



BARBARA A. WILSON

Why I study ...

brain injury

WHAT is it about the study of brain injury that grabbed my interest in my student days and continues to intrigue me? I know that the division between normality and abnormality, and the frail dividing line that separates them, have always stimulated my curiosity. Working with people with brain injuries, one soon recognises that most of them are not psychiatrically disturbed, nor do they have learning disabilities. They are, for the most part, just like the rest of us. Yet their particular forms of brain injury may lead to specific deficits causing unusual problems in their daily lives.

From a commonsense point of view, it does not seem plausible that someone with good eyesight, good language and good intellectual functioning cannot recognise his wife, or thinks that a picture of Concorde is Pegasus the flying horse. Yet this behaviour can be seen in people with prosopagnosia or visual object agnosia.

And who would not be intrigued by finding someone who can read nouns but not adjectives or verbs, even when the words have the same or similar spellings? Take the word 'nice', for example. It can refer to a city in the south of France or to an adjective meaning 'pleasant'. A brain injured person with deep dyslexia may be able to read that word when it refers to the city, but not when it is used as an adjective.

I could provide numerous examples from people with unilateral neglect who may wash only one side of their face, or with amnesia who cannot remember having seen you a few minutes earlier, or with apraxia who cannot wave goodbye despite understanding the requirements and having the necessary range of movements involved in the gesture.

These people and their problems are fascinating in themselves, but I am grabbed, intellectually and emotionally, most of all by studying ways and means of attempting to overcome these problems so that people with brain injuries can lead lives that are less blighted by them. I shall return to this theme once I have provided a potted

account of important stages in my early career that led me inevitably towards the study of brain injury and its consequences.

During clinical training, I was fortunate in having a neuropsychological placement with Tony Buffery, who was a brilliant teacher (as well as being a kind of comic genius who could entertain an audience with his funny stories or just by miming). It was in Tony's tutorials that I became excited by the relationship between brain and behaviour.

During that time, I was privileged to observe the neurosurgeon Charles Polkey carry out a temporal lobectomy lasting seven hours! As I am so short, Mr Polkey kindly arranged for a stool to be provided so that I could see more clearly. Another trainee was there and managed to faint several times, for which she received much sympathy; my own stoicism, prompted by the knowledge that I was likely never to see such an operation again, went unrewarded. I remain to this day a little shocked that the other trainee's inappropriate behaviour was reinforced, while my own appropriate behaviour was disregarded!

At the end of my training, I took a job at the Institute of Psychiatry and Bethlem Royal Hospital. At the Institute I worked two days a week at teaching and research, mainly in neuropsychology. The other three days were spent at Bethlem, working clinically with children who had severe learning difficulties.

My colleagues there were Janet Carr, Glynis Murphy and Pat Howlin, all excellent psychologists, good teachers, and lovely people with whom I have remained friends ever since. The teaching techniques that these colleagues applied to children with learning difficulties have, to this day, been of enormous practical use to me in my work in neuropsychological rehabilitation.

After two years, I was able to get a full-time neuropsychological post at a brain injury rehabilitation centre in Oxford. Although I was hesitant about applying for this job because of my relative inexperience in that field, I was encouraged to go ahead by May Davidson, who was then the District Psychologist in Oxfordshire. It was

the right move for me at the right time in my career. Since then, I have never wanted to leave this branch of neuropsychology.

The puzzling mixture of normality and abnormality, which I mentioned earlier, fascinates me not only because it is there to behold but also, and more importantly, because it can sometimes be unravelled by theoretical and practical investigations. Why, for example, is a particular person unable to recognise objects? Can she see? Does she have a word finding problem? Can she recognise manufactured objects more easily than living ones or vice versa?

Trying to sort out cognitive strengths and weaknesses — and looking for reasons why a certain pattern of deficits occurs — is intellectually exciting, and part of this excitement comes from the fact that both theoretical and practical aspects are examined. Theoretical models from language, memory, attention, reading and perception have greatly influenced neuropsychological assessments over the past 15 years or so.

The field of brain injury rehabilitation is challenging because it continues to expand with our growing knowledge. It is also rewarding when we apply some of the older, more traditional approaches to assessment that have stood the test of



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