<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Type of intervention (E = experimental, C = control)</th>
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<tbody>
<tr>
<td>Mielentoiminnnot (n = 2)</td>
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<tr>
<td>Edmans 2000</td>
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<td>Objective: To compare the effectiveness of the transfer of training and functional approaches in improving perceptual and functional abilities after stroke.</td>
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<td></td>
<td></td>
<td>E: The basic assumption of the transfer of training approach is that practice on a particular perceptual task will affect a patient’s performance on similar perceptual tasks, i.e. this approach is concerned with treating the cause of the perceptual problem.</td>
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<td></td>
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<td>C: The functional approach is the repetitive practice of particular tasks, usually activities of daily living, in order to make the patient more independent. The emphasis is on treating the symptom rather than the cause of the problem.</td>
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<td></td>
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<td>Both groups was given perceptual treatment two and a half hours per week for six weeks, in addition to their general OT treatment (stroke unit).</td>
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<tr>
<td>Fong 2007</td>
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<td>Objective: To investigate the effectiveness of voluntary trunk rotation and half-field eye-patching to treat patients with unilateral neglect in stroke.</td>
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<td>E1: Subjects in the voluntary trunk rotation (TR) group received 60 minutes of daily experimental training in an occupational therapy session which consisted of 45 minutes of voluntary trunk rotation using set-up equipment as well as 15 minutes of activities of daily living (ADL) training five times a week for 30 days.</td>
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<td>E2: Subjects in the voluntary trunk rotation and half-field eye-patching (TR EP) group received exactly the same training as the trunk rotation group except they had half-field eyepatching to the ipsilesional (right) hemifield by wearing specific goggles during both the TR and ADL training. The trunk rotation element was not controlled for any transfer practice upon training in ADL at bedside for these two groups.</td>
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<td>C: Subjects in the control group received conventional occupational therapy for hemiplegia which consisted of 15 minutes of training in ADL and 45 minutes of training in hemiplegic upper extremity with the same contact time during the intervention period.</td>
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<td>Settings: Rehabilitation hospital in Hong Kong.</td>
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<td>Oppiminen (n = 4)</td>
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<td>Chan 2006</td>
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<td>Objective: To study the efficacy of the motor relearning approach in promoting physical function and task performance for patients after a stroke.</td>
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<td>In both groups, the patients received training for a total of six weeks in the form of three 2-hsessions each week (18 sessions total) by occupational therapist.</td>
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E: In the motor relearning programme, the intervention technique followed four sequential steps: identification of the missing performance components (step 1), training using remedial exercises (step 2), training using functional task components (step 3), and transfer of skills to functional task performance (step 4). A total of 24 remedial tasks (used in step 2) and 10 functional tasks (used in step 4) were designed to cover deficits in static and dynamic sitting balance, and static and dynamic standing balance. Throughout the training session, the therapist stressed the importance of relating the training processes taking place in steps 2 and 3 to practices in step 4. The training progressed by advancing from a sitting to a standing position, and from static to dynamic balancing. The criteria established for progression were clearly defined, and those patients who demonstrated the desirable skills were upgraded to another stage of training.

C: The skill training method was adopted for use with patients receiving the conventional therapy programme. The same number of remedial and functional tasks was covered as in the motor relearning programme. The selection of remedial tasks followed the principle of progressing from a sitting to a standing position, and from static to dynamic balance. The training of functional tasks began with simple self-care and bedside tasks, such as bed mobility, and progressed to more complicated tasks, such as use of community facilities. Unlike the motor relearning programme, the patients were not involved in identifying their own missing performance components. The relationships between the practices of the remedial tasks and the entire functional task performance were not reinforced.

Donkervoort 2001 & Geusgens 2006

Objective: To examine the transfer of the effects of cognitive strategy training for stroke patients with apraxia from trained to non-trained tasks.

E: Strategy training consisted of the standardised treatment programme for left hemisphere stroke patients with apraxia, which is based on teaching patients strategies to compensate for the presence of apraxia. By means of this programme the patient is gradually taught more efficient strategies. The aim of the therapy is to maximize the patient's independence by improving ADL functioning. During a detailed diagnostic assessment of disability (standardised ADL observations), the specific problems of each individual patient are examined. These problems become the focus of attention during therapy; an intervention is chosen in correspondence with the observed problems. ADL tasks are conceptualized as being composed of three successive phases, according to the framework of information processing: the proper plan of action and the correct objects have to be selected (initiation and orientation), followed by adequate execution of the selected plan (execution), which has to be evaluated in terms of the result, and if necessary corrected (control and correction). Corresponding to these phases, the specific interventions focus on instructions, assistance and feedback, respectively. This diagnostic assessment is strictly used for clinical purposes and is therefore independent of the study.
C: Usual occupational therapy concentrated on (sensory) motor, perceptual and cognitive deficits of the stroke patient and aimed at increasing independent functioning in ADL tasks. In general, the main focus of the therapy was on (sensory) motor impairments (e.g., muscle tone, reflexes, controlled movements, muscle strength, contractures) and disability due to these impairments. A variety of treatment methods have been mentioned in the literature and used in daily practice. Nowadays, strategy training is incorporated more in the usual occupational therapy.

Liu 2004

Objective: To compare the effect of a 3-week, standardized, mental imagery program with that of a conventional, functional rehabilitation training program on promoting relearning after stroke.

In both groups, patients received training for a total of 3 weeks with five 1-hour sessions each week. Two occupational therapists provided the training in the mental imagery program, and 2 other occupational therapists provided training in the functional retraining program.

E: In the mental imagery program, patients were trained in the technique of mental imagery to practice specific tasks. Different but related mental imagery skills and the actual performance of tasks were practiced each week to help patients develop competence in using imagery as a learning tool. In the first week, the focus was on analyzing task sequences to facilitate the motor planning and problem identification process using computer-generated pictures and movies. In the second week, patients identified their own problems for rectification through the use of mental imagery. Picture cards depicting the task sequences were used if the patients needed help recalling the steps. In the third week, the focus was on practicing the rectified task performance using mental imagery and actual practice. To further standardize the protocol, a computer program was developed to guide patients to relearn the steps involved in performing each of the 15 tasks. Each step was presented as a picture, with verbal explanations of the physical and mental demands of that particular step (to enhance task analysis). Visual aids were also used to help patients reflect on the problems that they encountered when they actually performed the tasks. They watched the video playback to confirm the problems that they identified (to enhance problem identification). Patients were guided to develop strategies to overcome the problems. The tasks, with or without modifications, were mentally rehearsed before patients practiced them. Mental rehearsal and actual practice were intertwined throughout the relearning process.

C: In the functional retraining program, the demonstration then practice method was adopted. Patients were required to practice the same tasks following a sequence and training schedule similar to that of the mental imagery program. Unlike the mental imagery program, however, the problems encountered by patients were rectified with the help of therapists. Common problems were mainly associated with sensorimotor and cognitive functions, such as decreased motor control over the limbs and difficulty planning before performing a task. The
therapists considered the limitations of patients and designed and adapted task performance. Each step involved in the adapted performance was demonstrated to the patients. The demonstration was repeated until patients gained confidence to practice them. Patients then practiced the tasks under the supervision of therapists. Further task modification and demonstration was provided throughout the program to maximize the functional patients’ regain.

### Päivittäiset toiminnot (Itsestä huolehtiminen ja kotielämä) (n = 13)

**Chiu 2004**

Objective: To evaluate whether an additional home training program on bathing devices would improve the rate of use, personal independence, and service satisfaction of older adults who had experienced strokes.

The prescription of and training in the use of assistive devices were demonstrated to both groups while they were in hospital.

**E:** Additional home-based training in the use of assistive devices by occupational therapists immediately after being discharged. At first visit an occupational therapist demonstrated and explained the use of assistive devices and safety techniques to the subjects and care-givers. The second visit was related to bathing practices, and time was allowed for the subject and the caregiver to express the problems and difficulties encountered in using such devices. The subjects were encouraged to use the bathing devices every time they bathed. In addition, the devices were checked for correct fit and safety. The third visit was optional and depended on the patients’ proficiency in device use skills.

**C:** The control group was provided a pre-discharge home visit for preparing a suitable environment for the client’s living and conventional training in the hospital, but did not receive any treatment post-discharge.

**Corr 1995**

Objective: To evaluate the influence of continued rehabilitative intervention by an occupational therapist on stroke patients after their discharge from a stroke unit.

**E:** Appropriate therapeutic interventions were carried out as needed, based on the model of human occupation (Kielhofner 1985). The interventions included teaching new skills; facilitating more independence in activities of daily living; facilitating return of function; enabling patients to use equipment supplied by other agencies; giving information to the patient and carer; and referring to or liaising with other agencies. Intervention was in addition to any other follow-up services arranged, such as day-hospital attendance and community physiotherapy.

**C:** No special intervention of follow-up, although they could receive any available services as required. They had no contact with the researcher.


**Egan 2007**

Objective: to evaluate the potential effectiveness of community-based occupational therapy to enhance participation in valued activities 6 months postdischarge from an inpatient rehabilitation program.

**E1:** Patients in the intervention group received up to eight visits from the study occupational therapist to work on issues related to participation in valued activities...
identified by the patient during administration of the COPM. These visits took place over 2–4 months. Intervention was carried out by one registered occupational therapist using a client-centered occupation-based approach guided by Canadian Model of Occupational Performance and the Occupational Performance Process Models. These models espouse a collaborative partnership between therapist and patient in which the patient is assisted in identifying personally meaningful daily activities that they are having difficulty carrying out ("occupational performance issues"). Then the therapist and patient design a plan to address these issues by examining barriers to and facilitators of participation in these activities. Methods of carrying out the plan may include coaching, education, changes to the physical environment, and use of resources with the goal of enabling the client to achieve identified goals. The investigative team regularly reviewed the occupational therapist’s notes to ensure that she consistently provided such care.

C: The control condition was usual care, which does not typically include occupational therapy. We had originally planned to provide friendly visiting as a control condition, but this was not well received by participants and was discontinued very early in the study.

References:

Gilbertson 2000a ja 2000b

Objective: To establish if a brief programme of domiciliary occupational therapy could improve the recovery of patients with stroke discharged from hospital.

E: The intervention service was designed to be client centred and was developed through focus group sessions with patients, carers, and local occupational therapy staff. From these sessions a six week domiciliary programme was developed (comprising around 10 visits lasting 30–45 minutes) tailored to recovery goals identified by the patient such as regaining self care or domestic or leisure activities. The therapist worked with the patient to achieve these goals and also liaised with other agencies for advice, services, and equipment.

C: Routine services included inpatient multidisciplinary rehabilitation, a predischarge home visit for selected patients, the provision of support services and equipment, regular multidisciplinary review at a stroke clinic, and selected patients referred to a medical day hospital.

Gilmore 2007

Objective: to determine the effectiveness of an experimental therapy combining videotape feedback with occupational therapy compared to only occupational therapy in learning the motor skill of donning socks and shoes after stroke.
The task of donning socks and shoes was chosen because therapy literature supports the use of goal-directed activity and purposeful occupations to enhance motor learning. All of the participants indicated that donning socks and shoes was meaningful to them. Treatment was considered successful and was stopped if the participant was able to independently don his or her socks and shoes prior to the 10 session maximum. Full score on the KB-ADL in three consecutive sessions indicated, for the purposes of this study, that the participant was able to independently don his or her socks and/or shoes. During each intervention session, the researcher demonstrated the whole task of donning socks while the participant watched, then the participant practiced donning socks three times per session. The researcher then demonstrated donning shoes and the participant practiced donning shoes three times per session. The use of adaptive equipment was permitted. The researcher provided verbal feedback to the participant after each practice performance. Treatment sessions were videotaped for all participants to minimize the Hawthorne Effect and to assess the ability of participants to don socks and shoes using the KB-ADL socks and shoes subtests.

E1: Group B received verbal feedback augmented with feedback from the videotape replay. For both groups, the previous session’s feedback was reviewed before beginning a session. Group B viewed the previous day’s performance on the videotape.

E2: Group A received verbal feedback without the use of videotape replay.

Jongbloed 1989

Objective: To compare the effectiveness of two occupational therapy approaches to treating cerebrovascular accident patients – the functional and sensorimotor integrative approaches.

E1: Functional Approach emphasizes the practice of particular tasks, usually activities of daily living, which make the patient more independent in meeting his or her basic needs. These tasks may include dressing, grooming, bathing, toileting, mobility, and homemaking. The emphasis is on treating the symptoms rather than the cause of the dysfunction. It can be subdivided into two aspects: compensation and adaptation.

1) Compensation: The therapist facilitates awareness of a problem and then helps the patient make allowances for it.
2) Adaptation: The environment of the patient is modified to allow that person to function with greater ease and independence.

E2: Sensorimotor Integrative Approach combines sensorimotor theories, primarily those described by Bobath, Rood and Ayres. It is based on belief that the brain functions holistically and that motor and sensory areas are interdependent. Therefore, stimulation of one system can influence another. This approach emphasizes treating the cause of the dysfunction rather than compensating for, or adapting to, the problem. The principles of treatment are a) provide planned and controlled sensory input, b) elicit an adaptive response, c) enhance organization of brain mechanisms, d) facilitate the developmental sequence, e) consider the
interdependence of sensory systems, f) maintain a balance of sensorimotor integration, and g) focus on sensory integration and its integration with movement.

Logan 1997

Objective: To determine whether stroke patients referred to the Social Service occupational therapy service would benefit from an enhanced service compared to the usual service.

E: Stroke patients discharged home from hospital and referred to Social Service occupational department. The enhanced service group were seen and treated by a single research occupational therapist. OT could see patients sooner and more often than possible by the routine service. OT has equal access to aids and budgets for adaptations and she was able to check that equipment provided was appropriate.

C: In the routine service all patients were prioritized by the senior OT and only the urgent cases were seen immediately whereas others were placed on a waiting list.

Morgan 2002

Objective: To study the effectiveness of a client-centered occupational therapy intervention at home for stroke survivors, following hospitalization.

E: The experimental group was given an occupational therapy intervention programme, which was planned using the “Guidelines for client-centered occupational therapy” (CAOT, 1991). Here the therapist plans therapy with the client as the decision-maker and implements therapy based on the goals and priorities identified by the clients themselves, to deal with various deficit occupational performance components. Also they were given an activity schedule, which included activities to enhance the occupational performance components that were identified by the subjects as ‘important’ according to the COPM. Each occupational performance component that was prioritized as important by the client was broken down into subtle elementary tasks. Each of these tasks were taught by the occupational therapist and later incorporated into the activity schedule that would enable the subject to monitor his own progress. Likewise each occupational performance component was addressed and the activity schedule was upgraded once in 2 weeks depending on the subjects’ progress. The caregiver was made responsible for supervising daily schedule, and to give a suitable reinforcement preferred by the client, to maximize compliance. The various occupational performance components that were addressed were personal care, functional mobility, community management, household management, work, quite recreation, active recreation, and socialization. For example: If Indoor mobility was a problem, the therapist would train the patient in certain pre-requisite skills and elementary tasks like bed mobility, weight bearing on the affected side, sitting and standing balance which would enable them to accomplish the identified problem. Each of this was then added to the activity schedule so that the client can practice these skills daily. He would then be supervised and reinforced appropriately for his progress by his caregiver. This would then be
upgraded after 2 weeks according to the needs and priorities of the client by the occupational therapist.

C: Each subject in the control group was given functional activities based on the level of recovery using conventional treatment techniques. Here an eclectic approach was used to enhance the process of recovery with therapist taking decisions for the subjects. And the grading of activities depended upon the subject’s recovery and achievement of independence in a particular tasks rather than addressing individual occupational performance components according to subject’s priority and felt needs.

Sackley 2006

Objective: A pilot evaluation of an occupational therapy intervention to improve self-care independence for residents with stroke-related disability living in care homes was the basis of this study

E: The intervention was developed by using existing evidence and the consensus of a group of expert occupational therapists. The intervention was provided by an experienced qualified occupational therapist and was delivered at the level of the individual. It was targeted toward improving independence in personal activities of daily living, such as feeding, dressing, toileting, bathing, transferring and mobilizing. The frequency and duration was dependent on the resident and therapist’s agreed goals, and it took place over the 3-month period that the therapist was attached to the home. Occupational therapy followed a routine process using a "client-centered approach," as far as possible and included a continuous process of assessment, treatment and reassessment.

Occupational Therapy Intervention at the Level of the Resident: The content of the occupational therapy intervention was potentially multifaceted in that it could address (1) the resident’s performance of a specific task (e.g., eating, mobilizing) in given environment (e.g., bedroom, bathroom), (2) the physical environment in which the task was being performed, and (3) specific impairments that may limit performance in activities of daily living (ADL) or cause discomfort (e.g., tissue shortening in a hand). Techniques used by the occupational therapist to improve performance in activities of daily living were likely to include (1) task-specific practice including dressing practice, transfer practice, mobility training, etc, (2) reducing the complexity or demands of the task by changing the tools required to perform the task or by altering the environment through the provision of aids and adaptations, or by simplifying the task, and (3) specific therapeutic interventions (e.g., stretching to relieve tissue shortening in a hand and providing a splint). As part of the treatment, progress was reviewed and goals modified accordingly.

Occupational Therapy Intervention at the Level of the Nursing Home Staff and Carers:
The content of the occupational therapy intervention would also include an element of education of nursing home staff and carers as to the purpose of the
intervention and the promotion of independence using techniques, such as providing information on how to continue therapy/treatment in the absence of the therapist, how, why and when to use aids or adaptations. The therapist was also able to refer/discuss any problems with the study team, general practitioner or other agencies.

C: Residents in the control homes received usual care. As usual in the UK, occupational therapy was not routinely used by any of the homes. None of the homes had an identified person with specific responsibility for ADL training or the provision of adaptive equipment.


Walker 1996

Objective: To determine whether giving dressing practice to patients at home with unresolved dressing problems following stroke reduces the problems.

E: Treatment was given by a senior occupational therapist at the patient’s home. Dressing practice was given on a regular basis, with the amount of therapy at the therapist’s discretion. Treatment involved teaching patients and carers appropriate techniques such as dressing the affected limb first, energy conservation, the use of red thread to overcome perceptual difficulties and to mark alignment of buttons, and advice on choice of clothing. Relatives were encouraged to continue the dressing practice between sessions with the occupational therapist.

C: Cross-over design: During no-treatment phase they had no contact with the research occupational therapist; all other rehabilitation continued as usual.

Walker 1999 ja 2001

Objective: To assess the efficacy of an occupational therapy intervention for patients with stroke who were not admitted to hospital.

E: Patients allocated to occupational therapy received visits from a research occupational therapist for up to 5 months. The frequency of treatment was agreed between the therapist, patient, and, if relevant, the carer. The aim of therapy was independence in personal and instrumental activities of daily living. Personal care included activities such as bathing, feeding, dressing, and stair mobility. Instrumental activities of daily living included activities such as outdoor mobility, driving a car, travelling by public transport, and household chores. Patients were also encouraged to take part in leisure pursuits. The focus of therapy was active intervention rather than assessment or liaison. Specific tasks were set as homework when possible.

C: Patients in the control group received no additional input from the research therapist, but may have received input from existing services, as would occur in routine practice.
Vapaa-ajan toiminnot, vapaa-ajan vietto (n = 6)

Desrosiers 2007

Objective: To evaluate the effect of a leisure education program on participation in and satisfaction with leisure activities (leisure-related outcomes), and well-being, depressive symptoms, and quality of life (primary outcomes) after stroke.

E: Experimental participants received the leisure education program at home. The experimental intervention was provided by 2 study personnel: another occupational therapist and a recreational therapist. The recreational therapist was responsible for the intervention whereas the occupational therapist acted as a consultant, her role being to facilitate leisure participation, mainly by adapting the material or the environment. The therapists met the participants once a week (8–12 wk), theoretically for 60 minutes, but the duration for the experimental group was slightly longer because the leisure activities took place both at home and in the community, whereas the control intervention was carried out at home.

Leisure Education program objectives were to enhance the participants' personal empowerment with a view to optimizing leisure experiences. The program was divided into 3 components. First, leisure awareness, which is defined as the perception and knowledge people have of their leisure activities and how important they consider them. Self-awareness relates to people's perception of themselves, and their values, attitudes, and capacities in regard to leisure activities. Finally, competency development encompasses the perceived and real constraints identified by the person and knowledge of alternatives to achieve autonomy in leisure activities. The program is divided into 12 steps. The maximum duration of the intervention for a participant usually does not exceed 12 sessions. The recreational therapist judged that a person had reached the end of the program when the following 2 conditions were present: (1) the participant had gone through all the steps in the program and (2) the person had integrated significant leisure activities in her/his life.

C: The control group participants were also visited at home by the recreational therapist but the topics discussed were unrelated to leisure (e.g., family, cooking, politics, news, everyday life).

Drummond 1995 & 1996

Objective: To evaluate a leisure rehabilitation programme with stroke patients (1995) and to assess the effects of the leisure rehabilitation programme on functional performance, psychological wellbeing and mood (1996).

E1: Leisure rehabilitation. The hobbies and interests of the subjects were discussed in detail and the importance of maintaining a leisure programme was stressed. The treatment programme for each subject was different, reflecting personal preferences and abilities. However, the advice and help offered fell into the following broad categories: treatment (e.g. practice of transfers needed for leisure pursuits); positioning; provision of equipments; adaptations; advice on obtaining financial assistance and transport; liaison with specialist organizations, and providing physical assistance (e.g. referral to voluntary agencies).

E2: Conventional occupational treatment. Subjects were seen for occupational therapy activities such as transfers, washing and dressing practice, and, where appropriate, perceptual treatments. In situation where subjects were virtually independent, the visits were check-up visits, and subjects were questioned about
their progress and any existing problems. The treatment programme for each individual in E2 was therefore different, to reflect their differing abilities and problems. No reference was made to the importance of continuing previous interests, and no help or advice was offered to encourage participation in leisure pursuits.

C: No additional input over that which they were receiving from hospital or social services.

**Jongbloed 1991**

Objective: To determine the efficacy of occupational therapy intervention related to the leisure activities of stroke survivors.

E: The objective of the occupational therapy intervention was to assist the subjects in resuming former leisure activities, to learn to engage new activities, or both. Occupational therapist had access to information on each subject’s physical and cognitive function (from the hospitals’ occupational therapy charts). In addition, the therapist assessed the subject’s environment (including home primary social contacts, and transportation and funds available for leisure activities). Also assessed were premorbid activities and the desire to attempt these activities adapted to accommodate disability or the subject’s desire to attempt different activities in keeping with the constraints of the disability. The subjects decided where they desired assistance from the therapist in terms of resuming former activities of learning new activities. Leisure activities included individual or social activities carried out in the home or community environment.

C: An occupational therapist visited and asked questions about leisure activity involvement throughout their life span. The therapist also asked each person about the effects of the stroke on his or her life. No intervention related to leisure activity involvement was provided. The therapist spent the same amount of time with subjects assigned to the experimental and control groups.

**Nour 2002**

Objective: To evaluate the impact of a different home leisure educational program on the depression and quality of life of older adults who have had strokes and had just been discharged from an intensive functional rehabilitation program.

E: The leisure educational program is based on a theoretical framework that promotes the empowerment and self-management of individuals toward their own optimal leisure life. It is a self-management program where the participant learns to rebuild his self-confidence in his capacities and abilities to manage his leisure activities. Through a leisure educational program, individuals’ perceptions need to change, i.e., perception of a) themselves (their capacity to do leisure activities, their interests and values about leisure, etc.) b) their leisure (activities and meaning, etc.) and c) their human and physical environment (availability and accessibility of the resources to do leisure activities). The 12 steps of the program were addressed during 10 intervention sessions. To make individuals progress faster in the program, they were having homework to do between intervention session, i.e., work and reflection on leisure issues. Concretely, the program can vary considerably from one participant to the next. The structure is the same for everyone, but the intervention differs.

C: Friendly visits at home.
Parker 2001

Objective: To evaluate the effects of leisure therapy and conventional occupational therapy (OT) on the mood, leisure participation and independence in activities of daily living (ADL) of stroke patients 6 and 12 months after hospital discharge. Participants allocated to the two treatment groups received occupational therapy interventions at home for up to six months after recruitment. The protocol specified a minimum of 10 sessions lasting not less than 30 minutes each.

E1: The treatment goals set in the ADL group were in terms of improving independence in self-care tasks and therefore treatment involved practising these tasks (such as preparing a meal or walking outdoors).

E2: For the leisure group, goals were set in terms of leisure activity and so interventions included practising the leisure tasks as well as any ADL tasks necessary to achieve the leisure objective. The treating therapist used a standard form to record brief details of date and duration of sessions.

C: Participants allocated to the control group received no occupational therapy treatment within the trial.

All participants were eligible for any existing rehabilitation services provided in their area, such as day hospital visits.

Liikkuminen (n = 4)
Desrosiers 2005

Objective: To evaluate the effect of an arm training programme combining repetition of unilateral and symmetrical bilateral tasks for people in the subacute phase after stroke.

E: The experimental group received a training programme mainly based on the practice of symmetrical bilateral tasks. The experimental programme was also based on motor learning model principles, including repeated practice and task variability. The programme consisted of standardized activities related to everyday tasks involving the arms. The activities were graduated in terms of difficulty and task requirements, according to the impairment level of the arm of each experimental group participant. The tasks required the subject's active participation. There were various types of tasks: symmetrical and asymmetrical bilateral, unilateral for the affected side and unilateral for the less affected side. The symmetrical bilateral tasks involved reciprocal or similar use of the two arms (such as wringing a garment, rolling a cylinder or doing unilateral tasks simultaneously with both arms) while the asymmetrical bilateral tasks involved greater use of one of the arms (such as making coffee). This type of bilateral task can also be done with minimal capacities in the affected arm, which allows the programme to be used with patients with moderate to severe deficits. The unilateral tasks for the affected side consisted of gross and fine dexterity tasks, depending on the impairment. The unilateral tasks for the 'less affected' side mainly comprised dexterity and motor co-ordination activities requiring some precision and speed.
These latter activities were retained because practising fine motor unilateral tasks on the less affected side could help improve the affected side.

C: The control programme for the arm consisted of functional activities and exercises to enhance strength, active, assisted and passive movements, and sensorimotor skills of the arm. The control programme was also based on some components of a neurodevelopmental approach by inhibiting abnormal patterns of movement and stimulating normal active reactions of the affected arm. The programme began with passive and assisted movements of the affected arm, followed by unilateral tasks, such as putting blocks or cones in a pile, unscrewing a light bulb, and symmetrical bilateral tasks, such as shuffling playing cards, putting a pillow in a pillowcase, tearing up sheets of paper. These tasks were adapted to the level of impairment and recovery of each patient. No asymmetrical tasks were done nor were unilateral tasks of the less affected arm done. Contrary to the experimental programme, the tasks were not repeated in a systematic way and the mental and physical effort required by the patient was lower (less intense).

Greenberg 1980
Objective: To assess the effectiveness of kinaesthetic biofeedback as a modality in the treatment of hemiplegia.

E: Kinesthetic biofeedback group: Subject in this group received audiovisual kinesthetic feedback associated with active elbow extension.

C: Conventional occupational therapy: Brunnstrom’s therapeutic approach for the treatment of the adult hemiplegic.

Logan 2004
Objective: To evaluate an occupational therapy intervention to improve outdoor mobility after stroke
1) to establish whether people who received the intervention were more likely to get out of the house as much as they wanted.
2) to examine whether the intervention increased the number of journeys taken outdoors, affected the performance of activities of daily living, leisure activity, or psychological wellbeing, and affected the psychological wellbeing of partners or carers.

First visit for both groups: advice, encouragement, and the provision of leaflets describing local mobility services. This session reflected a routine occupational therapy session and also served as the intervention for those who were later allocated to the control group.

E: OT made a clinical assessment of the barriers to outdoor mobility in the participants allocated to the occupational therapy intervention, negotiated mobility goals with them, and then delivered interventions to achieve those goals, using up to seven treatment sessions at home for up to three months. The treatment programme included the provision of information (for example, resuming driving, alternatives to cars and buses); the use of minor aids or adaptations, such as walking aids; and overcoming fear and apprehension by, for example,
accompanying participants until confidence was restored. Aids and appliances were obtained from usual sources.

C: One visit consisting advice, encouragement, and the provision of leaflets describing local mobility services.

Page 2000

Objective: To determine the efficacy of a therapy program combining a program of imagery with a program of occupational therapy for the paretic upper extremity (OT+I) in reducing impairment of the upper extremity. For both groups, each of the therapists provided treatment that consisted of 40% neurodevelopmental (NDT) techniques (e.g., mobilization of the scapula, place and hold activities with the affected arm) and 60% compensatory strategies (e.g., rolling and transfers while clasping the affected hand with the other hand) using the ipsilateral, unaffected limb.

E1: OT + I: After half an hour of OT, participants in Group E1 were administered a tape-recorded imagery intervention lasting 20 minutes. The intervention consisted of 5 minutes of relaxation followed by 10 minutes of suggestions for external, cognitive visual images related to using the affected arm in weight-bearing tasks and functional tasks that were being practiced during their OT sessions. Finally 5 minutes of refocusing into the room.

E2: OT: After half an hour of OT, members of Group E2 listened to a 20-minute tape with instructions and information requiring the patient’s attention and participation.