Focused Question

What is the evidence for the effectiveness of interventions to improve occupational performance for those with cognitive impairments after stroke?

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Guided Research Process

- Updating of: Occupational Therapy Practice Guidelines for Adults with Stroke
- AOTA Collaboration
  - Marian Arbesman, Ph.D., OTR/L
  - Deborah Lieberman, MHSA, OTR/L, FAOTA
- Focused on Level I – III studies published between 2003-2012

Guided Research Process

ABSTRACTS REVIEWED • 1,382
ARTICLES REVIEWED • 95
ARTICLES EXCLUDED • 49
ARTICLES INCLUDED • 47

Results of Search Process

<table>
<thead>
<tr>
<th>IMPAIRMENT AREAS</th>
<th>LEVELS OF EVIDENCE</th>
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<tr>
<td></td>
<td>I</td>
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<td>General Cognition</td>
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<td>Executive Function</td>
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<td>Unilateral Neglect</td>
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<td>Visual Dysfunction</td>
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<td>Memory</td>
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<td>Apraxia</td>
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<td>Attention</td>
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Results: Types of Outcome
Measures: Activity/Participation
- Barthel Index
- FIM
- AMPS
- Frenchay Activities Index
- Reading
- Multiple Errands Test
- BIT
- SF-36
- Driving
- Catherine Bergego Scale
- Rankin Scale
- Lawton IADL
- Mobility (W/C, street crossing)

Results: Types of Outcome
Measures: Impairments
- Perimetry
- Neglect
- Clock drawing test
- NIH Stroke Scale
- Apraxia Test
- Digit Span
- California Verbal Learning
- MVPT
- LOTCA
- MMSE
- Trail Making
- Stroop Test
- Rey Auditory Verbal Learning
- Etc.

Preliminary Results: General Cognition
Level I
- Insufficient evidence to either support or refute the use of cognitive-perceptual interventions (sensory stimulation, workbooks) to improve ADL function.
- Moderate evidence for the effectiveness of language and visuospatial training for aphasia and neglect syndromes after stroke.

Level III
- Limited evidence for home rehabilitation consisting of remediation therapy, story retelling, cognitive enhancing games, and aerobic exercise was beneficial for IADL.

Preliminary Results: Executive Functioning
Limited evidence that a variety of interventions are effective:
Level I
- Time Pressure Management Strategies improve speed in daily task performance in those with mental slowness.

Level III
- VMall: Improvements in both the virtual and hospital versions of the Multiple Errands Test.
- Recreation and leisure program: improved walking and talking ability and neuropsychological measures.
Maybe bullet some examples? I didn't mention all for motor just provided some examples for each category - what do you think? May allow you to combine the two slides

Dawn Nilsen, 3/26/2013
Preliminary Results: Attention Deficits

Insufficient:
Level I
- Attention Process Training: Improvement on neuropsychological measure of attention. No difference on QOL, Rankin scale, general health, Cognitive Failures Questionnaire.

Preliminary Results: Memory

Limited:
Level III
Ecologically-oriented, strategy-based intervention (WOPR): Improvements on some everyday memory simulations consisting of declarative memory tasks and one prospective memory task.
Insufficient:
Level I
- Computerized Memory Training: improvements in self-rated cognitive function (CFQ) and neuropsychological measures. No change on simulated ADL.
- Mnemonic strategies: no significant effects on outcomes. No evidence to support or refute the effectiveness on functional outcomes.

Preliminary Results: Apraxia

Level I
Moderate:
- Cognitive Strategy Training (teaching internal/external compensatory approaches to execute ADL): significant improvement in ADL and documented generalization to non-trained tasks.
Limited
- Gesture Training: significant improvement on ADL questionnaire and tests of apraxia.

Preliminary Results: Unilateral Neglect

Level II
- VST vs. OKS: OKS group improved on reading (decreased word omissions) and other measures of neglect as compared to VST.
- VST vs. Virtual Reality (VR): Both groups improved on ADL, improved virtual street crossing for VR, no difference in actual street crossing.

Preliminary Results: Unilateral Neglect

Level II
- Prisms/Prism Adaptation (PA) (mixed evidence)
Level I
- Two PA studies found no difference when compared to sham treatment on Catherine Bergego Scale and/or BIT. One study documented that those with mild neglect demonstrated a significant difference in the change of the BIT-C and FIM compared to sham. This was not true for severe neglect.
Preliminary Results: Unilateral Neglect

- Prisms and Prism Adaptation (PA)
  - Level II
  - Prisms during ADL vs. PA: No difference on cancellation, FIM, CBS, NIH stroke scale.
  - +/- PA and reading: Conflicting evidence based on 2 studies.
  - PA and w/c mobility: improved accuracy during propulsion.
  - PA and ADL: improvement on BIT and reading ability.
  - Level III
  - Long term improved BI, COG, eye movements and cancellation/bisection tests.

Preliminary Results: Visual Field Deficit

Scanning Training: Mixed evidence:

- Level I
  - Compensatory scanning/explorative saccade training: subjective improvements in mastering daily-life activities, ADL questionnaire, and mixed findings regarding reading speed.
- Level II
  - Systematic treatment program consisting of education, scanning training, coordinating head and eye movement, and tracking activities: significant improvement in the Nottingham Adjustment Scale, no difference on the BI or BIT.
- Level III
  - Perimetry training: improved reading speed for 4/7 subjects.

Limitations of Review

- Small sample sizes
- Inconsistent use of performance measures
- Simulation vs. actual observation of ADL
- Heterogeneous groups
- Long term effects not as well studied
- Limited the search to journals published in English
- Possibility of missing studies because of combinations of search terms

Implications for Practice/Education

- Evidence suggests there are emerging interventions that are effective at improving occupational performance for those with cognitive impairments after stroke
- Intervention Commonalities:
  - Performance focused.
  - Strategy training
  - Compensatory

Implications for Research

- Overall requires more attention in terms of volume and quality.
- Areas other than neglect also require increased focus (ex. attention, executive functions, etc.).
- Focus on inclusion of activity, participation, and quality of life, measures.