



# Variable heart rate and a flexible mind: Higher resting-state heart rate variability predicts better task-switching

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## Abstract

The neurovisceral integration model proposes that heart rate variability (HRV) is linked to prefrontal cortex activity via the vagus nerve, which connects the heart and the brain. HRV, an index of cardiac vagal tone, has been found to predict performance on several cognitive control tasks that rely on the prefrontal cortex. However, the link between HRV and the core cognitive control function “shifting” between tasks and mental sets is under-investigated. Therefore, the present study tested the neurovisceral integration model by examining, in 90 participants, the relationship between vagally mediated resting-state HRV and performance in a task-switching paradigm that provides a relatively process-pure measure of cognitive flexibility. As predicted, participants with higher resting-state HRV (indexed both by time domain and frequency domain measures) showed smaller switch costs (i.e., greater flexibility) than individuals with lower resting-state HRV. Our findings support the neurovisceral integration model and indicate that higher levels of vagally mediated resting-state HRV promote cognitive flexibility.

**Keywords** Cognitive control · Heart rate variability · RMSSD · HF · Task-switching paradigm · Cognitive flexibility · Cardiac vagal tone

## Introduction

The neurovisceral integration model (Thayer, Hansen, Saus-Rose, & Johnsen, 2009) proposes that individual differences in vagally mediated heart rate variability (vmHRV) may relate to differences in prefrontal cortex activity, as the heart and brain are connected via the vagus nerve. vmHRV, an indicator

of cardiac vagal tone, has been shown to predict performance on several cognitive control tasks that rely on the prefrontal cortex, a key area that drives cognitive control, i.e., the way we control our thoughts and goal-directed behavior (Miller, 2000). HRV is a measure of beat-to-beat temporal fluctuations in heart rate and it reflects autonomic control of the cardiovascular system (Pumprla, Howorka, Groves, Chester, & Nolan, 2002).

In brief, the neurovisceral integration model (Thayer & Lane, 2000; Thayer et al., 2009) proposes that the effective functioning of prefrontal-subcortical inhibitory circuits is crucial for self-regulation. These networks also provide inhibitory input to the heart via the vagus nerve (Levy, 1971; Benarroch, 1993; Ellis & Thayer, 2010). Several neuroimaging and pharmacological studies have shown a positive association between the activation of inhibitory prefrontal-subcortical circuits (including the ventromedial prefrontal cortex and anterior cingulate cortex) and cardiac vagal tone as reflected by resting vmHRV (Ahern et al., 2001; Lane et al., 2009; for a review, see Thayer et al., 2009). In line with these studies, Thayer, Åhs, Fredrikson, Sollers, and Wager (2012) have suggested that high resting-state vmHRV is associated with optimal functioning of prefrontal-subcortical inhibitory circuits that drive flexible and adaptive responses to environmental demands (Thayer & Lane, 2000; Thayer et al., 2009). To test

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the neurovisceral integration model (Thayer et al., 2009), the current study focused on the relationship between resting-state vmHRV and cognitive function. As a reliable index of resting-state vmHRV, we employed both time domain measures of HRV (as indexed by the root of mean squared successive differences in beat-to-beat-intervals; RMSSD) and frequency domain measures (as reflected by high -frequency changes in heart beat; HF). Both RMSSD and the HF component (0.15–0.40 Hz) of heart rate changes have been suggested as proxies of parasympathetic control and cardiac vagal tone (Task Force of the European Society of Cardiology and the North American Society of Pacing and Electrophysiology, 1996; Berntson et al., 1997). Whereas HF component indicates rapid changes in heart rate, the low-frequency component (LF; 0.04–0.15 Hz) refers to slower changes in heart rate and is unrelated to parasympathetic influence (Task Force of the European Society of Cardiology and the North American Society of Pacing and Electrophysiology, 1996; Berntson et al., 1997).

In a recent meta-analysis, Zahn, Adams, et al. (2016)<sup>1</sup> pointed out the positive relation between HRV and two core cognitive control functions: the inhibition of unwanted responses and the updating and monitoring of working memory (WM) representations. However, inhibitory control and the updating and monitoring of WM represent just two of a larger set of control functions. That is, findings by Miyake and colleagues suggest that, besides monitoring/updating and inhibition, a third function reflecting cognitive flexibility (i.e., the shifting between tasks and mental sets) can be identified (Friedman, Miyake, Corley, DeFries, & Hewitt, 2006; Miyake et al., 2000). So far, only three studies have investigated the link between vmHRV and cognitive flexibility (Zahn, Adams, et al., 2016). However, the three identified studies used a stochastic reversal learning task (Ohira et al., 2013), emotion regulation after mood induction (Volokhov & Demaree, 2010), and problem solving (as assessed by the Trail-making test, Gaebler, Daniels, Lamke, Fydrich, & Walter, 2013) to assess cognitive flexibility. Using a stochastic reversal learning task, no behavioral relationship with vmHRV (as indexed by HF) was found (Ohira et al., 2013). Concerning emotion regulation after mood induction, individuals with high baseline respiratory sinus arrhythmia (RSA; another marker of vmHRV (Yasuma & Hayano, 2004)) adopted reappraisal strategies more than those with low RSA (Volokhov & Demaree, 2010). Zahn, Adams, et al. (2016) classified reappraisal after mood induction as cognitive

flexibility, because reappraisal indicates a shift from the induced negative mood towards a more positive way of thinking. Lastly, patients suffering from social anxiety disorder showed a negative correlation between performance on the Trail-Making Test (part B) and vmHRV, indicating better flexibility for individuals displaying higher HF scores (Gaebler et al., 2013). Because these studies did not use reliable, process-pure measures of cognitive flexibility and employed different measures of vmHRV, further investigation is warranted.

Therefore, the goal of the current study is to examine the relationship between resting-state vmHRV (as indexed by RMSSD and HF) and performance in a task-switching paradigm that provides a relatively process-pure measure of cognitive flexibility (Monsell, 2003; Miyake et al., 2000). The amount of time required to switch between two different tasks has been considered to represent the efficiency in adapting and restructuring cognitive representations, such that smaller switch costs would indicate a higher level of cognitive flexibility. In this kind of paradigm, the switch between tasks is often regular and predictable (e.g., AABBAABB...). Consequently, participants know when to prepare for a task switch, so that the interval between the previous response and the upcoming stimulus (the response–stimulus interval or RSI) can be seen as a preparation interval. In switch trials participants usually make use of this preparation interval to reconfigure their cognitive task set. Hence, the shorter the interval the less likely this reconfiguration process will be finished before the stimulus is presented, which fits with the observation that switch costs (i.e., the increase in reaction time on task-switching trials relative to task-repetition trials) are more pronounced with short than with long RSIs (Monsell, 1996). In a nutshell, switch costs at a short RSI reflect a preparation component, whereas those observed at a long RSI relate to a residual component resulting from involuntary, presumably stimulus-triggered activation of the previous task set (Kiesel et al., 2010; Vandierendonck, Liefoghe, & Verbruggen, 2010). Although we expect resting-state vmHRV to positively predict the efficiency and speed of the task-switching process, this does not mean that individuals with low vmHRV would be entirely unable to switch. Instead, it is plausible to expect that the effect of vmHRV might be more evident for, and perhaps even limited to, the condition in which speed and efficiency really matter: when the RSI is short. In contrast, in the case of a long RSI, the time available to prepare for a task switch might be enough even for less efficient individuals (i.e., those displaying low resting-state vmHRV), so that the difference between high and low vmHRV individuals is smaller or even absent. Alternatively, given that (a) switch costs at long RSIs reflect stimulus-triggered interference (Kiesel et al., 2010; Vandierendonck et al., 2010) and that (b) vmHRV relates to inhibitory circuits in the PFC (Thayer & Lane, 2000; Thayer et al., 2009), it also

<sup>1</sup> Please keep in mind that Laborde & Mosley (Laborde & Mosley, 2016; but see Zahn, Wenzel, and Kubiak (2016) for a reply) pointed out the misleading focus of the meta-analysis, which (a) did not include markers exclusively related to vmHRV, (b) did not include studies related to HRV reactivity, and (c) did not point out that resting-state vagal tone and the outcome of a basic laboratory self-control task are likely unrelated if the measurements are realized at different time points.

might be that vmHRV predicts costs in the long RSI condition, because optimal inhibitory circuits might lessen the impact of stimulus-triggered interference.

Therefore, we expected a negative correlation between vmHRV (as indexed by both RMSSD and HF but not LF measures) and task-switching performance as indexed by switch costs. In other words, we expected individuals who have high vmHRV to demonstrate better task-switching than those who have low vmHRV in case of a short RSI (if the first hypothesis is correct) or at a long RSI as well (if the second hypothesis is correct). Furthermore, given that vmHRV is modulated by gender (Ryan, Goldberger, Pincus, Mietus, & Lipsitz, 1994; Sztajzel, Jung, & Bayes de Luna, 2008), body mass index (BMI; Karason, Mølgaard, Wikstrand, & Sjöström, 1999), anxiety (Thayer, Friedman, & Borkovec, 1996), stress (Dishman et al., 2000), smoking habits (Hayano et al., 1990), and heart rate (Gaşior, Sacha, Jeleń, Zieliński, & Przybylski, 2016), we measured and controlled for these factors in the current study.

## Methods

### Participants

Ninety Leiden University Caucasian undergraduate students participated in the study. Demographic statistics are provided in Table 1. Participants were recruited via an online recruiting system and were offered partial course credit for participating in a study on the relationship between HRV and cognitive processes. Participants were screened individually using the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998). The M.I.N.I. is a well-established brief diagnostic tool in clinical and stress research that screens for several psychiatric disorders and drug use, and it often is used in clinical and pharmacological research (Colzato, Szapora, Pannekoek, & Hommel, 2013; Colzato, Pratt, & Hommel, 2010).

Written, informed consent was obtained from all participants before participation. The experiment conformed to the ethical standards of the Declaration of Helsinki and the protocol was approved by the local ethics committee (Leiden University, Institute for Psychological Research).

### Procedure

All participants were tested individually. Upon arrival, participants read and signed the informed consent. Subsequently, participants were weighed using an OMRON Body Composition Scale Karada Scan, after which height was measured and their BMI was calculated. Next, daily smoking habits (cigarettes smoked per day) were recorded and participants completed four visual analogue scales (range of scores

**Table 1** Demographic characteristics, descriptive statistics for the visual analogue scale (VAS), for the HRV scores and behavioral parameters for the task-switching paradigm separated for short and long response-stimulus interval (RSI)

Variables (SD)	
N (M:F)	90 (30:60)
Age	22.1 (2.5)
Body mass index	23.4 (3.7)
Cigarettes (daily)	0.9 (3.0)
VAS anxiety	8.0 (11.3)
VAS nervousness	16.6 (17.6)
VAS insecurity	12.6 (12.9)
VAS stress	15.9 (17.2)
HRV scores	
Average BPM	77.7 (11.2)
RMSSD (ms)	46.5 (26.5)
HF (ms <sup>2</sup> )	1092 (1334)
LF (ms <sup>2</sup> )	1613 (1715)
Task-switching paradigm	
RSI short	
Task repeated (RT)	711 (101)
Task repeated (PE)	3.93 (4.4)
Task alternated (RT)	993 (151)
Task alternated (PE)	9.38 (6.9)
RSI long	
Task repeated (RT)	675 (103)
Task repeated (PE)	4.37 (3.7)
Task alternated (RT)	871 (165)
Task alternated (PE)	9.64 (6.6)
Overall switch costs RT (collapsed across RSI conditions)	239 (86)
Overall switch costs PE (collapsed across RSI conditions)	5.36 (3.7)

BPM, Heart rate in beats per minute; RMSSD, Root Mean Square of the Successive Differences; HF, high frequency; LF, low frequency.

Standard deviations are presented in parentheses.

from 0–100) to measure subjective self-reported current level of anxiety, nervousness, insecurity, and stress. Following this, participants were asked to remain seated and try to relax for 5 minutes, after which their HRV was recorded for 5 minutes. Participants were not instructed about breathing during the measuring period but instead were breathing spontaneously. As pointed out by Laborde, Mosley, and Thayer (2017), within the field of HRV research, controlling for respiration is still a matter of debate. The reasoning behind controlling for respiration is that HRV could be affected by several factors such as the amount of breaths per minute (Brown, Beightol, Koh, & Eckberg, 1993; Houtveen, Rietveld, & de Geus, 2002), respiratory depth and the amount of air taken into the lungs (Hirsch & Bishop, 1981). However, it is known that respiration rate does not modulate HRV in resting-state measurements (Denver, Reed, & Porges, 2007), such as measured in the

current study. Indeed, a new study has shown that resting-state high-frequency heart rate variability is linked to respiratory frequency in individuals with severe mental illness but not healthy controls (Quintana et al., 2016). After assessing HRV, participants performed the task-switching paradigm, which lasted approximately 30 minutes.

### Heart rate variability recordings

Inter-beat intervals (IBI) were measured for 5 min using a Polar H7 heart rate monitoring system (Polar Electro, Kempele, Finland), which wirelessly received HR data from a chest strap worn by the participants. Raw data were extracted as a text file and imported into Kubios (premium version 3.0, 2017, Biosignal Analysis and Medical Imaging Group, University of Kuopio, Finland, MATLAB; Tarvainen, Niskanen, Lipponen, Ranta-Aho, & Karjalainen, 2014). Artifacts were filtered out using the automatic thresholding procedure in Kubios. Then, RMSSD was calculated as the root mean square of successive differences of RR intervals, and HF HRV (0.15–0.4 Hz) and LF HRV (0.04–0.15 Hz) were calculated by means of a fast Fourier transformation. The validity of Polar monitors to measure IBI has been confirmed by Weippert et al. (2010), who measured them using a Polar monitor and an electrocardiogram simultaneously. Intraclass correlation coefficients (ICC) and the Bland-Altman limits of agreement (LoA) method revealed excellent agreement between the Polar monitor and ECG (lower ICC 95% confidence interval >0.99 and maximum LoA: –15.1 to 14.3 ms).

### Task-switching paradigm

We used the same experimental paradigm as in Steenbergen and Colzato (2017), Steenbergen, Sellaro, Hommel, and Colzato (2015) and Colzato, Waszak, Nieuwenhuis, Posthuma, and Hommel (2010), see Fig. 1. Throughout the task, a 10-cm square divided into four quadrants was displayed on the computer screen. On each trial, a character pair consisting of letters, numbers or symbols was presented in white uppercase Triplex font in the center of one quadrant. Each pair subtended a visual angle of 1.4° both horizontally and vertically. Participants had to either perform a letter task in which they classified the letter in the stimulus pair as a consonant or vowel, or they had to perform a number task in which they classified the number in the pair as odd or even. After their response or after 2,000 ms had passed, a new stimulus pair was displayed in the next quadrant following a clockwise pattern. The upper quadrants were assigned to the letter task and the lower quadrants to the digit task, so that the display location served as a task cue and the task changed predictably. Depending on the

task, the relevant character in the stimulus pair was either a letter or a digit, whereas the second and irrelevant character was either a member of the other category, so that the response afforded by this character could be congruent or incongruent with the task-relevant response or was drawn from a set of neutral characters.

Consonants were sampled randomly from the set <G, K, M, R>, vowels from the set <A, E, I, U>, even numbers from the set <2, 4, 6, 8>, odd numbers from the set <3, 5, 7, 9>, and neutral characters from the set <#, ?, \*, %>, with the restriction that a stimulus could not be repeated on successive trials. The position of the task-relevant character within a pair (left or right) was randomly determined on each trial. The participants responded with their left index finger (on the “C” key) to indicate “even” or “consonant” and their right index finger (on the “M” key) to indicate “odd” or “vowel.”

Participants completed a practice set of 9 blocks, each with 16 trials, before entering the experimental phase. This consisted of two sets of 15 blocks, each block again consisting of 16 trials. The RSI was 150 ms in one set and 1,200 ms in the other and remained constant within a given set. The order of sets was counterbalanced across participants. Stimuli were response-terminated or presented for a max duration of 2,000 ms. Stimuli were presented electronically using the E-Prime 2.0 software (Psychology Software Tools, Pittsburgh, PA).

### Statistical analysis

For reaction time (RT) analyses incorrect trials were excluded. For percentage error (PE), both missed responses and incorrect responses were included. Then, RT and PE were submitted to separate repeated measures ANOVAs with Task Repetition (i.e., repetition vs. alternation of task) and RSI (150 vs. 1,200 ms) as within-subject factors. Furthermore, Pearson’s correlation coefficients were computed to test whether resting-state vmHRV (as indexed by RMSSD and HF and, as a control, LF) predicted task-switching performance (as reflected by switch costs at a short and long RSI). Individual switch costs were calculated by subtracting mean RT on repetition trials from mean RT on alternation trials. Given that gender, BMI, smoking habits, average heart rate per minute (BPM), and level of stress and anxiety are known to affect vmHRV, we also ran partial correlation analyses to control for these factors. Lastly, to test for a potentially specific effect of vmHRV in either the short or long RSI condition, we ran the Steiger’s Z-test for correlated correlations. This test measures the equality of two correlation coefficients obtained from the same sample, with the two correlations sharing one variable in common (Steiger, 1980). We adopted a significance threshold of  $p < 0.05$  for all statistical tests.

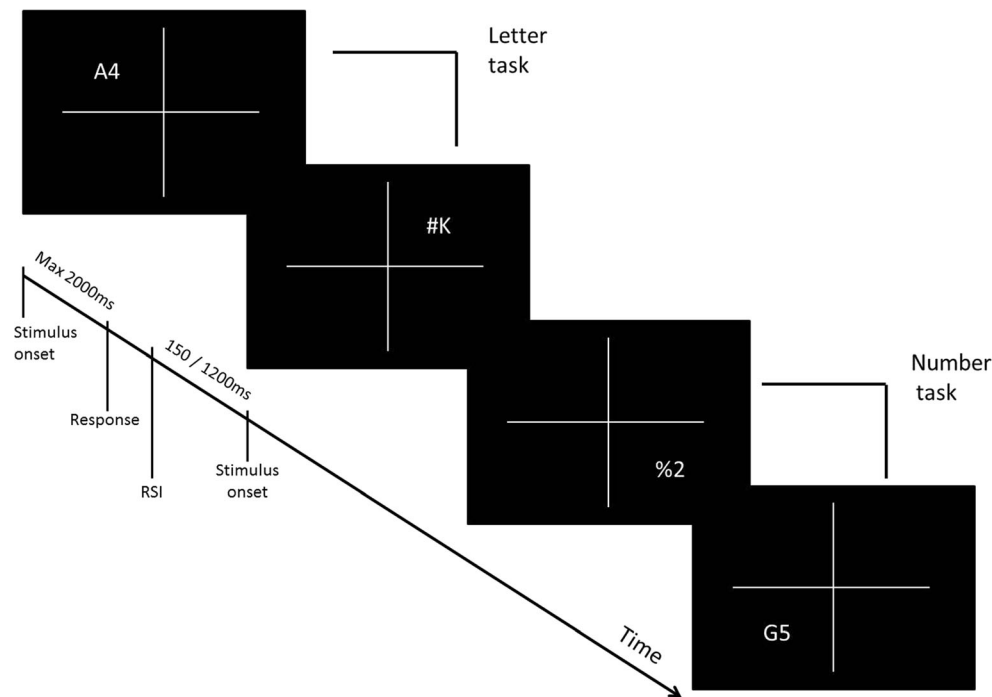


Fig. 1 Schematic illustration of the task-switching paradigm

## Results

### Task-switching paradigm

Table 1 provides an overview of the mean outcomes for RTs and PEs. RT analysis revealed a significant main effect of Task Repetition,  $F(1,89) = 691.80$ ,  $p < 0.00001$ ,  $MSE = 7419.28$ ,  $\eta^2_p = 0.89$ ; and of RSI,  $F(1,89) = 84.58$ ,  $p < 0.0001$ ,  $MSE = 6662.85$ ,  $\eta^2_p = 0.49$ . These two main effects were involved in a two-way interaction,  $F(1,89) = 129.54$ ,  $p < 0.0001$ ,  $MSE = 1318.99$ ,  $\eta^2_p = 0.59$ , indicating higher switch costs in the short RSI (282 ms) compared with the long RSI (196 ms) condition. PE analysis revealed only a main effect of Task Repetition,  $F(1,89) = 183.73$ ,  $p < 0.0001$ ,  $MSE = 0.001$ ,  $\eta^2_p = 0.67$ , demonstrating fewer errors were made when the task was repeated (4.1%) compared with alternated (9.5%).

### Correlations

RMSSD and HF, but not LF scores, correlated negatively with switch costs in RT in the short RSI condition,  $r = -0.295$ ,  $p = 0.005$ ;  $r = -0.294$ ,  $p = 0.005$  and  $r = -0.171$ ,  $p = 0.106$ , respectively. The same was true for the overall switch costs RT (collapsed across RSI conditions),  $r = -0.246$ ,  $p = 0.019$ ;  $r = -0.252$ ,  $p = 0.017$  and  $r = -0.103$ ,  $p = 0.335$ , respectively. Although the same trends were found in the long RSI condition,  $r = -0.156$ ,  $p = 0.143$ ;  $r = -0.168$ ,  $p = 0.114$  and  $r = -0.191$ ,  $p = 0.071$ , respectively, these were not statistically significant. Notably, correlation coefficients for the short RSI condition and for the overall switch costs increased after

controlling for gender, BMI, BPM, smoking habits, and level of stress and anxiety, although the pattern of results remained the same. See Table 2 for an overview of the outcomes of the partial correlations. These results indicate that higher vmHRV, as indexed by RMSSD and HF but not LF scores, predict lower overall switch costs (Fig. 2).

### Steiger's Z-test

Steiger's Z-test on the partial correlations between (a) RMSSD and switch costs in terms of RT in the short RSI condition and between (b) RMSSD and switch costs in terms of RT in the long RSI condition revealed no significant difference between these correlations,  $Z = -1.308$ ,  $p = 0.019$  (two-tailed). The same was true for the correlations involving HF,  $Z = -1.105$ ,  $p = 0.26$  (two-tailed) and LF scores,  $Z = 0.523$ ,  $p = 0.60$ .

## Discussion

The goal of the present study was to test the neurovisceral integration model (Thayer et al., 2009) by examining the link between resting-state vmHRV (as indexed by both time domain and frequency domain measures) and performance in a task-switching paradigm that provides a relatively process-pure measure of cognitive flexibility. Higher resting-state vmHRV (indexed by higher RMSSD and HF scores) predicted greater cognitive flexibility (i.e., decreased switch costs). This effect became stronger after controlling for gender (Ryan

**Table 2** Partial correlations (controlled for gender, BMI, daily number of cigarettes smoked, level of stress and anxiety, heart rate per minute) between switch costs in short and long response-stimulus interval (RSI) conditions, overall switch costs (collapsed across RSI conditions) for RTs and PEs, and vagally mediated (as indexed by RMSSD and HF and, as a control, LF) resting-state HRV

		RTs switch costs-short RSI	RTs switch costs-long RSI	RTs Overall switch costs	PEs switch costs-short RSI	PEs switch costs-long RSI	PEs Overall switch costs	RMSSD	HF	LF
RTs switch costs-short RSI	Pearson's r	1	0.694***	0.923***	-0.150	-0.140	-0.169	-0.314**	-0.297**	-0.161
	<i>p</i> value		0.00001	0.00001	0.173	0.205	0.124	0.004	0.006	0.143
RTs switch costs-long RSI	Pearson's r		1	0.918***	-0.190	-0.130	-0.188	-0.209	-0.208	-0.204
	<i>p</i> value			0.00001	0.083	0.238	0.087	0.056	0.057	0.062
RTs Overall switch costs	Pearson's r			1	-0.185	-0.147	-0.194	-0.282	-0.276	-0.198
	<i>p</i> value				0.093	0.183	0.077	0.009	0.011	0.071
PEs switch costs-short RSI	Pearson's r				1	0.469***	0.865***	-0.077	-0.039	-0.040
	<i>p</i> value					0.0001	0.0001	0.486	0.727	0.721
PEs switch costs-long RSI	Pearson's r					1	0.848***	0.034	0.036	-0.014
	<i>p</i> value						0.0001	0.756	0.742	0.900
PEs Overall switch costs	Pearson's r						1	-0.027	-0.003	-0.032
	<i>p</i> value							0.809	0.982	0.776
RMSSD	Pearson's r							1	0.892***	0.625***
	<i>p</i> value								0.00001	0.00001
HF	Pearson's r								1	0.581***
	<i>p</i> value									0.00001
LF	Pearson's r									1
	<i>p</i> value									

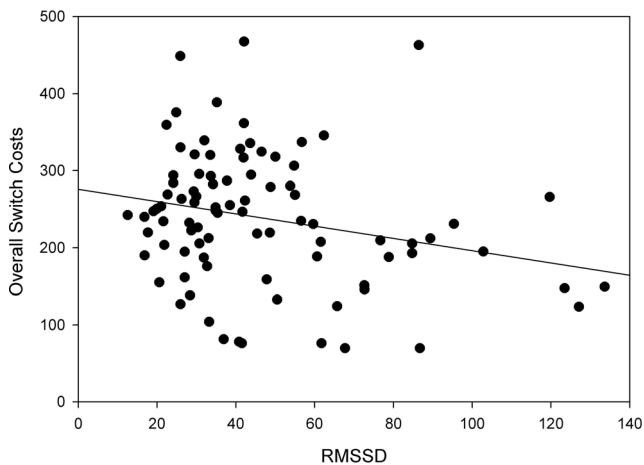
RMSSD, Root Mean Square of the Successive Differences; HF, high frequency; LF, low frequency.

\* $p < 0.05$ , \*\* $p < 0.01$ , \*\*\* $p < 0.001$ .

et al., 1994; Sztajzel et al., 2008), BMI (Karason et al., 1999), anxiety (Thayer et al., 1996), stress (Dishman et al., 2000), heart rate (Gašior et al., 2016), and smoking habits (Hayano et al., 1990)—factors that are known to affect vmHRV. Based on the neurovisceral integration model (Thayer et al., 2009), we expected higher vmHRV to reflect better functioning of inhibitory circuits in the PFC and this in turn to predict better flexibility. Considering that (a) the task that we used is a response switching paradigm (i.e., it required switching between two arbitrary S-R mappings), that (b) the dorsolateral prefrontal cortex (dlPFC) and the anterior cingulate cortex have been causally implicated in flexible behavior such as response switching performance (Kim, Cilles, Johnson, & Gold, 2012), and that (c) the dlPFC and anterior cingulate cortex are parts of the parasympathetic suppression network via which the PFC might influence control over vmHRV (Lane et al., 2009), our results are in line with this model. To further

support this interpretation of the current results, it would be important for a follow-up study to replicate our findings using a functional brain imaging protocol to investigate whether vmHRV might be specifically linked to activity in the posterior zone of the medial frontal cortex area which, according to de la Vega, Chang, Banich, Wager, and Yarkoni (2016), predicts switching performance.

Given the significant partial correlation with overall switch costs RT and that Steiger's Z-test on the partial correlations indicated no significant difference in the relationship between vmHRV and switch costs in the short and long RSI conditions, we can only cautiously speculate about the specific nature of the relationship between vmHRV and switching performance. The results seem to suggest that vmHRV reliably predicts both the preparation and the residual component of switch costs. Even if more research is necessary, it might be that individuals with higher resting-



**Fig. 2** Scatter diagram of individual root mean squared successive differences (RMSSD) against RTs overall switch costs (collapsed across RSI conditions) in the short response-stimulus interval (RSI) condition

state vmHRV were more efficient and faster in switching between tasks under time pressure and in the involuntary, presumably stimulus-triggered, activation of the previous task set. Hence, these results might indicate that optimal inhibitory circuits associated with high vmHRV lessen both the impact of the preparation component of switch costs and the impact of stimulus-triggered interference.

These results are in line with a previous study in which we employed a stop-change paradigm and found vmHRV to selectively predict performance when a stopping process and a change process towards an alternative response were required simultaneously but not when the processes could be cascaded due to a longer preparation interval (i.e., when the stopping process had already finished at the time the change to a different response was required) (Colzato & Steenbergen, 2017). Even if the stop-change paradigm is not a process-pure measure of cognitive flexibility, it requires one to rapidly switch to a different response in a manner reminiscent of the task-switching paradigm.

The current study has some limitations that warrant discussion. First, given that vmHRV seems to be sensitive to physical activity (Rossy & Thayer, 1998) and many other factors, such as endocrine conditions, meditation, and environmental factors (see Fatissou, Oswald, & Lalonde, 2016, and Laborde et al., 2017, for a complete overview), it is advisable for future studies to take individual differences in those factors into account. For the current study, we cannot rule out that these factors might have influenced our findings. Second, even if, as pointed out by Laborde et al. (2017), respiration rate is not systematically corrected for, it should at least be measured to evaluate its impact on the outcome measures. Third, we acknowledge that no causal relation can be established between the observed resting-state vmHRV and task-switching performance. Our study only shows that vmHRV predicts cognitive flexibility.

This renders our study correlational in nature, which is why future studies also should investigate the causal link between the vagus nerve and cognitive flexibility, for example by exploring the effect of transcutaneous vagal nerve stimulation (tVNS) on the efficiency of task-switching performance.

To conclude, our results are consistent with the idea put forward by the neurovisceral integration model of cognitive control (Thayer et al., 2009) that vmHRV is linked to PFC activity and therefore can predict performance on cognitive control tasks that rely on such activity. Our results extend previous findings by demonstrating that, in addition to inhibitory control and monitoring/updating of WM (see Zahn, Adams, et al., 2016), higher levels of resting-state vmHRV promote cognitive flexibility.

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