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Social problems of twenty epileptics and the contribution of social service: a study of twenty patients referred to social service of the psychosomatic clinic at the Massachusetts Memorial Hospitals

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SOCIAL PROBLEMS OF TWENTY EPILEPTICS
AND THE CONTRIBUTION OF SOCIAL SERVICE

A Study of Twenty Patients Referred
to Social Service of the Psychosomatic Clinic
at the Massachusetts Memorial Hospitals

A THESIS

Submitted by
Barbara Winifred Berman
(A.B., Wheaton College, 1946)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Work
1952
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CHAPTER I

INTRODUCTION

PURPOSE

The purpose of this study is:

1.) To analyze a group of twenty epileptic patients referred to Social Service at the Psychosomatic Clinic of the Massachusetts Memorial Hospitals by the Seizure Clinic of these hospitals, and to discover the social problems related to the disease with which the patients are faced. These problems are related to: the patient's attitude toward his illness, his personality difficulties, his problems in social relationships, and his work, school, and family adjustments.

2.) To discover the problems that the social worker faces in helping these patients, and to see how the worker can best use her skills, knowledge, and resources in an effort to help these patients.

METHOD

All records of the patients referred to Social Service from the Seizure Clinic of the Massachusetts Memorial Hospitals were used. Medical and psychiatric information was obtained from the records of these patients at the Seizure Clinic from its beginning in October, 1947, to March, 1952. Some records were more complete than others, and it was not always possible
to get detailed information on each case. No personal interviewing was done.

Current literature was read to give enough background to view the problems of these patients from a broad scope.

LIMITATIONS

This study has limited applications because of the small number of cases. The records were not consistent in the amount of material given and the objectivity of the records depended to some extent upon the individual worker assigned to the case. The patients were all from a low income group, and, therefore, not representative of the total epileptic population in the country. Because of the limitations outlined, the findings are applicable only to the group of cases studied.

SETTING

The Psychosomatic Clinic of the Massachusetts Memorial Hospitals is one of the three services of the Department of Psychiatry and Neurology of the Boston University School of Medicine. The clinic is part of the Outpatient Department. It treats patients and also serves as a teaching unit for resident psychiatrists, medical students, student psychologists, and student social workers.

The Psychosomatic Clinic consists of eight staff physicians, three psychiatric social workers, and one part-time psychologist. At the time of this study there were seven student social
workers from three different schools of social work, two psychology students, and four to five fourth year medical students who spent five weeks each during the academic year.

The Seizure Clinic is one of the three services of the Department of Psychiatry and Neurology. The other two are the Adult Psychosomatic Clinic and the Children's Clinic. The Seizure Clinic was established in 1947, with Dr. I. Charles Kaufman as its head. Patients come from many cities. Many are referred from outside sources and many from within the Massachusetts Memorial Hospitals.

Treatment for each patient includes a complete physical examination, an electroencephalograph report, social history, and sometimes psychological testing. Drugs are prescribed and the patient is seen according to need on a follow-up basis. Patients who exhibit more severe personality problems are transferred to the Adult Psychiatric or the Children's Psychiatric Units for psychotherapy. Patients are referred for help with various environmental and personality problems to the Social Service Department of the Psychosomatic Clinic.
CHAPTER II

EPILEPSY--A THEORETICAL DISCUSSION

HISTORICAL BACKGROUND

Since Biblical times society has viewed epilepsy as a degrading illness, and has placed a social stigma upon those afflicted with it. The popular misconception current since about 400 B.C. was that epilepsy was a "sacred disease". It was believed that the disease was caused by gods who possessed men's bodies with demons, making them unclean. These gods and demons were dreaded and the epileptic fit seemed a bad omen. An epileptic was thought to be unclean, and it was felt that anyone who came into contact with him might become a prey to the demon. This supernatural belief continued to the Middle Ages. The disease was most often associated with "lunacy". It was not until the eighteenth century that leading European physicians abandoned their belief in demon possession. Attempts were made to differentiate between the diagnoses of epilepsy and mental disease, but it was not until the twentieth century that new hope really came.¹ In the last two decades there has been great progress toward solving

the problem of epilepsy through better diagnosis and treatment.

A seizure is a temporary loss or impairment of consciousness; it usually occurs without any apparent cause, and it is usually accompanied by muscular movements which range anywhere from a slight twitching of the eyelids to a violent shaking of the entire body.²

Seizures are infinitely varied in form, but doctors recognize four main types: grand mal, petit mal, psychomotor, and Jacksonian.³

Grand mal: During a grand mal attack the patient loses consciousness, his muscles tighten, and he falls. He may cry out or groan, although he does not remember pain. Saliva appears on his lips; his face pales; he twitches violently for a moment or so. Usually in a few minutes he lies relaxed. Then he may sleep heavily for hours, or he may get up but feel dull for a short period.

Petit mal: The attacks are more frequent but are often overlooked because they last only a few seconds. Usually there is a rhythmic twitching of eyelids or eyebrows. The

² Herbert Yahraes, Epilepsy—The Ghost is out of the Closet p. 3. New York City: Public Affairs Committee.

³ The following group of classifications and explanations are paraphrased or quoted from Ibid., pp. 12-13.
patient rarely falls asleep.

**Psychomotor:** Here is a psychic disturbance as the principal feature. This type is not very frequently found. The patient is amnesic. He may appear conscious but afterwards does not remember anything that happened. Most attacks last only a few minutes, but with a few patients they continue longer. The seizure may appear to be only a temper tantrum or a period of queer behavior.

**Jacksonian:** The patient usually remains conscious but there is a twitching or numbness of one leg or arm or side of the face, which may gradually spread until consciousness is lost. A Jacksonian seizure indicates that the attack arises in a certain part of the brain's surface, opposite to the side of the body in which the attack begins. This means that something, perhaps a tumor or a scar is irritating the brain at that point.

The primary disorder in epilepsy is in the brain, either in its structure or its physiological activity. The fundamental cause of epilepsy is the inherent tendency or the predisposition to seizures, a tendency which was present when the patient was conceived and presumably will remain with him throughout life.4

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A number of circumstances can bring on seizures in a person predisposed to them. Injury to the brain may occur before birth or during birth. Seizures may be a result of an infection that has settled in the brain or may follow a severe head injury or may result from a tumor in the brain.

Emotion as a causal factor in the epileptic seizures is still questioned in many circles. The theory of the emotional factor was postulated by Freud. He stated that "An epileptic attack is characterized by preformed organic channels of discharge which are used when normal outlets of emotional tensions are inhibited or blended."\(^5\)

Dr. I. Kaufman states that:

Often emotional problems loom large in the total clinical picture. Frequently these are obviously the result of change in the person's relations resulting his disease. In other cases it seems as though the epileptic attack is originally an expression of these emotional problems. In any event the seizure can be seen as a pattern of reaction to the emotional stress. It is, therefore, frequently necessary to give psychotherapy to the epileptic patient.\(^6\)


DIAGNOSIS

The doctor learns from the patient's life history whether there was any type of head injury, whether there is a family history of seizures, and the details surrounding the experiencing of the seizures. Particularly helpful is the electroencephalograph, which was invented in 1929. This records the brain waves and indicates whether the disturbance is generalized or localized. It gauges the success of treatment, and helps to determine the factor of heredity.7

CONTROL

The grand mal attack is the best understood and the easiest type of seizure to treat. Phenobarbital, dilantin, and a new drug called mesantoin are highly effective in treating this type. Two new medicines, triodine and paradione have been highly effective in the treatment of petit mal seizures. Recently a new experimental drug called phenurone has been developed. This drug has been found to be effective in some cases of grand mal and petit mal, and seems to be more effective than any other substance in the treatment of psychomotor epilepsy.8

8 William Lennox, Science and Seizures, op. cit., p. 143.
There are precautions in the taking of medication, however. Bromides and phenobarbital are sedative drugs. In large doses they slow the activity of the body and mind. Medication which stops seizures but makes the patient too slow and stupid to function normally is a failure. A drug may stop the movements of a convulsion but accentuate other features of the seizure, or may increase the number of non-convulsive seizures.

As with many other diseases, "arrest" of symptoms is a better word to use than "cure". Therefore, the epileptic must be impressed with the long-time nature of the total treatment.9

"The EPILEPTIC PERSONALITY"

Many doctors, especially those who have worked with epileptics at institutions, believe that there is a definite epileptic personality. They describe it as basically egocentric, hypersensitive--displaying unsociability, moodiness, unreliability, with sudden outbursts of bad temper leading to antisocial acts and even crimes and violence.10

---


Dr. William Lennox states that physicians who deal with patients in a hospital clinic or in a private office, find that the majority of these patients are no more peculiar than the general run of the population. It is true, however, that many epileptics have psychological traits which any chronic disease is likely to produce—dependence, limitation of horizon, rigidity in habits, and feelings of insecurity.

To these are often added the fear of dropping out of the world at any time, of bodily injury, of humiliation, and the weight of public prejudice and ignorance about the condition.

Some of the problems inherent in the nature of the illness are:

1. The nature of the attack in relation to the complete disorganization of the individual during the seizure. This factor is constant, whether the spell is a prolonged and severe convulsion or the brief blackout of petit mal. To be out of contact with one's surroundings can be very disrupting, and the threat that this may occur at any time is an equally disruptive thought.

2. The public spectacle that the individual becomes if the attack is severe enough to be observed by others. No one likes to be remarkable for a condition that makes him feel inferior.

3. The unpredictableness of the attack. Fortunate are those patients whose attacks are nocturnal.
4. The dependent attitudes created in the patient, sometimes on a realistic basis. Where seizure control is poor or only fair, patients do not go out unaccompanied. It is common to find grown men and women followed about by aged parents. Unfortunately this attitude may be fostered by families and may persist in the patient after improved seizure control no longer makes such limitations necessary.\footnote{11}

It is important that the epileptic child have the security of his parents' love and acceptance. Anxiety, fear, and shame are contagious and very destructive to all children, but particularly to the child with a handicap.

Parents may take various attitudes: They may be oversolicitous and overprotective; they may be resentful of the illness, attempt to hide it, and punish the patient in subtle ways for it; or they may give the child an undue share of love and attention, relieve him of every duty in the home and at school and may make the patient a spoiled invalid incapable of taking his place in life even if the seizures are controlled.\footnote{12}

Working with parental attitudes is one of the ways in which the social worker can help the patient. In his work with the family, he can be of assistance by replacing an over-

\footnotesize
\begin{itemize}
\item \footnote{11} Ruth Gerofski, \textit{op. cit.}, p. 162.
\end{itemize}
protective, oversympathetic attitude with reasonable and constructive limitations. The worker can correct family ideas based upon misconception and prejudice. If the family can be helped to take a realistic view of the patient's handicap, the patient will stand a better chance of adjusting to it.

The epileptic is often thwarted in his attempt to adjust to the group, whether it be in school, at a club, or at work. The normal feeling of self-confidence, assurance, and security often gives way under the impact of the illness to a state of self-deprecation and guilt. He feels himself a failure, not appreciated by friends and family. To avoid exposing himself to comparisons to others, he sometimes withdraws into a shell and limits his activities. His reactions toward other people tend to grow increasingly abnormal unless modified with help from outside.

In our present social organization the person with epileptic seizures is seriously limited in outlets and activities. So much effort is required to maintain his place among friends and to face the misunderstandings and prejudices he meets, that life may become an unhappy struggle against unsurmountable odds.

Besides the fear of seizures in public, emotional conflicts arise over occupation, finances, love, and marriage. An attitude of hopelessness, and feelings of personal and social inferiority often constitute a more serious handicap.
to a person with epilepsy than do the seizures themselves.

School presents many difficulties for the epileptic child. His frequent seizures may make regular attendance difficult. He may fall behind in his work, and his anxieties may become increased. The attitude of the teacher and other pupils may be one of fright, hostility, and rejection.

"Whether the child secures his right to an education seems to depend upon the attitude of the teacher or the superintendent or upon the vigor of the objections of parents of other students." 13 Many epileptics have been asked to leave school after it was learned that they had seizures. The effect of having to leave school is not an isolated event for the child, but has a cumulative effect upon his whole adjustment, accentuating his feelings of inadequacy, rejection, and the loss of the opportunity of belonging to a group and learning to be with people.

Lack of education jeopardizes the person's chances of competing with others more skilled in this society. It is essential that the physically handicapped person have knowledge and skills to function adequately in this competitive society.

Employment is probably the biggest problem of the adult

epileptic patient. He must compete with others on the basis of skill, experience, and productivity. Dr. Lennox and Dr. Cobb analyzed the records of eleven hundred and five patients of working age and found that among this group fifty-one per cent were fully able to work, twenty-eight per cent were able to work partially, and twenty-one per cent were unable to work. Occupations followed by the group included those of salesman, farmer, clerk, laborer, mechanic, stenographer, clergymen, dentist, engineer, lawyer, teacher, and physician.  

One of the major considerations is the degree of employability of the epileptic. It is important that the employer hire people who will not endanger themselves or others on the job. The epileptic cannot operate dangerous machinery, nor can he work at dangerous heights. Tasks requiring speed and agility are not suited to anyone who may need large doses of sedative drugs over a period of many years. Often patients, as a result of an initial brain injury or of the secondary effects of seizures, suffer a slowing down and loss of acuity. To overlook this or to deny its existence and to proceed to accept an employment that is beyond the possibilities of satisfactory attainment is unwise. Whether the person with seizures

can get and hold work which he likes depends a great deal on the quality of medical care which he has secured, on the length of time he had had seizures, and on the frequency and severity of his seizures. In addition to the medical history, constructive advice will take into consideration the person's intelligence quotient, his scores on aptitude tests, his personality, his school or work history, and his social backgrounds and conflicts.15

Major extrinsic factors include the availability of jobs and the attitudes of employers. The attitude of employers toward the epileptic presents a discouraging picture of fear and rejection. A single seizure may cause the epileptic to lose his job. Very few epileptics will risk the chance of telling their employers of their condition. Holding a job until a seizure occurs, they are fired and then look again for work. When they are asked why they were dismissed from their last jobs, they cannot give adequate explanation and this jeopardizes their possibility of obtaining another job. Theirs is the recurrent tragedy of trying to decide whether to hide their illness or give up any attempt to work.16


One of the consequences of excluding the epileptic from employment is that many an epileptic conceals his illness, and may imperil the lives of others if he should have a seizure. There are definite jobs that an epileptic can do; but without the opportunity for proper placement, he sometimes has no choice but to conceal his disability and hope that he will not have an attack while on the job.

Many insurance companies refuse to insure the group in which an epileptic is involved, feeling erroneously that epileptics are much more prone to accidents. With the proper placement this need not be true. The attitude of employment agencies frequently reinforces the negative attitudes of the employers.
CHAPTER III

DESCRIPTION OF THE PATIENTS AND IMPLICATIONS

In order to understand the material more fully, it is necessary to have a general description of the types of patients being studied and their individual problems. Although the statistical material cannot be entirely accurate, it will afford a general picture of the cases.

AGE, SEX, AND MARITAL STATUS AT TIME OF REFERRAL

The age range for the patients was from fifteen years to forty-three. Twelve were men and eight were women. The largest number of patients was between the ages of twenty-four and twenty-seven, three males and four females. The second largest group was between fifteen and twenty years of age, two males and three females. (See TABLE 1, p. 18.)

AGE AT ONSET

The ages of the patients at onset were from infancy to thirty-five years, with the majority of cases beginning in early infancy.

In some cases there was a lapse of many years and seizures which began in childhood stopped, beginning again usually in adolescence. Since so many became ill so young, the
problem of adjustment for the group would be more difficult.

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21-23</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>24-27</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28-32</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>33-37</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>38-43</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>12</td>
<td>8</td>
</tr>
</tbody>
</table>

TABLE 2

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy to 4</td>
<td>9</td>
</tr>
<tr>
<td>5-9</td>
<td>4</td>
</tr>
<tr>
<td>10-14</td>
<td>3</td>
</tr>
<tr>
<td>15-19</td>
<td>3</td>
</tr>
<tr>
<td>20-34</td>
<td>0</td>
</tr>
<tr>
<td>35-39</td>
<td>1</td>
</tr>
</tbody>
</table>

TABLE I

DISTRIBUTION OF PATIENTS BY AGE IN RELATION TO SEX
CIVIL STATUS OF PATIENTS

Most of the patients were single. One fourth of the patients were under twenty years of age and none of these were married. Among those over twenty years of age, ten were single, three were married, and two were separated or divorced. The marriage experience for none seemed to be satisfactory. Those who were not separated or divorced found the responsibilities of marriage difficult and not too satisfactory.

TABLE 3
DISTRIBUTION OF PATIENTS CLASSIFIED BY CIVIL STATUS

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>Single</th>
<th>Married</th>
<th>Sep. or Div.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20</td>
<td>15</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>15-20</td>
<td>5</td>
<td>5</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>21-23</td>
<td>2</td>
<td>2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>24-27</td>
<td>7</td>
<td>6</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>28-32</td>
<td>2</td>
<td>2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>33-37</td>
<td>2</td>
<td>--</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>38-43</td>
<td>2</td>
<td>--</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Two of the unmarried girls dreamed of getting married, but because of unfavorable past circumstances and the duration of their attitudes of dependency and fear, and their inability to relate well to others, they were unable to establish rela-
tionships with males. One girl did not accept herself as a woman yet, and at sixteen rejected the idea of marriage and bearing children—not so much because of her seizures as because of the fact that her mother had died in childbirth and that she was therefore afraid. One of the married men resented his marriage and its responsibilities. He stated that if he were single he could live with his father and not have to worry about making money for his wife and three children. One male was rejected by his wife and family. While he was a patient at the Massachusetts Memorial Hospitals his wife refused to take him home, although the patient's seizures would be better controlled by medication after he left the hospital. The wife stated that she could no longer stand his spells. None of the women were married.

**TYPE OF SEIZURE AND DEGREE OF CONTROL**

The type of seizure and the degree of control are very important factors in the adjustment of the patient. Persons having petit mal seizures are more employable than those having grand mal seizures, for instance. However, when grand mal seizures are controlled by medication, the work possibilities of the person will change a great deal. In five cases the diagnosis was undetermined. Although they were described as "true" or "essential" idiopathic epilepsy, the type of seizures was not indicated. The description of idiopathic merely indi-
cates that the epilepsy is due to an inherent fault or disturbance of the brain. It is hereditary, differing from symptomatic epilepsy which is due to some injury or malfunctioning of the body which occurred after conception but before seizures began. Further study of these patients at the Seizure Clinic will indicate more specifically the type of epilepsy.

TABLE 4

DIAGNOSIS OF PATIENTS CLASSIFIED BY SEX

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Grand mal</td>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Grand mal and petit mal</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Petit mal</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Jacksonian</td>
<td>2</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Underdetermined</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Degree of control has been classified into three categories: complete, partial, and uncontrolled. A person who has had no seizures for a year or more was classified by the writer as completely controlled. A person having had no sei-

Zures for from six months up to a year was classified by the writer as partially controlled. Those who had one or more seizures during a six month period were classified by the writer as uncontrolled.

**TABLE 5**

**DEGREE OF CONTROL**

<table>
<thead>
<tr>
<th>Degree</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
</tr>
<tr>
<td>Completely controlled</td>
<td>3</td>
</tr>
<tr>
<td>Partially controlled</td>
<td>10</td>
</tr>
<tr>
<td>Uncontrolled</td>
<td>7</td>
</tr>
</tbody>
</table>

**REASON FOR REFERRAL**

All cases were referred from the Seizure Clinic of the Massachusetts Memorial Hospitals. Fourteen patients were referred for help with vocational planning. They were at various stages of readiness for a job, however. The referral entailed helping the person to become emotionally ready to accept a job as well as making a referral to the appropriate agencies. There were three cases which involved school problems, one which involved transportation, and three cases of parents whose attitudes were interfering with adequate ad-
equate adjustment. In all cases the establishing of a relationship with the worker was implicit in the referral, and was one of the main things that would enable the person to handle himself and his problems better.

**FAMILY ATTITUDES**

The family attitude was found to be negative in all cases. These attitudes included rejection of the idea of seizures, rejection of the patient, overprotection, and guilt. Since thirteen patients developed seizures before the age of ten, it is evident that the long range effects of such adverse attitudes would increase feelings of dependency, hostility, and immaturity in the patients.

**Case Illustrations**

These two cases illustrate some of the parental attitudes that have adverse effects upon the children involved.

**Case A**

Mrs. Rey refused to face the fact that her child Mary, age four, had developed seizures. The worker saw Mrs. Rey shortly after the doctor at the Seizure Clinic made the diagnosis and she stated that she believed that Mary had spells connected with eating food with acid. She suspected that these spells were merely tricks to avoid being punished. She stated that she could not believe that Mary had epilepsy "because no mother wants to believe that." She told the worker that she had spells, too, but that she tried to fight them and was usually successful. She tried to make Mary fight them. She refused to bring Mary back to the clinic for further
John Foster was fifteen years old. He had his first grand mal seizure at the age of thirteen. He stopped going to school a year later. He found it embarrassing to have his attacks in front of the other pupils. He and his parents agreed that it was not necessary for him to go to school. Following his coming to the Seizure Clinic, John's seizures were much better controlled, but he still did not wish to return to school.

Mrs. Foster stated that she never discussed John's illness with him, and did not believe that John knew what was wrong with him. She seldom discussed John with her husband because she did not want him to think about John's illness. Mr. Foster himself never talked about it and she felt that she did not wish to remind him.

Mrs. Foster did not give John pills to take with him because she did not want people to see him taking them. She stated that if people did not know about his condition there was no point in bringing it up. She stated that there was no reason for publicizing his troubles: "After all, he's not an oddity."

Mrs. Foster took John's illness as a punishment for some evil. She stated that it was unfair that it should happen to a child who had done nothing to deserve it. She said there was nothing that she and her husband had done that they knew of.

She feared that people would recoil from him and thought that it might be better if the family moved to the country. She believed that John would not run into so many problems there. There would be no competition and he would not be dependent upon others for holding a job.

John was seen in psychiatric treatment and was found to be very disturbed and hostile. He stated that his parents never let him out of their sight and had no confidence in him. Sometimes this made him lack confidence in himself. He frequently had an outburst of temper when his mother "nagged" him, and stated that one of his main problems was how to prevent this nagging.
Interpretation

In both cases there is a great degree of rejection of the illness. John's mother reacts with overprotection; Mary's mother reacts with hostility. Neither can accept the reality of the illness.

John cannot tolerate the overprotection and reacts in a very disturbed manner. Because he will not have the proper education, his life will be complicated further. Should the family move to a farm, thereby hiding and isolating him, his chances for adjustment will be further limited.

Mary will be made to feel responsible for her attacks and will be made to feel guilty and rejected when she cannot control them. She will not get proper medication unless Mrs. Rey is able to recognize the fact that Mary has seizures.

EDUCATIONAL ATTAINMENT

Only two patients went further than high school. One girl studied dramatics for a year. One man, who developed seizures at the age of thirty-six, had had specialized technical training.

Although seven patients were graduated from high school, their feelings about school were negative. Four felt that the teacher had "picked on" them. Five felt that they were rejected by the other children as being strange. Two felt uncomfortable
because they were the oldest in the class, and could not compete adequately with younger children. One stated that her teacher would become angry when she had a petit mal attack, interpreting this as laziness or stupidity. One patient was asked not to come back to school because the school was afraid that it would be held responsible if she had an attack.

None of these patients had enough education or training to prepare them to compete successfully after leaving school. The one person who did have more specialized training developed seizures as an adult.

EMPLOYMENT

The writer has classified regularity of employment into three categories: steady, irregular, and no work record. Steady refers to those patients who worked a continuous year or more at one job. Irregular refers to patients who have never worked a continuous year at one job. No work record indicates that the patients had not been employed for ten or more years. No patient had steady employment after the development of seizures. Thirteen worked irregularly. Six had no work history. Four of the latter were still of school age, however.

The jobs held by those who worked irregularly were of an unskilled nature. Many of the jobs held by this group were dangerous. (See Appendix A.) They included factory worker,
furnace attendant, laborer. Since the work that these patients could perform was of unskilled nature, they were often the first to be fired when the company began cutting expenses. This was not always due to their seizures, but to the fact that they were easily dispensed with. They had no specialized training that made them valuable to the company. Only two told their employers of their seizures. They both felt that these employers exploited them. Two men reported that their employers would have kept them on after they had had a seizure at work, but that it was because of the attitude of the insurance companies that they felt they could not take a chance.

The following four case summaries will illustrate some of the difficulties the patients have had in vocational adjustment.

Case A

Frank Brown had grand mal seizures which dated back to early childhood. They had been fairly well controlled by medication. He did not want people to know about his seizures because of their ideas about the illness. They might pity him and think him peculiar. He did not tell people when he looked for a job because he felt that he would not be hired. He said that if he were they, he would not hire an epileptic either.

Because of his secretiveness about his seizures, he had lost many jobs when they were discovered. Furthermore, he had taken jobs which he felt no epileptic should take. These included jobs as coal tender at a sewage disposal, where he fainted once because of the heat, and as laborer, where he had to lift very heavy articles.
When seen at the Clinic he was holding a job as night watchman in a trucking firm. His hours were long, and he was alone most of the time. He felt that this was a lonely kind of job and wished he could do something better. Because he had been to school for only seven years, and because of his epilepsy, he felt that people would not hire him for anything else.

**Case B**

Norman Anderson, twenty-eight years of age, had petit mal and grand mal seizures which were fairly well controlled. For the past five years his jobs were in a stock room, in a shipping room, and in a soap factory. He had a seizure in the presence of the foreman in the stock room. He had been doing well at this job, had received several promotions and several raises. It was brought to the attention of the management that he had seizures and he was asked to leave because it was claimed that his presence would jeopardize the insurance policy of this company. His attitude when he came to the Clinic was very negative. He felt that people would not hire him because of his sickness and even if they did, the insurance companies would interfere.

After three visits to the Clinic, he failed to return. When the worker called his home, his brother stated that Norman had gone to Florida. He stated that Norman had had many jobs and they had never lasted because of his sickness. He said that Norman had run away from home like this before, but that he always came back. "He doesn't like it around here. He's a grown man, and it's not easy for him just to hang around the house."

**Case C**

Florence Green's seizures consisted of her being sleepy for a few minutes, but without loss of consciousness. After high school she went to dramatic school for a year. For two years she did clerical work for the government but was fired at the end of the war because they were cutting down on personnel. She wanted above everything else to become a dental assistant, and she registered at a dental school. After about two months she was asked to leave.

By visiting the school, the social worker learned
that Gladys did not coordinate sufficiently to be a dental nurse. It is unfortunate that she desired to do something that required such precision. With the proper vocational guidance Florence can be helped to find something more suitable and perhaps as satisfying.
CHAPTER IV

THE ROLE OF SOCIAL SERVICE
ILLUSTRATED BY CASE STUDIES

The major problems of the epileptic patients referred to Social Service of the Massachusetts Memorial Hospitals have been discussed in previous chapters. This chapter will consist of cases that illustrate some of these problems. It will also show some of the possibilities and limitations of casework with the epileptic patient.

One of the major problems the worker found in working with these patients was an inability of many to relate on a casework basis. In all instances this was partially due to previous factors of personality difficulties. In four cases an additional factor was the patient's inability to accept the fact that social service was not an employment agency and had no jobs waiting for them to choose. This may be connected with the way in which the role of Social Service was explained by the doctors who referred them from the Seizure Clinic or the way in which they interpreted the doctor's referral. Three patients became angry when they learned that the worker did not have a job for them and refused to return after a few visits. Two became discouraged when a job did not materialize immediately after the worker referred them to a vocational agency.
Only three patients wished to take advantage of the State Rehabilitation Program, and of these, two were unable to carry through the plans. This is unfortunate, because their potentialities for being placed in a job would be greatly increased. It is interesting to note that one patient who welcomed the idea of vocational rehabilitation, and was able to accept the difficulties involved in returning to school for an eight month period, was the only patient who was successfully placed in a job that he liked. There he utilized the skills he had acquired during his vocational rehabilitation, the cost of which was paid by the Division of Vocational Rehabilitation (See Appendix B).

Another of the major problems encountered by the worker was adverse parental attitudes. This was obvious in all cases. Seven patients had been overprotected; five had been rejected. The remaining eight had been treated with both overprotection and rejection in an inconsistent manner. None of the parents took a realistic, accepting, and helpful attitude toward the handicap of these patients.

In all cases the worker attempted to counteract adverse parental attitudes by her own more constructive attitudes. This provided the patient with a relationship of a positive nature, and was a good first step in his being able to move toward more maturity. The effects of this were obvious in four cases, and present in various degrees in five other cases.
In six cases this was a factor, but the patient was not able to utilize the relationship well because of past relationships and because of his own feelings.

The worker had some contact with five parents. In two cases she was able to modify parental attitudes somewhat. Resistance to help was great, however. No parent wanted to change his own attitude toward the patient. Old patterns of reaction were well established—patterns of denial, overprotection, and rejection. As one mother explained: "No mother wants to believe that her child has epilepsy."

The worker can help the handicapped individual only as she understands his needs as a person, not only the needs created by his handicap, but also those which he has in common with other human beings. This focus implies ability on the worker's part to: be ready to acknowledge the patient's difficulties, be ready to help the patient express his feelings about them, be ready to offer protective measures and supportive help in accordance with the patient's need, and be ready to use his own strengths and resourcefulness in managing his own affairs. The worker attempted this in all cases.

The social worker's purpose is to assist the person to deal more adequately with his situation either through some changes in outer factors, in his own attitude, or in both. When the obstacle is an external reality which cannot be changed, the person may be able to move ahead through some
modification in his feelings about the difficulty. In many cases the emotional release which comes from expressing partially repressed feelings to a professional person—who understands and accepts them without imposing his own needs, demands, or values—may relieve the patient's anxiety. The acceptance may give a sense of support which increases the patient's ability to face and act upon his problem. This was true in three cases to a large degree and in five cases to a smaller degree.

Successful rehabilitation hinges upon two factors: Is what the person needs within his reach, and, if so, can he reach for it?

If what he needs is not within reach, we have a problem for community planning. However, if the person is unable to use the facilities he needs and which are available, the problem requires a personal answer. The social worker can be active in helping with both aspects of this problem.¹

Because of her understanding of the illness, and its implications, the worker is invaluable as a person who can interpret to the school, the community, and to the family of the patient. The total number of interpretations made to people other than patients was nine.

Working with the epileptic patient requires the greatest of skill and sensitivity. The worker must be aware of the meaning the seizures have to the individual patient, whether he expresses it directly or not. She must understand hostility and be able to accept it. She must understand that patients who have been as frustrated on as many levels as these patients have, and for so long a period of time are apt to project many negative feelings into the present situation. She must recognize ambivalence, the patient's wanting to move out—and his fears concerning his ability to function in a competitive society, concerning his ability to do the work, and concerning the ability to gain the acceptance of those with whom he works.

The following five cases will illustrate this discussion.

Case A

The case of Jane Marsden shows some of the difficulties that the adolescent with epilepsy encounters because of her illness, and because of extremely difficult environmental factors. The referral was for help with school planning and need of a supportive figure.

Jane was sixteen at the time of her referral to Social Service. Her seizures began at the age of two, subsiding for several years until the onset of menstruation at the age of thirteen. She lived with her stepmother, father, and three younger stepsiblings. Her own mother had died in childbirth. She had a twin sister and a married sister, both of whom did not live at home. Her seizures were both petit mal and grand mal. They were both fairly well controlled.
Jane felt that everything was done for her stepsiblings and nothing for her. She felt that she had to do most of the menial tasks in the home. Her father's attitude toward her was often one of ridicule. He laughed at some of the things she made in sewing class. He compared her marks with those of her stepsiblings and stated that she was very stupid. He told her that they would have to carry her out at graduation because she would be so old. Jane felt that because she was not her stepmother's child, the latter did not show any interest in her. Because Jane's stepsiblings got more affection and approval and because Jane was responsible for minding them much of the time, Jane was very hostile toward them.

Jane had many problems at school. She found it difficult to learn, although she attempted to do her assignments conscientiously. She found it difficult to relate to her teachers because she projected many of her needs upon them and had not been treated with much understanding. When she was fifteen she had an attack and broke her nose at school. On registration day of the next year she was told that she could not return without a note from the doctor because she had reached her sixteenth birthday and the school did not want to assume the responsibility, should she have another accident on school premises. The other children showed very little interest or understanding, and made fun of her when she did not do well. Many times she wished to stop school, but she was faced with the alternative of having to stay at home and mind the children. She decided that school was the better of the two alternatives. She found the attitudes of the teachers to be inconsistent. One day a teacher would tell her that if she did not feel well she did not have to do her homework, and then the next day would scold her for not doing it. From a visit the worker made to the school, she learned that most of the teachers connected epilepsy with feeble-mindedness, and some wondered whether it might be an attention-getting device. The worker discussed future planning for Jane, and the school felt that Jane could be better helped were she placed in the special class. When the school suggested this to Jane she reacted violently. She told the worker that the children in this class were called bums by the other children, that this class was full of people who could not learn like other people. The school told Jane to ask the worker's advice but the worker said that it was something that Jane would have to work out for herself, with the help of the worker. As time went on, Jane decided that she would prefer to go to
vocational school. The worker emphasized the many positive factors that would result should she prefer to go, counteracting the negative responses of Jane's family, who told her that then she would surely be an old maid. The worker showed Jane that this change did not mean a rejection by the school, as Jane felt it did, but that it meant that they were interested in helping her to do the thing that was best for her. Jane liked the idea of taking subjects that did not seem so hard, and learning to cook and sew.

Nobody from Jane's family showed interest in her work at the new school. She felt particularly bitter about this on parents' visiting day. She often invited the worker to come, and was always pleased when the worker appeared at the school. It gave her a feeling that somebody was interested in her, and she was proud when the other students remarked about her nice friend. She often brings some of the things she has made to the worker and is pleased with the worker's warm enthusiasm about her attainments.

Jane is disturbed about her role as a woman. She thinks of being a woman in terms of suffering. This is connected with the death of her mother, and the difficulties she has with her menstruation. Having babies to her means danger of death, or a lifetime of drudgery caring for them should death not occur at childbirth. This attitude is reflected in her family's feelings about being a woman. Her sister explained to her about womanhood at the time of onset of her menstruation in very negative terms. Her father has expressed the wish that she were a boy. She envies boys because she feels that they do not have to suffer the way girls do.

She reacts to her handicap with great anger and shame, usually referring to her seizures as "getting it".

Jane has established a relationship with a boy who seems to like her very much. Her parents often joke about him. Once when she had a seizure they said that it was because she was thinking about him too much. She is ambivalent about her relationship with him, wondering what it is that girls get out of going with boys.
Interpretation

Jane presents the picture of an extremely deprived adolescent. Her parents seem to be rejecting, but much of her difficulty in her relationship with them is due to her own projections and misunderstandings.

She was unable to compete successfully at the first school mentioned because she felt rejected there as she did at home, and also because of the attitudes of the teachers and other pupils and her own limited ability to learn quickly.

Much has been accomplished by the worker during the two year period that Jane has been coming to the Clinic. Interpretations were given to the school, so that more satisfactory arrangements were made. She was supported in her decision to go to vocational school and the proper interpretations about this school were given her so that she was able to make a more positive adjustment to it. She was able to express her anger at some of the things that her parents said and did and to have them accepted as natural and acceptable reactions. She is free of much of the guilt she had about her feelings about her parents.

The worker's positive and accepting attitude toward Jane has helped to counteract the negative attitudes with which she was surrounded at school and at home.

Jane has found in the worker a female figure with whom she
could identify and begin to complete her psycho-sexual development. There is a question as to whether Jane will ever be able to accept her womanhood completely because of the many deep-seated anxieties she has about this. But it is possible that through identification with the worker, she can begin to move toward a more adequate adjustment.

The case of Jane illustrates some of the benefits that may accrue from supportive casework. Jane came at a time when many decisions had to be made, and when attitudes could be shaped. Her outlook for the future seems brighter than the outlook of patients who came to social service after they had left school and had had many more frustrating experiences.

Case B

Margaret Chase was twenty-five years of age. She had had seizures since she was three, both petit mal and grand mal. She went as far as the first year in high school. Since then she had worked at many jobs: in a factory, in stores, and in a cafeteria. Her last job was as attendant in a hospital. She was fired from this job because of her seizures and because of difficulty in adjusting to her supervisor to whom she showed a great deal of hostility. After that job she remained at home for about a year, but became bored and unhappy staying around the house. She resented her mother who dominated her greatly, and she wanted a job in order to earn some money, to get away from her mother, and to fill the long days with thoughts other than her seizures.

From the beginning of her contact with social service she expressed great ambivalence about getting a job. She also had a great amount of hostility, which she often displaced onto the worker. She looked upon social service as an employment agency, and was angry that there
was no immediate job for her. She saw no advantages in the worker's suggestion that further vocational training might be of advantage, but wanted a job immediately.

Some of her ambivalence about taking a job concerned guilt about leaving her mother. She had spent a year taking care of her mother while she was ill, but resented this. Much hostility that she had toward women was displaced from her feelings about her mother.

The worker referred her to a vocational agency trained to help with her type of problem, but she was angry at this agency after her initial contact. She stated that the worker who had interviewed her was "mean" and that she had gone home crying. She was angry at the kind of jobs that were offered her as a possibility by this agency. These jobs were mainly jobs for people without skills, as was the case with Margaret.

As time went on and no job was forthcoming, Margaret's hostility increased. She said that she was being sent from place to place and nothing came of it. She had a terrible feeling that she was a "nothing with nobody to take care of me". Margaret stopped coming to the Clinic, stating that she would prefer to look for a job by herself.

**Interpretation**

Margaret is an immature, dependent person with a great deal of hostility toward her mother and woman figures in general. She was impatient with the casework process, and was unable to relate to any appreciable degree to the worker. Although it had been explained to her that she was being referred for help with vocational planning, she continued to feel that the worker should get her a job, and that that was the limit of her relationship. The worker was able to understand the meaning of her hostility, and to help her to express it. She
tried to help her think more clearly about the usefulness of added training and planning for the future, but without success. Many of Margaret's difficulties, but she was not able to utilize the worker in securing help with them.

Case C

Selma Caplan had had seizures since she was a small child. She was twenty at the time of referral to Social Service. During childhood, her seizures had been both petit mal and grand mal; at the time of referral they were petit mal seizures, which she had about three times a day. She was referred for help with social problems and job planning.

She had gone to school until the fourth grade, and was tutored at home from the fourth grade to the second year of high school, when she returned to school. She felt strange and different at school. She was not accepted by the other children, and often the teachers got angry with her for being slow and not being able to answer their questions quickly. She often had a petit mal seizure when they called on her.

She was overprotected by her parents who would not let her go out alone. She had a sister three years older than she, who was constantly telling her what to do, and how to act. She had a hostile-dependent relationship with this sister, wanting to be like her, have the fun she had, be as popular--and yet Selma resented her. Her sister seemed to be a negative influence in Selma's adjustment. She was constantly emphasizing Selma's inadequacies, and often told her that it was dangerous for her to go out with boys since a boy might "take advantage" of her if she should happen to have a seizure while she was out on a date.

Selma's parents accompanied her to work until she refused to go if they continued this. She has been less protected in the past few years and is allowed freedom to come and go as she pleases now.

Selma has had difficulty in getting and keeping jobs.
Part of her difficulty is that she finds it hard to get along with her employers. She had a job as a stenographer for a short time but left because she could not get along with her employer. The other difficulty is that she works slowly, and this was the trouble when she worked in a candy factory where speed was essential. She was fired from a job as salesgirl in a department store because of her seizures.

Selma's major concern was the fact that she had very few friends and did not seem to be able to relate well to people her own age. She was uncomfortable in her relationships with boys, and was disturbed because they dated her only a few times.

**Interpretation**

Although Selma is twenty, she is on a much less mature level of development. She is painfully aware of herself and the impression she creates. She is unable to relate adequately to people. She has never had a satisfying relationship before in which she could be herself and begin to grow. It is important for her to have a person who accepts her and whom she respects and trusts. It has been difficult for her to understand the meaning of such a relationship. She has wanted to thrust the worker into the role of social adviser, asking such questions as what should she do in order to be more popular with boys, and wanting reassurance that she is doing the right thing. She showed anger because the worker would not answer these questions directly, in an authoritarian manner. After some time she began to understand the relationship better, to use the worker more as an understanding friend with whom she
could talk over her problems.

She has had much difficulty in obtaining and holding jobs during this time and comes to the worker for support when she feels discouraged. Her failures often seem to prove to her that she is not adequate and this feeling is supported by parental attitudes. She was able to gain support from the worker during many difficult periods and continues to seek help.

Supportive casework with Selma can help to build more ego strengths so that Selma may begin to realize herself as a more adequate, less frightened person.

Case D

Anita Clark was twenty-four years old when she was referred. She had grand mal seizures when she was a child. They disappeared until she was ten, and then began again. She left school early and was educated at home until she reached high school, when she stopped. She seldom left the house and when she did she was accompanied by her mother. She was referred to social service for help with transportation and help in beginning to become independent.

Her mother was extremely overprotective. She feared that something would happen to Anita, imagining her falling down before a train or hitting her head somewhere. She feared that Anita might get into difficulty with men because she felt that Anita is very naive and men might take advantage of her. Anita resented her mother's close supervision and yet welcomed it because of her very great dependency needs. This made it difficult for Anita to begin to move outward.

The doctor felt that Anita's seizures were well enough controlled for her to begin moving out. The first
step the worker took was to call for her and bring her to the Clinic without her mother. When Anita expressed interest in going to the museum and shopping with the worker, the worker accompanied her. When Anita expressed interest in taking singing lessons, this was arranged on a scholarship basis with a settlement house. But Anita's mother frustrated her continually. She would not let her go to her music lessons herself, and pleaded with her to stop because it made Mrs. Clark tired to take her. She questioned the need for Anita's coming so often to the Clinic, and felt that she was not getting anything from it. Anita was anxious not to anger her mother. She once said, "Of course, my mother cannot forbid me anything, but I don't like to go against her."

Mrs. Clark was seen by the worker several times in an attempt to help her decide to let Anita come to the Clinic alone. Finally she did agree to allow this. This was one of the first steps in helping Anita to move outward.

**Interpretation**

Anita's picture is similar to the picture of many patients who develop epilepsy in early childhood. There is overprotection and fear on the part of Mrs. Clark; dependency and fear on the part of Anita. Since this situation has not been altered for twenty-four years, it is not likely that too great goals can be achieved. Casework with Anita was terminated because the doctor wished to test whether Anita would be able to come to the Clinic herself. It was found that she was able to do this. Finding that she can do this successfully, it is possible that Anita will begin to do other things with more independence and confidence.
Case E

William Hawthorne was twenty-two at the time he was referred to social service. He had petit mal attacks from the age of nine. After being graduated from high school he worked in a clothing factory for three years. He was discharged in favor of a returning veteran. After that he worked in a department store, but was fired because he was not quick enough.

He was interested in getting further training in radio repair work. The worker contacted Vocational Rehabilitation and they arranged for him to go to a special training school. During the time he was at school the worker continued to see him, showing much interest in his courses and marks. School was difficult and he needed much encouragement to continue to make the effort. The worker kept in close contact with Vocational Rehabilitation, sharing information that would help them to help William.

During this period William was under a great deal of adverse pressure from his family. His mother's attitude toward him was one of depreciation. She felt that he could never do anything well, and did not believe that he would be adequately trained even after he got his training. His father was not interested in his specialized training, but felt that William ought to get out immediately and start earning money. He felt that any job would do.

There was a period of discouragement after William finished his course, because he could not get a job. The worker encouraged him to continue his contact with various employment agencies. Several months later William got a job working on electric tubes and wires. This job was obtained through one of the agencies the worker had contacted and had encouraged William to utilize. The job was in a sheltered shop which employed other handicapped people. He stated that his bosses were good people, and very understanding. He got along well with the other men and enjoyed the freedom of the place. After he began to feel secure in his job, his contact with social service was terminated because the goals had been accomplished.
Interpretation

William was able to utilize the casework relationship to advantage. The worker supported him over the period of a very difficult year. She helped him to decide to get specialized training, referred him to the right source, and helped to build up ego strengths. Now that William works in a sheltered shop, earning as adequate a salary as other men but not having to compete or work under the strain of fear, his chances for an adequate adjustment are good.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was twofold:

1. To analyze a group of twenty patients referred to Social Service of the Massachusetts Memorial Hospitals and to discover the social problems related to the disease with which the patients are faced. These problems are related to: The patient's attitudes toward his illness, his personality difficulties, his problems in social relationships, and his work, school, and family adjustments.

2. To discover the problems that the social worker faces in helping the patients and to see how she can best use her skills, knowledge, and resources in an effort to help these patients.

Epilepsy was discussed from both a general and a specific point of view. The general picture gave an account of the attitude toward epilepsy from Biblical times to the present day. Although many medical gains have been made for the epileptic, the thinking about epilepsy has lagged far behind. The public is still very much misinformed and reacts to the illness with fear and rejection. The idea that epilepsy is connected with insanity is still prevalent, as it was in ancient days when epileptics were believed to be possessed by demons.
The four main types of seizures have been described as grand mal, petit mal, psychomotor, and Jacksonian. Their different characteristics have been described.

The primary disorder in epilepsy is in the brain, either in its structure or its physiological activity. The fundamental cause is the inherent tendency or predisposition to seizures. The emotional factor as a causal factor in epilepsy is still disputed, but it is believed by many that this is of great importance.

In most cases seizures can be partially or fully controlled by proper medication. The main drugs used are phenobarbital, dilantin, messantoin, triodine, and paradione. These control but do not cure the disorder.

Although some doctors describe the "epileptic personality" as a certainty, this type of personality does not necessarily develop. Many epileptics have psychological traits which any chronic disease is likely to produce, such as dependency, limitation of horizon, and feelings of insecurity. These are not inherent in the illness itself, but are the results of unfortunate environmental factors.

The twenty patients studied included twelve men and eight women, ranging from fifteen to forty-three years of age. Fifteen were single, three married and two separated. The majority of the patients were referred for help with vocational
planning.

They were at various stages of emotional and physical readiness for work. Referral usually entailed helping the person to become better prepared to accept and handle a job, as well as contacting the appropriate agencies. Other reasons for referral included help with parental attitudes, personality problems, and school problems.

In all cases where information could be obtained, the attitude of the patient's family was negative. The main attitudes were denial, rejection, overprotection, and guilt.

The level of education of the patients was not adequate to prepare them to face the responsibilities and satisfactions that might otherwise have been achieved. Seven patients were high school graduates. None of the group had specialized skills, except the one epileptic patient who developed seizures at age thirty-six. This fact, combined with adverse attitudes on the part of employers, fellow workers, and insurance companies, made vocational rehabilitation difficult.

The past vocational experiences of most of the patients showed that they had held many jobs unsuitable for epileptics. These often involved working near dangerous machinery, performing hard manual labor, or working at jobs that required great swiftness and precision. Many had a series of jobs. They were fired after each seizure or, being unskilled, were easily dispensed with by the companies. Only two told employ-
ers of their seizures. The others felt that they would not be hired if the fact had been known.

This creates the problem of the "unknown epileptic in industry", and causes a situation where the epileptic may be working at a job that might endanger himself and others, when he could be handling jobs less dangerous and managing well at them.

The problems that the social worker encounters in her effort to help these patients are many. Adverse environmental factors--such as family attitudes, frustrating school and work experiences--combined with the problems that the illness itself brings must be thoroughly understood by the worker. She must be able to accept the patient's ambivalence, hostility, dependency, and other characteristics that he may have developed in an effort to adjust to an extremely difficult environment. She must be able to understand the meaning that the illness has for each individual, whether it is verbalized or not. It is her task to try to give the patient a positive, accepting, corrective experience, different from those he has usually encountered in the past. In this manner, she can help build up ego strengths which have been weakened by adverse experiences.

Sometimes she must accept very limited goals, and work within these, realizing that each small step is a beginning in helping the patient to move outward, and to experience himself as an independent, worthwhile human being. In some cases
she will encounter adverse attitudes on the part of employers or educators. With great tact she can carry on the educational process of the public, so that the environment will be altered somewhat for the epileptic.

She must understand fully the community resources, particularly the nature of each agency, which she uses for referral. She must be able to make accurate interpretations of the patients to these agencies, as well as being able to interpret the policies of these agencies to the patient.

Because of the limited sampling of cases and the low educational and economic level of these patients, the findings are not applicable to the epileptic population as a whole. With adequate training and more healthy attitudes on the part of those surrounding the epileptic his chances of leading a happy, rewarding life are much better than these cases show. (It must be kept in mind that the well-adjusted epileptic patient would not be referred to social service for help with the problems which have been described here.)

A few case studies reveal that a corrective experience with the worker can help to rehabilitate the patient and to mitigate adverse conditions. Casework with the epileptic adolescent stands a greater chance of success, since the adolescent is more ready for change, and can more easily utilize a corrective experience. The proper educational and vocational
plan can be worked out so that the patient does not have to experience as many frustrating experiences because of lack of training.

The social worker can help in the re-education of the public in various ways. She comes in contact with people in the epileptic's environment: the parents, the school authorities, and employers--on behalf of the patient. Being informed herself, she can by her attitudes and explanations, help to bring her information to the public. In this way she can help to modify the unfavorable environment of the epileptic. Social workers can contribute their findings to the growing literature about the epileptic, since they are in particularly favorable situations to observe these problems.

Approved:

Richard K. Conant
Dean
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APPENDIX A

LIST OF OCCUPATIONS HELD BY PATIENTS AFTER ONSET OF SEIZURES

Cashier
Salesgirl
Grocery clerk
Ticket seller
Night watchman
Household worker
Ward attendant
Factory worker
Furnace attendant
Laborer
Dishwasher
Railroad worker
Blacksmith
Messenger boy
Filling station attendant
The Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation is financed jointly by the state and federal governments. The aim of the Division is the readjustment and return of the handicapped individual to a productive job. This readjustment is accomplished through the training and development of the patients. Training is given free of charge to those who can take advantage of it. The services of the Division are available for any resident of Massachusetts of legal employable age who has a physical or mental disability which is a vocational handicap and who reasonably can be expected to be fitted for employment. Each handicapped person is studied individually and an earnest attempt is made to draw up a rehabilitation program that will meet his special needs.¹

Women's Educational and Industrial Union

The Women's Educational and Industrial Union promotes the educational, industrial, and social advancement of women. The

¹ Commonwealth of Massachusetts, Department of Education, Vocational Rehabilitation for Persons Disabled in Industry and Otherwise, Bulletin No. 2, 1947.
Bureau of Occupations for the Handicapped Woman gives advice and aid in placement of those handicapped physically, emotionally, or because of age.

**United States Employment Service—Handicapped Division**

The United States Employment Service aids the handicapped to find employment suitable to his needs and abilities.

**Morgan Memorial Goodwill Industries of Boston**

The Morgan Memorial Goodwill Industries accepts a small number of epileptics for work under sheltered conditions. A store is operated in connection with this project, making possible a limited income for the handicapped worker. The Morgan Memorial Employment Bureau also aids in placing workers ready for competitive employment.

**Jewish Vocational Service**

The Jewish Vocational Service gives individualized help to handicapped people seeking employment. In some cases they are able to make job placements, and in all cases they are able to evaluate the person's potentialities by individual testing and counseling.
The Community Workshop of Boston

The Community Workshop is an agency for the training, placement and aiding with adjustment of physically, mentally, or socially handicapped people. It accepts all people with a special problem in the vocational field. It provides work under sheltered conditions and helps to prepare the handicapped for jobs. It began to accept epileptics in 1939. It works closely with the doctors and social workers who make referrals. A client must be under medical supervision and must carry out treatment plans. Social and medical histories are obtained when a client is accepted. Each client is watched to see his adjustment. When the client leaves for regular work, the Workshops are ready to interpret to the employer any work limitations imposed by the possibility of a seizure.¹

¹ Most of this information was obtained from an unpublished thesis by Joan Pinanski, Simmons College, 1947.
APPENDIX C

SCHEDULE

DESCRIPTION OF THE PATIENTS:

Name
Age
Sex
Civil status
Education
Position in the family
With whom patient lives
Length of treatment at the Clinic

MEDICAL INFORMATION

Diagnosis
Type and frequency of seizures
Date of onset
Prognosis

SOCIAL INFORMATION

Personality and attitudes of patient
Family problems and adjustment
School problems
Vocational problems
Social life (friends, activities, etc)
Work history, attitude toward work
Attitude toward problems

THE ROLE OF THE SOCIAL WORKER

Working with patient's attitudes
Working with family attitudes
Working with attitudes of outside agencies
How the patient utilized the worker