Working memory training increases neural efficiency in Parkinson's disease: a randomized controlled trial

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Abstract

Impairment of working memory and executive functions are already frequently observed in early stages of Parkinson's disease. Improvements in working memory performance in this cohort could potentially be achieved via working memory training. However, the specific neural mechanisms underlying different working memory processes such as working memory maintenance as opposed to working memory manipulation are largely under-investigated in Parkinson's disease. Moreover, the plasticity of these correlates as a function of working memory training are currently unknown in this population.

Thus, the working memory subprocesses of maintenance and manipulation were assessed in 41 cognitively healthy patients with Parkinson's disease using a newly developed working memory paradigm and functional MRI. Nineteen patients were randomized to a 5-week home-based digital working memory training intervention while the remaining patients entered a control, wait list condition. Working memory task-related activation patterns and context-dependent functional connectivity, as well as the change of these neural correlates as a function of training, were assessed.

While both working memory processes activated an extended frontoparietal-cerebellar network, only the manipulation of items within working memory also recruited the anterior striatum. The intervention effect on the neural correlates was small, but decreased activation in areas relevant for working memory could be observed, with activation changes correlating with behavioural change. Moreover, training seemed to result in decreased functional connectivity when pure maintenance was required, and in a reorganization of functional connectivity when items had to be manipulated. In accordance with the neural efficacy hypothesis, training resulted in overall reduced activation and reorganized functional connectivity, with a differential effect on the different working memory processes under investigation.

Now, larger trials including follow up examinations are needed to further explore the long-term effects of such interventions on a neural level and to estimate the clinical relevance to potentially delay cognitive decline in cognitively healthy patients with Parkinson's disease.

Keywords: idiopathic Parkinson's disease, home-based working memory training, functional magnetic resonance imaging, BOLD, functional connectivity

Abbreviations

AS	anterior striatum
BOLD	blood oxygen dependent
CG	control group
dlPFC	dorsolateral prefrontal cortex
FC	functional connectivity
fMRI	functional magnetic resonance imaging
GLM	general linear model
GDS	Geriatric depression score
H&Y	Hoehn & Yahr scale
LEDD	Levodopa equivalent daily dose
MoCA	Montreal Cognitive Assessment
PD	Parkinson's disease
PD-D	Parkinson's disease with dementia
PD-MCI	Parkinson's disease with mild cognitive impairment
PPI	psycho-physiological interaction
POST	post-testing
PRE	baseline testing
RCT	randomized-controlled trial
SMA	supplementary motor area
UPDRS-III	Unified Parkinson's disease Rating Scale-III
WM	working memory
WMT	working memory training

Introduction

Cognitive impairment is a very frequent non-motor symptom of Parkinson's disease (PD) (Aarsland *et al.*, 2010) with a detrimental effect on quality of life in affected individuals (Lawson *et al.*, 2014). Especially, deficits in working memory (WM) and executive functions are common and reported already in newly diagnosed patients (Muslimović *et al.*, 2005) and even possible prodromal cases of PD (Fengler *et al.*, 2017). For WM, two sub-functions are distinguished: While WM maintenance refers to the pure storage of information, WM manipulation is characterized by the additional demand to operate on this stored information using executive resources (Cowan, 2017; Chai *et al.*, 2018). On a behavioral level, it has been shown that these different facets of WM are variably impacted in PD with greater impairments observed during the manipulation information with a relative preservation of performance when pure maintenance within WM is needed (Lewis *et al.*, 2003). In line with this, a recent cognitive intervention study in PD resulted in improved performance on a WM manipulation task, but not on a trained task of pure WM maintenance (Fellman *et al.*, 2018). Supporting this dissociation, neurophysiological studies in healthy individuals have shown that the maintenance and manipulation of information in WM rely on different neural substrates (Lewis *et al.*, 2004; Suzuki *et al.*, 2018). Whereas both processes seem to engage a widespread fronto-parietal network (Owen *et al.*, 2005; Suzuki *et al.*, 2018), the manipulation of WM content in particular additionally recruits increased anterior striatal contribution (Lewis *et al.*, 2004). Corroborating this, the basal ganglia have been associated with the dopamine-dependent (Gruber *et al.*, 2006) updating of WM and gating of task-relevant information into WM (Awh and Vogel, 2008). Thus, especially in the context of PD marked by substantial dopamine depletion in the basal ganglia (Schapira, 2009; Volpicelli-Daley *et al.*, 2011) and variable behavioural manifestations of WM impairment, the differential examination of WM subprocesses seems necessary. However, MRI-suitable designs targeted at specific cognitive processes of interest (e.g. manipulation in WM) with the aim of understanding the specific neural underpinnings are sparse in PD (Giehl *et al.*, 2019).

Due to the increased vulnerability of patients with PD for cognitive decline, addressing this detrimental process during the early disease phase is crucial to maintain high-level functioning. Previously, cognitive training has been identified as a new route of non-pharmacological intervention to preserve or even improve cognitive function in PD (Leung *et al.*, 2015; Glizer and MacDonald, 2016). However, the potential of focused interventions on cognitive domains specifically vulnerable in PD - such as WM - are sparse, despite convincing evidence of working memory training (WMT) effects from healthy individuals (Klingberg, 2010; Melby-

Lervåg and Hulme, 2013; Karbach and Verhaeghen, 2014; Constantinidis and Klingberg, 2016) and brain-injured non-PD populations (Johansson and Tornmalm, 2012; Aguirre *et al.*, 2019).

Cognitively healthy elderly have frequently been observed to expend more neural resources in order to successfully complete a cognitive task when compared to young individuals, which has often been interpreted as a compensatory mechanism to account for less sufficient processing with increasing age (Li *et al.*, 2015; Suzuki *et al.*, 2018). In addition, WMT studies in healthy individuals have often resulted in decreased neural responses after invention completion (Brehmer *et al.*, 2011; Buschkuehl *et al.*, 2012). Taken together, it seems conceivable that WMT could result in less need for such supposedly compensatory activation, resulting in an overall reduction of neural response. This is in accordance with the neural efficiency idea, stating that highly trained processes require less neural energy (Haier *et al.*, 1988; Neubauer and Fink, 2009). Although first results of WMT in PD show promising behavioural WM improvements (Giehl *et al.*, 2020; Ophey *et al.*, 2020), the neural effects of WMT underlying these effects are currently unknown.

We therefore conducted a single-blind randomized controlled trial (RCT) to investigate the effects of a 5-week home-based WMT in patients with PD without cognitive impairment compared to a no-intervention PD control group (CG) (Ophey *et al.*, 2020). While the clinical and neuropsychological outcomes are reported elsewhere (Giehl *et al.*, 2020; Ophey *et al.*, 2020), this report focuses on the neural effects of the conducted WMT on different aspects of WM using a newly-developed WM paradigm and functional magnetic resonance imaging (fMRI). Specifically, activation and functional connectivity (FC) changes with regards to pure maintenance as opposed to manipulation of WM content were examined. Considering the underlying neuropathology of the disease and its variable behavioural manifestation (Lewis *et al.*, 2003; Kudlicka *et al.*, 2011), we hypothesized that WMT would have a differential effect on neural correlates underlying WM maintenance and WM manipulation in PD. Moreover, we expected activation and FC changes resulting in a more efficient underlying neural network similar to long-term WMT effects induced in healthy elderly (Brehmer *et al.*, 2011; Buschkuehl *et al.*, 2012). In addition, presuming that even cognitively healthy patients might experience PD-related inefficient processing, we further hypothesized that WMT might also result in increased activation in those particularly vulnerable areas, as e.g. the striatum, potentially associated with changes in WM performance (Brehmer *et al.*, 2011).

Methods

Study design

The presented neuroimaging data originate from a patient cohort enrolled in a large single-blind RCT conducted at the University of Cologne aiming to investigate effects of WMT in PD (Ophey *et al.*, 2020). The RCT was conducted in accordance with the latest declaration of Helsinki (WMA, 2013), approved by the ethics committee of the Medical Faculty of the University of Cologne (vote no. 16-043) and registered at the German Clinical Trial Register (drks.de, DRKS00009379). All patients gave written informed consent prior to study entry.

In brief, during an initial appointment, all patients were screened for eligibility and performed an extensive neuropsychological test battery (Litvan *et al.*, 2012). Second, eligible patients who agreed to the imaging module of this trial completed the WM-fMRI paradigm on another day within the same week. Third, all included patients entered the 5-week invention period after being randomly assigned to the WMT group or the waiting list arm of the study. The WMT was based on the online cognitive training program NeuroNation (http://www.neuronation.com/) and included tasks addressing different WM processes with varying task demands. Finally, all patients were re-evaluated following the invention using the identical fMRI-paradigm as for baseline testing. Clinical and neuropsychological examinations were repeated after WMT completion and again after 3 months with no training in-between. Details of the randomization, the WMT intervention, feasibility and immediate as well as long-term clinical and neuropsychological effects of the intervention can be found elsewhere (Giehl *et al.*, 2020; Ophey *et al.*, 2020).

Participants

All patients were diagnosed with idiopathic Parkinson's disease (Hughes *et al.*, 1992), were aged between 45-85 years, and had normal or corrected to normal vision and hearing. Exclusion criteria were mild cognitive impairment (PD-MCI) or dementia associated with PD (PD-D) according to level-II diagnostic criteria (Litvan *et al.*, 2012), any other neurological or psychiatric disorder including major depression (Geriatric depression score; GDS > 11) (Yesavage *et al.*, 1982), any other life-threatening disease, deep brain stimulation and, additionally for the imaging study module, the inability to undergo MRI scanning. Patients were instructed to continue their regular medication at all times. For detailed information regarding patient demographics see Table 1.

WM-fMRI task

During fMRI we employed a novel WM paradigm inspired by earlier work from Lewis and colleagues (Lewis *et al.*, 2004) (see Figure 1). All letters and signs were displayed in white font against a black background and positioned in the centre of the screen, unless stated otherwise. Name of event and presentation times are given in brackets. Each trial started with a fixation cross and the number "3" or "4" below fixation, indicating how many letters were to follow (load cue, 2.5 sec). Accordingly, 3 or 4 letters were presented sequentially (presentation phase, 1 sec/letter). Then, a cue was presented instructing the patient if these letters had to be remembered (German word: "merken") or could be discarded (German word: "verwerfen") (trial cue, 1 sec). This cue was followed by an interval marked by another fixation cross in which the patient either had to remember the presented letters (maintain, time window jittered 7-11 sec, following "remember cue") or could rest (rest, time window jittered 7-11 sec, following the "discard cue"). In case of a resting period, a new trial started after the resting time window elapsed. Otherwise the patient was presented with an arrow (arrow cue, 1 sec), indicating whether the previously seen letters had to be maintained in the observed, forward order (→) or whether the letter sequence had to be reversed (←) in the upcoming time window (second maintenance phase following or manipulation phase following, time window jittered 5-8 sec). This was followed by the sequential presentation of 3 or 4 letters in identical/correctly reversed or incorrect order (offered answer, 1 sec/letter). Subsequently, the possibilities "right" or "wrong" were displayed left and right from the centre of the screen. From those the patient had to choose by pressing the corresponding button on the button box (choice, displayed until button press recorded with a maximum answer period of 3 sec). Finally, the patient received feedback about the performance on every trial in form of a smiley or frowny face (feedback, 1 sec).

The experiment was divided into 5 blocks with 16 trials each. Each block was comprised of 4 rest trials and 12 remember trials, of which 8 were high-load (4 letters) and 4 were low-load trials (3 letters). Half of the high-load trials were pure maintenance trials (arrow cue= right), whereas the other half were manipulation trials (arrow cue= left). Altogether, the experiment comprised 80 trials which were equally distributed between trial types (20 rest, 20 low-load, 20 high-load maintain, 20 high-load manipulate). The experiment code was executed and responses recorded using Matlab v.R2015a (MathWorks, Inc).

Image acquisition

MRI scanning was performed using a 3T whole body MRI scanner (Philips Ingenia; Philips Healthcare, Best, the Netherlands) and a 32-channel head coil. An MRI-compatible visual system (SensaVue fMRI, Invivo Corporation, Gainesville, USA) displaying the WM-fMRI paradigm was placed at the head-end of the scanner and viewed by the patients via a mirror-system position on the top of the head coil. Responses were recorded using a button box held in the right hand.

For fMRI, the first five scans of each session were discarded due to non-equilibrium of magnetization, followed by 180 echo planar images (EPI) with 28 interleaved transversal slices (scan duration= 8 min 2.5 s; FOV= 220 x 220 x 139 mm^3, voxel size= 3.4 x 3.4 x 4 mm^3, slice thickness= 4 mm, gap= 1 mm, TR= 2500 ms, TE= 30 ms, flip angle= 90°).

For spatial normalization and exclusion of gross structural abnormalities, a 3D T1-weighted image was acquired (scan duration= 5 min 55 s, 165 transverse slices, thickness= 1 mm, FOV= 250 x 230 x 165 mm^3, voxel size= 1 x 1 x 2 mm^3, TR= 9.6 ms, TE= 4.8 ms, flip angle= 8°). In addition, a 3D FLAIR image was recorded to check for gross vascular lesions (scan duration= 4 min 33.6 s, 326 interleaved transverse slices, thickness= 1.12 mm, FOV= 250 x 250 x 182.6 mm^3, voxel size= 1.12 x 1.12 x 1.12 mm^3, TR= 4800 ms, TE= 281 ms, flip angle= 90°).

Image preprocessing

Preprocessing and statistical analysis of the image data were done using SPM12 (www.fil.ion.ucl.ac.uk/spm/software/spm12/) executed in MATLAB version 8.5 (R2015a) (www.mathworks.com). To account for movement of the subject, all fMRI image volumes were realigned to the first volume of the corresponding session and subsequently coregistered to the corresponding structural T1 image using rigid-body transformation. A Volterra expansion was performed on the generated six realignment parameters to model residual movement artefacts (Lund *et al.*, 2005) resulting in 24 movement parameters, which were later entered into the design matrix as regressors of no interest.

For the T1 image the origin was set to the AC-PC plane and the images were segmented using the SPM12 segmentation procedure. The produced normalization parameters were then applied to all coregistered fMRI image volumes. Successful normalization to standard MNI coordinate space was checked at random for each subject using ventricles and brain borders as landmarks. Finally, all fMRI image volumes were smoothed with an isotropic 8 mm full width half maximum Gaussian filter.

Statistical analysis

Demographic, clinical and behavioural data

Demographic and clinical data at baseline were compared between groups using Wilcoxon rank-sum tests, independent sample t-tests or chi^2-tests as appropriate. fMRI-task performance was determined as percentage of correct answers during the forced-choice period of the paradigm. Data were entered in a 2x2 repeated measure ANOVA with time (PRE vs. POST) as intra-subject and group (WMT vs. CG) as inter-subject factor.

Statistical analysis of fMRI data

Activation analysis

First-level analysis was performed using a General linear model (GLM) with 12 regressors of interest (all events) and 34 regressors of no interest (all 10 events of a remember trial preceding an erroneous response of the patient plus 24 realignment parameters). On a single subject level, we then computed four contrast images for events of interest: maintain vs. rest, manipulate vs. rest, manipulate vs. maintain and high-load vs. low-load.

On the second level, we computed the main effects of condition at baseline across both groups by means of a one sample t-tests with the respective first level contrast images. Group differences following WMT were assessed using a full factorial ANOVA design with time and group as factors and masked using a binarized grey matter mask implemented in SPM (mask thresholded at >0.2).

Reported clusters for main effects of task are significant on $p < .05$ (FWE-corrected on voxel-level), whereas comparisons between groups over time, i.e. effect of WMT, are reported at $p < .001$ uncorrected. Anatomical labelling was conducted using the Harvard-Oxford brain atlas. If locations could not be determined the AAL atlas was consulted.

Functional connectivity analysis: Psycho-physiological interaction (PPI)

In order to understand the effect of WMT on FC observed for the different experimental contexts, i.e. WM maintenance and manipulation, we opted for the PPI analysis approach as implemented in SPM12.

Based on the task activation patterns observed during the activity analysis of our data, we chose areas displaying the highest activity across the task as seed regions. Thus, a sphere of 8mm was drawn around three peak voxels in the left dorsolateral prefrontal cortex (dlPFC) (-42/8/26), left supplementary motor area (SMA) (-2/2/62) and left anterior striatum (AS) (-18/14/-2). In order to understand whether those regions interacted differently during the pure

maintenance or a pure manipulation process, we calculated the interaction term between contrast 1 (maintain vs. rest) and all seeds separately, and contrast 3 (manipulate vs. maintain) and all seeds separately, resulting in six different models.

Each first-level GLM included the following regressors: PPI-interaction term, the activity time course of the seed (physiological regressor), the contrast of interest (psychological regressor) as well as nuisance regressors (24 movement and one session regressor).

On a group-level, we submitted the contrast images of all patients derived from the according first-level PPI-interaction term to a full factorial ANOVA design with time and group as factors to test for effects of WMT on FC in different psychological contexts. Masking, determination of significance and anatomical location were conducted as for the WMT-induced change of activation. Results of the baseline FC analysis can be found in supplementary material.

Behaviour-Brain correlations of WMT-induced changes

Since the fMRI paradigm used here was not designed to pick up small variations in behaviour, we used results from more sensitive measures of WM from the neuropsychological test battery to calculate correlations between behaviour and WMT-induced neural change. Thus, change scores for significantly improving neuropsychological measures including a verbal WM composite score (Ophey *et al.*, 2020) and an experimental measure of visuospatial WM function (Giehl *et al.*, 2020) were calculated. These were then correlated with the mean BOLD signal change associated with each task condition showing a significant WMT effect (maintain vs. rest; manipulate vs. rest; manipulate vs. maintain), extracted from an 8mm sphere around the overall WMT-induced peak corresponding to the left AS (-4/4/-4).

Data availability

The data generated during this study are available on reasonable request.

Results

Participant characteristics

Initially 85 patients were screened for this trial from which 76 were eligible. Nine patients (9%) had to be excluded due to incidental PD-MCI. A subset of 48 patients agreed to the imaging module of this study. From those, 22 were randomized to the WMT group, and 25 entered the waiting phase. One patient declined post-intervention scanning. Six data sets had to be excluded for various reasons (excessive movement= 2; scanner artefact= 2; incidental finding=2; for details refer to CONSORT flow chart, Figure 2), leaving 41 data sets for analysis (WMT=19; CG=22).

At baseline, patients (46.34% female; 2 left-handed) included in the final analysis had an average age of 64.34±8.96 years and an average disease duration of 5.71±5.12 years. The majority was mild to moderately affected (mainly Hoehn & Yahr stage II) with an average Unified PD Rating Scale-III (UPDRS-III) score of 29.12±1.23. Patients received a levodopa equivalent daily dose (LEDD) of 573±377 mg. Overall, patients were relatively highly educated with 15.46±2.94 years of education, achieved a high average MoCA score of 27.4±1.6 and showed only minor symptoms of depressed mood (average GDS score: 2.37±1.58). Importantly, no significant difference on any demographic or clinical measure was evident between groups at baseline (see Table 1).

In-scanner task performance

There was no significant main effect of time [$F(1,39)= 3.56$, $p= .067$, $\eta^2= .08$] or group [$F(1,39)= 0.38$, $p= .540$, $\eta^2= .01$] on task performance, nor an interaction [$F(1,39)= 1.26$, $p= .269$, $\eta^2= .03$]. Across groups and time, participants reached on average 88.1±10.62% accuracy.

General task activation

In order to examine whether this newly designed paradigm indeed targeted WM as hypothesized, we firstly examined task activation at baseline across both groups for our four contrasts of interest (see Figure 1 and Table 2). During maintain vs. rest extensive frontal activation was observed encompassing orbitofrontal cortex, inferior and middle frontal gyrus, supplementary motor area (SMA) and precentral gyrus. In addition, strong activation was observed in the superior parietal lobe and supramarginal gyrus, inferior temporal gyrus, thalamus and the cerebellum. The manipulate vs. rest contrast relied on very similar brain regions, however additional strong activation of the precuneus and bilateral AS was observed.

A similar activation pattern was found when contrasting manipulate vs. maintain. When comparing the high-load vs. low-load memory condition, only 2 clusters of increased activation were observed in the SMA and paracingulate gyrus.

Effects of WMT

Neural activation change

No activation increases following WMT could be observed in the training group for any of the investigated contrasts (see Figure 3 and Table 3). In contrast, clusters of decreased activation following WMT were located in the middle frontal and precentral gyrus, precuneus, brain stem, cerebellum, and AS for the pure maintenance process. Stronger and more spatially extended WMT-induced decreased activation clusters were found when manipulation was required. The largest cluster was observed in the midline area encompassing the bilateral AS and subcallosal cortex. In addition, clusters of decreased activation were located in the SMA, bilateral insular cortex, precuneus, superior temporal and lateral occipital gyrus, brain stem and cerebellum. For the specific manipulation contrast only two small clusters of decreased activation, one encompassing the subcallosal cortex, thalamus and lateral ventricle as well as one in the anterior cingulate gyrus were observed. The differential effect of load did not change as a function of WMT. Since dopamine replacement therapy could potentially impact cortical activation patterns (Nombela *et al.*, 2014), we conducted an additional analysis including LEDD as covariate in the full-factorial model to account for variations in medication. However, only marginal changes could be observed.

Functional connectivity change

Following WMT, no clusters of increased FC could be observed in the context of maintenance for any of the seeds. However, reduced FC was evident between the dlPFC seed and the left middle frontal gyrus, right superior frontal gyrus, right cingulate, left lingual gyrus and left AS (see Table 4). The AS seed showed decreased FC towards white matter adjacent to the lateral ventricle, parahippocampal gyrus, and precuneus.

Following WMT, a redistribution of FC in the context of manipulation was observed with a tendency towards reduced FC from the dlPFC and increased FC from SMA and AS.

More precisely, from the left dlPFC seed one cluster of increased FC was evident in the left parietal operculum, while a widespread reduction of FC was observed towards the right superior, right middle and bilateral inferior frontal gyrus, left frontal pole, right cingulate, right insula, right precentral gyrus and right cerebellum. In contrast, from the left SMA, several

clusters of increased FC towards the left postcentral gyrus, left planum polare, left angular, fusiform, lingual, supramarginal gyrus and right SMA were observed, accompanied by only one cluster of reduced FC located near the left lateral ventricle. From the AS, increased FC was observed towards the superior frontal gyrus, lateral ventricle, superior parietal lobe and hippocampus. No decreased FC from the AS was evident.

Brain-behaviour correlations of WMT-induced changes

When investigating the relationship between WMT-induced activation change in the AS and the observed significant POST-PRE-change in cognition as operationalized via a neuropsychological composite score of verbal WM (Ophey *et al.*, 2020) and a measure of visuospatial WM (Giehl *et al.*, 2020), a moderate positive correlation between both WM measures and BOLD signal change could be observed for the maintain vs. rest contrast ($r(17)= .48$, $p= .039$ for verbal WM, and $r(17)= .50$, $p= .029$ for visuospatial WM, respectively). For the manipulate vs. rest contrast, there was a moderate positive correlation for verbal WM only ($r(17)= .56$, $p= .013$). No correlations could be observed for the specific manipulate vs. maintain contrast (see Figure 4). When including LEDD as a covariate into the brain-behaviour correlation analyses, again only marginal changes could be observed.

Discussion

Using a newly designed WM-fMRI paradigm we were able to identify specific neural correlates underlying WM maintenance and WM manipulation in patients with PD without cognitive impairment. While both WM processes relied on a network of increased left-dominant frontoparietal-cerebellar activation, only WM manipulation seemed to evoke additional, rather bilateral neural responses including the right precuneus and bilateral AS. Following ~~the~~ WMT, generally less activation and FC was observed for the WMT group as compared to the CG, mainly focused around the AS. Activation change in this region was also correlated with neuropsychological performance gains.

The identified frontoparietal-cerebellar network associated with the WM task is in accordance with previous meta-analyses on neural correlates underlying WM in healthy individuals (Owen *et al.*, 2005; Emch *et al.*, 2019). While we observed that both WM processes relied on roughly similar neural networks (Veltman *et al.*, 2003), the additional neural responses elicited during manipulation only are in line with previous studies showing increased activation of the parietal lobe in relation to WM manipulation (Veltman *et al.*, 2003; Koenigs *et al.*, 2009; Emch *et al.*, 2019) and the role of the striatum in gating information to and updating of WM (Lewis *et al.*, 2004; Gruber *et al.*, 2006; Dahlin *et al.*, 2008; McNab and Klingberg, 2008; Baier *et al.*, 2010; Yu *et al.*, 2013). Using recurrent neural network models, it has recently been proposed that pure WM maintenance can be achieved via low-activity synaptic short-term plasticity, while the WM manipulation process cannot. For the manipulation operation, persistent neural activity is needed, even scaling with increasing manipulation complexity (Masse *et al.*, 2019). This might be a potential explanation for the generally increased activation observed in our manipulation contrast. Moreover, it might also account for the rather weak effect that we observed when introducing a slightly higher load in the pure maintenance condition evident in the SMA.

Following WMT, several clusters of decreased activation in WM associated regions were observed, implying that the WMT group performed the WM-task using fewer neural resources than the CG after training completion. In line with our results, long-term WMT as implemented here has often been associated with decreased activation in healthy young (Schneiders *et al.*, 2011; Clark *et al.*, 2017) and elderly (Brehmer *et al.*, 2011; Miró-Padilla *et al.*, 2019) as well as neurological non-PD patients (Aguirre *et al.*, 2019). These findings all align with the neural efficacy idea, postulating that better or as in this case "trained" cognitive performers need less neural resources in order to successfully complete a task (Haier *et al.*, 1988; Neubauer and Fink, 2009). Interestingly, the observed effect was located in and close to the anterior striatal area,

the region uniquely contributing to the additional activation observed for the manipulation process in our study. In addition, another major WMT-induced change was observed in the right precuneus which also contributed majorly to the manipulation contrast. One might speculate that these areas were recruited as a compensatory strategy prior to the intervention in order to maintain high cognitive performance. Similar supporting activation has already been described during WM tasks for the dlPFC in healthy elderly (Suzuki *et al.*, 2018), and for the striatum in patients with PD (Poston *et al.*, 2016; Simioni *et al.*, 2017). Thus, since both groups performed behaviourally on comparable levels on the WM-fMRI task for both time points, it is conceivable that most trained patients were able to produce the same cognitive performance, however using less neural resources (Clark *et al.*, 2017).

Within the trained group, the change in activation correlated with the observed change in neuropsychological measures of WM, indicating that the greatest increase in BOLD signal was associated with the greatest cognitive improvements. Importantly, only the verbal WM task required the maintenance and manipulation of WM (Ophey *et al.*, 2020), while the visuospatial WM task relied on WM maintenance only (Giehl *et al.*, 2020). Accordingly, both tasks correlated with the activation change extracted from the maintain contrast, but only the verbal WM task (i.e. the task also requiring manipulation) correlated with the activation change for the manipulation condition, supporting the idea that the observed specific neural changes support these specific cognitive processes. Interestingly, no correlation was found between the specific manipulation contrast and behaviour. Thus, one might speculate that the neural change was more associated with the pure maintenance of information in WM, rather than the executive demand of operating on this information.

This observed positive relationship between behaviour and brain activation might firstly seem at odds with the results of our WMT analysis showing decreased activation clusters only. However, despite the inclusion of a rather homogenous cohort of cognitively unimpaired patients with PD, considerable variation within this group regarding cognitive performance is theoretically still possible. Assuming this, one might speculate that the majority of patients recruited additional neural resources in order to produce high cognitive performance prior to WMT. WMT could have potentially made this compensatory hyperactivation redundant while keeping cognitive performance stable, resulting in a more efficient underlying neural network and ultimately in an overall reduction of persistent activation. The observed positive correlations between activation change and behavioural improvements in the WMT group on the other hand could be driven by a subgroup of patients who did not perform at their optimal level prior to WMT, potentially related to early insufficient processing or an incomplete

compensatory coping mechanism. Supporting this idea, increased activation following cognitive training in patients with MCI has frequently been observed (Belleville *et al.*, 2011; Rosen *et al.*, 2011). Also, in our study, a true performance increase (as opposed to maintaining the same close-to-optimal cognitive level) could be associated with a net increase in activation in the AS, as shown previously (Brehmer *et al.*, 2011).

In accordance with the intervention effect observed for our activity analysis, WMT had some effects on FC of the 3 seed regions towards other regions of the brain. For the pure maintenance context, either no (SMA) or small clusters of negative interaction (dlPFC, AS) could be observed, again supporting the idea of increased neural efficiency of the WM network. However, in the context of manipulation decreased FC, especially from the dlPFC, and increased FC from the SMA and the AS were observed, pointing to a general reorganization of FC when the manipulation of WM was required. While previous research has mainly focused on the investigation of task-independent FC in healthy individuals, our results support the general notion that WMT could have the potential to alter the FC of the brain (Buschkuehl *et al.*, 2012; Jolles *et al.*, 2013; Takeuchi *et al.*, 2013).

Strengths and limitations

Our results should be interpreted taking the strengths and limitations of our study design into consideration. To the best of our knowledge, this is the first RCT on WMT in PD implementing neuroimaging methods with the aim to elucidate the underlying neural mechanism of effects induced by such an intervention. In addition, we used a new fMRI-paradigm which was designed to distinguish between different processes in WM as they could potentially be variably affected in PD. Utilizing a robust sample size, our analyses are sufficiently powered resulting in highly reliable results for our WM-task.

Next to understanding how WMT could work on a neural level, it is important to know who would benefit from such an intervention and thus the thorough characterization of the sample is essential. Therefore, patients enrolled in this RCT were limited to individuals without MCI to understand whether benefits could already be observed at this early stage before major cognitive decline has occurred. While the inclusion of such a homogeneous cohort enables to draw specific conclusions for this patient group, potentially informing clinicians how to optimize preventive interventions for patients in stages before the dopaminergic deficit has had an impact on cognition, it limits the generalizability of our results towards patients with PD in other cognitive states. Therefore, more RCTs should be conducted including well characterized patients regarding cognitive stages (PD versus PD-MCI versus PD-D) and other variables, e.g.

demographic groups (e.g. higher vs. lower educated). Moreover, longitudinal studies including follow-ups examinations over several years are urgently needed to understand whether WMT could have clinical relevance to delay or even prevent cognitive decline for patients with PD at this early stage.

While some beneficial effects were evident on a behavioural level (Giehl *et al.*, 2020; Ophey *et al.*, 2020), WMT-induced change on underlying neural correlates could only be observed in an exploratory analysis not corrected for multiple comparisons and should thus be interpreted with caution. However, due to our target group of cognitively healthy patients, large effects were not expected since similar findings in healthy and thus cognitively healthy adults have been observed previously (Ripp *et al.*, 2019).

It is important to note that both groups performed the fMRI-task equally well across time points. Although the lack of behavioural change in the fMRI-task could potentially indicate a lack of transfer from the WMT towards the in-scanner task, it might also just reflect the low sensitivity of the task to pick up behavioural change (i.e. as half the answers are correct simply by chance). In contrast, the absence of behavioural change speaks for the suitability of this task for fMRI. If behavioural performance had been different between time points, it would have been impossible to discriminate whether the observed neural effect was due to a change in behaviour per se or a change induced by WMT. Considering that neuropsychological improvements were observed using more sensitive neuropsychological measures (Giehl *et al.*, 2020; Ophey *et al.*, 2020) and that these changes were correlated with the observed change in activation, is seems plausible that the observed neural effects relate to WMT and are thus meaningful.

Conclusion

Using a new WM paradigm, we were able to successfully differentiate between different WM processes in patients with PD and shed light onto the potential effect of home-based WMT on the neural correlates underlying these in this patient group. While WM maintenance and manipulation relied on a widely distributed fronto-parietal-cerebellar network, only manipulation of information relied on additional activation of the AS.

WMT led to the reduction of activation and reorganization of context-dependent FC, especially when manipulation of WM content was required suggesting increased neural efficiency after WMT in PD. Activation changes were correlated with behavioural training gains.

This RCT is the first to explore the neural effects of WMT in PD. Although results should be considered with caution, our findings are promising in that WMT may enhance neural efficiency in early phases of PD. More research in this area should be highly encouraged in order to understand if such interventions have clinically relevant potential to delay or prevent cognitive impairment in early PD and elucidate the underlying neural mechanism of action.

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Competing interests

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References

Aarsland D, Bronnick K, Williams-Gray C, Weintraub D, Marder K, Kulisevsky J*, et al.* Mild cognitive impairment in Parkinson disease: a multicenter pooled analysis. Neurology 2010; 75(12): 1062-9.

Aguirre N, Cruz-Gómez ÁJ, Miró-Padilla A, Bueichekú E, Broseta Torres R, Ávila C*, et al.* Repeated Working Memory Training Improves Task Performance and Neural Efficiency in Multiple Sclerosis Patients and Healthy Controls. Multiple sclerosis international 2019; 2019.

Awh E, Vogel EK. The bouncer in the brain. Nat Neurosci 2008; 11(1): 5.

Baier B, Karnath H-O, Dieterich M, Birklein F, Heinze C, Müller NG. Keeping memory clear and stable—the contribution of human basal ganglia and prefrontal cortex to working memory. J Neurosci 2010; 30(29): 9788-92.

Belleville S, Clement F, Mellah S, Gilbert B, Fontaine F, Gauthier S. Training-related brain plasticity in subjects at risk of developing Alzheimer's disease. Brain 2011; 134(6): 1623-34.

Brehmer Y, Rieckmann A, Bellander M, Westerberg H, Fischer H, Bäckman L. Neural correlates of training-related working-memory gains in old age. NeuroImage 2011; 58(4): 1110-20.

Buschkuehl M, Jaeggi SM, Jonides J. Neuronal effects following working memory training. Dev Cogn Neurosci 2012; 2: S167-S79.

Chai WJ, Abd Hamid AI, Abdullah JM. Working memory from the psychological and neurosciences perspectives: A review. Front Psychol 2018; 9: 401.

Clark CM, Lawlor-Savage L, Goghari VM. Functional brain activation associated with working memory training and transfer. Behav Brain Res 2017; 334: 34-49.

Constantinidis C, Klingberg T. The neuroscience of working memory capacity and training. Nature Reviews Neuroscience 2016; 17(7): 438–49.

Cowan N. The many faces of working memory and short-term storage. Psychonomic bulletin & review 2017; 24(4): 1158-70.

Dahlin E, Neely AS, Larsson A, Bäckman L, Nyberg L. Transfer of learning after updating training mediated by the striatum. Science 2008; 320(5882): 1510-2.

Emch M, von Bastian CC, Koch K. Neural correlates of verbal working memory: An fMRI meta-analysis. Front Hum Neurosci 2019; 13: 180.

Fellman D, Salmi J, Ritakallio L, Ellfolk U, Rinne JO, Laine M. Training working memory updating in Parkinson's disease: A randomised controlled trial. Neuropsychol Rehabil 2018: 673-708.

Fengler S, Liepelt-Scarfone I, Brockmann K, Schäffer E, Berg D, Kalbe E. Cognitive changes in prodromal Parkinson's disease: a review. Mov Disord 2017; 32(12): 1655-66.

Giehl K, Ophey A, Reker P, Rehberg S, Hammes J, Barbe MT*, et al.* Effects of Home-Based Working Memory Training on Visuo-Spatial Working Memory in Parkinson's Disease: A

Randomized Controlled Trial. Journal of Central Nervous System Disease 2020; 12: 1179573519899469.

Giehl K, Tahmasian M, Eickhoff SB, van Eimeren T. Imaging executive functions in Parkinson's disease: An activation likelihood estimation meta-analysis. Parkinsonism Relat Disord 2019: 137-42.

Glizer D, MacDonald PA. Cognitive training in Parkinson's disease: a review of studies from 2000 to 2014. Parkinsons Dis 2016; 2016.

Gruber AJ, Dayan P, Gutkin BS, Solla SA. Dopamine modulation in the basal ganglia locks the gate to working memory. J Comput Neurosci 2006; 20(2): 153–66.

Haier RJ, Siegel Jr BV, Nuechterlein KH, Hazlett E, Wu JC, Paek J*, et al.* Cortical glucose metabolic rate correlates of abstract reasoning and attention studied with positron emission tomography. Intelligence 1988; 12(2): 199-217.

Hughes AJ, Daniel SE, Kilford L, Lees AJ. Accuracy of clinical diagnosis of idiopathic Parkinson's disease: a clinico-pathological study of 100 cases. J Neurol Neurosurg Psychiatry 1992; 55(3): 181-4.

Johansson B, Tornmalm M. Working memory training for patients with acquired brain injury: effects in daily life. Scand J Occup Ther 2012; 19(2): 176-83.

Jolles DD, van Buchem MA, Crone EA, Rombouts SA. Functional brain connectivity at rest changes after working memory training. Hum Brain Mapp 2013; 34(2): 396-406.

Karbach J, Verhaeghen P. Making working memory work: a meta-analysis of executive-control and working memory training in older adults. Psychol Sci 2014; 25(11): 2027-37.

Klingberg T. Training and plasticity of working memory. Trends Cogn Sci 2010; 14(7): 317-24.

Koenigs M, Barbey AK, Postle BR, Grafman J. Superior parietal cortex is critical for the manipulation of information in working memory. J Neurosci 2009; 29(47): 14980-6.

Kudlicka A, Clare L, Hindle JV. Executive functions in Parkinson's disease: Systematic review and meta-analysis. Mov Disord 2011; 26(13): 2305-15.

Lawson RA, Yarnall AJ, Duncan GW, Khoo TK, Breen DP, Barker RA*, et al.* Severity of mild cognitive impairment in early Parkinson's disease contributes to poorer quality of life. Parkinsonism Relat Disord 2014; 20(10): 1071-5.

Leung IH, Walton CC, Hallock H, Lewis SJ, Valenzuela M, Lampit A. Cognitive training in Parkinson disease A systematic review and meta-analysis. Neurology 2015: 1843-51.

Lewis SJ, Cools R, Robbins TW, Dove A, Barker RA, Owen AM. Using executive heterogeneity to explore the nature of working memory deficits in Parkinson's disease. Neuropsychologia 2003; 41(6): 645-54.

Lewis SJ, Dove A, Robbins TW, Barker RA, Owen AM. Striatal contributions to working memory: a functional magnetic resonance imaging study in humans. Eur J Neurosci 2004; 19(3): 755-60.

Li H-J, Hou X-H, Liu H-H, Yue C-L, Lu G-M, Zuo X-N. Putting age-related task activation into large-scale brain networks: a meta-analysis of 114 fMRI studies on healthy aging. Neurosci Biobehav Rev 2015; 57: 156-74.

Litvan I, Goldman JG, Tröster AI, Schmand BA, Weintraub D, Petersen RC*, et al.* Diagnostic criteria for mild cognitive impairment in Parkinson's disease: Movement Disorder Society Task Force guidelines. Mov Disord 2012; 27(3): 349-56.

Lund TE, Nørgaard MD, Rostrup E, Rowe JB, Paulson OB. Motion or activity: their role in intra-and inter-subject variation in fMRI. NeuroImage 2005; 26(3): 960-4.

Masse NY, Yang GR, Song HF, Wang X-J, Freedman DJ. Circuit mechanisms for the maintenance and manipulation of information in working memory. Nat Neurosci 2019: 1159-67.

McNab F, Klingberg T. Prefrontal cortex and basal ganglia control access to working memory. Nat Neurosci 2008; 11(1): 103.

Melby-Lervåg M, Hulme C. Is working memory training effective? A meta-analytic review. Dev Psychol 2013; 49(2): 270-91.

Miró-Padilla A, Bueichekú E, Ventura-Campos N, Flores-Compañ M-J, Parcet MA, Ávila C. Long-term brain effects of N-back training: an fMRI study. Brain imaging and behavior 2019; 13(4): 1115-27.

Muslimović D, Post B, Speelman JD, Schmand B. Cognitive profile of patients with newly diagnosed Parkinson disease. Neurology 2005; 65(8): 1239-45.

Neubauer AC, Fink A. Intelligence and neural efficiency. Neurosci Biobehav Rev 2009; 33(7): 1004-23.

Nombela C, Rowe JB, Winder-Rhodes SE, Hampshire A, Owen AM, Breen DP*, et al.* Genetic impact on cognition and brain function in newly diagnosed Parkinson’s disease: ICICLE-PD study. Brain 2014; 137(10): 2743-58.

Ophey A, Giehl K, Rehberg S, Eggers C, Reker P, van Eimeren T*, et al.* Effects of working memory training in patients with Parkinson's disease without cognitive impairment: A randomized controlled trial. Parkinsonism Relat Disord 2020: 13-22.

Owen AM, McMillan KM, Laird AR, Bullmore E. N-back working memory paradigm: A meta-analysis of normative functional neuroimaging studies. Hum Brain Mapp 2005; 25(1): 46-59.

Poston KL, YorkWilliams S, Zhang K, Cai W, Everling D, Tayim FM*, et al.* Compensatory neural mechanisms in cognitively unimpaired Parkinson disease. Ann Neurol 2016; 79(3): 448-63.

Ripp I, Emch M, Quiong W, Cabello J, Koch K, Yakushev I. Does working memory training change the brain? A simultaneous PET/MRI study. J Nucl Med 2019; 60(supplement 1): 1312-.

Rosen AC, Sugiura L, Kramer JH, Whitfield-Gabrieli S, Gabrieli JD. Cognitive training changes hippocampal function in mild cognitive impairment: a pilot study. J Alzheimers Dis 2011; 26(s3): 349-57.

Schapira AH. Neurobiology and treatment of Parkinson's disease. Trends Pharmacol Sci 2009; 30(1): 41-7.

Schneiders JA, Opitz B, Krick CM, Mecklinger A. Separating intra-modal and across-modal training effects in visual working memory: an fMRI investigation. Cereb Cortex 2011; 21(11): 2555-64.

Simioni AC, Dagher A, Fellows LK. Effects of levodopa on corticostriatal circuits supporting working memory in Parkinson's disease. Cortex 2017; 93: 193-205.

Suzuki M, Kawagoe T, Nishiguchi S, Abe N, Otsuka Y, Nakai R*, et al.* Neural correlates of working memory maintenance in advanced aging: Evidence from fMRI. Front Aging Neurosci 2018; 10: 358.

Takeuchi H, Taki Y, Nouchi R, Hashizume H, Sekiguchi A, Kotozaki Y*, et al.* Effects of working memory training on functional connectivity and cerebral blood flow during rest. Cortex 2013; 49(8): 2106-25.

Veltman DJ, Rombouts SA, Dolan RJ. Maintenance versus manipulation in verbal working memory revisited: an fMRI study. NeuroImage 2003; 18(2): 247-56.

Volpicelli-Daley LA, Luk KC, Patel TP, Tanik SA, Riddle DM, Stieber A*, et al.* Exogenous α-synuclein fibrils induce Lewy body pathology leading to synaptic dysfunction and neuron death. Neuron 2011; 72(1): 57-71.

Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey M*, et al.* Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res 1982; 17(1): 37-49.

Yu Y, FitzGerald TH, Friston KJ. Working memory and anticipatory set modulate midbrain and putamen activity. J Neurosci 2013; 33(35): 14040-7.

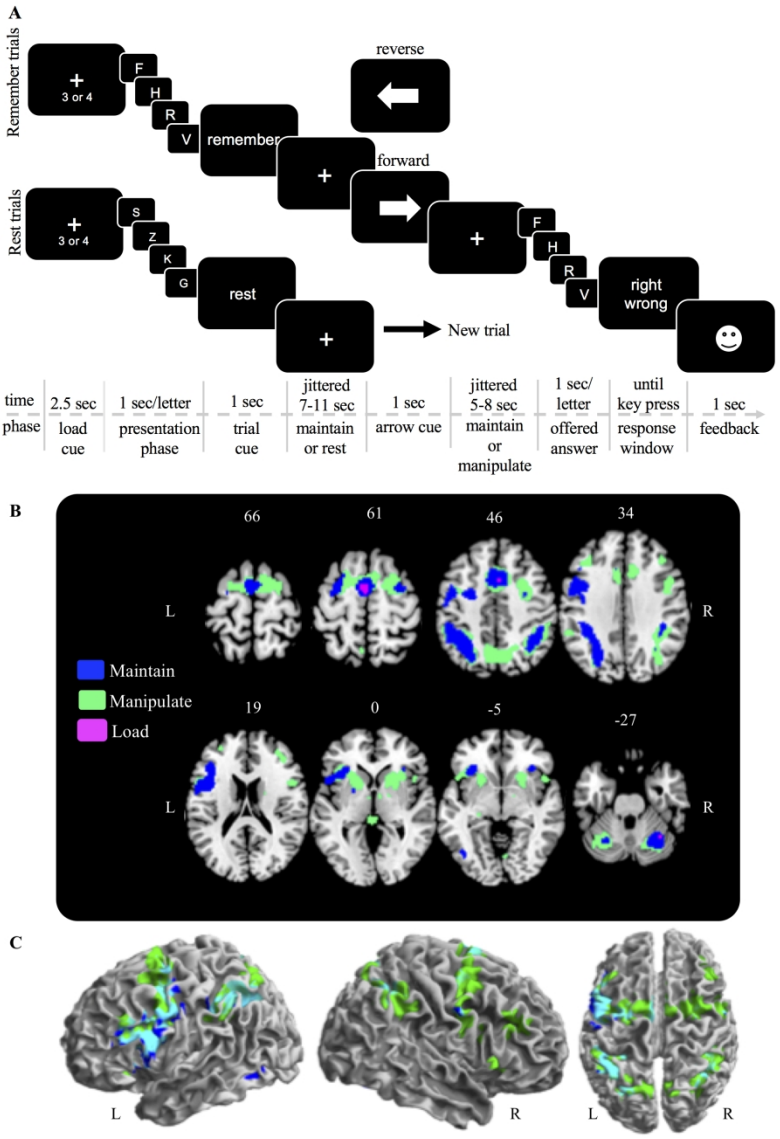
Figure captions

Figure 1: WM-fMRI paradigm and task-related activation pattern. A, The patient had to remember 3 or 4 letters; following a right arrow, the sequence needed to be maintained in forward order, while the sequence had to be reversed following a left arrow; the offered answer was then judged correct or incorrect via button press. B, Axial view of baseline activation pattern shown for: maintain vs. rest (blue); manipulate vs. maintain (green); high-load vs. low-load (pink); C, surface rendering of maintain vs. rest (blue); manipulate vs. rest (green); overlap (turquoise); Binary maps of all voxels with $p < .05$ FWE-corrected on voxel-level. L=left, R=right; displayed using MRIcron; surface rendering via SPM12.

Figure 2: CONSORT flow chart. Participant enrolment, allocation and analysis.

Figure 3: Neural WMT-induced effect. Axial view of WMT-induced activation decreases for the manipulate vs. rest contrast. Illustratory threshold $p < .005$ uncorrected. L=left, R=right; displayed using MRIcron.

Figure 4: Behaviour-brain correlations. Correlations between neuropsychological WM change scores [visuospatial WM (A, C, E); verbal WM (B, D, F)] and BOLD signal change [maintain vs. rest contrast (A, B); manipulate vs. rest contrast (C, D); manipulate vs. maintain (E, F)] derived from an 8mm sphere around WMT-induced activation change peak at the AS (4/-4/4).



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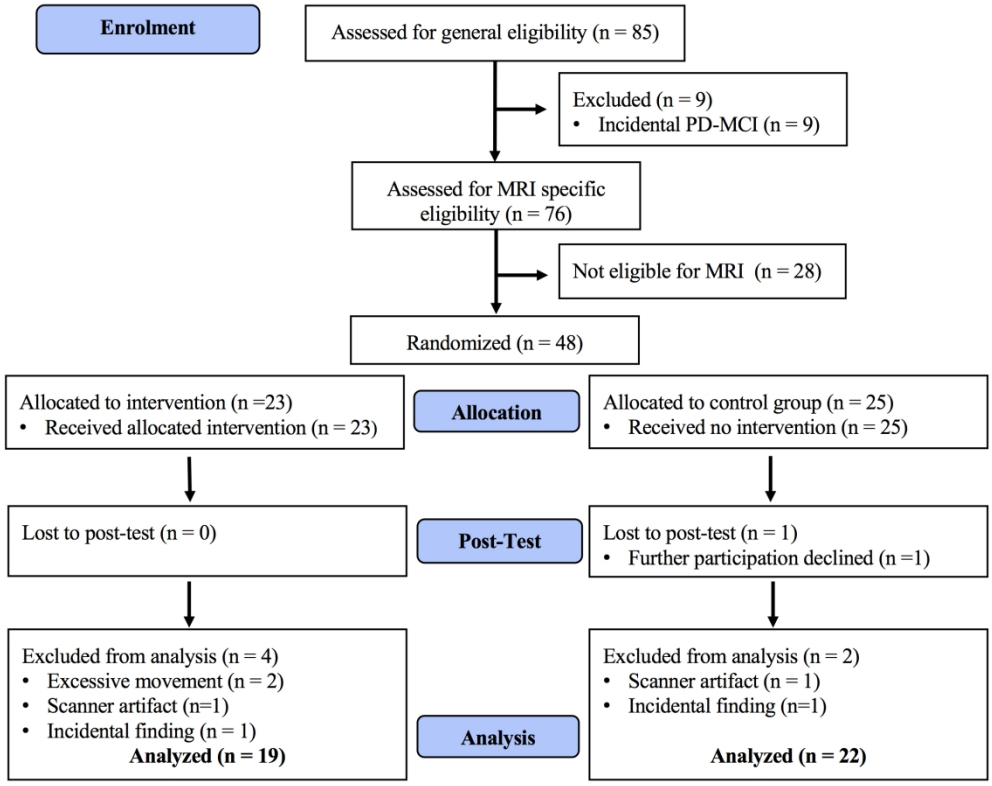

Figure 2: CONSORT flow chart. Participant enrolment, allocation and analysis.

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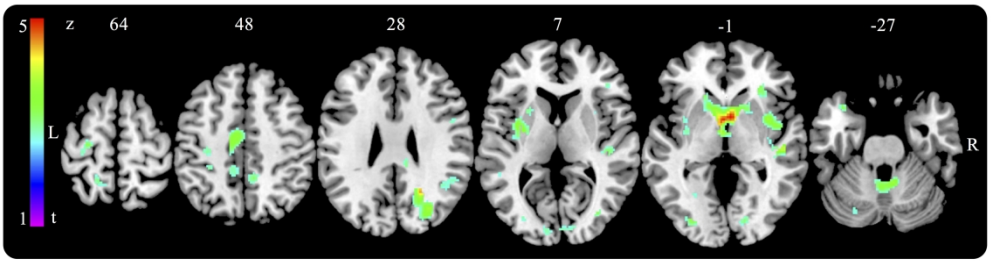

Neural WMT-induced effect. Axial view of WMT-induced activation decreases for the manipulate vs. rest contrast. Illustratory threshold p < .005 uncorrected. L=left, R=right; displayed using MRIcron.

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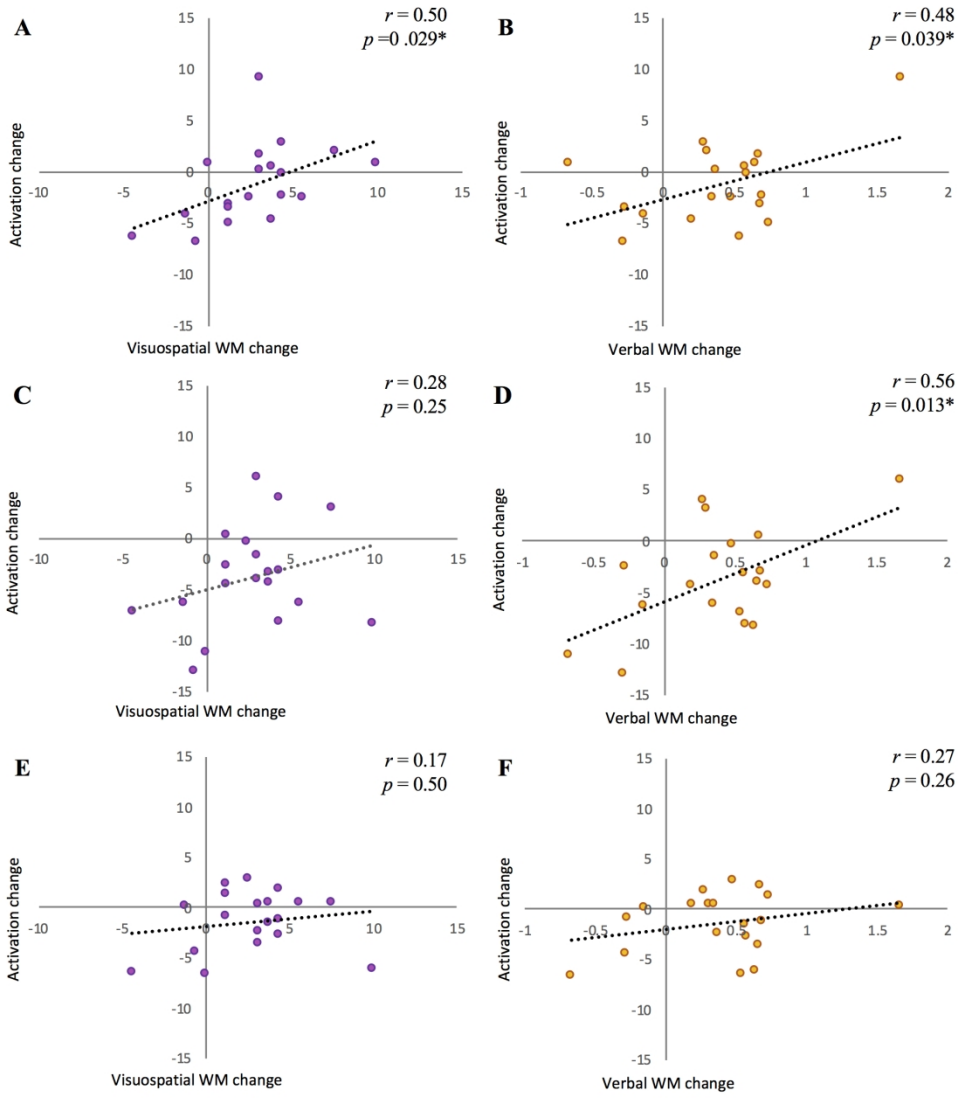


Behaviour-brain correlations. Correlations between neuropsychological WM change scores [visuospatial WM (A, C, E); verbal WM (B, D, F)] and BOLD signal change [maintain vs. rest contrast (A, B); manipulate vs. rest contrast (C, D); manipulate vs. maintain (E, F)] derived from an 8mm sphere around WMT-induced activation change peak at the AS (4/-4/4).

176x198mm (300 x 300 DPI)

Table 1: Final sample characteristics per group at baseline.

		WMT (n = 19)	CG (n = 22)	p-value
Age in years		65.3 ± 8.9 (47.9 – 78.7)	63.5 ± 9.1 (46.3 – 79.0)	.54[b]
Sex	female, n (%)	10 (52.6)	9 (40.9)	.54[c]
	male, n (%)	9 (47.4)	13 (59.1)	
Handedness	right, n (%)	17 (89.5)	22 (100)	.21[c]
	left, n (%)	2 (10.5)	0 (0)	
Education in years		15.3 ± 3.4 (11 – 22)	15.6 ± 2.6 (10 – 22)	.34[a]
Global Cognition MoCA score		27 ± 1.7 (24 – 29)	27.7 ± 1.4 (25 – 30)	.26[a]
Disease duration in years		5.5 ± 4.1 (0.8 – 16.1)	5.9 ± 5.8 (0.4 – 23.2)	.62[a]
UPDRS-III		28.6 ± 8.0 (13 – 45)	29.6 ± 7.9 (17 – 49)	.69[b]
H&Y	Stage 2, n (%)	18 (94.7)	21 (95.5)	.99[c]
	Stage 3, n (%)	1 (5.3)	1 (4.5)	
LEDD in mg		667 ± 451 (120 – 1785)	493 ± 286 (100 – 1180)	.29[a]
Depression GDS score		1.7 ± 1.9 (0 – 7)	2.9 ± 2.7 (0 – 9)	.17[a]

Data are mean values ± standard deviation (range), unless stated otherwise. For baseline comparison between groups, p-values of Wilcoxon rank-sum tests[a], independent sample t-tests[b], χ2-tests[c] are reported as appropriate. Variables were previously inspected visually by qq-plots and statistically by Shapiro-Wilk tests for normal distribution.

CG, control group; WMT, computerized working memory training group; GDS, Geriatric Depression Scale; H&Y, Hoehn & Yahr scale; LEDD, levodopa equivalent daily dose; MoCA, Montreal Cognitive Assessment; UPDRS-III, Unified Parkinson's Disease Rating Scale Part 3.

Table 2: Task-associated activation

Brain region	side	MNI peak coordinate x	y	z	cluster size [voxel]	peak t-values	p-value
contrast 1: maintain vs. rest							
Inferior/middle frontal gyrus/precentral gyrus	L	-42	8	26	2695	10.13	<.001
Cerebellum/fusiform gyrus	R	28	-64	-26	716	9.41	<.001
Supplementary motor area	L	-2	0	62	985	9.15	<.001
Supramarginal gyrus	R	38	-48	40	722	8.88	<.001
Superior parietal lobule	L	-30	-58	40	1756	8.64	<.001
Middle frontal gyrus	R	30	0	56	199	7.35	<.001
Inferior temporal gyrus	L	-44	-54	-14	180	6.85	.001
Orbitofrontal cortex	R	34	28	-6	47	6.45	.002
Precentral gyrus	R	56	-4	40	40	6.23	.004
Thalamus	L	-10	-16	4	39	6.23	.004
Cerebellum	L	-2	-50	-20	97	6.01	.007
Cerebellum	L	-28	-64	-28	39	5.78	.014
contrast 2: manipulate vs. rest							
Middle frontal gyrus/ supplementary motor area	R	30	-2	54	5603	10.55	<.001
Superior parietal lobule	R	38	-48	42	1510	9.58	<.001
Superior parietal lobule/lateral occipital cortex/supramarginal gyrus	L	-32	-52	42	2289	9.17	<.001
Orbitofrontal cortex	R	34	28	-4	281	8.88	<.001
Orbitofrontal cortex	L	-32	26	-4	259	7.94	<.001
Cerebellum/fusiform gyrus	R	28	-66	-26	519	7.69	<.001
Middle frontal gyrus	R	38	34	26	283	7.36	<.001
Precuneous cortex	R	10	-68	50	204	7.23	<.001
Anterior striatum	R	16	14	-4	176	7.14	<.001
Anterior striatum	L	-16	14	-4	147	6.57	.001
Cerebellum	L	-28	-64	-28	150	6.35	.002
Inferior frontal gyrus	L	-52	12	0	63	6.04	.006
Cerebellum	R	2	-50	-18	50	5.98	.006
Inferior temporal gyrus	L	-48	-56	-14	27	5.81	.010
Thalamus	R	8	-20	-4	34	5.67	.015
contrast 3: manipulate vs. maintain							
Middle frontal gyrus	R	38	32	26	441	9.31	<.001
Middle and inferior frontal gyrus	L	-36	32	36	752	9.29	<.001
Anterior striatum	R	22	12	-4	629	9.11	<.001
Paracingulate gyrus/middle and superior frontal gyrus	R	10	14	46	4077	8.86	<.001
Insular cortex/Anterior striatum /Thalamus	L	-40	20	-2	848	8.82	<.001
Supramarginal gyrus/lateral occipital cortex	R	46	-46	48	1210	8.41	<.001
Lateral occipital cortex/superior parietal lobule/Precuneus	L	-26	-68	34	2534	8.23	<.001
Cerebellum/lingual gyrus	R	38	-60	-30	969	8.15	<.001
Cerebellum	L	-34	-58	-28	337	7.49	<.001
Thalamus	L	-2	-28	4	243	6.82	.001
Precentral gyrus	R	44	10	30	227	6.62	.001
Inferior frontal gyrus	R	52	10	16	52	6.34	.003
Frontal pole	L	-32	50	18	20	6.24	.004
Temporal pole	R	48	16	-6	82	6.18	.004

Lingual gyrus	L	-2	-72	6	38	6.08	.006
Cerebellum	R	2	-50	-20	20	5.87	.010
Thalamus	L	-14	-14	8	16	5.63	.019
contrast 4: high load vs. low load							
Supplementary motor area	L	-4	0	60	47	6.75	.001
Paracingulate gyrus	R	2	12	46	13	5.70	.021

Peak coordinates of significant clusters following voxel-wise FWE correction (p<.05) exceeding 10 continuous voxels are reported; L= left; R=right

Table 3: WMT-induced activation changes

Brain region	side	MNI peak coordinate x	y	z	cluster size [voxel]	peak t-values	p-value
contrast 1: maintain vs. rest							
negative group x time interaction							
Middle frontal gyrus	R	30	-4	54	75	4.21	<.001
Anterior striatum /lateral ventricle	L	-6	4	0	36	4.04	<.001
Cerebellum	R/L	0	-54	-26	38	4.01	<.001
Precuneus	R	22	-58	28	26	3.97	<.001
Brain stem	L	-2	-18	-22	14	3.92	<.001
Precentral gyrus	L	-36	0	28	33	3.6	<.001
contrast 2: manipulate vs. rest							
negative group x time interaction							
Anterior striatum (including bilateral nucleus accumbens and subcallosal cortex)	L	-4	4	-4	311	4.99	<.001
Precuneus	R	22	-58	28	137	4.46	<.001
Superior temporal gyrus	R	50	-22	0	29	4.09	<.001
Brain stem	L	-6	-38	-8	36	3.95	<.001
Lateral occipital cortex	R	28	-72	26	35	3.76	<.001
Cerebellum	R	8	-50	-26	42	3.76	<.001
Insular cortex	R	36	4	0	49	3.72	<.001
Insular cortex	L	-32	-2	10	68	3.66	<.001
Lateral occipital cortex	R	32	-74	14	16	3.54	<.001
Supplementary motor area	L	-6	-10	48	51	3.54	<.001
contrast 3: manipulate vs. maintain							
negative group x time interaction							
Subcallosal cortex, thalamus, lateral ventricle	R	2	4	0	40	3.78	<.001
Anterior cingulate gyrus	L	-2	-4	42	27	3.64	<.001
contrast 4: high load vs. low load							
no group x time interaction							

Peak coordinates of significant clusters exceeding 10 continuous voxels (p<.0001 uncorrected) are reported; L= left; R=right

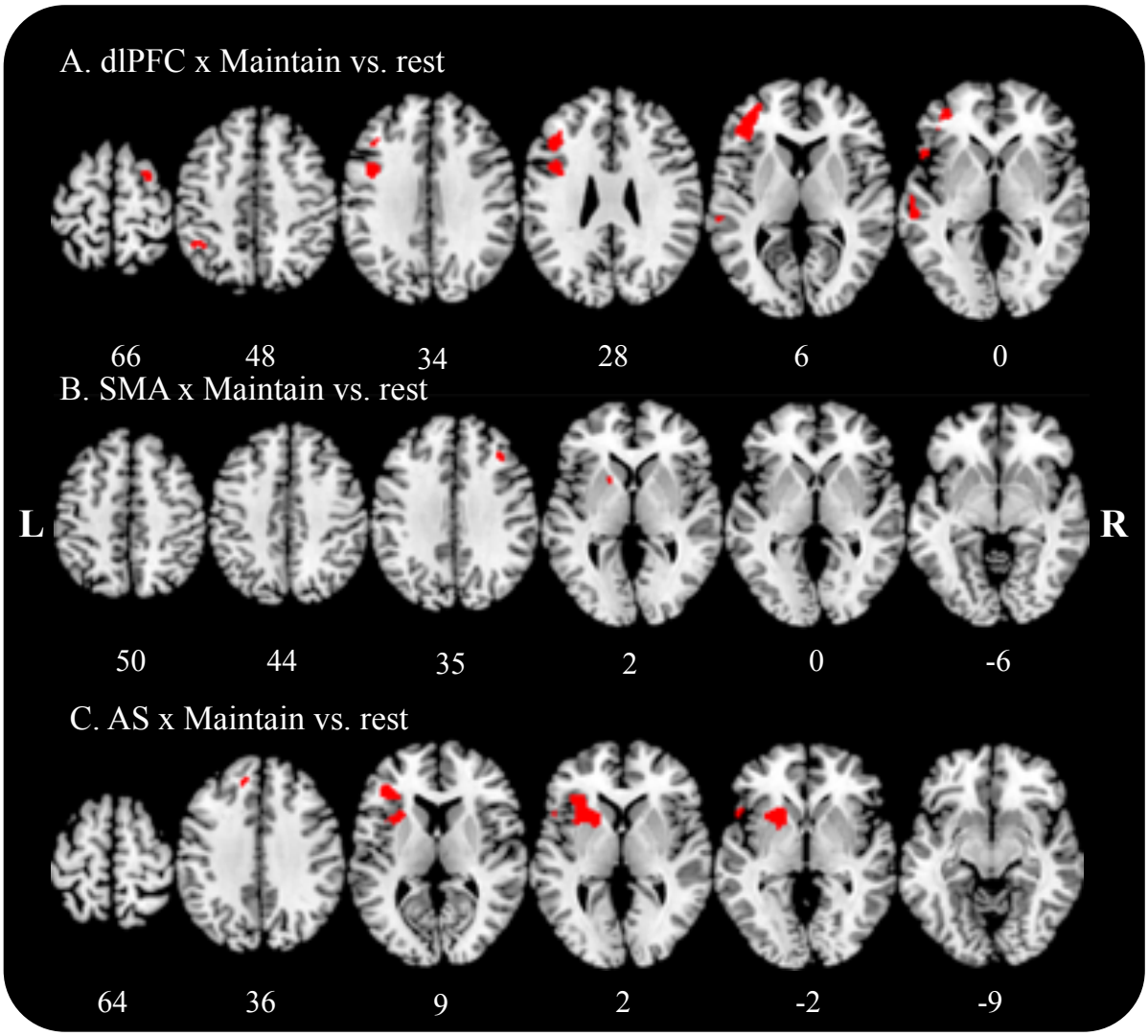
Table 4: WMT-induced connectivity changes

Brain region	side	MNI peak coordinate x	y	z	cluster size [voxel]	peak t-values	p-value
dlPFC x contrast 1: maintain vs. rest							
No positive group x time interaction							
Negative group x time interaction							
Middle frontal gyrus	L	-34	20	46	23	3.824	<.001
Cingulate gyrus, posterior division	R	4	-44	16	31	3.811	<.001
Anterior striatum /insula	L	-34	0	-4	13	3.524	<.001
Lingual gyrus	L	-12	-44	-12	10	3.483	<.001
Superior frontal gyrus	R	20	44	30	14	3.443	<.001
Cingulate gyrus, anterior division	R	10	30	24	10	3.375	0.001
dlPFC x contrast 3: manipulate vs. maintain							
Positive group x time interaction							
Parietal Operculum Cortex	L	-38	-34	18	50	4.117	<.001
Negative group x time interaction							
Middle frontal gyrus	R	24	38	26	62	4.202	<.001
Cerebellum crus 1	R	32	-70	-34	19	4.192	<.001
Frontal pole	L	-26	50	20	13	4.185	<.001
Cingulate gyrus, anterior division	R	4	-10	34	39	4.146	<.001
Inferior frontal triangularis	L	-34	30	16	12	3.977	<.001
Inferior frontal gyrus, pars triangularis	R	48	28	-2	72	3.929	<.001
Cingulate	R	12	14	32	13	3.751	<.001
Insula	R	34	2	8	43	3.726	<.001
Superior frontal gyrus	R	16	-18	68	13	3.702	<.001
Cingulate gyrus, anterior division	L/R	0	26	28	35	3.670	<.001
Inferior frontal gyrus, pars triangularis	L	-46	34	-2	13	3.643	<.001
Insula	R	40	-24	2	13	3.630	<.001
Middle frontal gyrus	R	42	34	26	17	3.557	<.001
Precentral gyrus	R	46	8	32	12	3.422	<.001
SMA x contrast 1: maintain vs. rest							
No group x time interaction							
SMA x contrast 3: manipulate vs. maintain							
Positive group x time interaction							
Postcentral gyrus	L	-34	-28	52	98	4.266	<.001
Angular gyrus	L	-46	-52	30	105	4.098	<.001
Fusiform gyrus	L	-36	-42	-8	61	4.094	<.001
Lingual gyrus	L	-4	-48	-4	35	4.008	<.001
Planum polare	L	-46	2	-16	87	3.813	<.001
Fusiform gyrus	L	-32	-62	-8	20	3.767	<.001
SMA	R	12	-8	42	24	3.761	<.001
Supramarginal gyrus, posterior division	L	-48	-48	42	23	3.645	<.001
Negative group x time interaction							
Lateral ventricle	R	4	8	-2	10	3.838	<.001

AS x contrast 1: maintain vs. rest							
No positive group x time interaction							
Negative group x time interaction							
Lateral ventricle	R	20	-24	26	16	3.821	<.001
Parahippocampal gyrus, anterior division	R	20	-18	-24	18	3.765	<.001
Precuneus	L	-4	-52	8	14	3.567	<.001
AS x contrast 3: manipulate vs. maintain							
Positive group x time interaction							
Superior frontal gyrus	L	-20	36	30	22	3.723	<.001
Lateral ventricle	L	-12	-28	22	15	3.649	<.001
Superior parietal lobe	L	-30	-58	52	27	3.633	<.001
Hippocampus	L	-36	-36	-8	10	3.439	<.001
No negative group x time interaction							

Peak coordinates of significant clusters exceeding 10 continuous voxels (p<.0001 uncorrected) are reported; L= left; R=right; dlPFC= dorsolateral prefrontal cortex; SMA= supplementary motor area; AS= anterior striatum

Supplementary material



Supplementary Figure 1: Context-dependent functional connectivity pattern

Axial view of baseline functional connectivity between maintain vs. rest and; A, dorsolateral prefrontal cortex (dlPFC); B, supplementary motor area (SMA); C, anterior striatum (AS). Binary maps showing all voxels with $p < 0.05$ FWE-corrected on voxel-level. L=left, R=right; displayed using MRIcron.

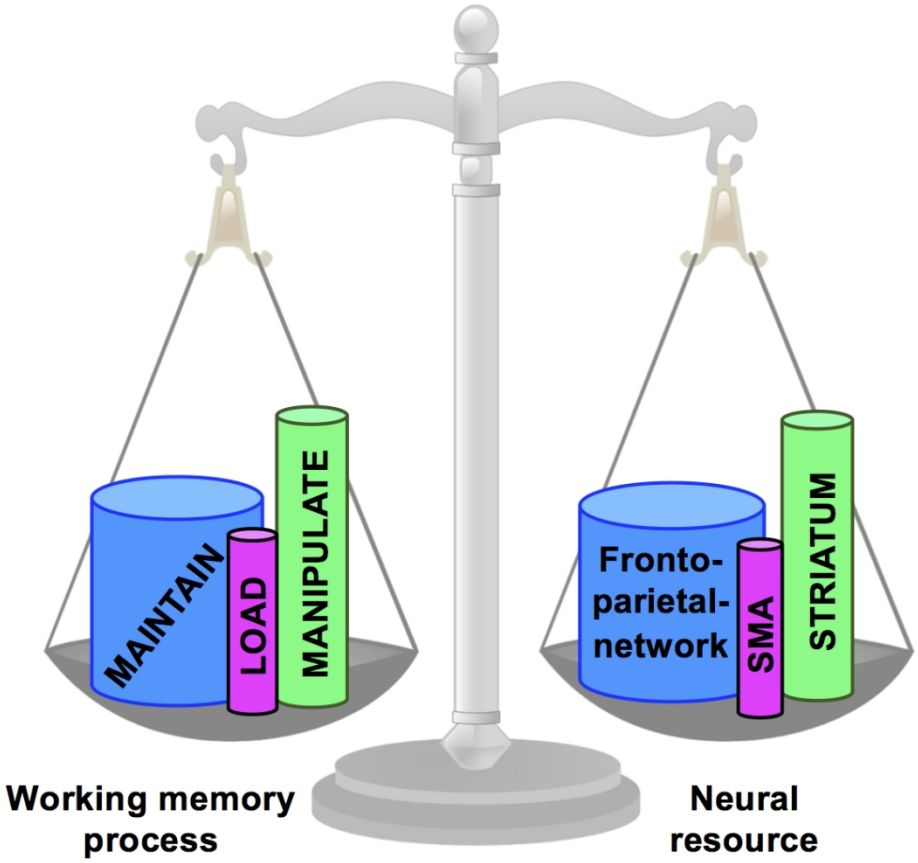
Supplementary Table 1: Functional connectivity at baseline (PPI-analysis)

Brain region	side	MNI peak coordinate x	y	z	cluster size [voxel]	peak t-values	p-value
dlPFC x contrast 1: maintain vs. rest							
Positive interaction							
Frontal Pole	L	-42	36	6	330	8.765	<.001
Middle Frontal Gyrus	L	-42	24	26	127	7.881	<.001
Middle Frontal Gyrus	L	-42	8	34	185	7.280	<.001
Superior Frontal Gyrus	R	26	0	68	24	7.253	<.001
Inferior Frontal Gyrus, pars opercularis	L	-54	18	-2	27	5.822	.009
Supramarginal Gyrus, posterior division	L	-44	-50	48	56	5.821	.009
Planum Temporale	L	-62	-16	2	76	5.733	.012
Inferior Frontal Gyrus, pars opercularis	L	-48	14	10	19	5.620	.016
No negative interaction							
dlPFC x contrast 3: manipulate vs. maintain							
No interaction							
SMA x contrast 1: maintain vs. rest							
Positive interaction							
Middle frontal gyrus	R	36	28	36	41	5.700	.011
Anterior striatum	L	-18	10	4	11	5.485	.02
No negative interaction							
SMA x contrast 3: manipulate vs. maintain							
No positive interaction							
Negative interaction							
Lateral Occipital Cortex, superior division	R	36	-82	18	73	6.713	.001
Lateral Occipital Cortex, inferior division	R	40	-82	0	30	5.917	.01
AS x contrast 1: maintain vs. rest							
Positive interaction							
Anterior striatum	L	-20	12	-2	541	10.199	<.001
Inferior Frontal Gyrus, pars opercularis	L	-52	16	-2	31	7.013	<.001
Superior frontal gyrus	L	-12	42	36	17	5.768	.011
No negative interaction							
AS x contrast 3: manipulate vs. maintain							
No interaction							

Peak coordinates of significant clusters following voxel-wise FWE correction ($p<.05$) exceeding 10 continuous voxels are reported; L= left; R=right; dlPFC= dorsolateral prefrontal cortex; SMA= supplementary motor area; AS= anterior striatum

Abbreviated summary (50 words maximum)

Giehl et al. report the effects of working memory training on neural correlates underlying working memory in Parkinson's disease. In accordance with the neural efficacy hypothesis, an overall reduction of neural activation and the reorganization of functional connectivity was observed following the intervention.



102x96mm (300 x 300 DPI)

CONSORT: Reporting guidelines checklist of information to include when reporting a randomized trial

SECTION	ITEM NUMBER	CHECKLIST ITEM	REPORTED ON PAGE NUMBER:
TITLE AND ABSTRACT			
	1a	Identification as a randomized trial in the title	1
	1b	Structured summary of trial design, methods, results, and conclusions	2
INTRODUCTION			
Background and objectives	2a	Scientific background and explanation of rationale	3-4
	2b	Specific objectives or hypotheses	4
METHODS			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	5
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	N/A
Participants	4a	Eligibility criteria for participants	5
	4b	Settings and locations where the data were collected	5
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	5 (Ophey et al. 2020)
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	5 (Ophey et al. 2020)
	6b	Any changes to trial outcomes after the trial commenced, with reasons	N/A
Sample size	7a	How sample size was determined	5 (Ophey et al. 2020)
	7b	When applicable, explanation of any interim analyses and stopping guidelines	N/A
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequence	5 (Ophey et al. 2020)
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	5 (Ophey et al. 2020)

SECTION	ITEM NUMBER	CHECKLIST ITEM	REPORTED ON PAGE NUMBER:
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	5 (Ophey et al. 2020)
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	5 (Ophey et al. 2020)
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how	5 (Ophey et al. 2020)
	11b	If relevant, description of the similarity of interventions	N/A
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	8-9
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	N/A
RESULTS			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analyzed for the primary outcome	10 & Figure 2
	13b	For each group, losses and exclusions after randomisation, together with reasons	10 & Figure 2
Recruitment	14a	Dates defining the periods of recruitment and follow-up	5 (Ophey et al. 2020)
	14b	Why the trial ended or was stopped	N/A
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	Table 1
Numbers analyzed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	10 & Figure 2
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	N/A
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	N/A
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory	N/A
Harms	19	Important harms or unintended effects in each group	N/A
DISCUSSION			

SECTION	ITEM NUMBER	CHECKLIST ITEM	REPORTED ON PAGE NUMBER:
Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses	14-16
Generalizability	21	Generalizability (external validity, applicability) of the trial findings	15
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	12-14 & 16
Other information			
Registration	23	Registration number and name of trial registry	5
Protocol	24	Where the full trial protocol can be accessed, if available	drks.de
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	16

If relevant, CONSORT extensions for cluster randomized trials, non-inferiority and equivalence trials, non-pharmacological treatments, herbal interventions and pragmatic trials are available www.consort-statement.org