#### REFERENCES

Alexander M.P. The role of neurobehavioral syndromes in the rehabilitation and outcome of closed head injury. In Levin H.S., Grafman J. and Eisenberg H.M. (eds.) Neurobehavioral Recovery from Head Injury. Oxford University Press, New York, 1987.

Artiola i Fortuny L., Briggs M., Newcombe F., Ratcliffe G., & Thomas C. Measuring the duration of post-traumatic amnesia. Journal of Neurology, Neurosurgery and Psychiatry. 43:377-379, 1980.

Baddeley A.D. Implicit memory and errorless learning: A link between cognitive theory and neuropsychological Rehabilitation. In Neuropsychology of Memory. (2nd edition) Squire L.R. & Butters N. (eds.) The Guilford Press, New York, 1990.

Benson D.F. & Geschwind N. Shrinking retrograde amnesia. Journal of Neurology, Neurosurgery and Psychiatry. 30, 539-544, 1967.

Benson D.F., Gardner H., & Meadows J.C. Reduplicative Paramnesia. Neurology. 26:141-151, 1976.

Benton A.L. & Blackburn H.L. Practice effects in reaction time in brain-injured patients. Journal of Abnormal and Social Psychology. 54:109-113, 1957.

Benton A.L., van Allen A.M., & Fogel M.L. Temporal orientation in cerebral disease. Journal of Nervous and Mental Disease. 139: 110-119, 1964.

Bishara S.N., Partridge F.M., Godfrey P.D. and Knight R.T.G. Post-traumatic amnesia and Glasgow Coma Scale related to outcome in a consecutive series of patients with severe closed -head injury. **Brain Injury.** 6, 4, 373-380, 1992.

Blumbergs P.C., Jones N.R., & North J.B. Diffuse axonal injury in head trauma. Journal of Neurology, Neurosurgery & Psychiatry. 52: 838 - 841, 1989

Broe G.A. The brain, ageing and behaviour. **Proceedings of the 15th Annual Brain Impairment Conference.** Newcastle, N.S.W., 1990.

Brooks D.N. 'Memory and head injury. Journal of Nervous and Mental Disease. 155,350-355, 1972.

Brooks D.N. Recognition memory and head injury. Journal of Neurology, Neurosurgery and Psychiatry. 37:794-801, 1974.

Brooks D.N. Measuring neuropsychological and functional recovery. In Levin H.S., Grafman J. and Eisenberg H.M. (eds.) Neurobehavioral Recovery from Head Injury. Oxford University Press, Oxford, 1987

Brooks D.N., Aughton M.E., Bond M.R., Jones P., & Rizvi S. Cognitive sequelae in relationship to early indices of severity of brain damage after severe blunt head injury. Journal of Neurology, Neurosurgery and Psychiatry. 43:529-534, 1980.

Brooks D.N. & Baddeley A.D. What can amnesics learn? Neuropsychologia. 14,111-122, 1976.

Brooks D.N., Deelman B.G., van Zomeren A.H., van Dongen H., van Harskamp F., & Aughton M.E. Problems in measuring cognitive recovery after acute brain injury. Journal of Clinical Neuropsychology. 6:1,71-85, 1984.

Brooks N. (ed.) Closed head injury. Psychological, social and family consequences. Oxford University Press, Oxford, 1984.

Brouwer W.H. & van Wolffelaar P.C. Sustained attention and sustained effort after closed head injury:detection and 0.10 Hz heart rate variability in a low event rate vigilance task. Cortex. 21:1, 111-119, 1985.

Bruhn P. & Parsons O.A. Reaction time variability in epileptic and brain-damaged patients. Cortex. 13,373-384, 1977.

Buchtel H.A. Attention and vigilance after head trauma. In Neurobehavioral **Recovery from Head Injury.** Levin, H.S., Grafman J. & Eisenberg H.M. (eds) Oxford University Press, New York, 1987.

Butschke H. & Fuld P.A. Evaluating storage, retention. and retrieval in disordered memory and learning. Neurology. 24:1019-1025, 1974.

Corrigan J.D. Development of a scale for assessment of agitation following traumatic brain injury. Journal of Clinical and Experimental Neuropsychology. 11: 2, 261-277, 1989.

Corrigan J.D. & Mysiw J. Agitation following traumatic head injury: Equivocal evidence for a discrete stage of cognitive recovery. Archives of Physical Medical Rehabilitation. 69,487-492, 1988.

Corrigan J.D., Mysiw J., Cribble M.W. & Chock S.K.L. Agitation, cognition and attention during post-traumatic amnesia. **Brain Injury**. 6,2,155-160, 1992.

Cripe L.I. The neuropsychological assessment and management of closed head injury:general guidlines. Cognitive Rehabilitation. January/February, 18-22, 1987.

Crovitz H. Techniques to investigate posttraumatic and retrograde amnesia after head injury. In Levin H.S., Grafman J. and Eisenberg H.M. (eds.) Neurobehavioral Recovery from Head Injury. Oxford University Press, New York, 1987.

Crovitz H.F., Horn R.W., & Daniel W.F. Inter-relationships among retrograde amnesia, post-traumatic amnesia and time since head injury: A retrospective study. **Cortex.** 19: 407 - 412, 1983.

Daniel W.F., Crovitz H.F. & Weiner R.D. Neuropsychological aspects of disorientation. Cortex. 23,169-187, 1987.

Dikman S., Temkin N.R., McLean A., Wyler A.R. & Machamer J. Memory and head injury severity. Journal of Neurology, Neurosurgery and Psychiatry. 50,1613-1618, 1987.

Eson M.E., Yen J.K. & Bourke R.S. Assessment of recovery from serious head injury. Journal of Neurology, Neurosurgery and Psychiatry. 41:11,1036-1042, 1978.

Ewert J., Levin H.S., Watson M.G. & Kalisky Z. Procedural memory during post traumatic amnesia in survivors of severe closed head injury. Implications for rehabilitation. Archives of Neurology. 46,911-916, 1989.

Forrester G., Encel J. & Geffen G. Measuring post-traumatic amnesia (PTA): an historical review. **Brain Injury.** 8:2, 175-184, 1994.

Gasquoine P.G. Learning in post-traumatic amnesia following extremely severe closed head injury. Brain Injury. 5:2,169-175, 1991.

Geffen G.M., Encel J.S., & Forrester G.M. Prediction of everyday memory deficits using measures of Post-traumatic Amnesia. **Proceedings of the 14th Annual Brain** Impairment Conference. Melbourne. 1989.

Geffen G.M., Encel J.S., & Forrester G.M. Stages of recovery during post-traumatic amnesia and subsequent everyday memory deficits. **Neuroport.** 2, 105-108, 1991.

Geschwind N. Disorders of attention: A frontier in neuropsychology. Philosophical Transactions of the Royal Society of London: Biological Sciences. 298, 173-185, 1982.

Gronwall D. Advances in the assessment of attention and information processing after head injury. In Levin H.S., Grafman J. & Eisenberg H.M. (eds.) Neurobehavioral Recovery from Head Injury. Oxford University Press. New York. 1987.

Gronwall D. & Wrightson P. Duration of post-traumatic amnesia after mild head injury. Journal of Clinical Neuropsychology. 2, 51-60, 1980.

Gronwall D. & Wrightson P. Post-traumatic amnesia as a measure of severity of closed head injury. Supplement to the Bulletin of the Postgraduate Committee in Medicine. 36-42, University of Sydney, December 1981.

Hannay H.J., Levin H.S. & Grossman R.G. Impaired recognition memory after head injury. Cortex. 15,269-283, 1979.

Harper C. Neuropathology of blunt head injury. Supplement to the Bulletin of the Postgraduate Committee in Medicine. 31-35, University of Sydney, December 1981.

Haslem C., Batchelor J., Fearnside M.R., Haslam S.A. & Hawkins S. Further examination of post-traumatic amnesia and post-coma disturbance as non-linear predictors of outcome after head injury. **Neuropsychology.** 9, 4: 599 - 605, 1995.

High W.M. Jnr., Levin H.S. & Gary H.E. Jnr. Recovery of orientation following closed head injury. Journal of Clinical and Experimental Neuropsychology. 12, 703-714, 1989.

Hunkin N.M. & Parkin A.J. Recency judgements in Wernicke-Korsakoff and postencephalitic amnesia: Influences of proactive interference and retention interval. **Cortex.** 29,485-499, 1993.

Jackson R.D., Mysiw W.J. & Corrigan J.D. Orientation group monitoring system: An indicator for reversible impairments in cognition during PTA. Archives of Physical Medicine Rehabilitation. 70, 33-36, 1989.

Joslyn D. & Hutzell R.R. Temporal disorientation in schizophrenic and braindamaged patients. American Journal of Psychiatry. 136, 1220-1222, 1979. Katz D.I. Neuropathology and neurobehavioral recovery from closed head injury. Journal of Head Trauma Rehabilitation. 7:2, 1-15, 1992.

Levin H.S. Memory deficit after closed head injury. Journal of Clinical and Experimental Neuropsychology. 12:1, 129-153, 1989.

Levin H.S. & Benton A.L. Temporal orientation in patients with organic brain disease. Applied Neurophysiology. 38, 56-60, 1975.

Levin H.S., Benton A.L. & Grossman R.G. Neurobehavioral Consequences of Closed Head Injury. Ch.1,4 & 5. Oxford University Press, New York, 1982.

Levin H.S., High W.M. & Eisenberg H.M. Learning and forgetting during posttraumatic amnesia in head injured patients. Journal of Neurology, Neurosurgery and Psychiatry. 51, 14-20, 1988.

Levin H.S., High W.M., Meyers C.A., von Laufen A., Hayden M.E. & Eisenberg H.M. Impairment of remote memory after closed head injury. Journal of Neurology, Neurosurgery and Psychiatry. 48, 556-563, 1985.

Levin H.S., Papanicolaou A. & Eisenberg H.M. Observations on amnesia after nonmissile head injury. In Squire L.R. & Butters N. (eds.) Neuropsychology of Memory. Guildford Press, New York, 1984.

Levin M. Varieties of disorientation. Journal of Mental Science. 102, 619-623, 1956.

Lezak M.D. Neuropsychological Assessment. Oxford University Press, New York, 1976.

Lezak M.D. Recovery of memory and learning functions following traumatic brain injury. Cortex. 15,63-72, 1979.

Macflynn G., Montgomery E.A., Fenton G.W. & Rutherford W. Measurement of reaction time following minor head injury. Journal of Neurology, Neurosurgery and Psychiatry. 47:1326-1331, 1984.

Mandleberg I.A. Cognitive recovery after severe head injury. Journal of Neurology, Neurosurgery and Psychiatry. 38, 1127-1132, 1975.

Miller E. Simple and choice reaction time following severe head injury. Cortex. 6,121-127, 1970.

Moore B.E. & Ruesch J. Disturbance of consciousness following head injury. New England Journal of Medicine. 230, 445-452, 1944.

Moscovitch M. A neuropsychological model of memory and consciousness. In **Neuropsychology of Memory** (2nd edit.), Squire L.R. & Butters N. (eds). The Guilford Press, New York, 1992.

Mowbray R.M. Disorientation for age. Journal of Mental Science. 99, 698-701, 1953.

Mysiw W.J., Corrigan J.D., Carpenter D. & Chock S.K.L. Prospective assessment of post-traumatic amnesia: A comparison of the Goat and the OGMS. Journal of Head Trauma Rehabilitation. 5, 1, 65-72, 1990.

Natelson B.H., Haupt E.J., Fleischer E.J., & Grey L. Temporal orientation and education: A direct relationship in normal people. Archives of Neurology. 36, 444-446, 1979.

Nissen M.J. Procedural and declarative learning: Distinctions and interactions. In **Neuropsychology of Memory.** (2nd edition) Squire L.R. & Butters N. (eds.) The Guilford Press, New York, 1990.

Onofrj M., Curatola L., Malatesta G., Bazzano S., Colamartino P. & Fulgente T. Reduction of P3 Latency during outcome from post-traumatic amnesia. Acta Neurologica Scandinavica. 83, 5, 272-279, 1991.

Parkin A.J. & Leng N.R.C. Neuropsychology of the amnestic syndrome. Lawrence Erlbaum Associates, Hove U.K., 1993.

Parkin A.J., Leng N.R.C. & Hunkin N.M. Differential sensitivity to context in diencephalic and temporal lobe amnesia. Cortex. 26, 373-380, 1990.

Paterson A. & Zangwill O.L. Recovery of spatial orientation in the post-traumatic confusional state. **Brain.** 67, 54-68, 1944.

Ponsford J. Design and evaluation of treatment programmes - why do we avoid these issues? **Proceedings of the 10th Annual Brain Impairment Conference.** Melbourne, 1985.

Ponsford J. & Kinsella G. An investigation of attentional deficits following closed head injury. Proceedings of the 13th Annual Brain Impairment Conference. Sydney, 1988.

Russell W.R. The Traumatic Amnesias. Oxford University Press, Oxford, 1971.

Russell W.R. & Smith A. Post traumatic amnesia in closed head injury. Archives of Neurology. 5,16-29, 1961.

Schacter D.L. & Crovitz H.F. Memory function after closed head injury: A review of the quantitave research. Cortex. 13,150-176, 1977.

Schneider W. & Shiffren R.M. Controlled and automatic human information processing: I Detection, search, and attention. **Psychology Review.** 84, 1-66, 1977.

Shiffren R.M. & Schneider W. Controlled automatic human information processing: II Perceptual learning, automatic attending, and a general theory. **Psychology Review.** 84, 127-190, 1977.

Shores E.A. Discussion at Symposium on Post-traumatic Amnesia. Pacific Rim Conference, Gold Coast, Australia. 1991, July.

Shores E.A., Marosszeky J.E., Sandanam J., & Batchelor J. Preliminary validation of a clinical scale for measuring the duration of post-traumatic amnesia. The Medical Journal of Australia. 144, 569-572, 1986.

Sisler G. & Penner H. Amnesia following severe head injury. Canadian Psychiatric Association Journal. 20, 5, 333-336, 1975.

Silver J., Judofsky S. & Hales R. (eds.) Neuropsychiatry of Traumatic Brain Injury. American Psychology Press Inc., Washington D.C., 1994.

Stuss D.T., Stethem L.L., Hugenholtz H., Picton T., Pivik J., & Richard M.T. Reaction time after head injury: fatigue, divided and focussed attention and consistency of performance. Journal of neurology, Neurosurgery and Psychiatry. 52: 742-748, 1989.

Stuss D.T., Pogue J., Buckle L., & Bondar J. Characterization of stability of performance in patients with traumatic brain injury: Variability and consistency on reaction time tests. Neuropsychology. 8, 3: 316 - 324, 1994.

Tate R.L., Broe G.A. & Lulham J. Impairment after severe head injury: the results from a consecutive series of 100 patients. Acta Neurologica Scandinavia. 79, 97-107, 1989.

Tate R.L., Broe G.A. & Lulham J. Patterns of neuropsychological impairment after severe blunt head injury. Journal of Mental & Nervous Diseases. 179: 3, 117-126, 1991.

Teasdale G. & Brooks D.N. Traumatic amnesia. In Handbook of Clinical Neurology. 1: 45, 185-191, 1985.

Teasdale G. & Jennett B. Assessment of coma and impaired consciousness. A practical scale. Lancet. ii, 81-84, 1974.

Trexler L.E. & Zappala G. Neuropathological determinants of acquired attention disorders in traumatic brain injury. **Brain and Cognition.** 8, 291-302, 1988.

Tromp .E. & Mulder T. Slowness of information processing after traumatic head injury. Journal of Clinical and Experimental Neuropsychology. 13, 6, 821-830, 1991.

Van Zomeren A.H. The comeback of attention in neuropsychology. Proceedings of the 14th Annual Brain Impairment Conference. Melbourne, 1989.

Van Zomeren A.H. & Brouwer W.H. Head injury and concepts of attention. In Levin H.S., Grafman J. & Eisenberg H.M. (eds.) Neurobehavioral Recovery from Head Injury. Oxford University Press, New York, 1987.

Van Zomeren A.H., Brouwer W.H. & Deelman B.G. Attentional deficits: the riddle of selectivity, speed and alertness. In Closed Head Injury:Psychological, social and family consequences. Brooks N. (ed.) Oxford University Press, Oxford, 1984.

Van Zomeren A.H. & Deelman B.G. Long-term recovery of visual reaction time after closed head injury. Journal of Neurology, Neurosurgery and Psychiatry. 41:5,452-457, 1978.

Wilson B., Baddeley A., Shiel A & Patton G. How does post-traumaic amnesia differ from the amnesic syndrome and from chronic memory impairment? **Neuropsychological Rehabilitation** 2: (3) 231-243, 1992.

Wilson B., Cockburn J. & Baddeley A.D. The Rivermead Behavioural Memory Test. Titchfield : Thames Valley Test Company, 1985.

Wilson J.T.L., Teasedale G.M., Hadley K.D., Wiedmann K.D. & Lang D. Posttraumatic amnesia: still a valuable yardstick. Journal of Neurology, Neurosurgery and Psychiatry. 56: 198-200, 1993. Zangwill O.L. Disorientation for age. Journal of Mental Science. 99,698-701, 1953.

#### APPENDIX 1. RESULTS OF C.T. SCANS

Note: L = left, R = right.

#### SUBJECT J.Z.

11.6.91 Large R frontotemporal haematoma.
Large displaced R frontoparietal fracture with underlying cerebral contusion and small acute subdural haemorrhage.
Shear haemorrhage in internal capsule and top of thalamus.
Marked mass effect with midline shift to left and effacement of basal cisterns and 4th ventricle.

Depressed fracture of L zygoma with disruption of lateral wall of L maxilla, inferior orbital margin on left and L zygomatic arch. Fracture of the base of skull crossing the middle cranial fossae bilaterally.

Disruption of vomer.

13.6.91 New large frontal and small L temporal subdural haemorrhages.
Shear haemorrhages increased in size, largest in R temporal lobe also in R internal capsule, L insula and R frontal lobe.
Midline shift largely resolved.
Basal cisterns and 4th ventricle visible.

#### SUBJECT F.G.

2.4.92 No abnormalities detected.

#### SUBJECT M.R.

- 7.12.92 Numerous foci contusions; frontal, parietal and temporal.Intraventricular blood in posterior horn of L lateral ventricle.
- **9.12.92** Multiple areas of contusions and small haematoma in both hemispheres. Small amount of blood in occipital horn of L lateral ventricle.
- 24.12.92 Well defined areas of low density both frontal lobes. Ventricles normal.L tripod fracture. Fracture of base of skull.

#### SUBJECT M.P.

- 26.7.91 Multiple cerebral contusions
  - -L parietal lobe
  - -R basal ganglia
  - -L temporal lobe
  - -R internal capsule
  - -L thalamus

#### SUBJECT B.J.

- 9.6.91 L temporal and parietal contusion with hypodensity and brain swelling
   Small isodense L parietal subdural haematoma
   Compression of L lateral ventricle and minimal shift to Right
   Generalised brain swelling and compression of 4th ventricle
- 11.6.91 Contusion slightly largerHaemorrhage in foramen of Munro
- 28.6.91 R frontal pulsating mass

#### SUBJECT K.C.

20.2.92 Thin bilateral subdural haemorrhages.Contusions of the corpus callosum and L putamen.

#### SUBJECT B.W.

26.12.92 Multiple white matter contusions.

#### SUBJECT P.R.

11.9.92 Multiple haemorrhagic contusions.Diffuse R cerebral contusions particularly in the frontal and parietal

lobes.

#### SUBJECT H.K.

- 12.7.93 No focal abnormalities.
- 13.7.93 No extradural collectionsSuggestion of a small area of contusion over the vortex of the R parietal lobe.
- 23.7.93 Bilateral frontal chronic subdural haematoma.
- 27.7.93 Bilateral shallow fronto-parietal subdural collections persist. No significant changes in their size in past 4 days.

No evidence of fresh haemorrhage.

#### SUBJECT O.L.

- 27.12.91 R internal capsule haemorrhage.
- 27.12.91 (Repeat scan)

R parieto-temporal haematoma

Small R internal capsule haemorrhage

Small foci of haemorrhagi in both fronto-parietal regions

Blood on tentorium and against posterior aspect of R side of falx. (cont.)

**30.12.91** R zyxgomaticomaxillary fractures Medial displacement at lateral maxillary wall otherwise little displacement.

#### SUBJECT C.C.

- 21.1.94 R fronto-parietal extradural haemorrhage Fractured squamous temporal bone
- 22.1.94 No resolution of extradural haemorrhage
- 14.2.94 No evidence of significant extradural collection

#### SUBJECT E.A.

- 27.6.94 Multiple contusions, depressed skull fracture
  - 3.7.94 R temporal depressed skull and underlying haemorrhagic contusions
    L basal ganglia haematoma
    Significant surrounding oedema and mass effect with midline shift R
    Generous CSF spaces of both frontal lobes
    Small amount of blood in posterior horns of the lateral ventricles.

#### SUBJECT L.A.

15.9.94 Shearing injury of the brainstemOccipito-parietal skull fractureSmall amount of subarachnoid blood

#### NON GROUP SUBJECTS

#### SUBJECT M.A.

- 11.8.91 Generalised haemorrhages especially in parietal lobesL periorbital haematoma
- 14.8.91 Bilateral parietal haemorrhagesR basal shadowing

#### SUBJECT N.B.

#### C.T. SCANS

24.3.94 Fracture of lateral wall of R orbitFractured roof of L orbit, fragments pushed posteriorly and laterally intoL frontal lobe

30.3.94 Small retro-orbital haematoma

#### M.R.I. SCAN

1.6.94 The long narrow path of the deep penetrating injury from above the left eye to the R thalamus is well demonstrated with a small amount of surrounding haemosiderine. There is a small intracranial bone fragment at the entry point through the floor of the L anterior cranial fossa. The path of the injury passes through the inferior L frontal lobe, head of the caudate nucleus inferiorly, genu of the internal capsule adjacent to the fornix anteriorly, third ventricle and R thalamus. There may also be a shorter second path a little more superiorly in the L frontal lobe.

#### **APPENDIX 2. MEDICATION**

#### SUBJECT J.Z.

Medication:	
Carbomazopene (Anti-convulsant)	11.7.91 - 16.7.91
Dilantin (Anti-convulsant)	17.7.91 - 29.7.91
Chloropromazine (Anti-psychotic)	10.7.91 - 23.7.91

This patient was on medication while taking part in the first 3 test occasions of the study.

#### SUBJECT M.P.

Dilantin (Anti-convulsant)	28.8.91 - 28.9.91
Tegretol (Anti-convulsant)	9. <b>8</b> .91 - 9.1.92

This subject was taking Tegretol for the entire period during which testing was taking place. However, Dilantin was only being administered at the time of the first occasion of testing.

#### SUBJECT F.G.

Melleril (Anti-psychotic)

21.4.92 - 12.5.92

This patient was taking medication during the period of the first three test occasions.

#### SUBJECT K.C.

Tegretol (Anti-convulsant)	29.4.92 - 10.6.92
Melloril (Anti-psychotic)	6.4.92 - 6.5.92
Neulactil (Anti-psychotic)	6.5.92 - 2.7.92

Tegretol was taken up until 8 days prior to Test Occasion 2.

Melloril was ceased 12 days before Test Occasion 1.

Neulactil was taken during the period of the first two test occasions.

## SUBJECT P.R.

Rivotril	(Anti-convulsant)	6.1.94 - 7.2.94
Temazepam	(Sedative)	6.1.94 - 13.2.94
Indocid	(Anti-inflammatory)	8.1.94 - 13.3.94

This subject was taking medication during the entire period of the study.

#### SUBJECT H.K.

Temazepan (Anti-convulsant)	16.8.93 - 22.8.93
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Administration of Temazepan was ceased 3 days prior to Test Occasion 1, therefore, it would be expected that there would be no traces of the drug in his system at the time of the first test occasion.

## **NON GROUP SUBJECTS**

## SUBJECT M.A.

Dilantin (Anti-convulsant)

27.8.91 - 14.9.91

Medication was being administered during the entire testing period.

9 of the 15 subjects were not taking any medication while they were participating in this study.

### APPENDIX 3. P.T.A. SCALE (Adapted from Artiola i Fortuny et al, 1980)

- Q 1(a) Have you seen me before ?
  - (b) Do you remember my name ?
- Q 2. When is your birthday ?
- Q 3. How old are you ?
- Q 4. What year is it now ?
- Q 5. What month is it now ?
- Q 6. What day of the week is it ?
- Q 7. What time is it is it morning, afternoon or night ?
- Q 8. What is the name of this place ?
- Q 9. Which city are we in ?
- Q 10. Yesterday I showed you 3 pictures and asked you to remember them. Can you tell me what the pictures were ?

## APPENDIX 4. RESOLUTION OF P.T.A

<b>SUBJECT</b>	J.Z.
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Date of injury : 10.6.91

## Order of recall

(1) Pictures - recognition	17.7.91 (5 days from first exposure )
- free recall	19.7.91
(2)Year	18.7.91
(3) Month	19.7.91
(4) Name of therapist	23.7.91
(5) Place	25.7.91
Day	25.7.91
Time of day	25.7.91

(Date of birth and age were always correct)

Date of injury : 9.6.91

#### SUBJECT B.J.

j j	
Order of recall:	
(1) Age	14.8.91
Place	14.8.91
(2) Pictures - recognition	21.8.91 (11 days after first exposure)
(3) Name of therapist	27.8.91
(4) Time of day	2.9.91
(5) Month	12.9.91
(6) Year	13.9.91

#### SUBJECT B.J. (cont.)

(7) Day 17.9.91

(Date of birth was always correct)

## SUBJECT M.P.

Date of injury : 26.7.91

## Order of recall:

(1) Place	14.9.91
(2) Age	23.9.91
(3) 3 Pictures - recognition	28.9.91 (11 days after first exposure)
- free recall	10.10.91 (achieved for only 2 pictures)
(4) Month	3.10.91
Name of therapist	3.10.91
(5) Year	8.10.91
(6) Day/ Time of day	10.10.91

(Date of birth was always correct)

#### SUBJECT O.L.

Date of injury : 27.12.91

#### Order of recall:

(1) Place	27.2.92
(Name of hospital only)	
(2) 3 Pictures - recognition	29.2.92 (9 days after first exposure)
Name of therapist	29.2.92

(3) Year	9.3.92
(4) Time of day	20.3.92
(5) Month	25.3.92
Age	25.3.92
(6) Place (City)	1.4.92
(7) Day	2.4.92

(Date of birth was always correct)

\* Although this subject recalled the name of the hospital correctly at an early stage, his recall of which city he was in fluctuated for some weeks afterwards. He often believed himself to be in the region where his accident had occurred and to which he had been a frequent visitor prior to the accident.

#### SUBJECT F.G.

Date of injury : 2.4.92

## Order of Recall :

(1) Pictures - recognition	27.4.92 (5 days after first exposure)
- free recall	3.5.92
Year	27.4.92
(2) Place/Time of day	28.4.92
(3) Age	29.4.92
(3) Name of therapist	30.4.92
(4) Day	2.5.92
(5) Month	4.5.92

## SUBJECT K.C.

Date of injury : 20.2.92

## Order of Recall:

(1) Date of birth	28.5.92
(2) Age	15.6.92
(3) Name of therapist	17.6.92
(4) Pictures - recognition	18.6.92 (35 days after first exposure)
(5) Place	19.6.92
(6) Day	25.6.92
(7) Year	26.6.92
(8) Time of day	29.6.92
(9) Month	3.7.92

## SUBJECT M.R.

Date of injury : 7.12.92

Order of Recall:	
(1) Pictures - recognition	31.1.92 (7 days after first exposure)
- free recall	11.2.93
(2) Month	2.2.93
Date of birth	2.2.93
(3) Time of day	8.2.93
(4) Place	9.2.93
(5) Age	10.2.93
(6) Name of therapist	11.2.93

## SUBJECT M.R. (cont.)

(7) Year	12.2.93
(8) Day of week	17.2.93

#### SUBJECT B.W.

Date of injury: 26.12.92

## Order of recall:

(1) Month	2.3.93
(2) Age	3.3.93
(3) Time of day	4.3.93
Name of therapist	4.3.93
(4) 3 Pictures - recognition	5.3.93 (8 days after first exposure)
(5) Place	15.3.93
Year	15.3.93
(6) Day	17.3.93

( Date of birth was always correct )

## SUBJECT H.K.

Date of injury : 12.7.93

## Order of recall:

(1) Year	1.9.93
(2) Place	3.9.93
Day	3.9.93

## SUBJECT H.K. (cont.)

Time of day	3.9.93
Pictures - recognition	3.9.93 (10 days after first exposure)
(3) Name of therapist	5.9.93
Age	5.9.93
(4) Month	6.9.93

(Date of birth was always correct)

## SUBJECT P.R.

Date of injury : 11.9.93

## Order of recall:

(1) Pictures - recognition	18.1.94 (12 days after first exposure)
- free recall	4.2.94
(2) Date of birth	24.1.94
(3) Day	27.1.94
Month	27.1.94
Time of day	27.1.94
(4) Place	31.1.94
(5) Name of therapist	1.2.94
(6) Year	2.2.94
Age	2.2.94

## SUBJECT C.C.

Date of injury : 21.1.94

#### Order of recall :

(1) Year	19.2.94
(2) 3 Pictures - recognition	21.2.94 (10 days after first exposure)
Time of day	21.2.94
(3) Name of therapist	23.2.94
(4) Place	24.2.94
(5) Month	4.3.94

(Date of birth and age were always correct)

#### SUBJECT E.A.

Date of injury : 27.6.94

## Order of recall :

(1) Pictures - recognition	20.8.94 (7 days after first exposure)
(2) Name of therapist	25.8.94
(3) Year	27.8.94
(4) Place	14.9.94
(5) Day	30.9.94
Time of day	30.9.94
(6) Month	4.10.94

#### SUBJECT L.A.

#### Date of injury : 15.9.94

#### Order of recall:

(1) Recall of pictures - recognition	15.10.94 (3 days after first exposure)
- free recall	1.11.94
(2) Hospital	17.10.94
(3) Name of therapist	25.10.94
(4) Time of day	2.11.94
(5) Age*/Month/Year	12.11.94

( Date of birth and city were always correct)

\* Constantly gave age as 27 instead of 26 years. When I queried this and asked him whether he meant 27 last birthday or next birthday he stated that he was 27 years old on his last birthday. It was not until he was emerging from PTA that he was able to give his correct age.

#### **NON-GROUP SUBJECTS**

#### SUBJECT M.A.

Date of injury : 11.8.91

#### **Order of recall :**

(1) Day	30.8.91
Time of day	30.8.91
(2) 3 Pictures - recognition	2.9.91 (7 days after first exposure)
Year	2.9.91

#### SUBJECT M.A. (cont.)

(3) Place	3.9.91
Month	3.9.91
Name of therapist	3.9.91

#### SUBJECT N.B.

Date of injury : 24.3.94		
Order of recall :		
(1) Place *	12.5.94	
Year	12.5.94	
(2) 3 Pictures - recognition	21.5.94	(9 days after first exposure)
(3) Time of day	24.5.94	
(4) Name of therapist	10.6.94	
(5) Month	15.6.94	
Lidcombe*	15.6.94	

\* The subject was aware that she was in a hospital in Sydney on the date of admission to Lidcombe (10.5.94) but because of her severe amnesia, due to the penetrating injury, found it difficult to remember the name of the hospital and fluctuated between giving the name of Lidcombe and the name of the hospital she was in for her acute care. She did not achieve consistency for the name until 15.6.94 neither did she achieve orientation for the day of the week. To have continued to assess her daily in an attempt to see whether it was possible for her to become oriented for the day of the week would have distressed her unnecessarily. She remembered that she was being asked a series of questions each day and on several occasions stated that she felt stupid because she couldn't remember things, therefore I decided to cease the daily questioning once she was scoring 11 out of 12 consistently.

# **APPENDIX 5.** Attention and Memory - performance across the 4 Test Occasions

For each subject, and for the total group of 13 subjects, reaction times and memory scores have been plotted on graphs on pages A 22 to A36, to illustrate the interaction between attention and memory on each of the four test occasions. Ninety five percent confidence intervals have been calculated for reaction times to illustrate the variability of the subject's performance.

The memory score is the Standardised Profile Score as described in the manual of the Rivermead Behavioural Memory Test. As raw scores vary from one subtest to another some components would receive a heavier weighting than others if the raw scores were added together. Thus, the Standardised score equates the importance of each subtest.

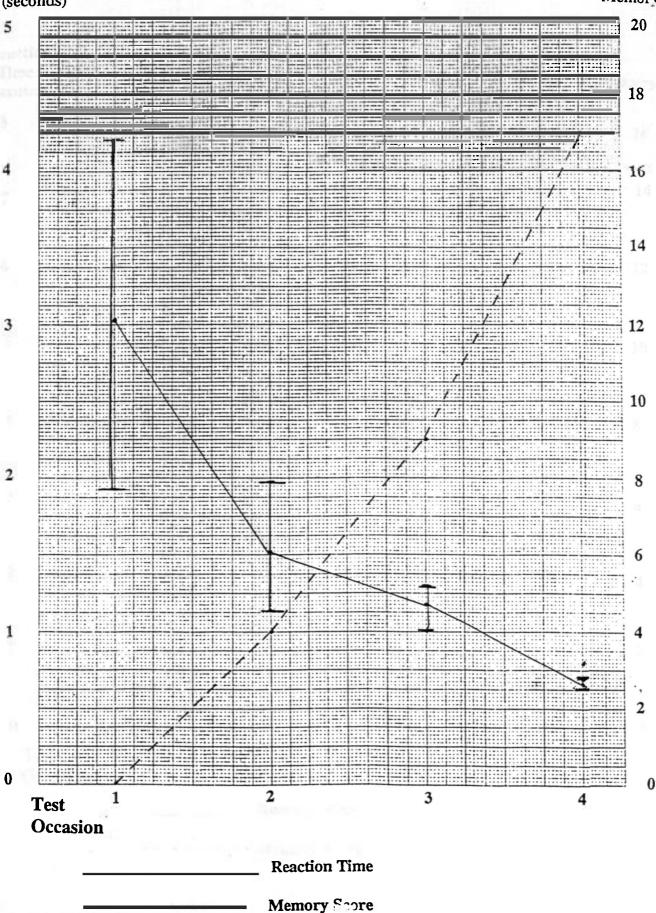
## SUBJECT: J.Z.

#### REACTION TIME AND MEMORY TASKS

#### Reaction Time (seconds)

Memory

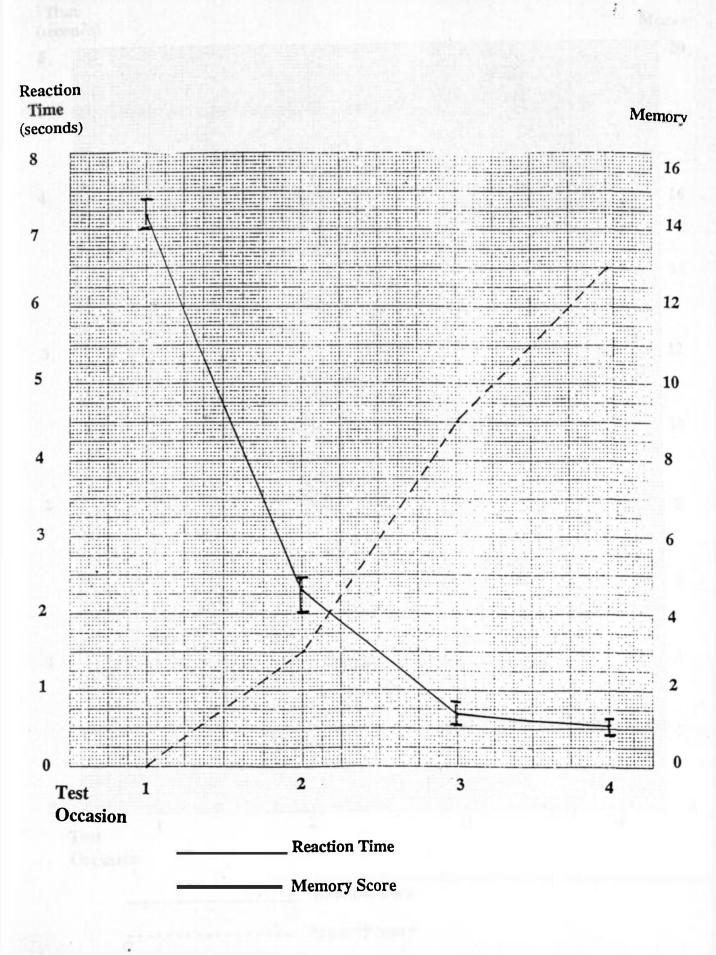
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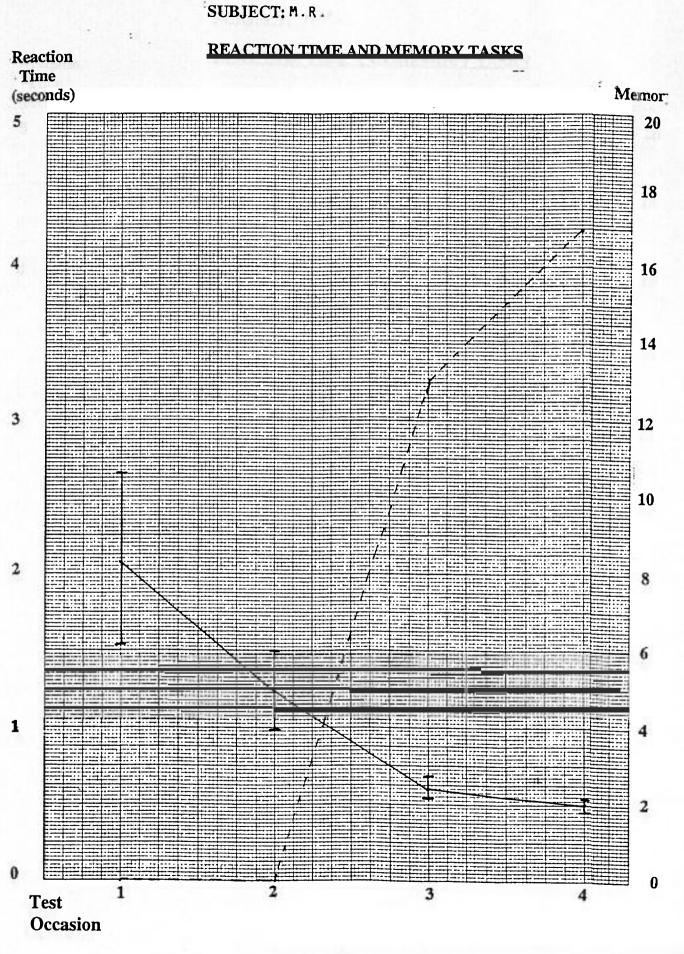


1

#### SUBJECT: F. G.

#### REACTION TIME AND MEMORY TASKS





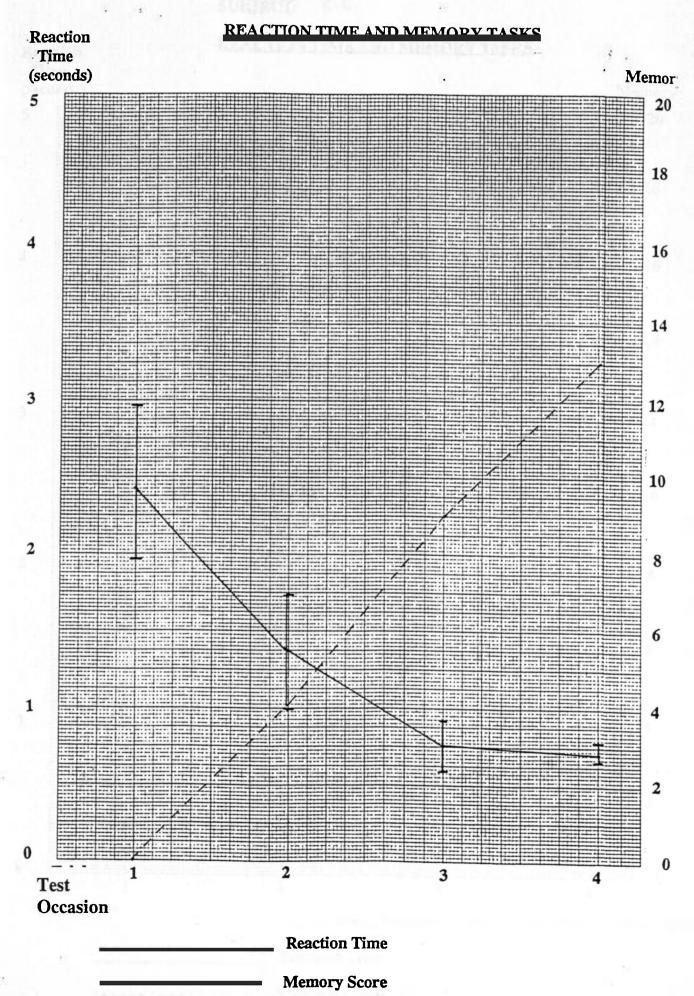
**Reaction Time** 

**Memory Score** 

A 24

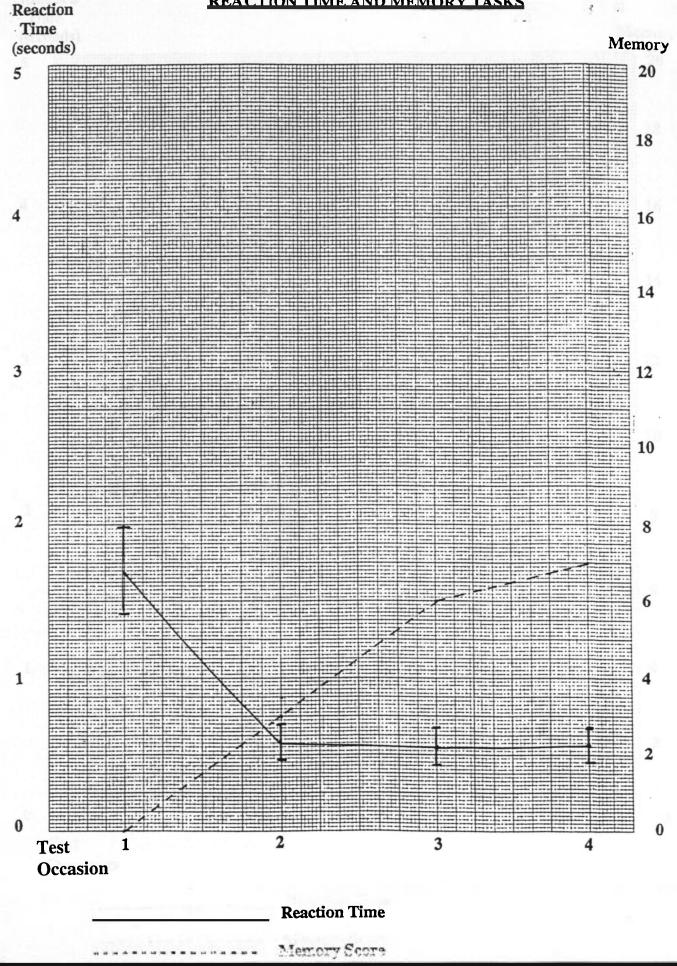
2





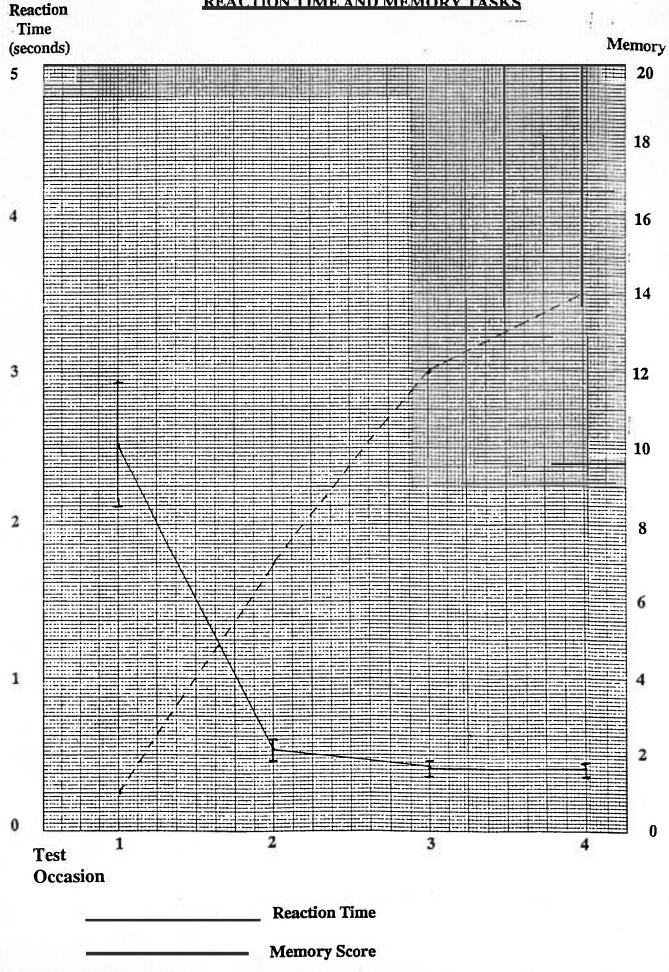
#### SUBJECT: K.C.





## SUBJECT: B.W.

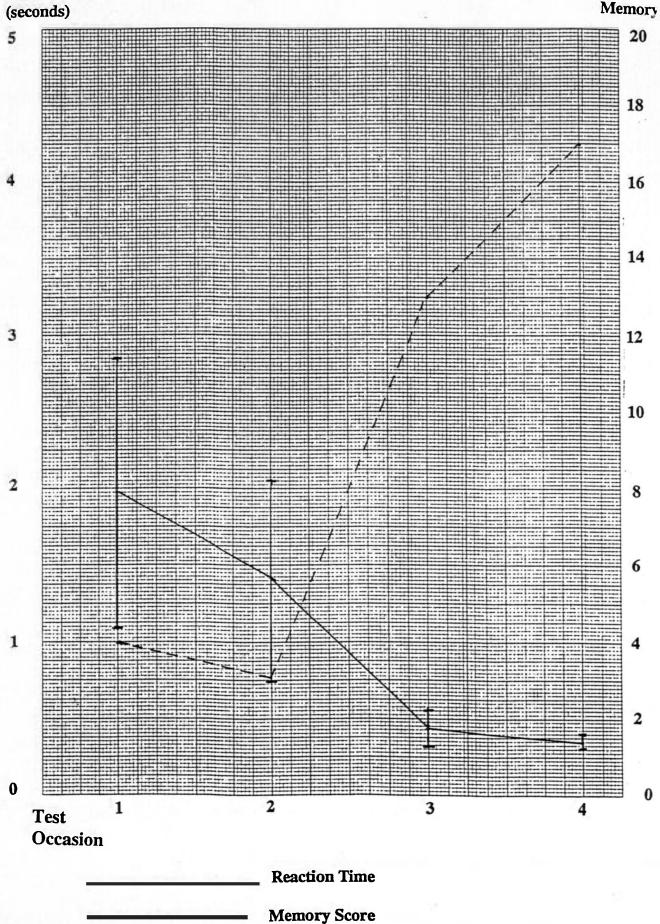
### REACTION TIME AND MEMORY TASKS



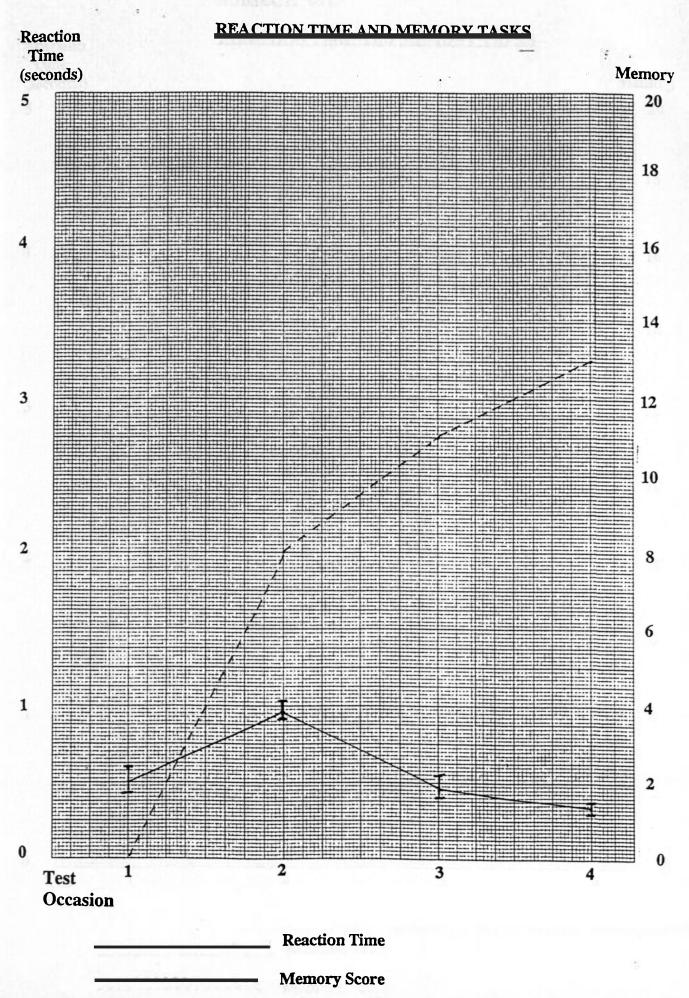
### REACTION TIME AND MEMORY TASKS

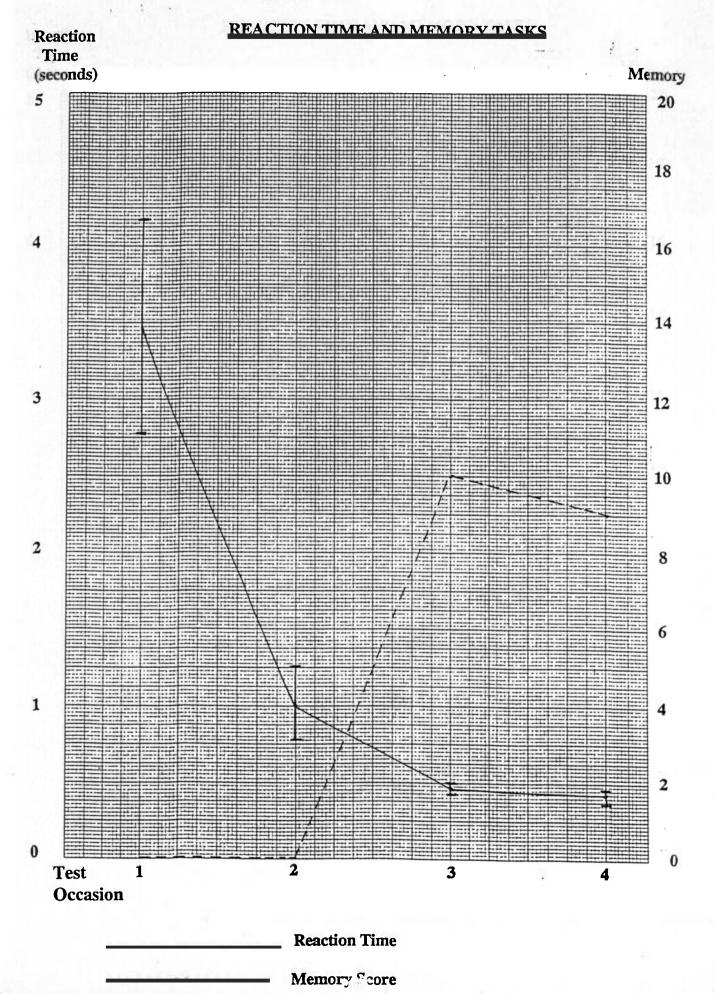
# Reaction Time

Memory



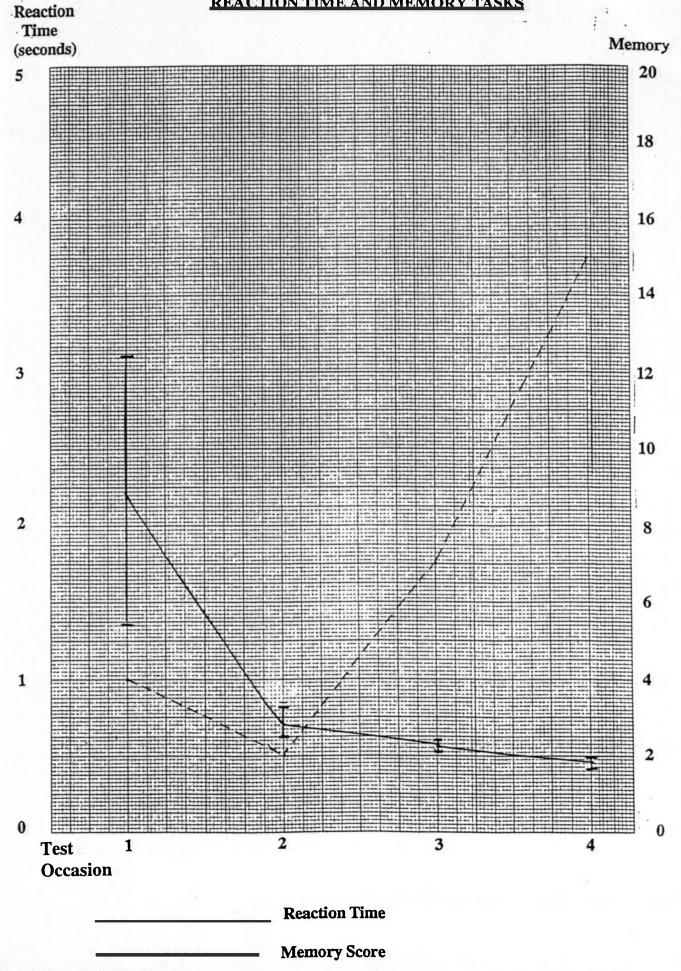
2 . SUBJECT: H.K.

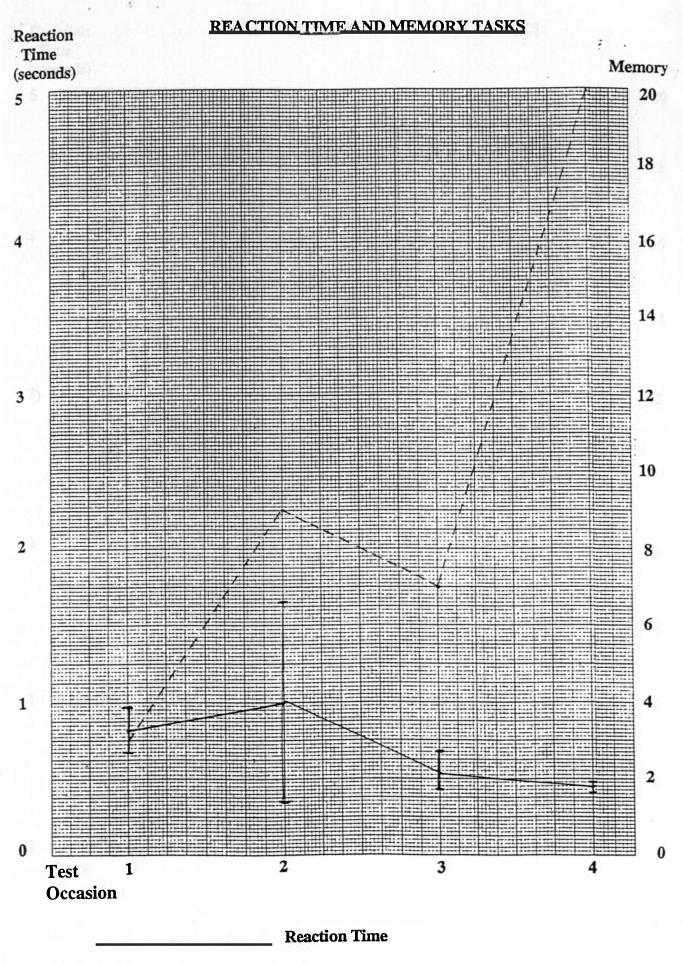




## SUBJECT: C.C.

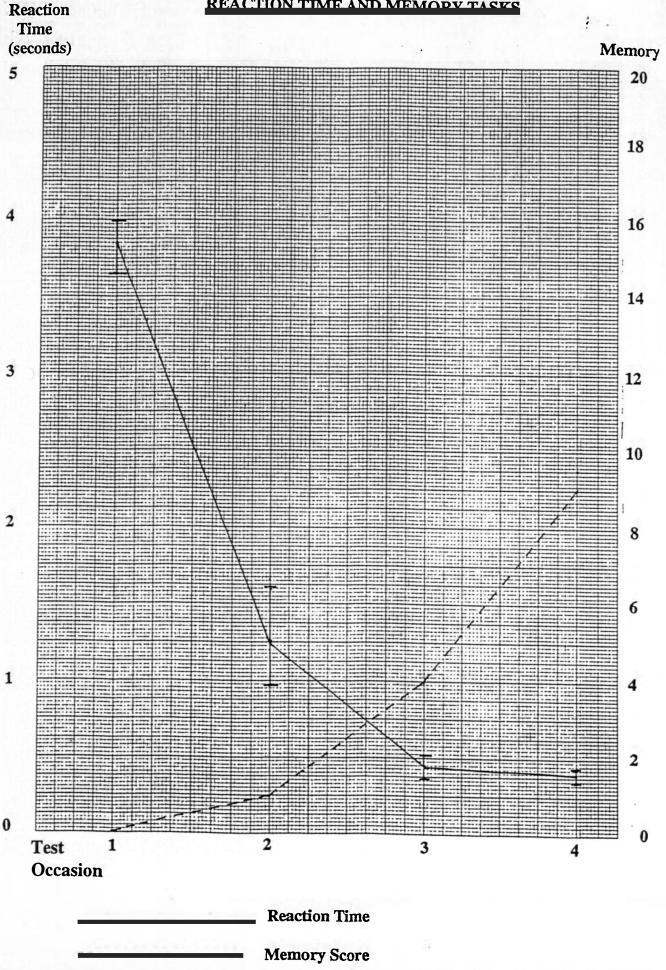
## REACTION TIME AND MEMORY TASKS





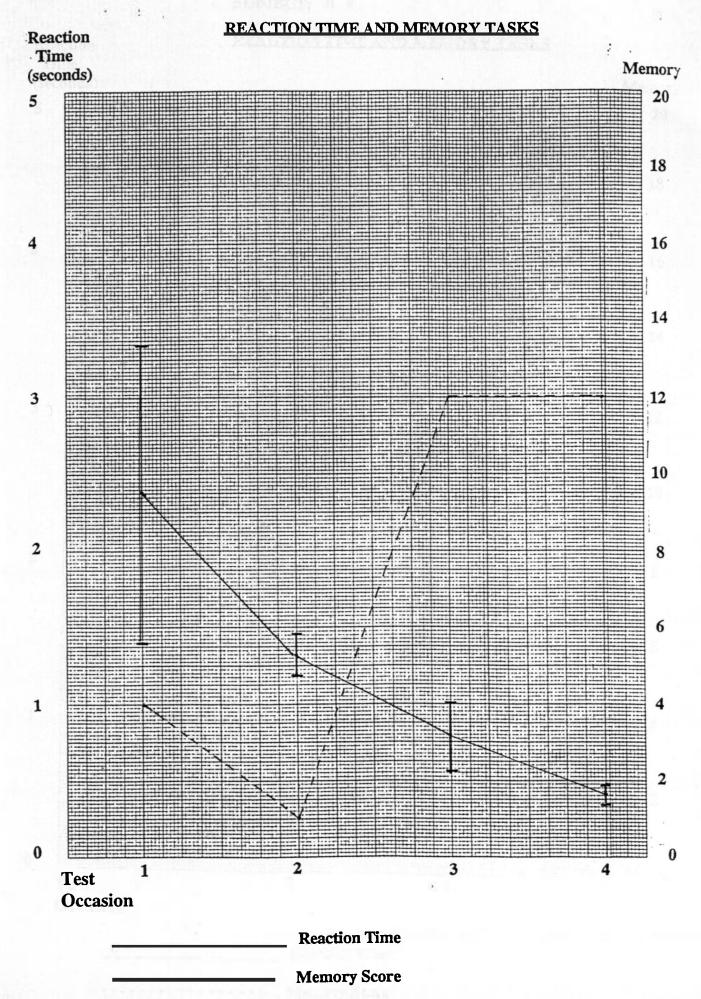
Memory Score

## REACTION TIME AND MEMODY TASKS



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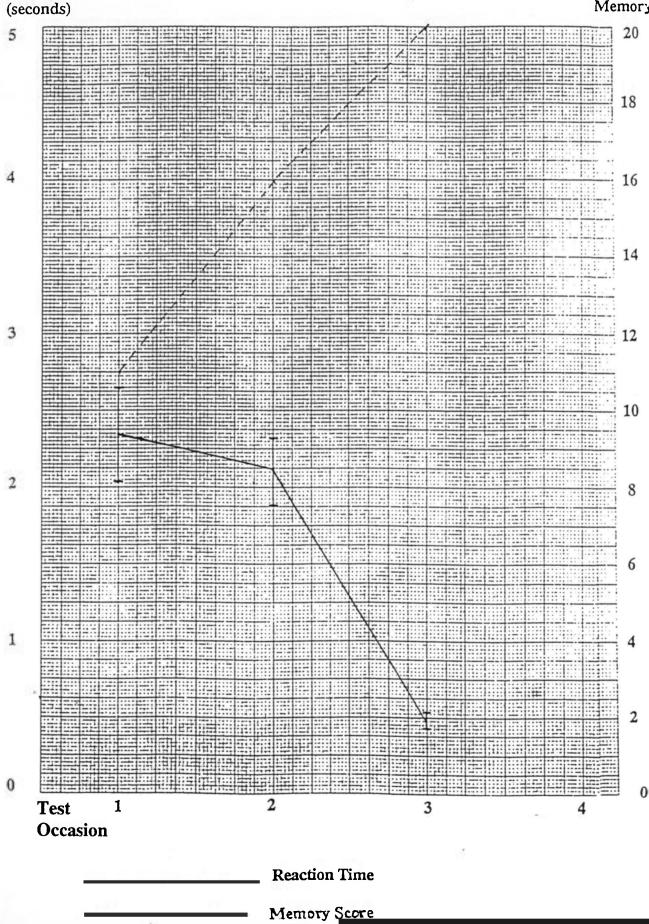
#### **REACTION TIME AND MEMORY TASKS**

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## Reaction Time

#### Memory

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# SUBJECT: N.B.

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## REACTION TIME AND MEMORY TASKS

### Reaction Time (seconds)

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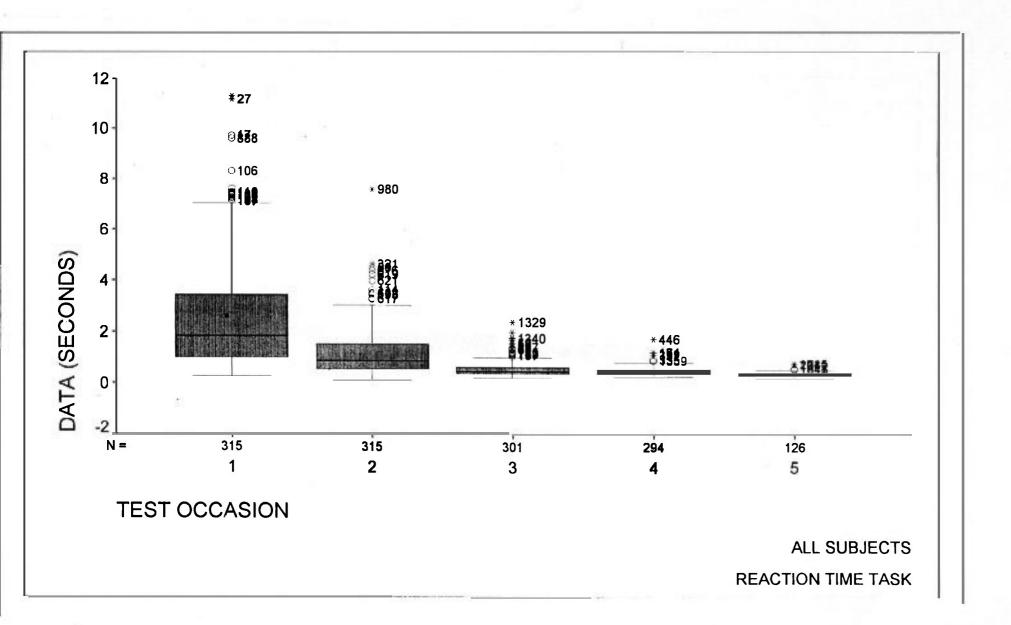
## **APPENDIX 6. BOXPLOTS**

To better appreciate the shapes of the distribution, boxplots have been drawn (pages A38 to A54) for each subject and for the group of 13 subjects.

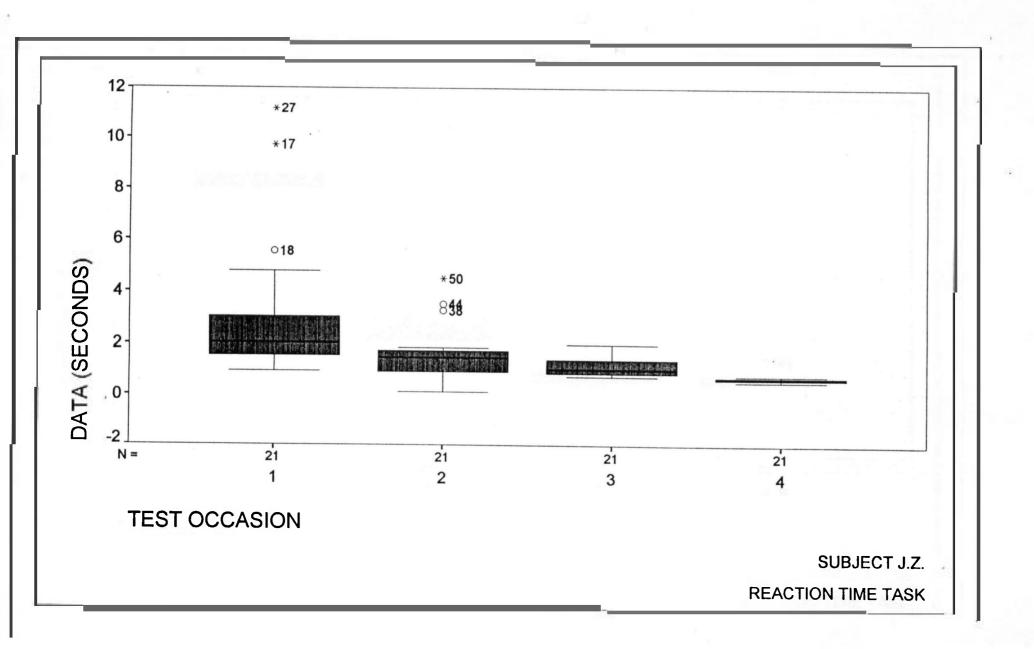
In the boxplots :

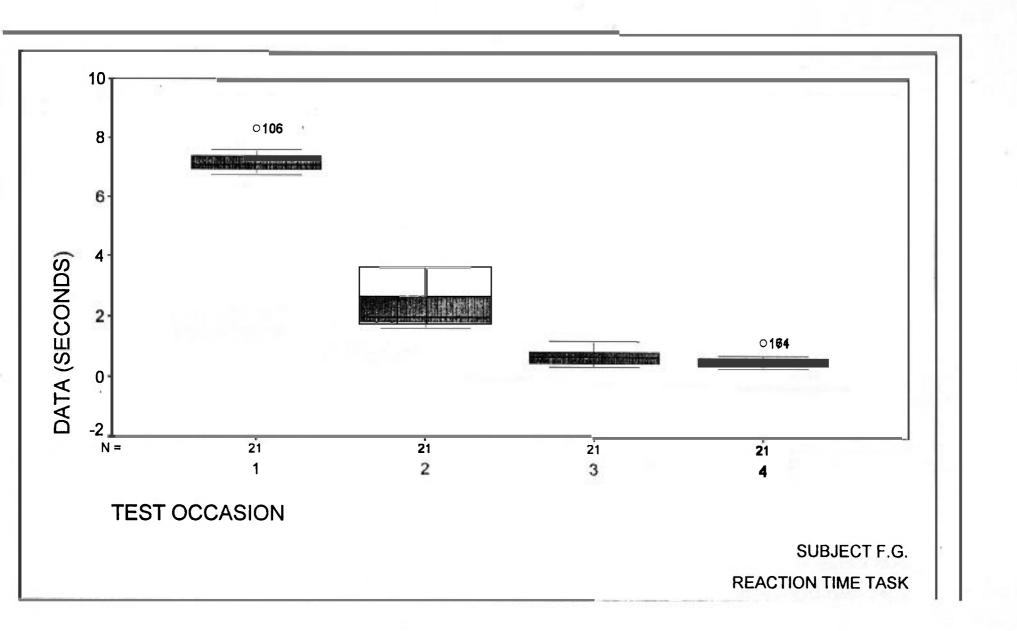
- the lower boundary of the box represents the 25th percentile
- the upper boundary of the box represents the 75th percentile
- " \* " represents extreme values i.e. values more than 3 box lengths from the upper / lower boundary
- " o " represents outliers i.e. values between 1.5 and 3 box lengths from the upper / lower boundary
- the largest and smallest values that aren't outliers are shown and lines, or 'whiskers', are drawn from the ends of the box to these values
- if the line, representing the median, is not in the centre of the box this indicates that the distribution is skewed
- if the median is closer to the top of the box then the distribution is positively skewed and if it is closer to the bottom of the box then it is negatively skewed.

Extreme values were recorded for most subjects on Test Occasion 1, however, even on Test Occasions 3 and 4 where subjects were more consistent there were still some extreme values recorded, as demonstrated by the extremely short 'whiskers'.



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