

have to have Ellie sat on my hip and keeping her moving. My husband would have to take her out in her pram, at all hours of the night just to calm her down. The head banging happened when I physically couldn't carry her any longer. I would place her on the floor and immediately she would start banging her head on the floor until she was back in my arms. Her aggressiveness was a problem to her older brothers, in her frustration she would pinch them and be very nasty towards them. For comfort she would play with her dad's ears, making them bleed. This was all due to frustration again. Ellie would be very distressed when around loud noises and sudden movements. Moving traffic and car journeys made her even worse. When in her car seat she would find the strength to release herself so that she could be on my lap. Her strength was abnormal. As every year went by slowly being weaned off her medication, her behaviour steadily improved. Ellie is now nine years old, she doesn't really have any major behaviour problems but when becoming ill we notice she can still be slightly aggressive. Also Ellie is very protective over her possessions and doesn't like change. She will notice the smallest of differences whether it is a new piece of furniture or something not being in its usual place.

The emotional side of things have been very hard for all the family. When Ellie was in the prime of her illness, the emotional strain was unbearable. The constant attention Ellie both wanted and needed was a massive strain for the immediate family. Ellie was very sensitive to everything. My husband had to give up work as it became impossible for me to care for Ellie 24 hours a day as well as keeping a normal family environment. Our much loved family dog that had been with us for five years had to go as

we just couldn't look after him any longer. The strain got so bad on my two sons who were only 11 and 13 that they stayed with their grandparents. This was just for them to get peace and quiet as they were both at school. Myself and my husband's marriage was at breaking point due to the stress and strains of looking after a child with dancing eye syndrome. Sleep was a huge factor, as we were lucky to get 2-3 hours a night. Ellie would sleep in bed with us as this is the only place she would settle. This went on until the age of seven.

There were times when we couldn't see any light at the end of the tunnel. Ellie had been off steroids for six months where she was making really good progress. Then she had a virus and she lost all of her abilities again. At this stage I just couldn't take anymore, I became so low that I didn't really want to carry on. The doctor prescribed me anti-depressants which helped. As each year has gone by Ellie has improved slightly with her emotions. She is still very sensitive and shy. She finds it hard to play in a group and prefers to have one to one company. She has a very caring and gentle nature, to the extent that I have concerns especially with her school life which I will go into further now.

Ellie found starting school hard as she was so used to being with me 24 hours a day. She went to playschool, where she had one to one support. The hardest part was separating her from me; I had to stay with her as it was impossible to leave her. After a year of being at play school she accepted me leaving her, although at times it was hard. She started mainstream school still with the problem of being away from me. They suggested that a statement wouldn't be needed as they didn't detect any learning difficulties at this stage. They wanted to concentrate more on settling Ellie into the

schooling environment as this was the main concern of the time. As Ellie progressed through the years it was evident Ellie had quite severe learning difficulties. It was quite evident that Ellie needed to be statemented in year three. I felt they had left it too late as Ellie was so far behind. I strongly believe that a child with dancing eye syndrome should be statemented as soon as they start schooling. She struggles with the academic pace as tests have proven that she is about two and half years behind her peers. She gets a lot of pressure from her peers as they notice she can't keep up as well as they do. She accepts now that she has to go to school but doesn't enjoy it. She has one to one help every morning at school with her maths and literacy and in the afternoons she is left to her own devices. Ellie is very behind with her reading and writing skills, hopefully she will be able to pick it up one day. Ellie is in year five now so in a year's time she will be moving onto secondary school. We have been advised by the SENCO at her school that Ellie would benefit more academically if she went to a special needs school. My husband and I are at the stage now where we are going to have to make the best decision for Ellie's future.

On a positive note, Ellie is a happy go lucky little girl. We never thought she would be able to ride a bike without stabilisers but she can. She is a very good swimmer and belongs to a swimming club which she enjoys very much. We feel very lucky as the dancing eye syndrome seems to have disappeared from her but unfortunately it has left her with severe learning difficulties. Life now is so much easier for the whole family unit, it's been a tough ride but things have definitely improved over time. ♦

BOOK REVIEWS

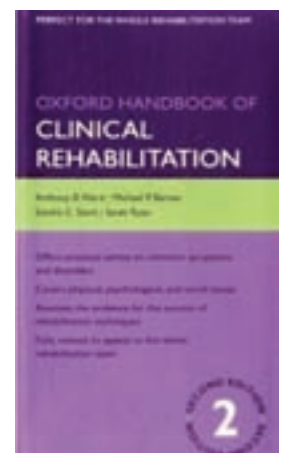
Oxford Handbook of Clinical Rehabilitation Second Edition

It is daunting to review an Oxford handbook, especially when written by colleagues whom I admire and who are experts in the field of rehabilitation. The handbook has the reputation for being an essential part of every rehabilitation clinician's bookshelf. It is primarily aimed at a wider multidisciplinary audience and not just at doctors in the field of clinical rehabilitation. I would like to emphasise that this review of the book is more from the perspective of a medic within the multidisciplinary team and specifically a trainee's viewpoint.

The book easily fits in the coat pocket with less than 500 pages of standard Oxford handbook size. The initial five chapters deal with the general concepts of rehabilitation like the ICF and multidisciplinary team. These are followed by chapters on management of some common clinical themes encountered in rehabilitation like spasticity, continence, sexuality, eating and swallow-

ing disorders, communication, technical aids, cognitive and behavioural problems. And then there are chapters dedicated to specific neurological conditions like multiple sclerosis, stroke, etc.

The ICF model and general concepts in epidemiology are brilliantly summarised. The chapters on the rehabilitation team and services are relevant and to the point. The chapter on assessment and outcome measures describes the types of scales and some scales relevant to common clinical problems. This is an area which is emphasised more in rehabilitation practice than in other clinical specialties, and which every rehabilitation MDT member (medic, physio, occupational therapist, speech and language therapist, etc.) should be well informed about. I think a brief description of the different psychometric properties like validity, reliability, and floor and ceiling effect could be included in this chapter for the benefit of junior clinicians. One



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topic missing in the initial chapters is 'assessment of capacity' with reference to the Mental Capacity Act (MCA) and the recent Deprivation of Liberty Safeguards (DOLS).

Among the clinical theme chapters, the systematic approach to treating spasticity and urinary continence is very useful. The book rightly has a separate chapter dealing with sexual problems in complex neurological conditions. The chapters on behavioural disorders, psychiatric problems and cognitive dysfunction carefully define the role of psychological strategies/medication and the fine balance between the two needed in a rehabilitation setting. The flow chart on vocational rehabilitation and section on challenges during transition to adult life are impressive. It is a surprise not to find management of sialorrhoea in the chapter on swallowing disorders.

The chapters on specific neurological conditions deal excellently with the epidemiology, management and most importantly prognosis which are core essential facts needed when dealing with family and carers. The conditions

covered are multiple sclerosis, stroke, traumatic brain injury, spinal cord injury, Parkinson's disease, MND, peripheral nerve disorders, epilepsy and dementia. There are two chapters dealing with common (non-inflammatory) musculoskeletal conditions and inflammatory rheumatologic conditions.

The practice of neurorehabilitation and musculoskeletal rehabilitation is very closely linked in countries outside UK because rehabilitation physicians are trained in both before they sub-specialise in their areas of interest. Oxford handbooks usually have substantial international readership and to maximise this, I feel the handbook should provide more room for musculoskeletal rehabilitation. For example, the latest evidence on different rehabilitation approaches for chronic back pain like functional restoration programmes could be added in the section on chronic back pain. The evidence for specific exercise regimens, steroid injections, autologous blood injections (approved by NICE) in the rehabilitation of tendinopathy could be included in the rele-

vant chapters. Rehabilitation of concussion in sport could also be considered for inclusion.

The chapter on amputation is brief and could do with more facts on prostheses, it omits management of phantom pain altogether (in fact it does not feature anywhere in the book). Normal gait cycle (and abnormal gait patterns) is another important topic missing from the book. There is a section on 'chronic pain' in one of the earlier chapters but it lacks sufficient detail. A dedicated chapter on pain management among the initial chapters would have been ideal.

Overall, this is an excellent pocket guide on a par with other Oxford handbooks. A little more expansion in a few chapters and some additional topics would make the handbook more appealing to doctors in the field and give it a better international readership. There is already sufficient blank space in the book and such expansion can easily be made without increasing the volume of the book. I am aware the blank space is meant for reader's notes and observations, but frankly speaking how often does this happen? ♦

The Confabulating Mind. How the brain creates reality Confabulation.

Views from neuroscience, psychiatry, psychology, and philosophy

Two books on confabulation published within a year by OUP: one thinks, perhaps, of London buses, but, by contrast, these books are an experience well worth waiting for. For example, did you know that in German, WIGAN is a non-word (Schnider, p 149)?

Schnider's monograph is suffused with his clinical experience of trying to rehabilitate confabulating patients: even in the midst of the science he acknowledges that this is a "gruelling experience" (p243). A review of the history of confabulation, including translations from the early works of Korsakoff, Kraepelin, Pick and others, is followed by the thorny issue of classification, with Schnider developing a 4-fold schema of intrusions, momentary confabulations, fantastic confabulations, and behaviourally spontaneous confabulations (p63-4), of which the latter form his main area of study. The aetiology is examined, with anterior limbic structures thought culpable, and the pathogenesis, including a wide variety of diseases, along with associated disorders (amnesia, disorientation, false recognition syndromes including the Capgras delusion, and anosognosia). Mechanisms are elucidated by means of psychophysical and neuroimaging studies, leading to the proposition that confabulators have reality confusion and a failure to integrate contradictory information due to the failure of a filtering process, 200-300 ms after stimulus presentation and before recognition and re-encoding, which normally permits suppression of currently irrelevant memories. This is a fascinating

book, systematic in its approach. For those disinclined to battle through the detail, the conclusions to each chapter are excellent.

Hirstein's multi-author volume is, as expected, more diffuse than Schnider's but none the less stimulating. False memories, only briefly touched on by Schnider, are described at greater length here, in two chapters (from Loftus and Zaragoza) the import of which I found rather chilling: our brains have a surprising cognitive vulnerability to forced fabrication (I would be interested to know if this also applies to eidetics). Coltheart & Turner present evidence that the normal response to questions we don't know the answer to is not, as might be imagined, to admit ignorance with an "I don't know" response, but to indulge in confabulation, a tendency exacerbated in certain brain disease states (and by some clinicians?). Wheatley, in what is the best chapter (or worst, depending on your degree of concreteness) I have read in many moons, demolishes the notion of the brain as veridical. The book is more philosophically oriented than Schnider's, and perhaps more peripheral to clinical interests, though still grounded in clinical neuroscience.

In summary: in the human brain, memory is a construction, confabulation is normative, perception is illusion, and "meaning" is privileged over accuracy. A nihilist might conclude that life mediated through such a prism is an essay in futility, and aporia the only tenable neurophilosophy. ♦



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