vertebral levels, the difference in EVS-EMG coupling between ipsilateral and

contralateral heel strikes might be explained by the functional differences of the two peak

activities at these phases of the gait cycle. At lumbar levels, the activations were described

as an eccentric contraction at contralateral heel strikes, and a concentric contraction at the

ipsilateral heel strikes (Shiavi, 1985; Anders *et al.*, 2007). Our results shows that only the

activity at ipsilateral heel strikes of the lumbar paraspinal muscles was affected by vestibular

input, which may signify its role in stabilizing the trunk over the new stance leg.

Vertebral Level Specific Response to EVS

In contrast to the expectation that, given a longer efferent pathway, the response delays

would increase from the higher to lower vertebral levels, we found no significant differences

in delays between the vertebral levels. This is consistent with a previous study addressing

paraspinal muscles from T7 to L4 (Guillaud *et al.*, 2020). However, we found differences in

the phases, in which EVS-EMG coherence occurred between vertebral levels. This indicates

that the modulation of paraspinal muscles activity based on vestibular afference is different

between vertebral levels. This vertebral level specific modulation may reflect differences in

vestibulospinal tracts transmitting the signals to motoneurons between vertebral levels

(Wilson & Yoshida, 1969; Wilson *et al.*, 1970; Wilson *et al.*, 1995; Kasumacic *et al.*, 2010).

Using selective lesions in the brainstem and/or spinal cord in neonatal mice, Kasumacic et al

(2010) showed that the vestibular inputs to motoneurons at the upper cervical levels

primarily derive from the medial vestibulospinal tracts, while at lower cervical levels, there

was a substantial contribution from the lateral vestibulospinal tract. This may potentially

explain the constant EVS-EMG coupling at C7 level in our study, which was different from

the distinctly phasic responses at the other vertebral levels. The continuous coupling at C7

may be related to head stabilization, an important function of the medial vestibulospinal

tracts (Goldberg & Cullen, 2011). At the lumbar levels in mice, vestibular input solely came

from the lateral vestibulospinal tracts (Kasumacic *et al.*, 2010). At thoracic levels, early

vestibular inputs originated from the lateral vestibulospinal tract, with later inputs

potentially transmitted by midline-crossing motoneuron dendrites and/or excitatory

commissural interneurons (Kasumacic *et al.*, 2010). Transmission of vestibular signals by

different tracts might be expected to cause a difference in response delays. However, the

faster conduction velocity (90 m/sec) of the longer lateral-vestibulospinal tract and a slower

conduction velocity (60 m/sec) of medial vestibulospinal tract (Peterson *et al.*, 1978) may

result in a similar delay and synchronized modulation of paraspinal muscle activity at

different vertebral levels as a consequence.

Interestingly, we found that coherent responses at the upper and lower vertebral levels

were mirrored, that is to say; at the lower levels, coherence was present around ipsilateral

heel strike, while at the higher levels, it was present around contralateral heel strike. From a

biomechanical point of view, this spatial pattern of vestibular induced activation could

ensure maintenance of head orientation in space, while moving the trunk to correct a

deviation of the centre of mass. To be more specific, a left displacement of the centre of

mass could be counteracted by the contraction of left lumbar muscles. To maintain the head

orientation in space, cervical and upper thorax muscles activity at the right side would be

needed. These mirrored responses between upper-ipsilateral and lower-contralateral

muscles to the vestibular signals have also been observed in mice (Kasumacic *et al.*, 2010).

After ipsilateral hemi-sections of the spinal cord at C1 level in mice, the responses to

electrical stimulation in vestibulospinal motoneurons at the contralateral side were

completely eliminated at the thoracic and lumbar levels, while at the cervical level the

contralateral responses remained unaffected, but disappeared after contralateral hemi-

section, and vice versa (Kasumacic *et al.*, 2010). Furthermore, signals from the ipsilateral-

descending lateral vestibulospinal tract are transmitted to contralateral motoneurons by

descending commissural interneurons. These interneurons are more prevalent at the T7

level than at L1, L2 and L5 level (Kasumacic *et al.*, 2010; Kasumacic *et al.*, 2015). This finding

is in line with our observation that at T5 and T7 levels, the spatial pattern of EVS-EMG

coupling resembles a combination of those at higher thoracic and lumbar levels.

The Contribution of The Vestibular System to Gait and Postural Control

In line with a previous study, both step width and cadence significantly increased when

walking with EVS in both step width conditions (Magnani *et al.*, 2023). As reported

previously, in response to perturbations, participants decrease their step length and

increase their step width and cadence to maintain balance in the mediolateral direction

(Hak *et al.*, 2012).

The presence of EVS evoked opposite responses in head and thorax rotation variability, i.e.,

when walking with EVS with preferred step width, head rotation variability significantly

decreased while thorax rotation variability significantly increased. These results are in line

with an earlier study reporting increased averaged thorax rotation and decreased head

rotation in roll during walking evoked by electrical vestibular stimulation (Deshpande *et al.*,

2015). A possible reason for this might be that lumbar movements are elicited by EVS to

counteract illusory movements while during walking the head is stabilized in space. To do so,

a counter rotation at the thoracic or cervical levels is required. This is in line with the

continuous EVS-EMG coupling at the C7 level and the mirrored EVS-EMG coupling between

the thoracic and lumbar levels.

With restricted foot placement, more use of alternative strategies for balance control can

be expected, i.e., larger shifts of the centre of pressure under the foot through ankle

moments or larger changes in the body's angular momentum through segmental

movements relative to the body's centre of mass (Hof, 2007).The latter could be expected

to involve increased trunk and head roll movement. However, we found overall less thorax

roll variability in the narrow than preferred step width conditions. This suggests that the

contribution of upper body rotations to balance control is limited during narrow base

walking. With the relatively narrow base of support provided by the narrow step width,

trunk rotations might lead to instability. Thus, controlling the centre of mass by shifting the

centre of pressure through ankle moments might be safer. This is in line with previous work

showing that if foot placement cannot be used for balance control due to foot placement

constraints, ankle moments are primarily used instead of angular momentum changes (van

Leeuwen et al., 2022).

Impact of Step Width on Vestibular Contributions

Surprisingly, our outcomes showed no statistically significant differences in EVS-EMG

coherence between walking at preferred and narrow step widths. In contrast, in an earlier

study, EVS-EMG coherence of the lumbar erector spinae muscle significantly increased

when walking with narrower step widths, while in medial gastrocnemius and gluteus medius

coherence decreased or remained unchanged, respectively (Magnani *et al.*, 2021). However,

we confirmed the hypothesis that EVS-evoked responses increase when walking with

narrow step widths by observing a significant increase in the coupling between EVS and the

horizontal ground reaction force in medial-lateral direction during mid-stance phase (Figure

9). This observation is consistent with Magnani et al. (2021).

The possible reasons of finding the opposite in EVS-EMG coherence can be: 1) the ground

reaction force is the summation of all muscle activity, it is reasonable to find the significant

difference in EVS-GRF coherence but not in paraspinal muscle EVS-EMG coherence; 2)

participants did not fully keep to our instructions of halving step width; 3) we did not ask

participants to walk with an upward head tilt of 18 degree as Magnani et al. (2021). Such a

posture maximizes the perception of head roll during EVS (Fitzpatrick & Day, 2004; St

George & Fitzpatrick, 2011; Magnani *et al.*, 2021). Since we imposed step width by lines

projected on the treadmill, it was impossible to keep this head orientation. Besides, this non

neutral posture can lead to a different trunk posture resulting in differences in trunk muscle

activity. Moreover, the tilted head posture can limit visual cues. Based on the theory of

sensory reweighting, vestibular information might have been up-weighted amplifying any

effects on EVS-EMG coherence.

Figure 8. EVS-GRF Coherence in NSW (A), PSW (B) and Effects of Step Width (C).

The coherence between EVS and GRF in medial-lateral (ML) when walking with narrow step width (NSW) (A) and preferred step width (PSW) (B); (C) The difference in coherence between walking with narrow step widths and preferred step width (NSW - PSW). The X-axis is the time, normalized to gait cycle, starting at the right heel strike. The Y-axis is the frequency range (from 1Hz to 25 Hz). The magnitudes of coherence in NSW (A), PSW (B) and the difference of coherence between NSW and PSW (C) are indicated by the colour bar. For illustrative purposes, only significant difference was plotted.

Limitations

One important limitation of this study is that currently there is no validated method to eliminate the artifacts of electrical stimulation from EMG signals. Although the filtered EMG still contains the timing information of activation in muscles evoked by stimulation (Forbes *et al.*, 2018), it is unclear how appropriate the filtering is. Filtering EMG data to remove the EVS artifacts will inevitably also remove EMG and while information on lower bandwidth changes in muscle force is largely maintained or even enhanced (Potvin & Brown, 2004), information on muscle activation in the frequency range of interest here may be lost due this procedure. In addition, rectification of the EMG signals may cause a nonlinear distortion (Neto & Christou, 2010; McClelland *et al.*, 2014), which may enhance (Ward *et al.*, 2013) or decrease coherence (Neto & Christou, 2010) or create false coherence in a frequency range where there is no input (Neto & Christou, 2010). Still, the application of filtering and rectification is reasonable in view of our primary interest in the modulation of muscle activation and coherence over the gait cycle (Myers *et al.*, 2003; Halliday & Farmer, 2010; van Asseldonk *et al.*, 2014; Jiang *et al.*, 2019). Nevertheless, finding an appropriate method for artifact removal may further strengthen our understanding of the electrical stimulus-response relationship.

Conclusion

We explored how vestibular signals influence paraspinal muscle activity at different vertebral levels in walking with preferred and narrow step width. EVS and the modulation of step with induced significant increase in muscle activity at the lower vertebral levels. Significant EVS-EMG coupling was observed at all recorded sites around the ipsilateral and/or contralateral heel strikes. This coupling was vertebral level specific and exhibited a mirrored pattern between the left and right side of the body, as well as between the higher and lower vertebral levels. In other words, at the same vertebral level, the coupling on the left side exhibited a phase shift of half a gait cycle compared to the right side. Along the vertebral levels, a peak occurred at ipsilateral heel strike at lower levels, while it occurred at the contralateral heel strike at higher levels. We found that the EVS-EMG coupling partially coincided with the peak muscle activity. No significant differences were found in gain and delay between either the vertebral levels or step width conditions. Significant increase was found in cadence and step width when walking with EVS in two step width conditions. EVS evoked opposite responses in head and thorax rotation, i.e., the head rotation variability significantly decreased while the thorax rotation variability significantly increased when walking with EVS with preferred step width. Vertebral level specific modulation of paraspinal muscle activity based on vestibular signals might allow a fast, synchronized, and spatially coordinated response along the trunk during walking.

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Additional information

Data Availability Statement

The original data are available from the corresponding author upon reasonable request.

Competing Interests

The authors declare that there are no conflicts of interest.

Author Contributions

Experiments were performed at the Dual Belt Lab in the Vrije Universiteit Amsterdam.

Conception and design: Y.C.L., S.M.B., K.K.L. and J.H.D. Data acquisition: Y.C.L. Analysis and

interpretation: Y.C.L., S.M.B., K.K.L., S.B. and J.H.D. Drafting and revising manuscript: Y.C.L.,

S.M.B., K.K.L., S.B. and J.H.D. All authors have read and approved the final version of this

manuscript and agree to be accountable for all aspects of the work in ensuring that

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investigated and resolved. All persons designated as authors qualify for authorship, and all

those who qualify for authorship are listed.

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