a distance from psychoanalysis, psychoanalytic thinking and theory.

Judith Hughes writes in a clear style, leading the reader through the work of Klein, Fairbairn and Winnicott, opening up their theories in a new and lively way with biographical and contextual information which is never sensationalistic. The reader is led inside the laboratory of the psychoanalytic situation, providing an opportunity to see and assess how each of these leading figures in psychoanalysis grappled with new ideas in the process of theory formation. For those unconvinced about psychoanalysis this would be well worth reading and an opportunity to look and think again, as many critics tend to take their stance in relation to early Freudian paradigms. Here, Hughes surveys and illustrates the British School of Psychoanalysis based upon Object Relations Theory, producing *en passant* a history of the British Psychoanalytic community.

Her account of these three Analysts retains a critical objectivity while being genuinely caught up in the lively journey into the lives and minds of Klein, Fairbairn and Winnicott. For me personally, the main challenging statement and perhaps the starting point of the book was Hughes reporting a story in which Klein, on hearing Fairbairn reporting a Paper to the British Psychoanalytic Society, is reported to have commented indignantly, "That isn't what Psychoanalysis is!"

If I have one criticism, it is that I did not feel Hughes emphasised the boundary between Psychoanalysis and Psychotherapy in charting this area of the psychoanalytic domain. But she certainly did draw out the intriguing area of one mind being used to think about and make sense of another mind. I found her account of Guntrip's analysis with Fairbairn fascinating and touching in its frankness. By the end, I felt that this was a book I could read again, and I look forward to any future books Judith Hughes might write, as so many in this area are overly dry and dense.

R CAWTHRA

Mild Head Injury. Edited by HARVEY S LEVIN, HOWARD M EISENBERG and ARTHUR L BENTON. (Pp 288; H/b £32.00.) Oxford: Oxford University Press, 1989.

There are two main problems with mild head injuries: the first is that people think because they are mild they are not serious and secondly, neurosurgeons, in Europe anyway, do not manage most of these patients.

However, all neurosurgeons known that post-concussional syndrome can be incapacitating for the patients and their families. This book (printed on acid-free paper) based on a conference held at the University of Texas in March 1987, is an excellent contribution to this important subject. Various aspects interested this reviewer. Eisenberg and Levin discuss the MRI scan in 20 patients. Their studies suggest that the concussional pathology is in fact multi-focal, particularly affecting the frontal and temporal regions rather than diffuse. The severity of altered consciousness is proportional to the number and depth of the MRI abnormalities as indeed is the quality of outcome. They note that the MRI lesions took up to three months to recover as did the abnormalities on neuropsychological testing.

There is considerable debate on how to define a mild head injury. Kraus and Nourjah define a mild head injury as someone with a Glasgow coma scale of between 13 and 15. However, Jennett stated that the Glasgow coma scale was not designed to classify mild head injuries. I wonder why they could not use the well-tried concept of post-traumatic amnesia. Surely this has stood the test of time and is the best index of a deceleration/acceleration injury to the head. The reviewer would not agree with Schoenhuber and Gentilini who state (page 149) quantificational PTA is "very difficult". My main criticism of this book is that the use of post-traumatic amnesia and its relationship to magnetic resonance imaging and neuropsychological testing is not explored as fully as it might have been.

Snoek highlights the rare but distressing sudden deterioration that can occur in children after an apparently mild head injury. Although this author states it to be usually benign and short-lasting, it is certainly my experience that this "post-traumatic delayed encephalopathy in children" (a term which at least does not attempt to describe the cause or pathology of this condition) can be fatal even in children who walked and talked after the injury.

Dacey of North Carolina discusses the criteria for admission, pointing out that this depends particularly on facilities and social circumstances. He points out the tenfold increase in the number of CT scanners in the USA (and the reviewer would add the tenfold increase in number of neurosurgeons there) creates a different scenario from Europe. Thus CT scanners are used to decide about admission to hospital whereas in Europe the clinical state and the presence of a skull fracture are the most important

criteria for admission. Surely both approaches are correct and reliance on CT scanning alone is not the whole answer.

Gronwal states the commonest symptom of post-concussional syndrome is "poor concentration". Gentilini *et al* describe measurements of "attention" whereas Gronwal emphasises the importance of reduction in information processing capacity, i.e. the quantity and rapidity with which information can be processed, after a head injury. She points out that the majority of young adults obtain normal scores within four weeks after mild head injury but those over the age of 40 or who have had previous concussive injuries show a persistence of neuropsychological abnormalities beyond four weeks. She makes the further point that return to normal test scores does not imply full recovery from trauma.

Philip Wrightson emphasises the important secondary effect of stress in reducing performance and slowing recovery from a concussive injury. This obviously has important implications for those of us managing post-concussional syndrome. Rutherford, writing from Belfast, makes the interesting and important point that "there seems little doubt that being the object of litigation is an experience that causes considerable emotional strain. Even patients not involved in litigation find it difficult and embarrassing trying to explain to others the exact nature of their complaint. . . . the patient is carried by the rest of the family and a less dominant spouse will take over the leading role exercised by the patient. Once this pattern is established it is difficult to reverse." Thus Rutherford feels the stress of litigation may well have an important effect on maintaining and increasing the symptoms of post-concussional syndrome.

The last chapter describes the experience of a neurosurgeon who, while attending a national traumatic coma data bank meeting, tried his hand at skiing in the afternoon and was rendered unconscious for a period of more than ten to fifteen seconds. He describes how for the following 18 months he was more distractible than normal and found it necessary to make lists to recall daily tasks. His symptoms persisted and gradually improved over a period of 18 months. He makes the point that perhaps even subtle neuropsychological tests now developed to assess lack of attention and speed of information processing following a concussive injury are in fact insufficient to measure the entire effects of post-concussional syndrome. One can only conclude that neurosurgeons should stick to tennis or, if less agile, golf!

CBT ADAMS