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Grey scales uncover similar attentional effects in homonymous hemianopia and visual hemi-neglect

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Abstract

Multi-component models of visual hemi-neglect have postulated that visual hemi-neglect is characterised by various attentional deficits. A grey scales task has been developed to quantify the early, automatic, (perhaps obligatory) ipsilesional orienting of visual attention, frequently assumed as the first of these attentional deficits. Explanations for this attentional imbalance are up until now mainly formulated in terms of right hemisphere activation. This lateral attentional bias has also been demonstrated in controls, in whom it is expressed as a leftward perceptual asymmetry. We reproduced previous literature findings on a grey scales task, considering controls and neglect patients. Three patients with neglect showed an extreme ipsilesional lateral bias. This bias did not change during or after cognitive rehabilitation. Additionally, we presented this grey scale task to 32 patients with left- and right-sided homonymous hemianopsia (HP). HP is the loss of sight in one visual hemi-field. The HH patients had no clinical signs of impaired lateralised attention. Results revealed that HH patients showed a similar ipsilesional bias, albeit to a lesser degree than in neglect. Left-sided HH patients presented a quantitatively similar, but qualitatively opposite bias than the right-sided HH patients. We suggest that sensory effects can be an alternative source of attentional imbalance, which can interact with the previously proposed (right) hemispheric effects. This suggests that the perceptual asymmetry in the grey scales task is not necessarily an indicator of impaired right hemisphere attention. It rather suggests a pattern of functional cerebral asymmetry, which can also be caused by asymmetric sensory input. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Attentional imbalance; Perceptual bias; Hemispheric specialisation; Laterality

1. Introduction

Several authors (e.g. [11,16,23]) suggested that the clinical syndrome of unilateral visual spatial neglect (UN) can be described/explained as a series of successive attentional events beginning with (1) an early, automatic, chronic, perhaps obligatory, orienting of attention toward the ipsilesional half space, followed by (2) a deficit in disengaging attention from that side in order to reorient it toward the contralateral half space. In addition to these two deficits, (3) a generalised (i.e. directionally non-specific) reduction in attentional-information processing capacity is assumed. The first component underlies an anomalous lateral preference. The second component gives rise to the clinical signs of UN (e.g. left-sided omissions on cancellation tasks) [23]. Karnath [16] proposed that this second component (reorienting) recovers faster than the other two, and this has been confirmed by several authors (e.g. [23,28]). Mattingley et al. [23] concluded that the apparent recovery of UN constituted of the restitution in reorienting of attention, but that the early ipsilesional orienting remained. They further postulated this (residual) attentional bias to be characteristic of right hemisphere dysfunction, and posed that it could be predictive of persistent neglect-type behaviours. This attentional bias has been demonstrated in right hemisphere patients, not only using RT paradigms (e.g. [3]), but also under more naturalistic free viewing conditions. It has been demonstrated using several indexes and tasks. Gainotti et al. [11] operationally defined it as a “position preference”, namely as the tendency to identify first (and consistently) those parts of a composite diagram lying on the right or on the left of its centre. As a result of the early, automatic orienting of attention, UN patients frequently start scanning

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on the right side of a given composite stimulus (i.e. show a rightward bias). A further frequently used index expressing this lateral orienting bias is an asymmetry index (AI) derived from mainly paradigms using chimeric stimuli. For example, Mattingley et al. [23,24] concluded that this lateral preference is expressed (in UN) by a tendency to choose or prefer the right side of a composite image (rightward bias). In a face-matching task by Mattingley et al. [23], subjects were required to indicate which of two asymmetrical composites (one composed of the two left halves of an original face, the other composed of the two right halves) more closely resembled the (inherently asymmetrical) original. Patients with UN tended to judge the faces composed of the two right halves as more similar to the original than the face composed of two left halves (rightward bias). In another chimeric faces task, presented by the same authors, patients were required to judge which face of a given pair appeared “happier”. The faces were composed of two half-faces of the same person, one half smiling, the other in a neutral expression. In one pair, the smiling face was on the left, in the other on the right. Again, UN patients tended to judge the face with the “right-smile” as happier. This rightward bias was also demonstrated using grey scales [24]. In this task, the patient was required to compare two vertically aligned rectangular bars and indicate which one appears overall darker. The bars consisted of scales of semi-continuous shades of grey, ranging from white on one end to black on the other. Both bars were identical, but mirror-reversed. Patients with UN tended to choose the bar which was black on the right side as the darker one.

Lateral biases have also been demonstrated in healthy subjects using identical or comparable paradigms (e.g. [21,23,24,27]). Contrary to patients with UN, healthy subjects exhibit a significant leftward bias. Since this bias is displayed by healthy subjects, and hence is considered to be “normal”, it is often termed as a “perceptual asymmetry” instead of a “bias” (which suggests deviation from normality).

This left perceptual asymmetry in healthy subjects has been demonstrated using face-stimuli (judgements of emotions, similarity, and femininity) [21,23,24], using grey scales (e.g. [24]), and using stimuli asking for comparisons of dot numerosity and roundness (e.g. [21]), and size (e.g. [27]). The leftward bias occurs in all these tasks in more or less comparable intensities. Despite of the similar levels of perceptual asymmetry, only low to modest intercorrelations are observed. Nicholls et al. [27] suggest that these tasks do not index one single common factor, but tap a set of attentional processes, some of which are overlapping, and others which are task-specific. The community is suggested to consist in the common right hemisphere involvement.

Summarising the explanations provided in the literature, in healthy subjects the lateral bias is explained as the result of more right hemisphere activation due to the visuo-spatial nature of the stimulus [21–23,28]. It is argued that the differential activation of the right hemisphere generates a bias of attention to the left hemisphere, creating an attentional imbalance. In UN patients, the lateral bias results from disturbed right hemisphere function. It is suggested [19,20,23,24] that each hemisphere controls a contralaterally directed attentional vector. Damage to one hemisphere results in dysfunction of the associated vector and gives rise to an ipsilateral bias. In all accounts, the perceptual asymmetry is explained in terms of functional cerebral asymmetry and more specifically in terms of differential attentional right hemisphere activation. One other alternative account was proposed by Nicholls et al. [27]. They suggested the possibility that the asymmetry may be related to effects of directional scanning. In support of this proposal, they report a study by Sakhuja et al. [29] who found that readers of Hindi (left-to-right) showed the expected leftward bias, whereas readers of Urdu (right-to-left) showed the opposite bias. Nicholls and colleagues argue that the preferred directional scanning habit may lead to an over-representation of one side (i.e. ipsi-directional) of the stimulus and hence can influence the nature of the perceptual asymmetry. This conceptualisation, namely as a lateralised over-representation, also can be interpreted as an attentional account. It suggests an alternative nature or cause of attentional imbalance.

In our opinion, further alternative causes of the attentional imbalance cannot be ruled out on the basis of previous experiments. Mattingley et al. [23] demonstrated that patients no longer showing classical signs of UN, continued to show the ipsilesional attentional bias. The authors interpreted the persisting ipsilesional attentional bias in terms of a higher-order attentional right hemisphere dysfunction. However, five of the 13 patients also had visual field defects (VFDs), i.e. either homonymous hemianopia (HH) or quadrantanopia. Hence, the observed residual (group-) effects (in terms of the bias) could be attributable, not to a higher-order right hemisphere attentional problem, but alternatively to effects of the (lower-order) left-sided VFDs.

It is well recognised that visuo-spatial perception can be impaired in “pure” hemianopic patients (i.e. in patients with HH and without UN) [39]. Hemianopic patients have been reported to show impaired visuo-spatial exploration, especially in the hemianopic hemi-field [40]. Also a deviated subjective midline or subjective straight-ahead in visuo-spatial judgements has frequently been reported (e.g. [28,8,18]). Karnath and Ferber [17] discuss reports which show that misperception of horizontal space (hemiscopiasia) exists in (some) pure hemianopic patients. It is thus apparent that a homonymous VFD can give rise to lateralised visual impairments. Hence, it is not inconceivable that HH, which results inherently in a chronic differential lateralised visual input, also gives rise to an imbalance in processing efficiency of the visual space. We thus suggest that an attentional imbalance is not necessarily the result of a higher-order attentional right hemisphere dysfunction, but also can arise by the presence of a lower-order VFD.

It is hence our aim to investigate what is or can be the cause of the attentional imbalance resulting in the observed lateral biases. As argued, hemispheric specialisation for
visuo-spatial processing, hemispheric specificity with respect to directional attentional vectors and reading habits or scanning direction have been suggested as underlying mechanisms. We investigate if homonymous VFDs (i.e. HH), resulting in asymmetric visual input, can also be added to the list of mechanisms or factors producing attentional imbalance. If so, it should do so both in left-sided and right-sided HH, but in opposing directions (i.e. both contralaterally to the side of the VFD). If this is confirmed, previous explanations of the attentional imbalance stressing exclusively higher-order right hemisphere involvement may have to be revised.

2. Method

2.1. Participants

2.1.1. Controls

Sixty-three control subjects participated in this study (25 females, 38 males). All participants were naive as to the aims and expected outcomes of the study and reported to be right-handed. They all had normal or corrected-to-normal visual acuity. Their mean age was 47 years, ranging from 17 to 86 years.

2.1.2. Patients

Prior to testing, we administered a screening battery to exclude dementia [5,9], aphasia [7] and apraxia [6]. No impairments were found. All patients performed within the normal limits on the form discrimination screening test [36] confirming perceptual functions to be adequate for form discrimination. The nature and extent of the VFD was determined using the Humphrey Field Analyzer, which is a clinically widely used automated perimeter. We used the Full Field 246, age corrected, 3-zone strategy, screening program.

In order to identify patients with severe UN, we constructed a battery of clinical UN tests, namely, four clinical cancellation tasks, and a line bisection task. For Albert’s line cancellation test the cut-off score is two omissions [13,35]. For the Mesulam structured shape cancellation this was three omissions [38], for the Bells test four omissions [12,35], and three omissions on the search for Os. This last unstructured cancellation task is not publically available, but very frequently used for diagnostic purposes in The Netherlands. Also the line bisection task was scored as a function of omitted lines (cut-off = 2) [30,31,34].

For each task, we additionally imposed more stringent criteria. This was done in order to make a distinction between a general inattention deficit resulting in a general scanning deficit, and hemi-inattention resulting in a lateralised scanning deficit. We therefore imposed an additional “lateralisation-requirement”, namely that for a “UN-score” (as opposed to a “general attention deficit-score”) the difference between left-sided and right-sided omissions should also be equal to or exceed the cut-off score. For example, if the cut-off score for a particular test is three omissions, a UN-score is obtained only if also the number of omissions on either side exceeds the other side by at least three. Two left-sided omissions and one right-sided omission hence would not result in a UN-score, although it is indicative of a general attention and scanning deficit.

We decided that using this battery and cut-off criteria, a patient is considered to suffer severe UN if at least three (of maximally five) UN-scores are obtained and if these scores are identical in laterality (i.e. reach the lateralisation-requirements of the respective tests due to omissions on the same side).

2.1.3. UN patients

Three patients were classified as UN patients using our criteria. They were all males and suffered a right-sided stroke, resulting in UN and left-sided HH. One patient underwent extensive clinical rehabilitation in a clinical setting before participating, but the UN persisted. The other two patients were referred by their ophthalmologists because of “peculiar visual behaviour”. Their mean time since lesion was 16 months. Their visual acuity and contrast sensitivity were within normal limits. Their mean age was 64 years. Additional clinical information is provided in Table 1. On average they omitted 13 items (S.D. = 9) on the Albert’s line cancellation test, 23 items (S.D. = 22) on the Mesulam structured shape cancellation, 17 items (S.D. = 9) on the Bells test, 17 items (S.D. = 14) on the Search for Os, and three lines (S.D. = 3) on the line bisection task.

2.1.4. HH patients

Thirty-two patients with HH participated in this study. Their mean age was 51 years. The mean time since lesion was 55 months (S.D. = 80). Sixteen patients had left-sided HH (16 males, 2 females). Sixteen patients had right-sided HH (11 males, 5 females). All patients had normal or corrected-to-normal visual acuity and normal contrast sensitivity. For additional clinical data, see Table 1. None of these patients fulfilled the aforementioned UN criteria. Neither of them had ever been treated for or diagnosed with UN. They omitted no items on the Albert’s line cancellation test and on the line bisection task, on average three items (S.D. = 9) on the Mesulam structured shape cancellation, three items (S.D. = 4) on the bells test, and one item (S.D. = 3) on the search for Os.

2.2. Stimuli

We used grey scales as described in Mattingley et al. [24]. Our version contains 26 items. An item consists of an A4 (landscape orientation) white sheet of paper with two vertically aligned rectangular grey scales of equal lengths. A grey scale is a rectangular bar with a thin black border (see Fig. 1). Its dimensions are 20 mm in height and 20–260 mm in width with 20 mm increments. This rectangular is filled-in by a semi-continuous scale of different grey shades varying
### Table 1
Clinical data for the brain-damaged subjects

<table>
<thead>
<tr>
<th>S. no.</th>
<th>Age/gender</th>
<th>TSL (months)</th>
<th>Type of HH and macular sparing</th>
<th>Location* and cause of lesion</th>
<th>Other remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN group</td>
<td>Right-sided brain damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>50/M</td>
<td>34</td>
<td>C–L, no</td>
<td>T–O-P IC, CVA</td>
<td>Extensive clinical rehabilitation</td>
</tr>
<tr>
<td>2</td>
<td>74/M</td>
<td>7</td>
<td>C–C, no</td>
<td>O dS, CVA</td>
<td>Left hemiparesic</td>
</tr>
<tr>
<td>3</td>
<td>70/M</td>
<td>7</td>
<td>C–C, no</td>
<td>O–P, CVA</td>
<td></td>
</tr>
<tr>
<td>Left-sided HH group</td>
<td>Right-sided brain damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>76/M</td>
<td>13</td>
<td>I–L, yes</td>
<td>T–O–P, CVA</td>
<td>Left leg hemiparesic</td>
</tr>
<tr>
<td>2</td>
<td>69/M</td>
<td>12</td>
<td>I–C, yes</td>
<td>O–P, CVA</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>53/M</td>
<td>24</td>
<td>I–C, yes</td>
<td>O–P, CVA</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>56/M</td>
<td>9</td>
<td>I–C, yes</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>49/M</td>
<td>18</td>
<td>I–L, yes</td>
<td>O–T, tumour</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>26/M</td>
<td>9</td>
<td>I–C, yes</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>36/F</td>
<td>107</td>
<td>I–C, yes</td>
<td>O–T, CVA</td>
<td>Left hemiplegic</td>
</tr>
<tr>
<td>8</td>
<td>56/F</td>
<td>157</td>
<td>C–C, no</td>
<td>O–T, CVA</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>73/M</td>
<td>6</td>
<td>I–L, yes</td>
<td>O–P, CVA</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>31/M</td>
<td>12</td>
<td>C–C, yes</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>70/M</td>
<td>13</td>
<td>I–C, no</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>34/M</td>
<td>64</td>
<td>I–C, yes</td>
<td>O–P–F, CHI</td>
<td>Left hemispheric</td>
</tr>
<tr>
<td>13</td>
<td>54/M</td>
<td>24</td>
<td>I–C, yes</td>
<td>O–P–F, CVA</td>
<td>Left hemispheric, agnosia</td>
</tr>
<tr>
<td>14</td>
<td>53/M</td>
<td>11</td>
<td>C–C, no</td>
<td>O, CVA</td>
<td>Letter-by-letter reading</td>
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<tr>
<td>15</td>
<td>37/M</td>
<td>12</td>
<td>I–C, yes</td>
<td>O–P, tumour</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>67/M</td>
<td>47</td>
<td>C–C, no</td>
<td>O–T, CVA</td>
<td>Left hemispheric</td>
</tr>
<tr>
<td>Right-sided HH group</td>
<td>Left-sided brain damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>50/M</td>
<td>390</td>
<td>C–C, yes</td>
<td>O, tumour</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>51/F</td>
<td>37</td>
<td>C–C, yes</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>50/M</td>
<td>28</td>
<td>I–L, no</td>
<td>T–O–P, CVA</td>
<td>Word finding difficulties</td>
</tr>
<tr>
<td>4</td>
<td>39/F</td>
<td>142</td>
<td>I–C, yes</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>66/M</td>
<td>123</td>
<td>I–L, no</td>
<td>O, CVA</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>18/M</td>
<td>225</td>
<td>I–L, yes</td>
<td>O–P, hydrocephalus</td>
<td>Mild balance problem</td>
</tr>
<tr>
<td>7</td>
<td>43/F</td>
<td>60</td>
<td>C–C, yes</td>
<td>O–T, CVA</td>
<td>Letter-by-letter reading</td>
</tr>
<tr>
<td>8</td>
<td>52/M</td>
<td>6</td>
<td>I–C, yes</td>
<td>Nl, CVA</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>64/F</td>
<td>10</td>
<td>I–C, yes</td>
<td>O–T, CVA</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>65/M</td>
<td>32</td>
<td>I–C, yes</td>
<td>Na, CVA</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>48/F</td>
<td>11</td>
<td>I–L, yes</td>
<td>O–P, CVA</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>53/M</td>
<td>22</td>
<td>C–C, yes</td>
<td>O–T, CVA</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>56/M</td>
<td>14</td>
<td>I–L, no</td>
<td>O–T–P, CVA</td>
<td>Left hemispheric, blindsight</td>
</tr>
<tr>
<td>14</td>
<td>68/M</td>
<td>25</td>
<td>I–L, no</td>
<td>O–T–P, CVA</td>
<td>Word finding difficulties</td>
</tr>
<tr>
<td>15</td>
<td>24/M</td>
<td>63</td>
<td>C–C, no</td>
<td>Nl, CHI</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>57/M</td>
<td>3</td>
<td>C–C, no</td>
<td>O, CVA</td>
<td>Word finding difficulties</td>
</tr>
</tbody>
</table>

* Time since lesion in months.

1. Complete (C) vs. incomplete (I) — congenent (C) vs. incongruent (I) homonymous hemianopia.
4. Patient refused to give permission for scan inspection. Localisation is based on clinically motivated assumption and verbal description.

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Fig. 1. Example of an item in the grey scales task. Upper and lower bar are identical but mirror-reversed.
asked to judge which of the two grey scales appears overall darker. The choice is indicated by saying "top" or "bottom" after which the page is turned and the next item is presented. The subject is encouraged to make a judgement based upon spontaneous and immediate apprehension rather than on prolonged and detailed inspection but it is told that there is no time limit and hence can view freely. Most patients responded fluently and confidently. Many controls, on the other hand, felt they were making arbitrary choices.

In addition to this standard procedure, on a second occasion, we asked the UN patients to touch the left side of each bar, prior to judging, to ascertain the perception of the full length of the bars.

2.4. Scoring

Scoring is achieved as in Mattingley et al. [24]. For each stimulus, a response is defined as left-bias or right-bias, respectively, if the subject chose the grey scale with the black side on the left and right side, respectively, as the darker one. The asymmetry index (AI) was calculated as the number of items with a rightward bias, minus the number of items with a leftward bias, divided by the total number of items. This AI varies between −1 and +1, representing an extreme leftward and rightward bias, respectively. An AI of zero indicates no bias.

3. Results

We firstly checked whether we were able to replicate previous findings with control subjects. The mean AI was −0.3370 (S.D. = 0.4304) which is significantly different from zero (t(62) = −6.215, P < 0.0005). This confirms a significant leftward bias in control subjects. Secondly, we confirmed the extreme lateral bias displayed by our three UN patients. All AIs were equal to one (mean = 1, S.D. = 0), also on the second occasion, when both left ends of the bars had to be touched.

We then performed a one-way ANOVA, with both left-sided and right-sided HH groups and control subjects as a between-subjects (group) factor. This revealed a significant group effect (F(2, 92) = 40.757, P < 0.0005). The mean AI for left-sided hemianopic patients was 0.6317 (S.D. = 0.3725) and for right-sided hemianopic patients −0.5417 (S.D. = 0.3967). Post-hoc comparisons with Bonferroni correction revealed the HH groups to differ from each other (t(30) = 8.6, P < 0.0005) and the left-sided HH patients to differ from the control group (t(77) = 8.2, P < 0.0005). There was no significant difference between the right-sided hemianopic patients and control subjects (t(77) = −1.7, ns). The patients with UN were not included in the ANOVA analysis because of the low number of patients and the absence of variation in their AIs. To test whether the AIs by the left-sided HH patients significantly deviated from the AIs by the UN patients, we performed a one sample T-test on the data by the left-sided hemianopic patients with the AI from the UN patients (i.e. 1) as test value. This analysis revealed a significant difference (t(15) = −3.956, P < 0.001). With the same type of analysis but with the absolute value of the AI by the right-sided HH patients as the test value, we confirmed that the strength of the AI by both HH groups did not differ from each other (t(15) = 0.966, ns).

In the control group, we found no effects of educational level, nor of age. However, in the pooled HH-group, the effect of age was marginally significant as indicated by a Pearson's correlation of age with the absolute value of the AI (r(32) = 0.338, P = 0.059). Further, time since lesion proved to correlate significantly with the absolute value of the AI (r(32) = −0.456, P < 0.05). Time since lesion and age did not correlate in this sample (r(32) = −0.283, ns). None of the measures of the clinical UN battery correlated significantly with the absolute value of the AI.

We further had the opportunity to test 15 HH (seven left-sided and eight right-sided) patients on two different occasions (1 week interval, same standard procedure). The AIs on both occasions correlated significantly (r(15) = 0.968, P < 0.0005), and a paired T-test comparison showed no significant difference (t(14) = −1.662, ns) between the means.

4. Discussion

We replicated previous findings confirming (left) perceptual asymmetries under free viewing conditions in control subjects. Our AI (−0.337) clearly is in line with the AI reported by Mattingley et al. [24] using similar grey scales (−0.323). It is also well within the range of other AIs, using different types of chimeric stimuli ranging from −0.208 to −0.450 [21,23,24,27]. In controls, we found no effect of age, nor of educational level, suggesting the lateral bias to be a fairly robust phenomenon.

We secondly observed an extreme right-sided bias (AI = 1) in patients with UN. At first hand, our AIs might appear to be more extreme than those reported by Mattingley et al. [24] (AI = 0.849 for the grey scales). However, the authors report that four (of the 12 right-sided brain damaged) patients did not have UN. Removing those four patients from their results would increase their observed AI, since three of the four lowest scores on the grey scales are by a non-UN patient. Not including these non-UN patients would result in all AIs (except one) to be above 0.9.

One of our patients with UN participated in a cognitive rehabilitation program based on the principles mentioned in Prizzamiglio et al. [28] and was relatively successfully trained [32]. His AI, after rehabilitation, remained at its extreme. This confirms claims made by Mattingley et al. [23] that the AI represents a strong ipsilesional attentional bias which is insensitive to rehabilitation. We further confirmed the persistency of the lateral bias by, additionally and on a second occasion, asking our left-sided hemianopic UN patients...
to touch the left side of each bar separately before judging which one appeared darker. In order to touch the left side of each bar, the patients have to fixate the left side of it (as a consequence of their left-sided HH). This brings the total bar in the right (and normally perceiving) visual hemi-field, ascertaining us that, at least once, both bars have been fully perceived. Also in this condition, all As remained at their extremes. This suggests this bias to be a chronic, very early (low-level) component in the visuo-attentional process, not subjected to effects of behavioural compensation. Previously made claims that this ipsilesional bias represents a relatively early, automatic, chronic, perhaps even obligatory orienting of attention [23] are hereby strengthened.

We previously summarised present accounts of the attentional imbalance. Mattingley et al. [21] and Luh [22] suggested that the observed perceptual asymmetry in controls is the result the selective activation of the right hemisphere, as it is specifically dedicated to processing visuo-spatial stimuli. In line with this, Luh et al. [21] previously had argued that there is a great deal of evidence that the performance of cognitive tasks for which one hemisphere is specialised, does result in an asymmetric activational pattern. This had already been recognised very early on by Trevarthen [33]. He further suggested that one hemisphere could be differentially activated by many conditions such as electrical stimulation of one hemisphere and unilateral brain damage.

Similarly, Nicholls et al. [27] discuss an activation model of perceptual asymmetry presented by Milner et al. [26]. This model suggests that the asymmetry can be conceptualised as an attentional imbalance between resources allocated to the left and right hemispheres. Activation of the right hemisphere generates a bias of attention to the left hemispace, increasing the salience of stimuli located there. And since the right hemisphere is specialised for sensory tasks specifically activates the right hemisphere, resulting in a lefthand bias. Nicholls et al. [27] argue that this activation model can account for numerous observations in controls (e.g. the relatively low intercorrelations between the different, but equal in size, asymmetry scores), but fail to explain how this model could account for the rightward bias in right hemisphere brain damaged patients.

As already briefly mentioned, other authors have attempted to explain the rightward bias present in UN patients and also stressed the involvement of the right hemisphere. Mattingley et al. [24] suggest that the lateral bias reflects a gradient in perceptuo-attentional processing efficiency and note that the observed rightward attentional bias is consistent with a model of spatial attention suggested by Kinsbourne [19,20] which stresses the directional nature of space-related behaviour. It is argued that each hemisphere controls a contralaterally directed attentional vector. The net effect of both vectors gives rise to an attentional gradient (which can be conceptualised as processing efficiency) imposed on the attentional field. Damage to one hemisphere results in dysfunction of the associated vector and hence results in an ipsilesional bias. As such the attentional field is characterised by a gradient which allocates “more weight” or processing efficiency to the ipsilesional side. A unilateral lesion would also release the opposing hemisphere from inhibition, and thereby further inducing a pathological ipsilesional bias. A second critical element in Kinsbourne’s vectorial model is that the strength of the attentional vectors controlled by either hemisphere can be modulated by the activation of that hemisphere.

Hence, Kinsbourne’s vectorial model in combination with the assumed hemispheric specialisation for visuo-spatial tasks specifically activates the right hemisphere, resulting in a lefthand bias. Nicholls et al. [27] argue that this activation model can account for numerous observations in controls (e.g. the relatively low intercorrelations between the different, but equal in size, asymmetry scores), but fail to explain how this model could account for the rightward bias in right hemisphere brain damaged patients.

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A consequence of another dysfunction (e.g. a contralesional suggested by Kinsbourne’s model) or whether it resulted as an additional imbalance was considered to be the cause of UN (as indicated by subtle indications of UN behaviour), without objectively being associated with UN. This suggests, at least in our study, we cannot dissociate the sensory and attentional/hemispheric components, as traditionally conceptualised, since none of the clinical UN measures correlated with the AI.

We hence argue that the sensory effects can be another source of attentional imbalance, which can interact with the hemispheric effects. In controls, the (normal) leftward bias is due to right hemisphere specialisation for visuo-spatial events. This bias seems enhanced by the sensory effect of a right-sided VFD. This enhancement did however not reach statistical significance in our sample. Damage to the right hemisphere removes the (hemispheric) leftward bias, and induces a rightward bias. Right hemisphere brain damage can disrupt typical visuo-attentional and directional processes, thought to be typical in UN. But a similar rightward bias can also be elicited by left-sided VFDs, for the same (i.e. sensory) reason as with right-sided VFDs.

In our study, we envisage experiments where different types of homonymous VFDs can be simulated on (non-brain damaged) controls using sophisticated eye-movement equipment. In previous literature, it was not clear whether the attentional imbalance was considered to be the cause of UN (as suggested by Kinsbourne’s model) or whether it resulted as a consequence of another dysfunction (e.g. a contralesional attentional deficit in UN, or a VFD as in HH). Previous literature had shown that, in pure UN (UN without VFDs), an ipsilesional bias could be demonstrated (e.g. [23,24]), suggesting an attentional/hemispheric component. We found that HH also gives rise to a qualitatively similar bias, suggesting a sensory component. We hence argue that the sensory effects can be another source of attentional imbalance, with UN as its extreme. Secondly, the AI can give the clinician a clear indication of the possible presence and side of a homonymous VFD. Namely, in our brain damaged patient group with homonymous VFDs, we observed a sensitivity and specificity of 0.94 and 0.88 in predicting the side of the HH, given the direction of the AI. Thirdly, contrary to most cancellation tasks or other tasks clinically used to diagnose differential lateral performance, almost any patient can perform the grey scales task, because it has no identification component. We hence successfully applied this test to a patient with complete object-agnosia, while all cancellation tasks appeared unachievable. Finally, although not extensively investigated, we feel that the AI can also have some practical significance. In a larger study investigating practical fitness to drive in patients with HH (to be published), we found evidence that the AI was significantly related to visual performance during driving ($r(29) = -0.510, P < 0.005$), while AIs from other tasks were not or significantly less strongly related. This suggests the grey scales task to have some practical significance to at least this type of activity of daily living.

In conclusion, we do not refute that perceptual biases reflect a pattern of functional cerebral asymmetry. But the imbalance cannot be uniquely related to specialisation of the right hemisphere for visuo-spatial attentional function, since left- and right-sided hemianopic patients, with right- and left-sided brain damage, respectively, show similar but inverse lateral biases. Asymmetric activation of one hemisphere can be the result of asymmetric sensory input, caused by the HH.

To further understand the nature and cause of the different components which can give rise to the attentional imbalance, future research could concentrate on patients with left- and right-sided brain damage, without clinical signs of UN and without VFDs. This could elucidate the possible differential hemispheric involvement. Further, other types of homonymous VFDs could also contribute to the insight into the involvement of the sensory influences. In bilateral superior and inferior quadranopia (i.e. missing a lower and upper hemifield, respectively) and with the grey scales items 90° rotated, the attentional imbalance should result in a quantitatively similar upper and lower bias, respectively. We also envisage experiments where different types of homonymous VFDs can be simulated on (non-brain damaged) controls using sophisticated eye-movement equipment.
these kinds of paradigms, the observed asymmetries (if any) are unconfounded with respect to VFDS and brain damage. Finally, for clinical and practical use, the relationship with performance during activities of everyday life should be further investigated and confirmed.

References


