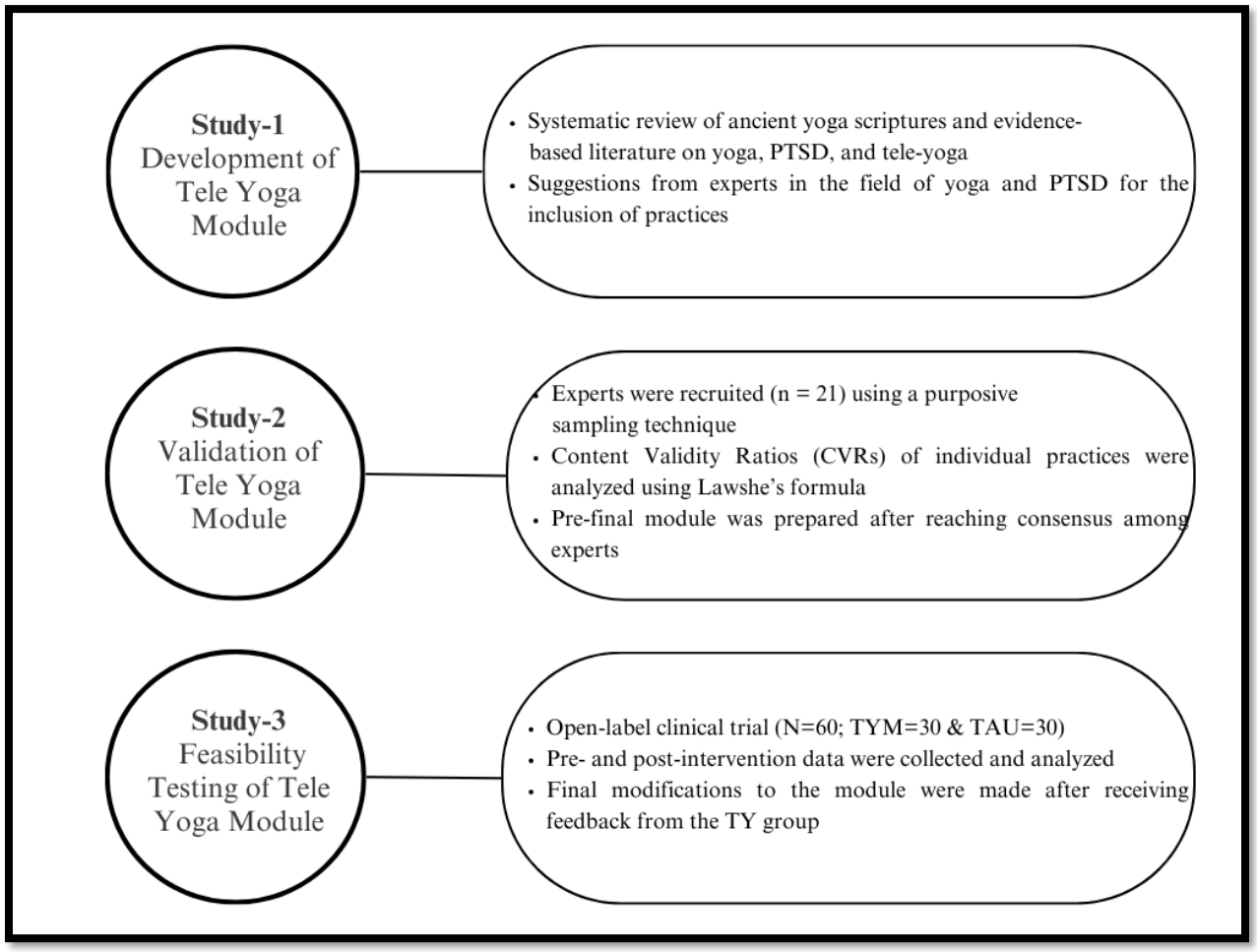
5.0 MATERIAL AND METHOD:

5.1 OVERVIEW OF THE STUDY DESING

The study was conducted at S-VYASA in three phases; Study 1: Development of TYM, Study 2: Validation of TYM and Study 3: Feasibility testing of the validated TYM using a quasi-experimental study design as shown in Figure 2. The TYM was developed and validated following the procedure presented in the protocol study (Katla et al., 2023).

Figure 2: Procedure used in the study which was conducted in three phases



5.2 Ethical Consideration: The study was approved by the Institute's Ethics Committee, Swamy Vivekananda Yoga Anusandan Samastana (S-VYASA), University, India, [Appendix I] and National Institute of Mental Health & Neurosciences(NIMHANS), Bengaluru, India, [Appendix I] and registered in the Clinical Trial Registry-India (CTRI):CTRI/2022/03/041356. The signed

informed consent form [Appendix III] was obtained from each expert and participant prior to the study, after explaining the nature of the study and the voluntary nature of participation. Confidentiality of all data collected during the study were assured and maintained. Subjects have the right to withdraw consent at any stage of the study.

5.3 STUDY 1: DEVELOPMENT OF TELE YOGA MODULE (TYM)

We systematically reviewed ancient yoga scriptures, and the scientific literature related to yoga and PTSD to generate a list of yogic practices that can help manage PTSD symptoms.

5.3.1 Ancient Literature Review

The module development was initiated through a comprehensive examination of foundational yoga texts, including *Pātañjali yōgasūtrā* (Iyengar, 1993) and *Bhagavad Gītā* (Goyandka, 1969), alongside practical *Haṭha Yōga* texts *Haṭhayōgapradīpikā* (Svatmarama, 2002), *Śivasaṁhitā* (Vasu, 1923), *Ghēraṇḍasaṁhitā* (Digambarji & Gharote, 1978) and *Haṭharatnavali* (Gharote et al., 2002). We aimed to gain insights into yoga's potential to directly or indirectly alleviate PTSD symptoms.

5.3.2 Identification of the practices from ancient yoga texts:

The identification of yoga practices involved a comprehensive review of ancient literature. Classical yoga scriptures do not outline precise symptom-based instructions for their implementation. Their main aim is to achieve mastery over the mind (Taimni, 1961) and physical and mental benefits are by-products of yoga. Therefore, the practices have been selected from the texts based on the approximating descriptions of mental and physical health benefits of specific yoga practices that are feasible to be practiced in online mode. Based on that we are focusing on elements those which near to PTSD symptoms such as *sanskrit* terms like: *sarva rōga harā/ārōgyaṁ/vyādhi-vināśakā* (promoting overall health), *citta-viśrānti-kārakam* (inducing mental tranquility), addressing *klēśāḥ* (mental afflictions), *śrānti-haraṁ* (alleviating fatigue), *bhayanāśak* (dispelling fear), *vishada hara* (mitigating sorrow), *abhyāsa* (consistent positive effort), *vairāgyam* (detachment), *cittavṛtti* (Modification of thought process), *pancakośa model* (five layers of consciousness), *ābhinivēśa/mṛtyubhaya* (fear of any traumatic event) and, *cittaprasādanam* (cultivation of mind or coping strategy).

5.3.3 Scientific Literature Review

5.3.3.1 Inclusion and exclusion criteria:

The studies that were eligible for the systematic review included those studies which evaluated Yoga therapies versus no intervention or non-Yoga interventions, which emphasized on Yoga interventions that resulted in a reduction in PTSD symptoms. Moreover, studies based on classical Yoga literature and reporting at least one Yogic practice such as *āsana* (Yogic pose) or *prāṇāyāma* (breathing practice), or *ḍhyāna* (meditation and relaxation practices)–were considered for the review. There were no restrictions on the frequency or duration or style of the yoga intervention. The type of studies was restricted to randomized controlled trials (RCT) conducted on adult participants and published in the English language only.

5.3.3.2 Search Strategy:

A systematic search was conducted in the PubMed, Google Scholar, and Scopus databases. The search was limited to RCT articles published from January 2000 to August 2022. The following search keywords were used: (Yoga or Yogic) AND (post-traumatic stress disorder, OR PTSD).

5.3.3.4 Screening and Extraction:

After searching, all identified citations underwent screening based on the predefined inclusion and exclusion criteria. Studies that did not fulfill the inclusion criteria were excluded. We followed an exhaustive iterative process to screen out the eligible practices for the module. These included trauma-sensitive yoga guidance (Emerson et al., 2009; Emerson & Hopper, 2012), yoga module development guidelines (Katla et al., 2022; Sherman, 2012). Two reviewers (NK/AY) participated in the process and independently assessed study titles, abstracts, and full texts, rated the study's methodological quality, and extracted data from the studies. Any differences they had were worked out through discussion.

Study characteristics of the included RCTs and the intervention details were extracted using a standardized data extraction tool. Practices were selected based on ancient texts and systematic reviews, with exclusion criteria such as omission of adrenal-activating poses (Emerson et al., 2009) and avoidance of advanced or difficult-to-teach *āsana* in an online mode. No restrictions were imposed on the frequency, duration, or style of the yoga intervention.

5.4 STUDY 2: EXPERT VALIDATION WITH CASE VIGNETTE METHOD

Delphi Process and Expert Selection

A modified Delphi technique was used (Scheibe, Skutsch, & Schofer, 1975). The Delphi technique used anonymity, iteration, and controlled feedback to arrive at a consensus. It was economical and not constrained by geographical limitations. This method gave equal weighting to the views of each participant, reducing the risk of one participant or opinion dominating. The geographical and occupational diversity of experts ensured international applicability of the recommendations and encompassed all areas of expertise and practice within the research team.To obtain expert input and consensus, two case-vignettes [Appendix VI] of patients with typical PTSD were developed and reviewed by two psychiatrists (BH and HB). Clinical case vignettes provide an in-depth narrative encompassing the patient's medical history, distinctive symptoms, and pertinent details related to their treatment. These case studies, along with the preliminary TY module developed during study 1, were sent out via emails to 40 yoga experts. Most Delphi studies involve between 11 to 50 experts (Diamond et al., 2014). Experts were operationalized as individuals involved in the conception, design, conduct, teaching, or analysis of yoga interventions for PTSD conditions. The validation process is initiated by sending the Google form with the list of practices and related pictures for a better understanding to 40 experts. Experts were given two weeks to respond. Reminders were sent to non-responders approximately one week after the initial email, with additional reminders at five-day intervals prior to the submission deadline. Only those experts who completed the survey were included in the statistical analysis.

5.4.1 Inclusion and exclusion criteria of experts

The inclusion criteria for the yoga expert selection were a minimum of five years of experience in yoga or holding a Master's/Medical Degree related to yoga. Additionally, mental health yoga therapists with at least three years of experience, along with two years of online yoga teaching, were considered.

The yoga experts were asked to rank the utility of each yoga practice for PTSD on a three-point Likert scale (range from 0-Not Necessary, 1- useful but not essential and 2-Essential). We asked the experts to provide feedback through open-ended questions. Those who responded with ratings of 0 or 1 were asked to explain why they felt the aspect was not important for participants diagnosed with PTSD. Additionally, adverse effects and suggestions for improvement were sought

for each aspect of the TYM. The experts' scores for the individual practices were tabulated, and the CVRs calculated. Lawshe's formula (Lawshe, 1975) was used to determine the CVRs.

CVR = (Ne - N/2)/(N/2)

Where Ne = the total number of panellists indicating that practice was essential and

N = to the total number of experts.

According to Lawshe's formula (Lawshe, 1975), if more than half of the experts rate an item as essential, it meets a minimum content validity standard. Based on the experts' responses in the validation of the yoga module, the CVR for the individual practices was calculated. Test content validity can be determined by calculating the mean CVR across items. As per the criteria, the practices with a CVR score ≥ 0.39 were included in the final list of practices.

Furthermore, the research team requested the experts' opinions and suggestions about the duration of the practices and their efficacy. They were also asked to provide input on the total duration of yoga intervention, dose, frequency, yoga practice sequences, the required training period, and any potential adverse effects related to the practices. The TYM was finalized after considering the expert opinions. The inputs provided by the experts played a crucial role in shaping and refining the TYM for PTSD.

5.5 STUDY 3: FEASIBILITY TESTING OF THE TYM

An open-label experimental design was conducted in consenting patients with PTSD to test feasibility. The following are the details of the feasibility test that was conducted

5.5.1 PARTICIPANTS AND SETTINGS

To demonstrate feasibility, an open label controlled clinical trial was done on consenting individuals with PTSD. Convenience sampling techniques were used to recruit participants from NIMHANS and S-VYASA as well as through social media using an online study information flier. The recruitment period was from August 2022 to May 2023. The required sample size of 60 people (Reyes et al., 2020) was computed with the G*Power 3.1 programme, assuming an effect size of 0.5, an alpha of 0.05, and a power of 0.8. A 20% attrition rate was assumed. In terms of selection criteria, the study included both male and female participants who were diagnosed by meeting the DSM-V PTSD criterion A1 for a traumatic event. The screening was assessed by PTSD using the PCL-5 (Post-traumatic Stress Disorder Checklist) (Blevins et al., 2015) and had a cutoff score of more than 33.

5.5.2 INCLUSION AND EXCLUSION CRITERIA

Inclusion Criteria:

1. Diagnosis of PTSD as per PCL-C (score of >33)
2. Both genders and aged between 18 to 65 years.
1. Mild to moderate depression or other anxiety disorders as comorbidity.
2. Controlling diabetes or hypertension.
3. Able to read/understand/speak English.
4. Those stabilized with medications or those not requiring pharmacological intervention as per the psychiatrist OR Participants who were under treatment (Psychotherapy) as usual were also included.
5. Regular internet access through an electronic device (mobile phone, desktop/laptop computer, tablet) was mandatory due to the Zoom online mode of delivery and
6. Willingness to be recorded.

Exclusion Criteria:

1. Diagnosed with co-morbid psychotic disorders in the past or present.
2. Those with intellectual disabilities/severe cognitive impairments.

3. Presence suffering from other physical medical illnesses, which may hinder the practice of yoga.
4. Those breastfeeding / pregnant/ suicidal tendencies/self-harm risk, and
5. Substance abuse or dependence (except nicotine) in the last 6 months.

After providing informed consent, participants were assigned by chance to one of two groups based on their preferences: the tele-yoga (TYM) group (n=30) and the treatment-as-usual group (TAU) (n=30).

5.5.3 INTERVENTION AND SETTING TO TYM GROUP

Participants were invited to an in-person information session and assessment, where they were reminded to bring their mobile/laptop and yoga mat for online conferencing practice. We provided them an instruction manual and demonstrated how to set up their home-based yoga practice and use internet conferencing. An individual Zoom session was held prior to beginning the online intervention to verify the correct home setup, including placing the device and changing the camera angle to capture the entire body. To guarantee a flawless intervention delivery, a group practice session was organized.

Participants in the study received three months of intervention (12 weeks), four times a week, with a dose of an hour per and delivered in small groups of approximately five participants. Participants were told to practice at home for at least 20 minutes per day for the next three days. As per the systematic review, experts' validation and existing tele-yoga literature (7.5 to 90-min sessions, once weekly to daily, for 2 to 12 weeks) (Donesky et al., 2017; Huberty et al., 2019, 2020; Jasti et al., 2020) Furthermore, a study that compared tele-yoga intervention doses showed greater adherence to the intervention with the lower dose (60-minutes per week) (Huberty et al., 2020). These one-hour classes were guided by a professional yoga instructor. The programme is designed for self-inquiry, promotes tranquility, peace, resilience, and encourages curiosity about body feelings. Key words such as "notice" and "allow," as well as inviting phrases, are used by instructors. Participants can change, maintain, or release their postures while practicing bodily control. They were given a pre-recorded video tutorial (https://www.youtube.com/watch?v=YoDqOmEo0y8) as well as a list of yoga practices (Table 11). Participants were instructed to keep track of how often and how long they practiced at home. We maintained phone contact during the trial to monitor their home practice and answer any issues they had.

5.5.4 TREATMENT AS USUAL (TAU) GROUP

The control group (TAU) did not receive any intervention during the study period. Upon completion of the study, Tele Yoga Module (TYM) sessions were offered to participants who expressed interest.

5.5.5 VARIABLE STUDY

The study used a set of domains based on Bowen's (Bowen et al., 2009) recommendations to assess feasibility. Among these domains were the following:

a) Acceptability: Acceptability was assessed by measuring participants' ability to engage with the intervention and their satisfaction. Dropout and completion rates for various intervention components were used to measure engagement. A feedback questions was used to assess satisfaction. The satisfaction goals were set at a minimum of 70% of participants indicating 75% satisfaction in terms of enjoyment, intervention, and instruction/instructors.

b) Demand: Participants' desire to promote yoga to others, intention to continue participating, and opinion of the program's ease of completion were used to gauge demand. The satisfaction survey was used to evaluate whether at least 70% of participants agreed on each component. Attendance at the intervention was also considered as a measure of demand,

c) Implementation: To what extent was the yoga intervention successfully given to research participants in some defined, but not entirely controlled context?

d) Practicality: Practicality, reflecting the feasibility of implementation, was assessed through a weekly log. The yoga instructor graded overall performance and evaluated participants' execution of each yoga practice to determine ease of practice.

e) Adaptation: Modifications that are required throughout the application of yoga practices for everyone based on their capacity and need

f) Safety: Safety was assessed through the recording of adverse events, their severity, and their relationship to the study. The Tele-Yoga Therapy Assessment Scale (TYTAS) (Jagannathan, Bhide, Varambally, Chandra, & Gangadhar, 2021) is a tool for assessing the quality of TY session delivery based on instruction evaluations, technique assessments, interpersonal assessments, and program assessments. The TYTAS would be rated by three stakeholders: (i) the participant, (ii) an external observer, and (iii) the trainer and

h) Limited Efficacy testing: Assessing whether the yoga intervention showed potential for success within the intended population, using a TYM group and TAU group.

1. **PTSD symptoms:** PTSD symptoms generally grouped into four types: intrusive memories, avoidance, negative changes in thinking and mood, and change in physical and emotional reactions. Symptoms can vary over time or vary from person to person.
1. **Feasibility:** It is to determine the acceptability, safety and usefulness of the TYM in patients with PTSD.
2. **Adherence:** The voluntary cooperation of the patient in taking a TYM session or as following the instruction of the practice list, this includes timing (schedule), dosage, etc. It implies active responsibility shared by the patient and TYM provider.
3. **Quality of TYM:** The quality of delivery of tele-yoga therapy sessions assessed in four domains. The first one is about instruction assessment, which refers to the delivering instructions of practice by the trainer to the patients with utmost clarity. Second is techniques assessment refers to the teaching methods to refer which enables delivery of an effective and a well-structured session. Third is interpersonal assessment for the knowing of the relationship and communication between the trainer and the patient and fourth one is program assessment for evaluation of the course, length content and quality of the program.
4. ***Triguṇās*:** According to the yoga philosophy, somatic issues are the result of an imbalance between the three *Guṇas* (*sattva, rajas, and tamas*) that make up an individual's body-mind complex (Goyandka, 1999). A *guṇas* also denotes a particular personality style in the popular scriptural text, the *Gītā*. *Tamas* indicates the mode of inertia, *rajas* the mode of activity, and *sattva* the mode of enlightenment. The concept of *triguṇās* will help us to understand PTSD in yogic point of view. Based on *guṇa* we can provide the specific yoga practices to the patient

5. ***Tridoṣās*:** *Tridoṣas Vāta, Pitta,* and *Kapha* are the three basic energies that maintain health when balanced and cause disease when disturbed. *Vāta*, made of air and space, controls movement like breathing and nerve signals. *Pitta*, made of fire and water, manages digestion and metabolism. *Kapha*, made of earth and water, provides stability, lubrication, and immunity. PTSD is often linked with *Vāta* imbalance, leading to anxiety and fear. *Pitta* imbalance may cause anger, while *Kapha* imbalance can lead to low mood and withdrawal (Rastogi, 2010) Viewing PTSD through *Ayurvedic doṣa* imbalance offers a mind-body healing approach

6. **Resilience:** Resilience defined as the dynamic ability to adapt successfully in the face of adversity, resistance to illness, trauma, or significant threat and the ability to bounce back or recover from stress. Those who are resilient are better able to move through the traumas of life (Smith et al., 2008).
7. **Psychosocial Functional Impairment:** PTSD is associated with impairment in functioning across a range of psychosocial domains. This PTSD-related functional impairment has been widely documented in research studies, particularly within occupational (Smith, Schnurr, & Rosenheck, 2005) and interpersonal domains (Watkins, Stafford, & Monson, 2011). The studies examining which PTSD symptoms have the strongest associations with functional impairment and emotional numbing have consistently been identified as a key contributor to psychosocial impairment.

8. **Anxiety**: Fear is a natural, healthy response and a necessary warning system in humans. Anxiety by away of contrast, it a response to irrational thinking about oneself, other people and the world. While fear and anxiety arise from different sources, they share physiologic pathways and expressions. The PTSD often occur with anxiety and depression

9. **Depression:** Depression in PTSD was characterized by the expression of constant, intense, unbearable sadness and a high level of pessimism about the future and their ability to deal with it. Decrease in quality of life in this population was characterized generally by feelings of strain, inability to sleep, loss of capacity to enjoy normal day-to-day activities and constant feelings of worry (Descilo et al., 2010).

10. **Yoga Module development and validation checklist:** The quality of the module development and validation process was assessed based on the yoga module development and validation checklist (Katla et. al., 2022). It has 23 items related to three domains namely: yoga module development, yoga module validation, yoga module feasibility. Score range: 0 to 7=Low quality, 8 to 16=Moderate quality, 17 to 23=High quality.

5.5.6 ASSESSMENT TOOLS

The following assessment tools for data collection were used through Google Forms at pre-intervention and post-intervention

1. **Primary care PTSD Screen DSM-V** (Prins et al., 2016)**:** The PC-PTSD-5 is a 5-item screen designed to identify individuals with probable PTSD diagnosis. Those screening positive require further assessment. The specificity is 0.7, sensitivity is 0.9 and efficiency is 0.5**.**
2. **PTSD Checklist Civilian Version (PCL-C)**: The PCL-5 is a standardized self-report rating scale for PTSD comprising 20 items that correspond to the key symptoms of PTSD and PCL-C is applied generally to any traumatic events and item number 1-5 on re-experience symptoms, 6-7 on avoidance, 8-14 on negative alterations in cognitions & mood symptoms and 15-20 on hyperarousal symptoms. Each item was rated by the participants on a five-point Likert-type scale, with scores ranging from “Not at all” (0) to “Extremely” (4) resulting in a symptom severity score between 0 and 80, with a cut-off total score of 33 for diagnosis of PTSD. PCL-5 scores exhibited strong internal consistency ($\alpha = .94$) and test-retest reliability ($r = .82$) (Blevins et al., 2015)**.**
3. **Vedic Personality Inventory (VPI)** (Wolf, 1999; Raghuram, Deshpande, & Nagendra, 2008)**:** The VPI is a "psychological construct" used to determine three personality patterns described in the Vedas, or ancient Indian scriptures. The assessment scale total of 56 items includes 15 *Sattva,* 19 *Rajas*, and 22 *Tamas* questions (total of 56). The reliability is 0.93 and validity is 0.53. This scale is used as a baseline for providing lifestyle modification recommendations and specific practices from the TYM to patients as per their personality and understanding of PTSD from a yogic point of view.
4. **AyuSoft Prakriti Diagnostic Tool:** The AyuSoft tool was developed by the Centre for Development of Advanced Computing (C-DAC), Pune, India (“Ayusoft,” 2021). It is used to determine the *prakriti ayurvedic* personality of *vāta pitta*, and *kapha* of the individuals. This software consists of 90 items, which involve components of both history and examination, based on ancient Ayurveda scriptures. Ayusoft assesses both mental and physical aspects of the *prakṛti* and is the most widely used tool in Ayurveda research studies. Interrater reliability is moderately strong for *vāta* (Cronbach's alpha = 0.83), good

for *pitta* (Cronbach's alpha = 0.62) and comparatively weak for *kapha dosa* (Cronbach's alpha = 0.51).

5. **Tele Yoga Therapy Assessment Scale (TYTAS)** (Jagannathan, Bhide, Varambally, Chandra, & Gangadhar, 2021): The TYTA is a valid tool to assess the quality of delivery of tele-yoga therapy sessions. There are 42 items in all, of four different domains. 1 to 9 items are related to instruction evaluations, 10 to 21 to techniques assessments, 22 to 31 to interpersonal assessments, and 31 to 42 are related to programme assessments. Three stakeholders would rate the TYTA: (a) the participant, (b) an external observer, and (c) self-rated by the trainer to further reduce bias. The internal consistency for the TYTA between all the three stakeholders was 0.80.
6. **Feedback questionnaire:** The feedback questionnaires will be used for assessing the overall feasibility, acceptability, any side effects, and adherence to the TYM. The participants rated the class on a 10-point Likert-like scale ranging from 1(dislike it very much) to 10 (liked it very much). They will be asked how likely they would be to participate in a future online yoga program on a 5-point scale from "not likely at all" to "very likely". The examples of the questions will be measured with a binary (yes/no question) i.e. Did you participate in the online class, and we also requested qualitative feedback on what was helpful about the class and what should be improved.
7. **Post-intervention interview:** The qualitative interview will be conducted with TYM classes based on a semi-structured interview. The schedule was taken from the study of perceptions of blood cancer patients participating in an online yoga intervention (Huberty, Eckert, et al., 2018). This will include open-ended questions on participants' overall impression of the intervention, the interventional aspects of the intervention that will or will not be beneficial, what made participation in the intervention easy or difficult, and plan for future use of yoga.
8. **Brief resilience scale (BRS)** (Smith et al., 2008): The Brief resilience scale intends to measure one's ability to bounce back or recover from stress. It consists of a total of 6 items and measures on a 5-point scale (1 strongly disagree and 5 strongly agreed). The internal reliability is 0.87
9. **Brief Inventory of Psychosocial Functioning (B-IPF)** (Kleiman et al., 2018): The B-IPF is a 7-item self-report instrument measuring PTSD-related functional impairment in the

past 30 days. There are seven functional domains evaluated: romantic relationships, family relationships, work, friendships and socializing, parenting, education, and self-care. The B-IPF consists of a strong Cronbach alpha of 0.84 and test-retest reliability is 0.64.

10. **Hamilton Anxiety Rating Scale (HAM-A)** (Hamilton M., 1959): The scale consists of 14 items, each defined by a series of symptoms, and measure both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). It is a self-report, and each item is scored on a five-point Likert scale of 0 (not present) to 4 (severe), with total score range of 0-56, where <17 indicates mild severity, 18-24 mild to moderate severity and 25-30 moderate to severe (Thompson, 2015).
11. **Hamilton Depression Rating Scale (HAM-D)** (Hamilton M.,1960): The scale consists of 17 items pertaining to symptoms of depression experienced over the past week. It is a self-report, and each item is scored on a 5-point Likert scale of 0 (absent) to 4 (incapacitating), with total score range of 10-13 mild, 14-17 mild to moderate and >17 moderate to severe. This scale had good reliability of internal consistence is 0.92, sensitivity is 0.95 and specificity 0.94

An independent researcher performed assessments at baseline, 48 TY sessions, and 12 weeks following TY sessions. At baseline, sociodemographic information, PCL-5, PC-PTSD, Vedic personality inventory (VPI) and Ayusoft *prakṛti* (*Vata, Pitta & Kapha*) assessments were used. At the two time points, the Hamilton Anxiety Rating Scale (HAM-A), Hamilton Depression Rating Scale (HAM-D), Brief Resilience Scale (BRS), and Brief Inventory of Psychosocial Functioning (B-IPF) were administered.

5.6 DATA EXTRACTION AND ANALYSIS

In study 1, we screened a list of practices (based on the *sanskrit* keywords selected as per the methodology) against our inclusion and exclusion criteria through an iterative process. Two reviewers independently assessed the selected practices, with differences reconciled through discussions with a third reviewer. Data from the included yoga texts, and randomized controlled trials (RCTs) were extracted, and we conducted a narrative data synthesis to compile a comprehensive list of yogic practices addressing PTSD symptoms.

For study 2, we used the Content Validity Ratio (CVR) (Ayre & Scally, 2014; Lawshe, 1975) to evaluate the yoga practices based on experts' Likert scale inputs (refer to Table 2).

In study 3, descriptive statistics were used to examine socio-demographic factors and clinical measures of the PTSD participants. The data were checked for normality using the Shapiro-Wilk test and an independent sample t-test was used to analyze the outcome variables. All statistical analyses were performed using R/JASP version 2.3.3, with detailed results presented in Table 3. The data and the R analysis script are available in the OSF link (https://osf.io/2q84h/?view_only=ec79c5fc80b84d618bee89dcdc6a74cb).