**Development of a Mobile Device-based Augmented Reality Mirror Therapy System for Rehabilitation of the Stroke Hemiplegia**

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Abstract

This study developed an augmented reality mirror therapy (ARMT) system based on mobile phones, aiming to provide the convenience of traditional mirror therapy (MT) while providing a relatively good rehabilitation quality. Ten young healthy subjects were recruited to participate in the clinical trial and divided into two groups. In the group, traditional MT and ARMT interventions were performed to observe the difference in hand function before and after the intervention. Functional near infrared spectroscopy (fNIRS) was used to evaluate the activation of different brain regions during the intervention. The results of the study found that there were significant differences in the pre- and post-tests of ARMT, but not in MT; and found that the two had similar blood perfusion patterns, which indicated the potential of ARMT in clinical rehabilitation applications.

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# Chapter 1 Introduction

## Background

For post-stroke survivors, the most common sequelae is hemiplegia, which is a type of paralysis that affects one side of the body, cause a range of physical impairments, including weakness, spasticity, and loss of sensation, and significantly impact a person's ability to perform daily activities. Hence, upper limb rehabilitation is a critical practice for stroke survivors to regain functional independence and improve their quality of life. Including grasp, reach, dexterity, and coordination, the importance of upper limb rehabilitation is such that many routine rehabilitation exercises mostly include their program.

In the recent years, there has been growing interest in innovative rehabilitation methods that incorporate technology, such as virtual reality and robotics, to enhance the effectiveness and efficiency of stroke rehabilitation. These methods offer potential advantages such as increased patient engagement, personalized feedback, and improved outcomes.

## [1.2] Rehabilitation on Stroke Patient

Many current rehabilitation treatments for hemiplegic stroke patients are grounded in the theory of neuroplasticity, which refers to the brain's ability to reorganize and grow by altering its neural connections over time. This phenomenon involves rewiring the brain to function differently from its previous state. Related research suggests that multisensory stimulation and explicit feedback principles should be implemented for motor-oriented rehabilitation.

Many current rehabilitation treatments for hemiplegic stroke patients are grounded in the theory of neuroplasticity, which refers to the brain's ability to reorganize and grow by altering its neural connections over time [[ref]](https://books.google.com.tw/books/about/Neuroplasticity.html?id=vvjdDAAAQBAJ&redir_esc=y). This phenomenon involves rewiring the brain to function differently from its previous state. Related research suggests that multisensory stimulation and explicit feedback principles should be implemented for motor-oriented rehabilitation. The consistency of action and motor intention, one or multiple sensory stimulation at the same time, is an important factor in inducing neuroplasticity [[ref]](https://pubmed.ncbi.nlm.nih.gov/31920570/), and this factor is also reflected in the research direction of these three effective stroke rehabilitation methods. As an indispensable role in dealing with daily life, upper limb rehabilitation training is currently the most mainstream and most researched rehabilitation goal, besides, two-thirds of the studied interventions deal with motor recovery in recent years. [[ref]](https://pubmed.ncbi.nlm.nih.gov/31983296/)

Reports from clinical and therapist experiences, the vast majority of scholars agree that rehabilitation after stroke has a decisive impact on patients' prognosis. Rehabilitation quality, immediacy, duration, and patients' adherence are crucial factors that directly affect post-stroke survivors' maximum recovery potential. Stroke can cause a decrease in functionality in various ways, depending on the affected brain region. However, the most common and frustrating defects are related to motor and sensory impairments, which often occur in groups of survivors. This is because the motor and sensory fibers are located in the superficial layer of the brain (cortex), which is more susceptible to damage from a stroke.

Theoretically, based on the systematic rehabilitation schedule and consistent practice with a therapist, most minor stroke patients can achieve complete recovery within six months. Although extensive stroke patients may require several years and may not fully recover, early exposure to therapy is critical during the recovery process. Therefore, balancing the quality of therapy and creating an interesting and immersive experience to support their willingness to participate has become a significant topic of research in recent years.

Rehabilitation aims to help stroke patients regain their general life skills. Upper limb rehabilitation, which focuses on recovering patients' arm, shoulder, hand, and wrist, is an essential part of the overall rehabilitation process. Not only is it complex to control, but human upper limbs also play a critical role in daily activities, such as self-care, intake, dressing, and working. The early and intensive upper limb rehabilitation can improve outcomes for stroke survivors, including better functional outcomes and restore the life quality before the stroke to the greatest extent. Hence, upper limb rehabilitation is considered a critical component of stroke rehabilitation, and it is often prioritized over other forms of rehabilitation.

Principles of stroke rehabilitation are almost inseparable from neuroplasticity. Based on the systematic review in the field of rehabilitation research in recent years, Canadian Stroke Best Practice Recommendations lists several rehabilitation methods that have a lot of evidence to support their effectiveness [[ref]](https://pubmed.ncbi.nlm.nih.gov/31983296/): functional electrical stimulation (FES), mirror therapy and virtual reality therapy. Whether these upper limb rehabilitation methods are implemented in the early or late stage of stroke, they have obvious curative effects in more than two randomized controlled clinical trials.

## 1.2.1 Functional electrical stimulation (FES)

FES uses small electrical currents to stimulate the muscles of the affected limb, this rehabilitation method usually targeted the wrist and forearm muscles to reduce motor impairment and improve function. promoting movement and strength. Due to the signal blockade caused by the damage to the associated motor cortex, stroke patients have difficulty triggering their bone muscles because of their impaired motor control, FES can surrogate the patient's motor intention to trigger related acceptor of muscle. In current research progress, Also based on the induction principle of neuroplasticity, the current mainstream hypothesis is that if the use of FES can synchronize the patient's motor intentions, there will be a better curative effect. Therefore, the FES rehabilitation systems combining electromyography (EMG) or even brain-computer interface (BCI) to predict motor intention have been proposed in recent years [[ref]](https://pubmed.ncbi.nlm.nih.gov/30763238/)[[ref]](https://pubmed.ncbi.nlm.nih.gov/30902630/).

## [1.2.2] Mirror Therapy (MT)

Mirror therapy (MT) is a commonly used rehabilitation technique for patients who suffer from stroke or phantom limb pain [2]. Traditionally, therapists use a custom-made mirror box placed directly in front of the patient to reflect a virtual image of the affected side, which deceives the brain into perceiving it as a healthy limb. The goal is to activate the mechanism of neuroplasticity to reduce painful sensory experiences and facilitate motor recovery.

Mirror therapy is a type of therapy that is used to release phantom limb pain and improve motor function in stroke patients, especially suitable for stroke patients with hemiplegia. In a traditional mirror therapy treatment, the therapist will ask the patient sitting in front of the mirror box and hiding their affected hand into that mirror box, on the other healthy hand will be asked to place outside of the mirror box, by adjusting the angle between the patient's perspective and the mirror on the mirror box, a affected hand image reflected by the healthy hand will show up in the mirror and create a visual illusion that tricks the brain into thinking that the missing or injured limb is functioning normally, performing the same movement with the healthy hand.

After a stroke, patients may experience a phenomenon called learned non-use, where they avoid using their affected limb because it feels weak or unresponsive. This can lead to further deterioration of motor function and make it more difficult to recover. By using a mirror to create an illusion of movement in the affected limb, mirror therapy can help to overcome learned non-use and promote recovery of motor function. The visual feedback provided by the mirror can help to retrain the brain and encourage patients to use their affected limb more actively. For a treatment based on visual deception, its efficacy is believed to be related to mirror neurons and neuroplasticity principles derived from the human brain.

The basis of mirror therapy is based on the neuralplasticity of the brain which can be repaired by itself. If the patient after the stroke keep looking at the weak side of the hand, and constantly inputting negative information to the brain, it will not be conducive to the repair of the brain. Therefore, the mirror is used to reflect the unaffected hand, so that the patient sees the image of the unaffected hand overlapping the affected side of the hand, and establishes the visual illusion of the affected side in the brain.

## 1.2.3 Virtual Reality Therapy

Virtual reality (VR) therapy is a type of digital therapeutic that will be interpreted in subsection **1.3.1**. The therapy uses virtual reality technology to simulate real world-like environments to help patients overcome a variety of physical, emotional, or psychological challenges. VR therapy can be used in a range of settings, including occupational therapy, physical therapy, and mental health therapy. Depending on the use case, research in VR therapy is broadly divided into immersive VR therapy and non-immersive VR therapy. Immersive VR therapy typically involves a headset/goggle that immerses the user in a computer-generated environment. non-immersive VR therapy, on the other hand, uses a flat display or projection to achieve a similar effect, and the user will still have part of his visual perception exposed to the real world.

By interacting with this virtual environment in a variety of ways, and using hand-held controllers or other devices, the VR experience can be adjusted to meet the specific needs and goals of the individual, and the therapist can guide and monitor the therapy session in real-time. Most of the VR training course can be designed and developed by software engineers, and can be adjust according to different needs, and different users. A well designed immersive VR therapy system can combine with another therapy practice, but more entertaining and fulfilling, which is an advantage for stroke patients who need to undergo rehabilitation for a long period.

## 1.3 Trend of Digital Health

According to the World Health Organization’s (WHO) definition in Global Strategy on Digital Health 2020-2025, digital health expands the concept of eHealth to include digital consumers, with a wider range of smart and connected devices. It also encompasses other uses of digital technologies for health such as the Internet of Things (IOT), advanced computing, big data analytics, artificial intelligence including machine learning, and robotics [[ref]](https://apps.who.int/iris/bitstream/handle/10665/344249/9789240020924-eng.pdf).

The concept of digital health is becoming increasingly important because it has the potential to revolutionize the way we deliver and receive healthcare services. Contrast to adopt healthcare workers, digital health refers to the use of technology to support and enhance healthcare services, including the delivery of therapy, evaluate, and scheduler system.

One of the main benefits of digital health is its ability to improve availability. With relative technologies, patients in need would have a chance to access healthcare services from anywhere, at any time, without the need for in-person visits. This is especially beneficial for stroke patients who may have difficulty accessing traditional healthcare services due to their defect on mobility or other barriers.

Digital health can also improve the healthcare quality that patients receive. With the use of digital tools such as telemedicine, remote monitoring, and online therapy platforms, healthcare providers can more easily monitor and track patients' progress, identify potential issues or complications, and adjust treatment plans as needed.

Furthermore, digital health can help to reduce healthcare costs by streamlining administrative tasks, improving efficiency, and reducing the need for in-person visits. This can lead to cost savings for both healthcare providers and patients.

In the recent years, due to its potential in clinical application, digital health has increased the rehab efficacy in the pandemic. Two of the following section, that is, digital therapeutics and telemedicine, will be proposed.

## 1.3.1 Digital Therapeutics

Digital therapeutics is an subset of digital health, they are evidence-based therapeutic interventions driven by high quality software programs to prevent, manage, or treat a medical disorder or disease [[ref]](https://www.nature.com/articles/nbt.3495). Same as the traditional therapeutics, a new proposed digital therapeutic should publish the reproducible trail result and meaningful clinical outcome to claim its effectiveness, and certified by national regulations. As a innovative field of therapeutic, digital therapeutic treatment is expected to start from the patient's behavior and lifestyle habits, because of the digital nature of the methodology, data can be collected and analyzed as both a progress report and a preventative measure [[ref]](https://www.sciencedirect.com/science/article/pii/S1359644616000301?via%3Dihub).

The use of digital therapeutics to improve health outcomes dates as far back as 2000 [[ref]](https://www.frontiersin.org/articles/10.3389/fdigh.2015.00006/full)., and the first mention of the term in a peer-reviewed research publication was in 2015, in which Dr. Cameron Sepah formally defined the field as: "Digital therapeutics are evidence-based behavioral treatments delivered online that can increase accessibility and effectiveness of health care [[ref]](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4409647/). For now days, digital therapeutics don’t just refer to one of these medical products or methods, products driven by digital devices or software that deliver medical interventions and therapies that can be called one of the digital therapeutics.

Digital therapeutics have made surprising progress since the evolution of the edge device cause in most of the cases. One example of the application is real time physiological signal monitor, the therapy of chronic disease patients have a high dependency with their life-style and behaviour changes, by utilizing low-cost devices nearby the side, physiological signal in time can be detected, collected and evaluated by patients and the medical assistants [[ref]](https://www.yourator.co/companies/AI4quant).

## 1.3.2 Telemedicine

Telemedicine is another one of a subset in digital health, it is a form of healthcare that allows healthcare providers to communicate with their patient remotely by using several communication technologies such as live streaming, phone calls, or non-instant methods like email, messaging platforms, and fax. Telemedicine is easy to perform, however, in many national laws and regulations, medical providers are only allowed to use remote consultation to issue medical orders under special circumstances. This is because of the concern that the lack of judgment information caused by distance restrictions will cause doctors to provide wrong or hasty prescriptions.

Telemedicine has been around for several years but has become increasingly popular and important during the pandemic era. The COVID-19 pandemic has caused a huge impact to traditional healthcare systems, policy lockdown and the treatment of the virus make patients difficult to transport between home and hospital. Telemedicine has provided a solution, reducing their risk of exposure to the virus while maintaining continuity of care. For patients with stable chronic diseases, the telemedicine solution can be used for routine consultation. For simple, less human-assisted routine rehabilitation needs, the telemedicine solution has the potential to be implemented. Telemedicine has provided an alternative, convenient way for patients with chronic conditions or other health issues to visit a healthcare facility with high risk and cost.

Source from Taiwan's Ministry of Health, in practice, telemedicine process design should preserve the quality in the traditional medication process and overcome some derivative problems:

1. Access: Accessibility should take into account both information and geographic construction. Without good construction, there will be no excellent medical quality.
2. Privacy: Information security issues such as where the information is stored, whether to protect the patient's personal information, etc.
3. Diagnostic Accuracy: Telemedicine is still a medical service, and diagnostic accuracy should be considered.
4. Communication: Telemedicine should also provide good communication services for people with special disabilities and language barriers.
5. Psychological & Emotional Safety: Telemedicine cannot be used for face-to-face diagnosis, and patients' sense of safety when seeking medical treatment should be more concerned.
6. System Design (Human Factors & System Design): Whether the overall process of telemedicine is integrated into the original medical service process.

Post pandemic era has revealed the potential for telemedicine to improve access to healthcare for patients in remote or underserved areas, or for those who have difficulty accessing traditional healthcare services for various reasons.

## 1.4 Objective of This Study

This study aims to investigate upper extremity rehabilitation in patients with post-stroke hemiplegia. As post-stroke rehabilitation is crucial for patients' recovery, this introduction highlights the significance of neuroplasticity as a rehabilitation theory and recommends evidence-based therapies such as FES, MT, and VR therapy to ensure high-quality care. Furthermore, the COVID-19 pandemic and the rapid growth of technology have led to a growing interest in digital health and telemedicine, offering new opportunities in stroke rehabilitation. However, there are still unmet needs in clinical practice that must be addressed to fully leverage the potential benefits of digital health in stroke rehabilitation.

Stroke rehabilitation typically involves long-term exercises, which can be costly and challenging for patients to perform without assistance from medical staff. To address these issues, this study will explore strategies for increasing the frequency of routine rehabilitation exercises while minimizing the cost of mobilizing medical staff. The primary focus will be on developing a home-based rehabilitation plan that is tailored to the needs of post-stroke patients.

Due to its simple concept and readily available rehabilitation materials, MT has emerged as one of the promising rehabilitation modalities for home rehabilitation during the COVID-19 pandemic. The use of virtual reality technology has also been incorporated into MT to enhance the immersive experience during the practice. Some studies have found that VR-based MT is more effective in improving patients' mobility compared to traditional MT [[ref]](https://ieeexplore.ieee.org/document/9319666)[[ref]](https://pubmed.ncbi.nlm.nih.gov/30681034/). However, expensive equipment costs and the complicated setting process of VR equipment make it difficult to be effectively used in clinical fields. According to statistical research, the predict of home penetration of VR equipment is only 6.3% in 2026 [[ref]](https://omdia.tech.informa.com/pr/2021-dec/omdia-research-reveals-12m-consumer-vr-headsets-sold-in-2021-with-content-spend-exceeding-2bn).

In addition, how to evaluate the rehabilitation status of home rehabilitation patients will also become a problem that medical staff needs to think about. In the traditional hand-function evaluation scale, the evaluator is often required to be face-to-face with the subject before the evaluation can be performed. By recording the user The development of digital health will bring the potential of remote assessment.

# Chapter 2 Literature Review

## 2.1 Objective

## [2.2] Rehabilitation of Stroke Patients

During the process that the patient observes the movement of the unaffected side in the mirror, the resulting visual illusion replaces the lost proprioceptive input [6] and activates the primary motor area of the brain by positive visual feedback. The premotor area and the somatosensory area promote the repair mechanism of the mirror neuron system in the brain, reorganizing the neural circuits around the brain area to which the damaged part belongs, and recovering normal movements and feelings.

Mirror neurons in the human brain are approximately 20% of all neurons. It can connect the messages and actions received by the brain to each other, and play an important role in the observation, intention understanding, association, imitation, and learning of action.

According to the literature, mirror image therapy was originally used to help patients with upper limb amputation and recovery from the sensation of phantom limb and phantom limb pain. In 1995, for the first time, scholars used the mirror therapy method in stroke cases and found that stroke patients with mild, moderate, and severe limb disability showed progress in the joint activity, speed, and accuracy. This not only increases the ability of the upper limbs but also encourages patients to increase the usage of the affected side in their daily lives [7].

## 2.3 Telerehabilitation

## 2.4 Digital Rehabilitation

## 2.4.1 Virtual Reality (VR)

## 2.4.2 Augmented Reality (AR)

## 2.4.3 Immersive Rehabilitation via Mobile Phone

## 2.5 Quantitative Analysis on Mirror Therapy

## 2.5.1 Brain Region of Interest

## 2.5.2 Functional Magnetic Resonance Imaging (fMRI)

## 2.5.3 Electroencephalography (EEG)

## 2.5.4 Functional Near-Infrared Spectroscopy (fNIRS)

## 2.6 Brief Conclusion

# Chapter 3 Methodology and Material

## [3.1] Augmented Reality Mirror Therapy System (ARMT)

To solve the defects of the virtual reality mirror therapy equipment mentioned above, in this study, we have developed a mobile device-based augmented reality mirror therapy (ARMT) system. This development aims to allow patients to receive immersive rehabilitation treatments only by using their own mobile device (iPhone) as a display instead of VR **(Figure 1)**. Writing in the iOS programming language Swift and trained human body semantic segmentation model, the philosophy of ARMT is to segment the hand contour in frames, rendering to the mirror side of the screen.

**Figure 1. Preview of ARMT**

## 3.2 Material of Development

## 3.2.1 Hardware

## 3.2.2 Integrated Development Environment (IDE)

## 3.2.3 Application Programming Interface (API)

## 3.2.4 System Architecture

## 3.3 Hand Joints Skeleton Approach

## 3.3.1 Hand Joints Detection

## 3.3.2 Depth Detection

## 3.4 Hand Contour Approach

## 3.4.1 Deep Learning Model for Image Segmentation

## 3.4.2 Masking

## 3.5 Cardboard and Fluency Approach

## 3.5.1 Cardboard Supported

## 3.5.2 Human Segmentation Model

## 3.5.3 ARHeadsetKit

## 3.6 Outcome Measurement

## [3.6.1] Hand Function Assessment Tool

The goal of this research is to investigate the difference in immediate effects on upper limb performance of the hands between receiving ARMT and MT intervention in healthy subjects. For the outcome measurements, several standardized upper limb tests are used to be pre- post-test such as Pinch-Holding-Up-Activity (PHUA), Purdue Pegboard Test (PPT), Semmes-Weinstein monofilament (SWM), Minnesota Manual Dexterity Test (MMDT). These assessment criteria will be assessed by a professional occupational therapist.

## [3.6.2] Brain Area Activity Measurement

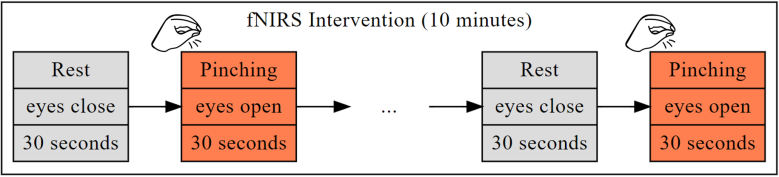
At the same time, for the sake of obtaining objective quantitative data, this research additionally collects the changes in cerebral blood perfusion to analyze bilateral motor cortex and prefrontal cortex activation via fNIRS when intervention begins. In terms of quantitative data, uses Homer3 [5] to remove signal artifacts, a bandpass filter (0.01~0.1 Hz) to remove physiological signals that may affect (heart rate, respiratory, etc.), and finally output the changes in oxyhemoglobin after block average in the specific cortex. The general linear model (GLM) was also applied for effect estimation, according to assumptions, the beta value generated by GLM indicates the strength of the modulation of the hemodynamic response.

# Chapter 4 Experimental Result

## 4.1 Procedure

The MT condition (with a mirror box) or ARMT condition (including an iPhone and a VRG headset) were deployed in the experiment. For all healthy subjects, they were told to sit on a chair and placed both of their hands on the table, and their right hand was instructed to stay still, for the purpose of regarding it as an affectation of stroke patients’ hemiplegia side.

During the first ten minutes of intervention, NIRScout (fNIRS, NIRx Medical Technologies, Glen Head, NY, USA) equipment was used to collect the changes in oxyhemoglobin in specific brain cortex regions of the subject, with a total of 16 detectors and 8 sources, arranged in an array 3 cm apart and distributed over the upper scalp of the motor cortex and prefrontal cortex. The experiments in both MT and ARMT conditions were arranged in a 1-minute block design repeated 10 times, including the first 30 seconds rest stage with eyes closed and the last 30 seconds of finger pinching trials, an audio clue indicates the subjects to open and close their hand, perform 2 times of pinches in 1 second **(Figure 3)**.

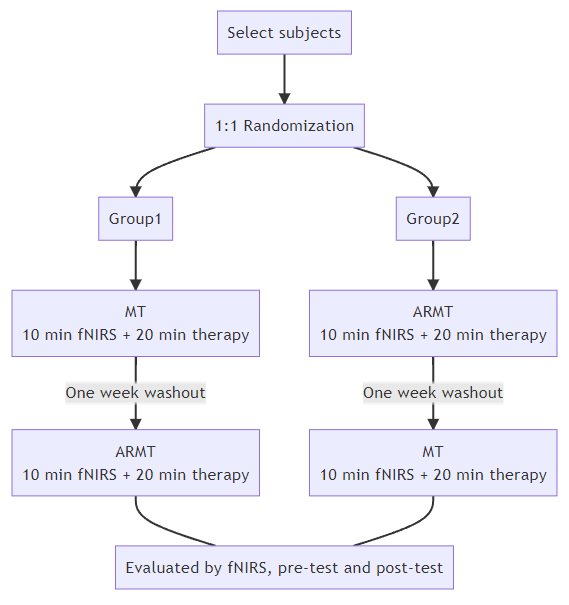


**Figure 3. Block design of the experiment for each condition**

In the last 20 minutes of intervention, subjects will be instructed by a professional therapist to continue performing repetitive movements for hand rehabilitation while using MT or ARMT. After the 30-minute intervention experiment, the subjects will immediately receive the hand function assessment post-test.

## [4.2] Participant Criteria

9 subjects (recruit 10, 1 was excluded) randomly divided into two groups and be asked to undergo two one-session interventions. Both groups received 30 minutes of ARMT or MT rehabilitation, after the one-week wash-out period, changing intervention groups respectively **(Figure 2)**. Before receiving the intervention, all of the subjects must be evaluated their upper limb functionality by the therapists as a pre-test.



**Figure 2. Flow chart of the clinical trial in healthy subjects.**

## 4.3 Enrollment Motion

## 4.4 Result and Comparison

## [4.4.1] Hand Function Evaluation

**Table 1** shows the difference in outcome measures between pre- and post-training in each assessment scale for 7 healthy subjects (recruit 10, 3 haven’t attended the trial) within the mean age of 22.9±2.8. Change in **FRPeak** and percentage of maximal pinch strength show statistically significant differences within ARMT condition (*p=.018* and *p=.028*). Also, a significant effect was detected in **PPTDH** (*p=.027*), **PPTBH** (*p=.026*), **MMDTplacing** (*p=.018*), and **MMDTturing** (*p=.018*). By contrast, none of the outcome results show significant differences in MT group. However, not have a significant difference between ARMT and MT groups, either. The observed insignificant differences between the groups may be attributed to inadequate sample size, or it implict that the ARMT exhibits comparable effectiveness to the MT when evaluated against identical testing criteria.

**Table 1. The outcome measures in each assessment scale.**

**\*DH: dominant hand, \*BH: both hands.**

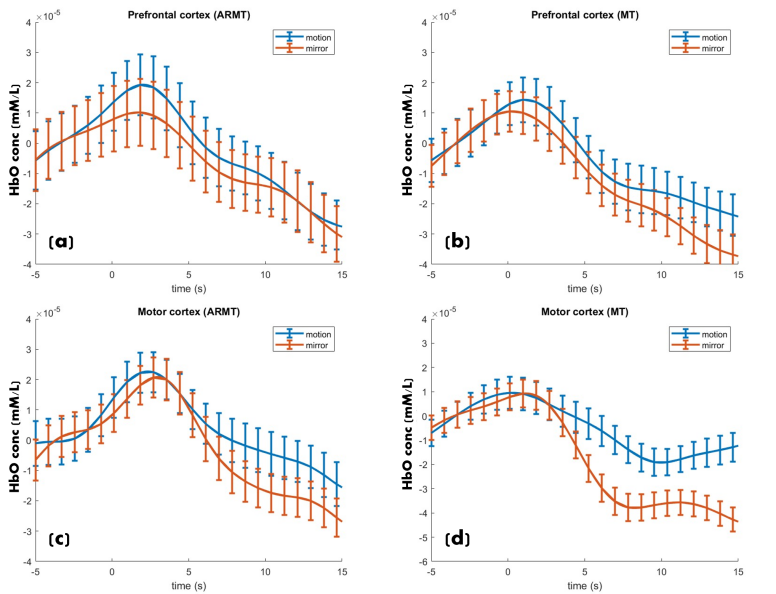
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Effectiveness**  **(INDEX)** | **PRE** | **ARMT** | | **MT** | | **Group Difference** | |
| **POST** | **P Value** | **POST** | **P Value** | **Z Score** | **P Value** |
| **PHUA**  **(FRPeak)** | 3.55±.59 | 2.93±.41 | **.018\*** | 3.26±.52 | .249 | -1.352 | .176 |
| **PHUA**  **(Percentage)** | 0.42±.13 | 0.32±.08 | **.028\*** | 0.41±.16 | 1.000 | -1.016 | .310 |
| **PPT**  **(\*DH)** | 14.86±1.57 | 17.07±1.34 | **.027\*** | 16.00±1.26 | .125 | -1.581 | .114 |
| **PPT**  **(Non-DH)** | 14.93±1.40 | 16.00±1.41 | .090 | 15.29±1.91 | .672 | -.631 | .528 |
| **PPT**  **(\*BH)** | 12.43±1.21 | 13.43±1.30 | **.026\*** | 13.43±1.17 | .206 | -.085 | .933 |
| **PPT**  **(Assembly)** | 41.57±3.85 | 45.00±4.10 | **.018\*** | 44.50±3.21 | .271 | -.169 | .866 |
| **SWM**  **(Thumb)** | 2.39±.04 | 2.39±.04 | .317 | 2.39±.04 | .655 | .000 | 1.00 |
| **SWM**  **(Little Finger)** | 2.38±.04 | 2.37±.03 | .317 | 2.41±.04 | .157 | -1.732 | .083 |
| **MMDT**  **(Placing)** | 64.67±7.82 | 58.36±5.64 | **.018\*** | 60.16±7.82 | .176 | -1.69 | .866 |
| MMDT  (Turning) | 46.35±5.20 | 38.71±3.65 | .018\* | 41.04±5.29 | .128 | -.676 | .499 |

## [4.4.2] fNIRS of ROI

9 healthy subjects (4 males, 5 females) participated in this trial and contributed a well-identifiable fNIRS signal. For channel-wise comparison, the ipsilateral hemisphere of the subject’s moving hand (left hand) will be called the mirror side (left hemisphere), while the contralateral hemisphere will be called the motion side (right hemisphere).

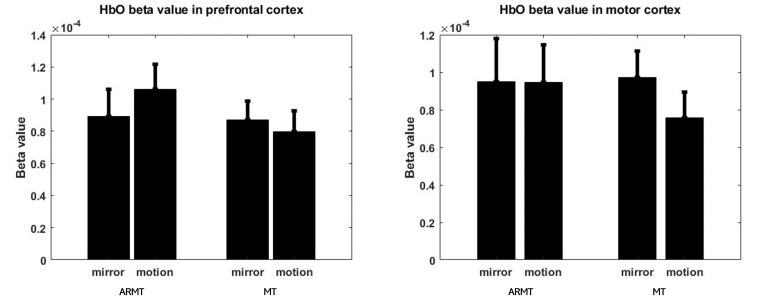
In the subjects’ prefrontal cortex region, both MT and ARMT group observed a tendency towards blood perfusion during the intervention **(Figure 4)**, it takes about 3 seconds to reach its highest peak after the start of the intervention and then quickly drops below the baseline. Besides, greater activation was observed on the motion side.

In the motor cortex region, longer-lasting and more pronounced activation was observed in the ARMT group, And the peak of the mirror side is slightly later than the motion side. Although the blood perfusion of HbO activation at the mirror side was not greater than that of the motion side in any circumstances, a highly correlated pattern of signals was still revealed.



**Figure 4. Trends in HbO during the intervention. (a) prefrontal cortex in ARMT group, (b) prefrontal cortex in MT group, (c) motor cortex in ARMT group, (d) motor cortex in MT group.**

**Figure 5** shows the motion side of ARMT group has the highest activation at the prefrontal cortex in the mean of HbO’s beta value of GLM. But the subjects who received MT have higher activation levels on the mirror side. This phenomenon is also shown in the motor cortex area. However, there were no statistically significant differences between groups or bilaterally (*p>.05*).



**Figure 5. Mean beta values and corresponding standard errors at the prefrontal (left) and motor (right) cortex.**

# Chapter 5 Discussion and Conclusion

## 5.1 Discussion

## 5.2 ARMT Potential on Stroke Rehabilitation

## [5.3] Conclusion

This study indicates the potential of the ARMT system in the field of rehabilitation at home. Using their personal mobile device, patients in need have an alternative method to traditional MT without requiring additional equipment. The ARMT system can provide a more realistic view that enhances the immersive experience. However, it remains to be seen whether the effectiveness of rehabilitation using ARMT is greater than that of traditional MT, in the purpose of approaching the answer, more clinical trial subjects should be recruited.

The limitation of this pilot study is the small number of subjects, which may cause individual differences to have a significant impact on the trial's results. Another limitation of the study is that the healthy subjects included did not have a history of stroke or any brain damage. Therefore, their blood perfusion signal response in the certain cortex may not be representative of the general behavior of stroke patients. Subjects with a history of stroke or hemiplegia will be considered to participate in the experiment in the future.

## 5.4 Limitation

## 5.5 Future Work

1. \* Student [↑](#footnote-ref-0)
2. \*\* Advisor [↑](#footnote-ref-1)