

Cognitive remediation

Introduction

Cognitive impairment is an affliction for many people with bipolar disorder, and affects domains including executive function, attention, memory (particularly verbal memory), and social cognition. These deficits interfere considerably with day-to-day function.

Cognitive remediation (or rehabilitation) interventions usually take the form of repetitive exercises (with or without computers and sometimes augmented by group sessions, strategy coaching and homework exercises) which serve as training for cognitive processes such as memory or attention, as well as social skills and communication. Strategy learning focuses on providing alternative strategies to compensate for the observed difficulties with cognition; in contrast, rehearsal learning is aimed at restitution of lost skills. This type of intervention is specifically targeted to particular cognitive domains which are known to be deficient in people with bipolar disorder, with the intention of compensating or improving functional outcome.

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2010 that report results separately for people with a diagnosis of bipolar or related disorders. Reviews were identified by searching the databases MEDLINE, EMBASE, and PsycINFO. Hand searching reference lists of identified reviews was also conducted. When multiple copies of review topics were found, the most recent and/or comprehensive review was included. Reviews with pooled results were given priority for inclusion.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis¹. Reviews rated as having less than 50% of items checked have

been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach² where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate or low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention, or other matter under review, are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large or if there is a dose dependent response. We have also taken into account sample size and whether results are consistent, precise and direct with low associated risks (see end of table for an explanation of these terms). The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

Results

We found one systematic review that met our inclusion criteria³.

- Low quality evidence is unable to determine any benefits of cognitive rehabilitation for people with bipolar disorder.

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Kluwe-Schiavon B, Viola TW, Levandowski ML, Bortolotto VR, Azevedo e Souza LS, Tractenberg SG, Soares T

A systematic review of cognitive rehabilitation for bipolar disorder

Trends in Psychiatry & Psychotherapy 2015; 37: 194-201

[View review abstract online](#)

Comparison	Cognitive rehabilitation interventions (average 17 hours of treatment, ~1 hour per week) vs. treatment as usual, psychoeducation, or pre- vs. post-treatment.
Summary of evidence	Low quality evidence (small to medium-sized samples, appears inconsistent, unable to assess precision, indirect) is unable to determine any benefits of cognitive rehabilitation.
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<p>3 small studies of the 4 studies included in the review (N range 14 to 239) reported better executive functioning after cognitive rehabilitation when measured by self administered scales but not when measured using structured neuropsychological tests.</p> <p>Social cognition and interaction training assessed in one small study (N = 37) found some evidence of improved social cognition.</p> <p>Review authors report that findings were not robust due to the variety of intervention designs, the methodological limitations of the studies, and the lack of studies in the field.</p>	
Consistency in results[‡]	Appears inconsistent.
Precision in results[§]	Unable to assess precision; no data is reported.
Directness of results	Indirect (mixed interventions and control conditions).

Explanation of acronyms

BPRS = Brief Psychiatric Rating Scale, CI = Confidence Interval, CT = cognitive training, d = Cohen's d and g = Hedges' g = standardized mean differences (see below for interpretation of effect size), MD = mean difference, N = number of participants, NS = not significant, OR = odds ratio, p = statistical probability of obtaining that result ($p < 0.05$ generally regarded as significant), Q = Q statistic for the test of heterogeneity, Q_w = test for within group differences (heterogeneity in study results within a group of studies – measure of study consistency), Q_B = test for between group differences (heterogeneity between groups of studies for an outcome of interest), RCT = randomised controlled trial, vs = versus, WAIS = Weschler Adult Intelligence Scale, WCST = Wisconsin Card Sorting Test



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Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small[†].

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives that are correctly identified (100% sensitivity = correct identification of all

actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomised trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardised mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) that allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. 0.2 represents a small effect, 0.5 a medium effect, and 0.8 and over represents a large effect[‡].

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. A medium effect is considered if $RR > 2$ or < 0.5 and a large effect if $RR > 5$ or < 0.2 [§]. InOR stands for logarithmic OR where a InOR of 0 shows no difference between groups. Hazard ratios measure the effect of an explanatory variable on the hazard or risk of an event.

Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often



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unforeseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised (b) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed⁶.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. I^2 is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity. I^2 can be calculated from Q (chi-square) for the test of heterogeneity with the following formula;

$$I^2 = \left(\frac{Q - df}{Q} \right) \times 100\%$$

|| Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when



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References

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