Feedback and Cognition in Arm Motor Skill Reacquisition After Stroke

C.M. Cirstea, PhD; A. Ptito, PhD; M.F. Levin, PhD

Background and Purpose—A debated subject in stroke rehabilitation relates to the best type of training approach for motor recovery. First, we analyzed the effects of repetitive movement practice in 2 feedback conditions (knowledge of results [KR]; knowledge of performance, [KP]) on reacquisition of reaching. Second, we evaluated the impact of cognitive impairment on motor relearning ability.

Methods—A randomized controlled clinical trial was conducted in Montreal-area rehabilitation centers between 1998 and 2003 with 37 patients with chronic hemiparesis. Patients were randomly assigned to 3 groups: (1) KR (n=14) practiced a reaching task involving 75 repetitions per day, 5 days per week for 2 weeks, with 20% KR about movement precision; (2) KP (n=14) trained on the same task and schedule as KR but with faded KP about joint motions; and (3) control (C; n=9) practiced a nonreaching task. Physical (motor impairment, function) and kinematic (movement time, precision, segmentation, variability) variables were assessed before and after (immediately, 1 month) practice. Cognitive functions (memory, attention, mental flexibility, planning) were also evaluated.

Results—Kinematic gains in KR (precision) and KP (time, variability) exceeded those in C and depended on memory and mental flexibility deficits. In KP, more severely impaired patients made the most clinical gains (>2×C), which were related to memory and planning abilities.

Conclusions—Use of KP during repetitive movement practice resulted in better motor outcomes. Stroke severity together with cognitive impairments are important factors for choosing motor rehabilitation interventions after stroke. (Stroke. 2006;37:1237-1242.)

Key Words: randomized controlled trials rehabilitation stroke cognition

Rehabilitation of arm motor function after stroke is a challenge to rehabilitation professionals. Of stroke victims, 30% to 66% continue to experience arm motor dysfunctions for >6 months. Various rehabilitation approaches have been used to improve skill reacquisition of the impaired arm. According to a review of 300 randomized controlled trials (RCTs) incorporating 2686 patients, enhanced clinical outcomes depend on 2 key elements: training intensity and task specificity. Most of these studies used various outcomes at different levels of body structure, activity, and participation measured at different times after stroke onset, making conclusions about intervention outcomes difficult.

Basic neurophysiological research suggests that repetitive motor activity forms the basis of skill (re)acquisition. Aside from practice, the type of feedback provided to the performer is another key factor in motor skill reacquisition. Feedback variables include the nature (knowledge of results [KR] or knowledge of performance [KP]), timing (concurrent, terminal), and frequency (summary, faded, etc) of information delivery to the learner. KR or terminal feedback about goal-related movement outcomes has been the focus of much research in healthy as well as stroke subjects, mostly because of the ease with which it can be manipulated and quantified. In contrast, concurrent feedback about goal-related performance (KP) is used frequently in stroke rehabilitation. Determining which feedback type optimizes motor recovery would increase the success of rehabilitation interventions.

We hypothesized that in patients with chronic hemiparesis, the kinematic and clinical effects of repetitive movement practice would differ according to the type of feedback provided. One participant group received 20% terminal KR about movement precision, and the other received faded concurrent KP about specific movement impairments (decreased active joint motion). Because cognitive functioning may potentially modify training effects, we also hypothesized that motor improvements would be related to cognitive abilities. See the abstract of Cirstea et al for preliminary results.
Methods

Participants
Candidates selected from discharge lists of Montreal-area rehabilitation centers between 1998 and 2003 were no longer receiving inpatient or outpatient treatment. Out of a 600-candidate pool, 60 met inclusion criteria according to chart review (Figure 1): (1) single stroke in the dominant hemisphere 3 to 24 months previously, and (2) able to reach with the impaired arm (at least stage 2 on Chedoke-McMaster Stroke Assessment\textsuperscript{10}). Individuals were excluded if they had occipital, cerebellar, or brain stem lesions, multiple strokes, major perceptual deficits, apraxia, shoulder subluxation, pain, or other neurological disorders. Of 60 candidates contacted, 37 expressed willingness to participate. After signing informed consent forms approved by local ethics committees, all but 2 participants completed the protocol. These 2 patients did not complete the follow-up (Retention [RET]) because of medical complications. No gender or racial/ethnic-based differences were present between groups. There were 14 subjects in each intervention group and 9 in the control (C) group. Despite the difference in number of participants between groups, demographic data were similar (Table 1). Ten healthy subjects (43.3±18.2 years; 6 females and 4 males) were recruited for comparison data.

Design
In this double-blind RCT, patients were stratified by age (±5 years) and severity (±1 CM) and randomly assigned to intervention (KR, KP) or C groups in blocks of 6 by an assistant who did not participate in subject evaluation or treatment. Physical, neuropsychological, and kinematic assessments were done before (PRE) a 10-day intervention. Physical and kinematic evaluations were repeated immediately (POST) and 1-month after (RET) intervention. Evaluators were unaware of patient group assignment. Participants were instructed to avoid mentioning details about their study experience to evaluators. Although therapists were aware that different patients received different training approaches, all involved were uninformed of study hypotheses or outcome measures.

The intervention, supervised by experienced physical therapists, consisted of movement repetition (1 hour per day) for 10 sessions delivered over 2 weeks. The training goal for all groups was to make movements as quickly and precisely as possible. The number of repetitions per session (n=75) was considered to be “intensive” practice according to previous results indicating that the learning curve asymptote in severely impaired patients occurred after 36±14 trials.\textsuperscript{7} Intervention groups (KR, KP) practiced a pointing movement (motor task 1 [MT1]; Figure 2) without vision so that movement repetition relied on proprioceptive information considered crucial for motor recovery after stroke.\textsuperscript{11}

Groups received different verbal feedback: (1) KR: terminal information about movement precision; at movement end, participants opened their eyes and corrected their finger position closer to the final target; and (2) KP: concurrent information about joint motion (shoulder flexion, elbow extension) during movement. To minimize dependence on feedback, summary length of KR was 5 trials (20%), whereas KP was given on a faded schedule (first 25

TABLE 1. Demographics, Stroke History, Motor Task Parameters, and Clinical Evaluations in Stroke Patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>KR (n=14)</th>
<th>KP (n=14)</th>
<th>C (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Age* (y)</td>
<td>55.7 (15.4)</td>
<td>59.1 (17.9)</td>
<td>64.5 (14.1)</td>
</tr>
<tr>
<td>Time since onset* (mo)</td>
<td>12.1 (4.9)</td>
<td>11.4 (6.3)</td>
<td>11.1 (5.9)</td>
</tr>
<tr>
<td>Lesion location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cortical</td>
<td>6</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Subcortical</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Cortical+subcortical</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>MT1*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height (cm)</td>
<td>83.7 (4.9)</td>
<td>81.1 (2.2)</td>
<td>81.3 (2.0)</td>
</tr>
<tr>
<td>Distance (cm)</td>
<td>76.7 (11.5)</td>
<td>71.6 (11.7)</td>
<td>70.2 (7.6)</td>
</tr>
<tr>
<td>Physical†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FM</td>
<td>45.8 (14.1)</td>
<td>40.8 (21.8)</td>
<td>47.7 (13.0)</td>
</tr>
<tr>
<td>CSI</td>
<td>6.5 (1.7)</td>
<td>7.7 (2.6)</td>
<td>7.7 (2.4)</td>
</tr>
<tr>
<td>TEMPA</td>
<td>−7.7 (6.3)</td>
<td>−7.3 (5.6)</td>
<td>−7.1 (5.0)</td>
</tr>
<tr>
<td>Cognitive†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal memory</td>
<td>34.7 (9.0)</td>
<td>29.1 (10.4)</td>
<td>26.7 (8.2)</td>
</tr>
<tr>
<td>Visuospatial memory</td>
<td>17.7 (14.4)</td>
<td>32.1 (21.8)</td>
<td>23.6 (10.3)</td>
</tr>
<tr>
<td>Attention</td>
<td>64.4 (23.9)</td>
<td>62.6 (8.7)</td>
<td>58.6 (17.9)</td>
</tr>
<tr>
<td>Mental flexibility</td>
<td>54.6 (11.7)</td>
<td>51.3 (7.1)</td>
<td>59.6 (9.9)</td>
</tr>
<tr>
<td>Planning</td>
<td>58.1 (33.5)</td>
<td>53.7 (29.5)</td>
<td>35.4 (20.9)</td>
</tr>
</tbody>
</table>

*Mean (SD); †mean (SD) of Z score (%).

Figure 1. Flow of stroke participants through RCT stages.
scores were determined for each cognitive domain from (number of omission errors), WCST (number of categories), ST (90-minute delayed recall), RAVLT (5 trials, 30-minute delayed recall). For each test, a...The FM evaluates muscle tone, range of motion, tendon reflexes, and proximal/distal voluntary arm movements, with a normal score of 66, in addition to proprioception on an 8-point scale. The CSI assesses biceps tendon jerks, resistance to passive stretch, and wrist clonus for scores ranging from 4 (normal tone) to 16 (severe spasticity). TEMPA incorporates proprioception and bimanual daily life tasks in 2 functional scores ranging from 0 (normal) to 12 (unimanual) and 15 (bimanual).

Neuropsychological
Performance across 5 cognitive domains was often impaired after stroke was assessed: verbal memory (Wechsler Memory Scale [WMSS]; Rey Auditory Verbal Learning Test [RAVLT]); visuospatial memory (Rey-Osterrieth Complex Figure Test [ROCFT]); attention (Cancellation test [CT]; ROCFT); mental flexibility (Wisconsin Card Sorting Test [WCST]; Stroop Test [ST]); and planning/problem-solving abilities (Tower of London [TOL]). For each test, a Z score (%) was calculated by selecting a representative variable from each test: WMSS (immediately after), RAVLT (5 trials, 30-minute delayed recall), ROCFT (copy, 40-minute delayed recall), CT (number of omission errors), WCST (number of categories), ST (interference score), and TOL (number of total moves). Mean Z scores were determined for each cognitive domain from Z scores of individual tests and compared with normative data.

Magnetic Resonance Imaging
MRI examinations (General Electric Sigma 1.5-T MRI) were made on 5-mm slices using a 256 matrix. T1-weighted images (repetition time [TR]=500 ms; echo time [TE]=20 ms) and proton density-, and T2-weighted images (TR=2595 ms; TE=20/80 ms) were obtained in the axial plane. Axial T2-weighted images were obtained with a fluid-attenuated inversion recovery sequence (TR=5000 ms; TE=150 ms; inversion time =1900 ms). Infarcts were detected using proton density and T2, and hemorrhage using T1 images. For 10 patients in whom MRI scanning was contraindicated, lesion location was obtained by chart review. Lesions were classified according to cortical, subcortical, or cortical/subcortical (Table 1).

Kinematic
Seated participants performed 25 pointing movements (MT1) with the dominant (impaired) arm from an initial target located ipsilateral...
age- and gender-matched healthy subjects (Table 2). There were no initial differences in mean age, chronicity, and clinical scores between stroke groups (Table 1). For kinematic outcomes, all groups were comparable except that movements in KR were less variable than those in KP or C with respect to velocity ($P_{<0.01}$; Figure 3).

**Intervention and RET**

All groups improved movement time by an average of 229 ms at POST and 299 ms at RET ($F_{2,66}=14.63; P_{<0.0001}$), segmentation by 0.5 peaks at both POST and RET ($F_{2,66}=21.99; P_{<0.0001}$), and velocity variability by 4% at POST and 5% at RET ($F_{2,66}=18.34; P_{<0.0001}$; Figure 3A). In KP, improvements in movement time ($F_{1,27}=4.39$) and segmentation ($F_{1,27}=4.35; P_{<0.05}$) were transferred to MT2. Arm motor impairment (FM; $F_{1,34}=12.24; P_{<0.002}$) and unilateral function (TEMPA; $F_{1,27}=5.57; P_{<0.03}$) but not spasticity improved in all groups with no between-group differences.

Between groups, improvements in precision in KR ($CR=45.3\%$) and in movement time ($CR=57.4\%$) and variability ($CRv=86.8\%; CRp=91.1\%$) in KP were larger than C ($P_{<0.01}$). Kinematic changes were accompanied by a decrease in spasticity ($CR=47.1\%$) in KP compared with C ($P_{<0.05}$).

By group, movements were more precise ($F_{2,66}=2.77; P_{<0.001}$) in KR, faster ($F_{2,66}=7.57; P_{<0.001}$), less segmented ($F_{2,66}=6.06; P_{<0.01}$), and more consistent ($CVv=19.5; CVp=4.09; P_{<0.05}$) in KP and less segmented ($F_{2,66}=20.9; P_{<0.001}$) and more consistent ($CVv=5.16; P_{<0.01}$) in C. The increase in precision in KR was correlated with an increase in movement speed (IIerror versus IItime; $r=0.63$). KP and C also made faster movements that were, however, not correlated with increased precision.

Retention of improved kinematics was related to baseline FM scores. For KR: retention of increased precision ($r=0.70$); for KP: retention of decreased movement time ($r=0.44$) and segmentation ($r=0.43$), increased precision variability ($r=0.01$).

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**Table 2. Preintervention: Kinematic Outcomes (mean $\pm$ SD) in Healthy and Stroke Participants**

<table>
<thead>
<tr>
<th>Kinematic Outcomes</th>
<th>Healthy</th>
<th>Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time (s)</td>
<td>0.7 (0.1)</td>
<td>1.3 (0.3)**</td>
</tr>
<tr>
<td>Precision (cm)</td>
<td>6.5 (1.0)</td>
<td>10.3 (5.5)**</td>
</tr>
<tr>
<td>Segmentation (No. peaks)</td>
<td>1.2 (0.6)</td>
<td>3.6 (2.4)*</td>
</tr>
<tr>
<td>CV velocity (%)</td>
<td>11.9 (3.7)</td>
<td>16.5 (5.3)**</td>
</tr>
<tr>
<td>CV precision (%)</td>
<td>28.4 (12.2)</td>
<td>31.6 (13.2)</td>
</tr>
</tbody>
</table>

* $P_{<0.05}$; ** $P_{<0.01}$.
Behavioral Outcomes and Cognitive Scores

Cognitive scores in stroke patients, on average, were decreased compared with the normative group (Table 1) and for all but planning were correlated with baseline arm clinical scores: FM (verbal memory: \( r = 0.41 \); visuospatial memory: \( r = 0.39 \)); attention: \( r = 0.52 \); mental flexibility: \( r = 0.39 \); CSI (visuospatial memory: \( r = 0.30 \); attention: \( r = -0.39 \); flexibility: \( r = -0.43 \); and TEMPA (verbal memory: \( r = 0.38 \); attention: \( r = 0.43 \)).

As shown previously,19,20 our results demonstrate that given appropriate feedback (ie, KP), even severely impaired patients decreased motor impairment (83% to 86% of patients), and 75% improved motor function.

Platz and Denzler24 suggested that cognitive processes only minimally determine the potential for motor recovery after stroke. Our results are in contrast to this viewpoint and suggest that successful motor intervention may involve varying degrees of cognitive processing depending on the cognitive demands of the intervention. For example, in KR, there was no correlation between improvements in precision and cognitive scores. This may be explained by the fact that feedback about precision does not tap into intellectual or executive functioning processes. In contrast, in KP, motor and clinical improvements were related to better memory, mental flexibility, and planning abilities. Presumably, these cognitive processes are more involved in making use of critical information about moving and adapting motor behavior to improve efficiency. The discrepancy between our results and those of Platz and Denzler may lie in differences in the severity of paresis. They studied patients with mild motor and cognitive impairments who may have already reached maximal clinical scores, whereas in our study, participants had more severe motor and cognitive impairments. In addition, because all groups in our study had similar baseline cognitive scores, differences in skill reacquisition seem to be related to the singular cognitive demands required by the feedback types and not to initial between-group differences.

Finally, the motor improvements in the KP group transferred to a related task as opposed to task-specific training approaches.26 This may be explained by the learning of a generalized set of movement combinations as a basis for an entire class of actions.3 Included in this process is the opportunity for learners to perform error detection and self-correction, which may be facilitated by the use of decreased feedback frequency. Consequently, our results suggest that learning was enhanced by providing feedback with a faded frequency.

The present study incorporated critical factors related to motor relearning after stroke, such as type, timing and frequency of feedback, and initial motor and cognitive impairment levels. The relatively small sample size limits generalization of results. However, our findings may have
important implications for motor rehabilitation after stroke. First, training incorporating information and practice of specific motor elements may have a larger impact on motor recovery. Second, the assessment and modification of cognitive impairment are essential elements of motor rehabilitation programs.

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References
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