THE ROLE OF THE MEDICAL SOCIAL WORKER

IN THE

TREATMENT OF EPILEPSY

An exploratory study of cases from the Seizure Clinic of the Vancouver General Hospital.

by

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Abstract

Medical science has done much to bring epilepsy out of the realm of mysticism and misconception, into the area of normal and natural diseases; but many persons subject to seizures experience difficulty in their attempts to live as others do. It is the purpose of this thesis to examine the ways in which medical social work can help them achieve this end.

The setting-up and the purpose of the Seizure Clinic of the Vancouver General Hospital is described. An examination of the social situations of fifty-three persons who were referred to the social worker during a period of seventeen months, for various kinds of help, reveals the problems which epilepsy presents to this group of people. There are numerous examples of difficulties associated with (a) parental attitudes, (b) social relationships, (c) employment, and (d) marriage. The material indicates clearly, that blanket statements regarding "epileptics" in general, are unfair and untrue. Each is an individual who requires help with his particular difficulties.

Analysis of the cases reveals that the medical social worker can contribute to the treatment of epilepsy by (a) enabling the physician to understand the patient's social situation as it affects his medical condition and his attitude toward medical treatment; (b) correcting the patient's misconceptions toward his illness, alleviating anxiety regarding treatment, and generally enabling him to obtain the greatest benefit from medical treatment; (c) helping the patient understand and accept his handicap; (d) helping parents develop healthy attitudes toward handicapped children, in order that they may be prepared to assume the responsibilities of adulthood; (e) familiarizing persons in the community with the facts regarding epilepsy and thus eventually reducing the stigma associated with the illness. The casework methods used by the social worker include, (a) modifying the environment, (b) psychological support, (c) clarification, and (d) insight. There is sufficient evidence in this study that medical social work can in various ways and to varying degrees, help epileptic persons to be useful members of the communities in which they live.
Acknowledgements

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Chapter I

SEIZURE CLINIC
AN EXPERIMENT IN CO-OPERATION

For too many years, the treatment of epilepsy has been regarded as the responsibility of the medical profession alone. However, with the trend toward specialization and the recognition that no one person could equip himself to treat the numerous phases of all illnesses, the idea of "teamwork" amongst various professional people, in clinics or in hospitals was initiated. Also, with an increasing acceptance of "psychosomatic medicine", that is the study of the influence of both the mind (psyche) and body (soma) in illness, medical social work gradually gained acceptance as one of the professions which could contribute to the total understanding of the patient. Epilepsy is an illness which appears to be as much a social problem as it is a medical problem, and it is therefore worthwhile to examine the extent to which medical social work can contribute to its treatment.

The degree to which epilepsy has been and continues to be a social problem, has been greatly influenced by the folklore and superstitions which, for centuries, have been associated with it. Earliest historians speak of it as a "Sacred Disease ... a visitation of the gods". Its causes have been "explained" in terms of vapours, the influence of the moon, and the sexual
misbehaviour of the parents of persons subject to seizures and the patient himself. Prior to the first half of the 18th century, treatment consisted of remedies with a superstitious connotation. These included the genitals of seals, charms and amulets. Isolation of the patient was recommended since he was considered a menace to society and the family group. Isolation took the form of custodial care in mental institutions or special colonies. Despite the efforts of such men as Hippocrates (460-378 B.C.), Thomas Willis (1621-75), John Hughling Jackson (1835-1911), Hans Berger (-1941), and W.G. Lennox, to mention only a few of the great men who have contributed to the understanding of epilepsy, a great deal more is required to bring it out of the realm of mysticism and misconception, into the realm of normal and natural diseases. For then, and only then, can treatment of epilepsy be effective.

The seizure clinic is a nebulous term describing a project of the Vancouver General Hospital, in which a varied programme gradually evolved out of a growing concern for the total well-being of the person requiring treatment for epilepsy. Formerly, because of the numerous difficulties associated with this illness and the community's lack of readiness to assume responsibility toward the person with epilepsy, treatment at the Outpatients' Department of the Vancouver General Hospital was confined, primarily, to the administration of drugs by members of the medical profession. Although individual attempts were made by physicians to treat the social and psychological
handicaps of the illness, the organization of the seizure clinic in June 1950 was the first co-operative attempt in British Columbia to treat its numerous aspects. Through the efforts of three Vancouver physicians, who were associated with the neurology clinic of the Outpatients' Department, funds were obtained from a mental hygiene grant of the Federal Government to carry out the programme of the clinic. The grant provided for an electroencephalographic machine, a full time social worker, a stenographer and an occupational therapist who would both work half time. The objective of the programme was the "diagnosis, treatment and rehabilitation of patients referred". ¹ The function of the medical social worker was defined as follows:

Referral to the social worker will come from the doctors in the clinic. The worker will compile social histories by interviewing patients and their relatives. He will carry on education re the illness with families, employers and associates and work closely with the patient to influence his attitude toward his illness. ²

It is obvious from this that the clinic was founded on an acceptance of the psychosomatic approach and of the need for "teamwork" in the treatment of epilepsy. It is a clinic in which the profession of social work is considered an essential part of a comprehensive programme.

The Outpatients' Department of the Vancouver General Hospital provides medical treatment for those persons in the community, who cannot, through lack of financial resources, obtain medical care on a private basis. Each year, out-door

¹ and ² taken from minutes of one of the first organizational meetings held June 9, 1950.
medical treatment is provided for approximately 7000 patients who have met the eligibility requirements. Medical treatment is available to:

(a) a single person earning up to $100 per month.
(b) two persons earning up to $130 per month.
(c) three persons earning up to $150 per month.

Twenty-five dollars is allowed for each additional member of the family until a maximum income of $250.00 per month is reached. A family may have savings amounting to $500.00. Persons whose medical care can be provided through company medical schemes are ineligible for treatment at the Outpatients' Department. However, if treatment for a particular condition is not provided by the company plan, and the patient is otherwise eligible, treatment is available through the Outpatients' Department. Consideration is given to the patient's social situation in those instances where the income is just beyond the eligibility requirements.

Patients are referred to the Outpatients' Department by physicians in private practice. Patients referred by the social agencies of Vancouver are also accepted for treatment. The procedure of sending a patient through the department begins with an examination of the patient by an intern. The patient is then sent to the clinic which can best provide for his treatment. In addition to the volunteer efforts of physicians, service is provided by a paid staff of resident internes, graduate nurses, nurses' aides, social workers, pharmacists, dieticians, laboratory technicians, clerks and stenographers. The teaching programme for nurses, social workers, dieticians and technicians adds to
the service provided by the Outpatients' Department.

The Seizure Clinic is similar to, but in many respects different from the other clinics in the Outpatients' Department. It may use the facilities provided for all clinics, but in addition it possesses the resources made possible by the federal grant. Within the structure of the Health Centre for Children is a clinic providing treatment for children with epilepsy. Although this is not in theory considered a part of the seizure clinic, it is so in practice. The neurologist, the social worker and the stenographer from the seizure clinic have assumed a measure of responsibility in the clinic of neurology at the Health Centre for Children. An additional neurologist and neuro-surgeon volunteer their service to this clinic.

The neurology clinic, already established in the Outpatients' Department for the treatment of epilepsy, served as the foundation for the new clinic. Through trial and error, the reorganization of the clinic resulted in the following framework. The regular clinics in neurology are held one day a week in the Outpatients' Department and in the Health Centre for Children. A clinic in neuro-surgery is held each Saturday morning in the Outpatients' Department. During the first year of the clinic's operation, a case-conference type of clinic was held on Saturday mornings for the discussion of a patient whose problem was difficult.

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3 The Health Centre for Children provides out-door care for children up to the age of sixteen years. The eligibility rules which apply to the Outpatients' Department, also apply in the centre.
and whose medical investigation had been thorough. Although the patient was not present, he was informed, before the conference was held, that his problems would be discussed by a group who were interested in helping him. This group included the neurologist, the neuro-surgeon, the psychiatrist and the social worker from the seizure clinic. Also, any interne, physician, public health nurse or social worker in the community who was interested in the patient, could attend. The purpose of this conference was twofold. Through discussion an attempt was made to evaluate the medical, psychological and social factors in each situation. Following this, a suitable plan of treatment was outlined.

As the clinic progressed, the problems associated with the illness became more obvious. Consequently, innovations were gradually introduced. An educational meeting for parents and relatives of patients was initiated when it was recognized that no amount of direct help to patients could counteract the negative influence of unhealthy parental attitudes. Group discussions, as well as individual interviews, seemed to be the best solution to this problem. Out of these meetings came the suggestion that patients should also have the opportunity to meet and discuss their common problems. When several patients themselves expressed this desire, a "patient's group" was organized as an experiment. The purpose of this group was twofold: (a) to inform the members about their condition and the ways of meeting the problems associated with it, and (b) to provide the members with social contacts and recreational activities.
In summary, the Seizure Clinic seeks to provide for the total well-being of the person with epilepsy in the following ways:

(a) through the co-operative effort of every member of the clinic staff;

(b) through the establishment and supervision of a suitable medical regime in the clinics of neurology at the Outpatients' Department and the Health Centre for Children;

(c) through an evaluation of the patient's psychological and social situation, and suggested treatment for it;

(d) through an educational programme for patients, parents and interested members of the community.

Assuming that the function of the medical social worker is dependent upon the social and psychological problems peculiar to a particular illness, it is the purpose of this thesis to examine the role of the medical social worker in the treatment of epilepsy. In order to achieve this end, a group of case-histories were selected for analysis from the total case-load of the social worker associated with the Seizure Clinic. Of the entire group of patients referred to the social worker for various forms of help, sixteen were considered inappropriate for this study for two reasons. First, a number of patients fell into a group about whom little was known. The scantiness of the information seemed to be the result of the patient's failure to keep clinic appointments, his antagonism toward referral to the social worker, or his unexpected departure from Vancouver. The patients whose seizures were not diagnosed as epileptiform were also excluded from this study since their problems appeared to differ
from those associated with epilepsy. Apart from the sixteen cases which were not considered suitable, fifty-three cases were found to have sufficient detail to present a clear picture of the patient's social situation.

A preliminary exploration of the case-histories selected for this study revealed that the problems of the epileptic child differed from those of the epileptic adult. Also, the service rendered by the medical social worker, of necessity varied in accordance with the kinds of situations with which the patient required and requested help. For this reason, following a presentation of the medical aspects of epilepsy, the method planned is to depict the problems peculiar to an epileptic child and the help the medical social worker can provide (Chapter III). From this it is possible to analyze further the ways in which the medical social worker can be of help with the problems which the epileptic adult must face (Chapter IV). Finally, from the specific problems revealing themselves in the sample cases, conclusions can be drawn as to the way medical social work can participate in the treatment of epilepsy.
Chapter II

THE MEDICAL ASPECTS
OF EPILEPSY

Medical research still has a great deal to contribute to the understanding of epilepsy. Because of the lack of scientific evidence, there are numerous opinions regarding the nature of the illness, the factors to consider in establishing a diagnosis, the definition and classification of seizures and the appropriate measures to use in treatment. It is beyond the scope of this thesis to present in detail the various points of view or to evaluate the benefits of each. However, it is essential to have some basic knowledge of the medical aspects of epilepsy if the social implications of the illness are to be understood.

One writer on the subject, Dr. E.M. Bridge considers epilepsy, "less as a disease in the literal sense than as a symptom consisting of sudden and recurrent lapses of consciousness often associated with convulsive movements." He goes on: "The symptom results from a disturbance in the functional state of nerve cells within the brain, but the disturbance itself may be set in motion by a variety of diseases and by different types of factors in the individual." Dr. Bridge therefore, considers it necessary to

determine the relative importance of (a) heredity, (b) structural
defect, (c) physiological disturbances, (d) personality maladjust-
ments and environmental strains, in establishing a diagnosis of
epilepsy. If treatment is to be thorough, each of these factors must
be considered.

The importance of heredity in epilepsy has caused a great
deal of controversy and a great deal of unhappiness. In the past,
too much emphasis has been placed upon it. Research has shown
that, in some cases of epilepsy, the heredity factor is significant.
In others, it is of no significance. In still others, it is only
one of many factors warranting consideration. It is accepted by
the authorities in this field, that convulsive disorders are several
times more prevalent among the relatives of people with epilepsy
than among those of non-epileptic individuals. Dr. W.C. Lennox
estimated that the chance of an epileptic individual producing an
epileptic offspring is approximately one in forty. He also concluded
from an analysis of 675 electroencephalograms, made of twins both
normal and epileptic and of parents and other near relatives of
epileptics, "that epilepsy per se, is not inherited, but a predis-
position may be."\(^5\)

Brain injury is thought to be of significance in approxi-
mately fifty per cent of all cases of epilepsy. Organic damage to
the brain may result from injuries acquired before birth, at birth
or during the neonatal period, vascular occlusion, head trauma and

\(^5\) Lennox, William C., M.D., Marriage and Children for Epileptics,
Pamphlet reprinted from Human Fertility, Vol. 10, No. 4,
Dec. 1945.
other conditions and diseases. The latter group includes encephalitis, cerebral degenerative diseases, lead encephalopathy, abscess and tumor, and syphilis. It is thought that the dead nerve cells resulting from cerebral injury, or the scar tissue that replaces the cells, do not themselves become foci of abnormal disturbances. Rather, the living nerve cells around the scar tissue, which have been subject to abnormal conditions, are thought to become the centres of explosive discharges. Medical research has not as yet provided a comprehensive explanation for the irritability of cells, which results in bursts of electrical discharges and which manifest themselves in the form of an epileptic seizure.

Dr. Bridge uses the term "physiological factor" to describe a "variety of influences that affect the epilepsy by precipitating seizures or by augmenting the tendency toward convulsive types of reactions". Whereas the factors of heredity and brain injury are fixed in terms of their contribution to the causation, the physiological factors are of a fluctuating nature. Infection and fever, the onset of menstruation, the sleep cycle, disturbed fluid regulation, chronic fatigue, and emotional disturbances: all of these factors are considered in the category of fluctuating phenomena. Environmental pressures and personality maladjustments are also fluctuating factors. It is a well-accepted concept that the emotional status of the patient, his personality, and the pressures which are brought to bear upon him, in some instances not only influence the frequency of seizures but also precipitate their

As stated previously, there has been a great deal of controversy regarding the classification of the types of seizures. No one set of classifications is acceptable to all physicians interested in this particular aspect of the practice of medicine. The terminology of Dr. E.M. Bridge has been employed in the following description of seizures. The term "focal seizure" is descriptive of the seizure which is initiated in specific areas of the brain. The seizure usually begins in the same way with limited and specific portions of the brain involved. A generalized convulsion may or may not follow. The terms "essential epilepsy" or "idiopathic epilepsy" apply to seizures which have no consistent point of origin. This term indicates that it has been impossible to obtain evidence of structural damage to the brain. As a result of medical research, it is known that certain portions of the brain are responsible for specific bodily functions. Therefore, the portion or portions of the brain from which the electrical discharges burst forth, determine the form which the seizures take. The seizure may pass through several stages as the discharge spreads over various portions of the brain. The lobes of the brain with some explanation of the function of specific areas, are illustrated on page 13 (Diagram 1).

Many seizures, whether major or minor, begin with an "aura", or warning, of the approaching seizure. Some physicians consider it important, for purposes of treatment, to look upon the aura as a
Examples: (a) if the electrical discharges arise in the occipital area of the brain, the seizure begins with the patient seeing "lights dancing" or "flickering stars".

(b) if the electrical discharges arise in the upper portion of the temporal lobe, the patient may experience a sensation of sound altering, becoming further away or louder.

form of seizure. They believe that the patient who experiences warnings, but presents no clinical symptoms, should have his medication increased to the point where even the warnings no longer manifest themselves. The warnings indicate that there is abnormal electrical activity which must be suppressed if complete control of seizures is to be achieved. The aura may take various forms and is dependent upon the site of origin of the abnormal electrical discharge. The patient may have a vague feeling of fear, dizziness,
faintness, or sensitivity in certain areas of the body. Approximately fifty per cent of all major seizures begin with an aura. The patient loses consciousness and becomes rigid. During this tonic stage, because of contractions of muscles which force the air from his chest, the patient may utter the "epileptic cry". The rigidity changes to rapid jerking movements, which become progressively slower. Bleeding may result if the tongue is caught between tightly clenched jaws. Evacuation of the bladder or bowel may result during the initial spasm of muscles. For this same reason, interference in breathing may cause the patient to become a blue or ashen colour. An increase in the flow of saliva may occur during the seizure and when regular breathing begins again, the familiar "frothing at the mouth" appears. The patient gradually sinks into a relaxed state of exhaustion. Vomiting and headache frequently occur when the seizure has ended. Although the patient is usually lethargic or confused and wishes to sleep, occasionally he is able to carry on immediately after the seizure occurs.

The seizure just described is the one which the average person visualizes when the word "epilepsy" is mentioned. However, there are numerous other types of epileptic seizures. The following are the more common minor seizures which occur.

(a) **Petit mal seizures.** These consist of sudden periods of staring, lasting only a few seconds. If there are any muscular movements they are confined to twitching of the eyelids and face or mild rhythmical jerkings of the hands and arms.

(b) **Minor motor seizures.** These begin with rigidity, but no convulsive movements follow. Sometimes consciousness is only dulled. Confused and irrational actions may occur. When the seizure is over, there is likely to be a transient period of disorientation, dullness or headache.
(c) **Akinetic seizures.** These are characterized by a sudden loss of postural control. In young children, only the head and upper extremities are involved. If the entire body is affected, the patient suddenly falls and almost immediately gets up. If consciousness is lost, it is of very short duration.

(d) **Myoclonic seizures.** These are seizures in which single contractions of muscles occur without loss of consciousness. The patient has no awareness of the initiation of the contractions and no control over them... i.e. an arm may suddenly be jerked out to one side. The patient is aware of its occurrence but can do nothing to stop it.

(e) **Psychic equivalents** or so called **psychomotor attacks.** These are seizures in which the patient suddenly performs some highly co-ordinated but irrelevant action that ends abruptly without recollection.

To aid in the establishment of a diagnosis of epilepsy, the following diagnostic procedures may be carried out after a medical history has been obtained and a thorough neurological examination done.

(a) **X-ray of the skull.** These X-rays reveal any abnormalities in the development of the skull.

(b) **Subdural puncture.** In children, less than two years of age, who have convulsions, progressive enlargement of the head, and unexplained vomiting, one might suspect the presence of a blood clot between the brain and its coverings. The diagnosis is established by inserting a needle through the "soft spot" or fontanel of the baby's head and finding bloody fluid.

(c) **The electroencephalogram (E.E.G.).** This is a record of the electrical activity of the brain. It is used to determine the nature and possible cause of the seizures. Frequently it is helpful not only in determining the kind of medication which should be administered but also in deciding whether or not increases or decreases in medication are warranted.

(d) **Pneumo-encephalogram.** This is a surgical procedure used to determine the location and nature of conditions within the brain which may be causing seizures. It is used primarily to determine whether or not surgery is indicated.
(e) Lumbar puncture. Many organic diseases of the brain produce alteration in the composition of the spinal fluid, the examination of which may lead to a diagnosis, i.e. syphilis.

Following the establishment of a diagnosis, attempts are made to control the seizures with the use of various anti-convulsants.

(a) Bromides. These are effective in some patients who have only major seizures. With the advent of newer, more efficient medications, its use has gradually decreased.

(b) Phenobarbital. It is considered one of the most effective and cheapest of anti-convulsants. Its main disadvantage is that if taken in large doses, it may cause the patient to become extremely sleepy.

(c) Dilantin. It has proven quite successful, both alone and in combination with other drugs, in controlling seizures. The toxic reactions may take the form of unsteadiness, double vision, and inflammation of the gums. Dilantin and phenobarbital are considered to be the mainstay of medical treatment since they are the cheapest drugs and they have proven themselves to be the most effective in achieving control of major seizures.

(d) Mesantoin and thiahtoin. These are recent additions to the anti-convulsant drugs. Since these medicines have a tendency to impair the formation of white blood cells, monthly blood counts should be taken. Some patients develop rashes as a result of sensitivity to the medications.

(e) Tridione and paradione. These are effective in the control of petit mal seizures. The side reactions may take the form of "glare" and impairment of the formation of white blood cells.

(f) Phenurone. It is one of the most recent additions to the anti-convulsant drugs. It is thought to be useful in gaining control of psychomotor seizures. It should only be used with patients who can be closely observed for side reactions.

Surgical treatment of epilepsy is considered appropriate
for only a small portion of patients. If the seizures constitute a serious handicap and medical treatment has failed, surgery is then considered. However, it is undertaken only if the epileptogenic area is definitely localized and can be easily reached. If there is any possibility that excision might result in other neurological disabilities, surgery is not done unless failure to do so would jeopardize the patient's life.

Dr. Douglas T. Davidson, Jr., considers the following principles as basic in the medical treatment of epilepsy.

1. Half of the battle of therapy is enlisting and maintaining cooperation of the patient. First we explain to the patient or his parents that while a particular drug is very likely to be helpful in controlling his particular type of seizure, we cannot predict its efficacy with certainty, nor can we determine the exact dosage beforehand. We stress need for close teamwork between doctor and patient over a period of months in order to discover the best medicine or combination of medicines and the optimal dosage. We point out that many different drugs are available today, that a medicine which helps in nine cases may fail in the tenth, and especially that failure with one or more drugs may be followed by success with another drug.

2. Maintenance of fairly constant systematic drug levels, through divided doses and daily administration.

3. Abrupt withdrawal of anti-convulsant medication is avoided when possible because of the danger of precipitating status epilepticus or distressing increase in seizure frequency.

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7 Davidson, Douglas T., Jr., M.D., "New Light on an Old Disorder", Lectures delivered at Institutes on Epilepsy, Tampa and Miami, April 1950. Dr. Davidson practices at the Neurological Institute, the Children's Medical Center, Boston, Mass.

8 Status Epilepticus ... a term used to denote a continuing state of unconsciousness and convulsions. Consciousness may remain lost for hours or even days. There is danger that the patient may die from exhaustion unless radical measures are instituted.
4. When used, a given drug is given to the point of either completely controlling seizures or of producing toxic side effects. The therapeutic dose is only slightly lower than that which produces toxicity.

5. Any unpleasant reaction is to be considered and reported immediately.

Since the contribution of the medical social worker to the treatment of epilepsy is greatly influenced by the adequacy of medical treatment, to consider the physician's responsibility in the management of this illness, would seem to be important. It begins with the recognition that extensive neurological training is required if the illness is to be adequately treated. Much damage has been done by the physician whose lack of understanding of epilepsy has resulted in an attitude of "Too bad, but there is nothing which can be done for you." The physician who fails to recognize the illness and suggests to parents that the convulsion is due to "teething" or "worms", "which your child will outgrow", has done a great injustice to the patient and his parents. It is his responsibility to send the patient to the physician who uses modern procedures in establishing a diagnosis of epilepsy and in treating it. Undertaking surgery when necessary and supervising medications do not relieve the physician of his responsibility to the patient and his parents. Dr. Davidson, in his address already quoted, very effectively outlines the physicians responsibility to parents:

Accurate diagnosis and skilful prescription of antiepileptic medications are an excellent beginning in the treatment of the seized child, but we have additional responsibilities. The parents' concept of epilepsy almost invariably requires reorientation and correction.
They want desperately to know what to do when the child has a seizure. They need to be told repeatedly and in various ways that the term epilepsy refers only to the fact of recurrent seizures, that epilepsy may be present in grades of severity, that epilepsy is usually not complicated by mental defect or by insanity either at its onset or later in its course, that the prospect of a seizure ending fatally is infinitesimal, that the outlook is for a full normal life if the child is normally endowed at the onset of seizures, that time as well as medication tends to bring an end to the seizures, and that pleasant physical and mental activity is a vital part of the treatment.

The physician's responsibility to the patient is to a large degree determined by the age of the patient and the extent of his handicap. The very young child wants to feel that he is actually participating in the treatment, and not being manipulated by his parents and the doctor. A child's questions regarding his illness need to be answered thoughtfully and honestly, since understanding of, and preparation for problems associated with this illness are therapeutic measures essential to the prevention of unsatisfactory behaviour and attitudes in adulthood. The patient, whether a child or an adult, whose emotional balance is considered to be seriously disturbed, requires the help of a skilled psychiatrist.9

The adult patient wishes to believe that his physician is interested in him not merely as "another epileptic", but rather as an individual with his individual problems. An individual approach suggests that treatment then becomes an extremely time-consuming venture. Nevertheless, the patient whose seizures are

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9 It is beyond the scope of this thesis to present the psychodynamics of epilepsy or the psychiatric treatment of the seized patient.
eventually controlled, but whose emotional status is so unbalanced that he cannot accept the responsibilities of every day living, can hardly in the opinion of the writer, be classified as an example of success in the treatment of epilepsy. For this reason, the physician who is interested in the total well-being of the person with epilepsy recognizes that,

No single physician, no matter how well trained, is capable of possessing all the skills necessary for the physical, emotional and social needs of large numbers of epileptic children. Some are so well adjusted to life situations that simple attention to physical needs enables them to hurdle the more serious obstacles and thereafter to be self-sufficient and serene. In others this is not enough, and in still another group the physical aspects of the problem are only a minor part of the total. Who should be responsible for the study and treatment of the many complex situations that arise? Certainly the solution lies not with any one group but in a coordination of the efforts and abilities of all.11

There is evidence of the acceptance of this concept in the seizure clinic. With regard to the particular contribution of the medical social worker, the physicians have recognized the service which can in some cases be provided to those patients whose progress in medical treatment is influenced by social and psychological problems. In the chapters which follow, there are indications of the contribution which the physician can make to the treatment of social factors, just as there are indications of the contributions which the social worker can make to the medical treatment.

10 For the purpose of this thesis, "successful treatment of epilepsy" suggests that the patient has gained control of his seizures, is able to support himself and meet life's frustrations with a measure of calmness and objectivity.

A full and productive adulthood is the wish most parents have for their children. Satisfaction of a child's need for love and security, and encouragement in meeting the day-to-day problems of childhood, prepare him for the more demanding responsibilities of adulthood. For the seizured child, preparation for adulthood is a more complex task which few parents seem adequately prepared to assume. Frequently, their own fears and misconceptions regarding the illness, prevent their handicapped youngsters from satisfactorily proceeding through the necessary stages of emotional growth into mature adulthood. Therefore, help for the seizured child must be considered not only in terms of direct help to the patient, but of indirect help through his parents. In the present study, the case-histories of fourteen children reveals a typical range of the difficulties which epilepsy presents in childhood. Parental attitudes toward the Health Centre for Children, parental attitudes toward epilepsy and its treatment, and parental attitudes toward the seizured child, also fall into this group of general considerations.

It is well to remember that all the children selected for this study attend the Health Centre for Children, which, as
stated previously, has certain eligibility requirements. In other words, the parents of the fourteen children live within a very limited income. The extent to which financial stress influences parental attitudes toward handicapped children, is difficult to measure. However, it seems likely that concern over financial matters could add little to the general good humour and understanding of parents. Also, although attendance at an outpatients' clinic frees parents of the financial responsibility of the illness, many parents have adverse reactions toward accepting help from a "free clinic". Again, to measure the extent to which this influences parental attitudes toward medical treatment, is difficult. However, comments made by the parents of the children, suggest that it does in some instances, affect medical treatment. There are parents who feel that doctors who volunteer their time cannot be intensely interested in treating the children who come to the clinic. There are other parents who believe that because the service is free, their children are being used for experimental purposes. Many parents are unable to believe that trial and error is the only way in which the correct dosage for control of seizures can be determined. Also, there are parents who, because of pride, experience both guilt and resentment about having to accept free medical care. This expresses itself in their failure to keep clinic appointments and also in their attitude toward the unwell child. These points regarding the influence of parental attitudes resulting out of attendance at an out-door clinic, have been explained in order to make clear, that the impressions gained from an examination of case records of the patients who attend this
type of clinic, may not hold true for patients who receive treatment on a private basis. There is no question that many of the problems associated with epilepsy constitute a burden to all economic strata of society. However, certain aspects of the illness are probably more burdensome to the group of people in the lower income brackets.

Since the measuring of attitudes is difficult and cannot be completely objective, no definite conclusions have been reached regarding the attitude of parents toward epilepsy. However, from the comments made when parents were first referred to the medical social worker, impressions were formulated in terms of, (a) indifference toward the illness, (b) concern about it but acceptance of the responsibilities associated with it, and (c) complete rejection of the medical diagnosis and failure to assume responsibility in the treatment process. No attempt was made to discover the extent to which the parents were familiar with epilepsy prior to the onset of seizures in their own children, and it is therefore impossible to determine whether or not this has any bearing on their acceptance of the diagnosis. Of the six cases where there was known to be a history of epilepsy in near relatives, four of the parents seemed to be in category (c) with the remaining two cases in category (b). In the seven cases where there was no known history of epilepsy,

12 It is perhaps important to point out that the impressions of the writer are not entirely the result of an objective analysis of the case records of this study. Her opinions have been coloured by her experience as medical social worker in the seizure clinic for a period of seventeen months.
the number of parents in category (c) totalled four. Two parents seemed to be in category (b) and only one in category (a). In the fourteenth case, the patient's mother periodically experienced "fainting spells" which were considered hysterical rather than epileptiform in nature. In this case the parents were completely rejecting of the diagnosis. These figures indicate that in nine of the fourteen cases, the parents were not accepting of the diagnosis. Nor were they able to assume the responsibility of constructively participating in the treatment. The following cases are presented to illustrate the ways in which this revealed itself.

(a) Johnny is a 14 year old boy whose grand mal seizures began at the age of 7. From that time until he was almost 13, Johnny and his parents, in their search for a "quick cure", frequented the offices of numerous physicians and chiropractors. Treatment included inadequate supervision of anti-convulsant drugs, "pills from a doctor in Chicago", a most uninteresting and unpalatable diet, severe discipline and also chiropractic "adjustments". When the school nurse was finally able to convince Johnny's parents of the advisability of taking him to the Health Centre for Children, he was desperately in need of adequate medical treatment. Because of the frequency of his seizures and the instability of his home environment, Johnny was placed in the children's ward of the Vancouver General Hospital for a period of three weeks. With numerous changes in his medication, the number of seizures was reduced, but not completely stopped. When Johnny returned to his home, arrangements were made for him to be seen at regular intervals at the Health Centre for Children. His mother complained about the frequency of his appointments and the inconvenience it was causing her. His medicine was blamed for his aggressive behaviour and his "stupidity". Interviews with the mother seemed always to be directed toward discussion of her own illnesses and the effect of Johnny's illness upon her. The father did not appear particularly interested in the illness or its treatment.
This case illustrates the harm which can be done when parents do not receive adequate medical advice at the onset of the seizures, and consequently begin their search for treatment which will not label their child an epileptic. The emphasis placed upon the inconveniences caused by the illness indicates an inability or unwillingness on the part of the parents to constructively participate in treatment.

(b) Jimmy is a three year old youngster whose myoclonic seizures began at the age of one year. A year later, during a high fever caused by measles, he had his first generalized convulsion. Although the E.E.G. test was within normal limits, from the description given by the mother, the doctor concluded that the child had epilepsy and therefore prescribed regular doses of anti-convulsant drugs. The need for regular intake of the medication was explained to the mother who seemed quite willing to carry out the physician's advice. A month later, when Jimmy was again brought into the clinic by his mother, she asked the doctor if it was necessary for Jimmy to take the medicine since the E.E.G. test was normal. Further discussion revealed that her husband did not like to see the child taking medicine and labelled an "epileptic" if he really did not have epilepsy. She was reassured about this and it was suggested that the social worker visit the home for the purpose of explaining epilepsy and its treatment to the father.

The home visit revealed that Jimmy was an unhappy little boy who because of his negativistic behaviour, was considered by relatives to be somewhat strange. The father commented that he did not wish to have the youngster labelled an "epileptic" because, "the folks would then be able to say that they always knew there was something wrong with him". It was also learned during this visit that Jimmy's great grandmother, on his mother's side also had epilepsy. Following this visit, Jimmy's condition was again explained to the father by the physician. It seemed that he was more accepting of the diagnosis and also more willing for Jimmy to take the medication. However, several months later when Jimmy began stuttering, the parents reduced his medication and remarked to the doctor that they knew the medication was responsible for the stutter.
This case illustrates several interesting points regarding parental attitudes toward epilepsy. It should be mentioned that the relationship between mother and father appeared somewhat strained. The father, in indirect ways, seemed to be attributing the child's illness to the fact that there was a history of epilepsy on his wife's side of the family. His refusal to accept the diagnosis seemed associated with an idea that something was "wrong" with the child's intellectual ability. This is believed to be so by a large number of misinformed people. Many parents indicate their inability to accept the diagnosis by refusing to follow the physician's advice regarding medication and also by blaming the medication for a child's undesirable behaviour. This case clearly illustrates, that despite numerous reassurances and explanations by both social workers and physicians, many parents, because of their own inner conflicts cannot intelligently assume their responsibility in the treatment of epilepsy.

(c) Mary is a seven year old girl whose petit mal seizures began when she was four years of age. Prior to her attendance at the Health Centre for Children, she was treated in Toronto by persons apparently not allied with the medical profession. The mother, who states that she is a graduate in metaphysics and well informed in all phases of medicine, speaks of the child's former treatment in terms of "wave lengths", "bowel obstructions", and "unsuitable diet". Mary's seizures persisted until appropriate medication was prescribed. Although the mother frequently comments on the amount of medicine Mary is taking, she nevertheless feels obliged to follow the doctor's advice because she is able to see the benefits of the medicine.

In one of the group discussions, she commented that prior to her attendance at the clinic, she would not use the term "epilepsy" when discussing Mary's illness. She considered these episodes
"fainting spells", which were not at all similar to the epileptic seizures with which she was familiar.

Because this mother, in the opinion of the writer, is verging on a psychosis, it is perhaps inappropriate to use this case as an example of parental attitudes toward epilepsy. Nevertheless it illustrates the tendency on the part of parents to "shop" for treatment from anyone who will not label their child an epileptic. It is also an excellent example of how parents, in their refusal to accept the illness, will refuse to call it by its proper name.

(d) Teddy is a four year old youngster whose major seizures began two years ago. He is the youngest child and the only boy in a family of three children. There is a history of epilepsy on the father's side of the family and the father himself had "fainting spells" as a child. Teddy's seizures have been controlled for over a year. Because of this, his mother refuses to come into the clinic except to have the prescription refilled. She agrees to see the doctor only when she is told that the prescription will not be refilled unless Teddy is seen by a doctor.

On one of these occasions a referral was made to the medical social worker on the basis that the parents needed help in understanding epilepsy. When this was discussed with the mother, she very emphatically stated that she knew all there was to know about epilepsy and that as far as she was concerned her son was a well and healthy boy.

Since the amount of information available in this case is extremely brief, it is difficult to ascertain the reasons for the mother's attitude. The way in which she spoke about him as her only son, may in part explain her refusal to see the boy's handicap. The history of epilepsy in her husband's family may also be a
factor. In any event, this case clearly illustrates a refusal on the part of a parent to accept a diagnosis of epilepsy to the point where she cannot bring herself to see a physician or to openly discuss the illness. One might be inclined to think her tendency to consider her child entirely well, a positive quality, were it not for her obvious anxiety about his health.

In examining the attitudes of the parents toward these children, an attempt was made to discover the extent to which their attitudes were influenced by the illness. Six cases evidenced a pattern of parental over-protectiveness. In two cases, the illness seemed to foster parental feelings of dislike for the child. The attitudes of parents toward the remaining six children did not appear to be particularly influenced by the child's illness. Failure to detect evidence of the influence of the illness upon parental attitudes, in some instances was due to an incomplete picture of the family situation. In the opinion of the writer, these figures have little meaning because of the smallness of the numbers, the degree of subjectivity which of necessity enters into an evaluation of this sort, and the lack of scientific method available for measuring "attitudes". However, the individual situations promote interesting speculation regarding parental attitudes toward epileptic children.

Whether or not parental attitudes were classified as over-protective depended upon the answers to the following questions.

(1) Do the parents insist upon having the youngster within view at all times, regardless of the extent to which the seizures have been controlled?
(2) Do the parents restrict the activities which the physician feels the youngster can do? i.e. .... playing with other children, refusing to permit them to ride a bicycle, etc.

(3) Are the parents able to accept permanent separation from the child where institutional care has been recommended by the physician?

(4) Are the parents inclined to meet the child's every whim?

(5) Are the parents constantly looking for symptoms of ill health in the child?

The following cases are presented to illustrate the manner in which the parents revealed their overprotectiveness together with an explanation of the possible reasons for their attitude.

(a) Bobby is a six year old, mentally retarded youngster whose seizures began at the age of six months. He has not learned to play with other children and at present spends his time playing alone or with his parents. The parents are unable to recognize that Bobby will never be like other normal children and that the over-indulgent environment at home will make it more difficult for him to accept institutional care in the future. Because of the extent of his mental handicap it does not seem likely that other plans can be made for him.

Undoubtedly his being an only child in part explains the attitude of the parents. However, the fact that his condition is attributed to a birth injury and that his mother was almost forty years of age at the time of his birth, would seem to be of greater significance. Guilt feelings over pregnancy at that late date may enter into the total picture.

(b) Benny is a sixteen year old boy who is in the moron group of general intelligence. The seizures which first occurred at the age of fifteen are now controlled. He has been an "ailing" child since infancy. Benny lives with an alcoholic father and an over-indulgent step-mother. Placement in Woodland School has
been suggested to these parents, but they have not been able to accept it. Nor are they able to offer any suggestions regarding future plans for Benny. His existence at home consists of an irregular routine of eating, sleeping and "playing with the boys". He has been given no responsibility for household tasks. He is not able to find any form of employment. In the opinion of the mother he is not able to work because of his health. She considers him a "good boy", but finds his constant demands for money, somewhat of a problem.

The father's attitude of indifference seems to be the result of his concern with his own problems. Also, from his past behaviour, it seems likely that he is the type of person who refuses to face a difficult situation. The step-mother's attitude toward Benny seems to have been influenced by her status in her own family situation. She speaks of "also having been the 'black sheep' in the family". For this reason, she states that she appreciates how Benny feels. She speaks of the inadequacies in her marriage and it seems likely that caring for Benny is one of her few pleasures in life.

(c) Joan is a four-year-old child whose petit mal seizures began at the age of two. Previously, she was permitted to play with other children only if her elder brother was with her. Her mother is constantly watching for symptoms of a seizure. In many respects the mother's concern is on a reality basis, since she seems less anxious to have Joan by her side now that the number of seizures is diminishing.

(d) Jimmy has already been mentioned on page 25. Although he is permitted to play with other children, he must always be within close distance of either his mother or father. Since the onset

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Woodland School accepts persons whose mental ability is below average intelligence. Provision is made for formal education. However, more emphasis is placed upon education in the daily routines of living, in order that those who live there may be better able to care for themselves. Provision is also made for training in the various trades. These resources together with the recreational facilities provided, make for contentment on the part of a large portion of the school's population.
of the seizures, the parents have not spent an evening together away from home. Although he has not had a seizure in several months, they are fearful of him having a seizure in the presence of a strange baby-sitter.

The mother's attitude toward Jimmy suggests guilt feelings on her part. She states she found it difficult to be good to him because he was a "whiney, unattractive and difficult" child. The onset of the seizures seems to have brought her guilt feelings to the fore and in some ways she seems to be punishing herself by being excessively concerned about Jimmy. The history of epilepsy in her family may also be a determining factor. The father appears to be an immature person who is more concerned with what his parents will think about Jimmy, than he is with Jimmy's welfare.

In the two cases where the dislike for the children was quite obvious, there were indications that the illness alone did not initiate these feelings. In both cases the parents had numerous problems of their own and as a result considered the responsibility of the illness more than they could endure. In one case the mother expressed her rejection of the youngster by having her placed in the Crease Clinic. In the other case, institutional care was suggested to the parents, but they were not able to accept it. Their guilt resulting out of their rejection of him, seems to be the basis for their inability to make these plans. He remains at home, and is frequently reminded that he is a problem to his family and particularly his mother.

The parents of the children in the six remaining cases

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14 Crease Clinic ... is a treatment centre for mentally disturbed people who are considered to be likely to respond to psychiatric treatment within a period of four months. At the end of this time, the patient is either discharged or moved to the buildings within the Provincial Mental Hospital.
revealed attitudes which did not appear to be influenced by the child's illness. One mother speaks of her son as having the same qualities of character as her husband from whom she is separated. Penny, who is now six, is disliked by her foster mother, because she is now at the age where she is asking questions about her natural mother. The foster mother, who is the sister of the natural mother, resents this. She states that she can see all the negative qualities of her sister in Penny. Sherry's parents seem fond of her and interested in her progress. On the other hand, her mother, who herself comes from a broken home, is so concerned about raising well-behaved, obedient children, that at times her demands are most unreasonable. In two of the three remaining cases, the parental attitudes seemed reasonably healthy. In the third, the impression gained from one interview was one of indifference on the part of the mother.

In summary, it may be noted that in 57% of the cases studied, the attitudes of parents seemed to be specifically influenced by the child's illness. Parental overprotectiveness and dislike or rejection were the most noticeable qualities. The group in which the attitudes of parents did not appear to be particularly influenced by the illness, clearly illustrates the way in which personal problems influence parental attitudes. There can be no doubt that this factor is of importance in the other two groups as well. Because of the extent to which parental attitudes influence children, the attitudes of the parents of the children in this study have been discussed in quite some detail.
Let us now consider some of the problems which epilepsy presents to children within the specific categories of the pre-school child, the child attending school and the child of school age who is not attending school. These categories were selected since examination of the material revealed that although there were many problems common to all children who have epilepsy, nevertheless the difficulties of the children attending school were quite different from those which presented themselves to children who were not attending school.

The first category consists of a group of four children. It has not been possible to determine the feelings of the children toward their handicap. Only one child, who has akinetic seizures, questioned her mother about her illness. She wondered why she fell so much more than other children. With this group, parental attitudes seem to be the most important feature. Since this has already been discussed, no additional discussion is necessary.

The six children attending school range in age from six to sixteen years. Because there is great variety in the type of seizures and the measure of control achieved, the situations of the children present few similar qualities. The one common feature is that none of the children have expressed their feelings about their illness. Several attempts have been made to discuss epilepsy with the older children particularly, but as yet they have shown no interest in becoming familiar with it. This is probably of significance. It is difficult to determine whether this is the result of true disinterest, refusal to accept the fact
that they are handicapped, or a tendency on the part of parents
to instil in the children the feeling that it is an undesirable
topic of conversation. In two of the six cases the children each
attended the clinic once, thus preventing the establishment of a
relationship which could eventually lead to a discussion on
epilepsy with either the physician or the medical social worker.
Impressions of the school adjustment of the children were based
upon comments made by the parents, the children and in three
instances, the school teacher. None of the children mentioned
being teased by other children about their seizures. Only two
children seem to be happy and making satisfactory progress in
school. Little is known about Danny or Kenny who attended the
clinic on only one occasion. Danny did not seem to be happy either
at home or in school, but the reasons for this could not be
ascertained. Kenny just began attending school and seems to be
keeping up with the other children. However he cannot be con-
sidered happy in his school situation since he is backward about
participating in group activities. Penny, who is in grade six
and making average grades, does not like school because she feels
that the other children do not like her. She is not able to find
an explanation for this. Since she is an unhappy little girl who
expresses strong feelings of worthlessness, it is not surprising
that she feels this way about her school situation. The cases of
Mary and Tony shall be explained in greater detail because their
school experiences seem to have been influenced, to a marked
degree, by their medical condition.
(a) Mary began school at the age of six years. However, because of the frequency of her petit mal seizures, she was compelled to leave school only a few days after she began. The following year, she enrolled again, her seizures now well controlled. This time it was not her seizures, but her behaviour which presented a problem. Her attention span was brief and her work habits poor. Unless the teacher was at her elbow, she was unable to complete her assignments. The other children frequently complained to the teacher about Mary having hurt them. She was inclined to be rough with the children and at times enjoyed biting them. Finally she was placed in a special class where it was felt she would be able to receive the attention she craved. Ordinary, she would not be considered an appropriate candidate for a special class because her intellectual ability appears to be beyond that of most students in special classes.

It is difficult to ascertain how much of Mary's behaviour is due, either directly or indirectly, to her illness, and how much is the result of her mother's behaviour. Comments regarding the mental status of Mary's mother have been made on page 27. In any event, Mary continues to be a problem in school.

(b) Tony is a sixteen year old boy who is now taking his grade ten. He managed to complete his lower grades with a minimum of effort but is now experiencing difficulty. Recent tests indicated that his intellectual ability was slightly below the average. However, in the opinion of the writer, this does not entirely explain his present difficulty. This past year has been the first year, since the onset of psychomotor and petit mal seizures five years ago, that Tony has been free of seizures. Although he refuses to discuss his feelings about his illness, there is evidence that he resents it, particularly since he has a twin brother who is completely well. Also, because of his handicap, Tony's mother has set down more restrictions for him than for his brother. This may have intensified his feelings of resentment and also fostered inferiority feelings. It does not seem likely that any youngster can do his best at school when his inner feelings are in constant turmoil.

15 Special classes are provided in many of the Vancouver schools for children who are intellectually handicapped. The number of children in these classes is fewer than in the regular classroom and the curriculum is in line with their capabilities.
The group of children who are of school age, but are not attending school constitute a problem in terms of future planning for them. In each of the four cases, the parents have not been able to face this problem in a realistic manner. In one case placement in the Crease Clinic has served as a temporary measure. However, this type of care will not meet Janey's needs in the future. The three other children, in the opinions of the doctors, require institutional care. However, the parents prefer to delay placement in an institution until absolutely necessary. Johnny's case, which has already been discussed in some detail, shall be presented to illustrate the difficulties encountered in planning the future of a mentally handicapped youngster.

(a) Johnny, who is now fourteen years of age, has been out of school for a year. He was a problem to the teachers first because of the frequency of his seizures. Later, when control of seizures was achieved, he was a problem because of his inability to absorb the material presented to him in a special class. Also, his aggressive and uncontrolled behaviour caused them a great deal of concern. When Johnny, because of his size, outgrew the special class in the public school, it was decided that he did not have sufficient ability to go into the special class in the junior high schools. Therefore placement in Woodland School was discussed with the parents. They visited the school, and decided it was not the place for their son. At present, Johnny remains at home and helps his mother with the housework. Because of his

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16 This would seem an appropriate place to point out that of the fourteen children in this study, institutional care, because of mental retardation, has been recommended for only three children. This is not in keeping with the very common belief that all persons with epilepsy are suitable candidates for a mental institution or an institution for mentally retarded persons. The one child who was placed in a mental institution showed symptoms of mental illness prior to the onset of seizures.
childish behaviour, his father, who is a painter, is not attempting to teach him his own trade. He states that Johnny might destroy a "paint job" that had already been completed. He plans to find employment for him as a "truck loader when he is a few years older". Perhaps this is the answer, but with Johnny's need for constant supervision, one might be inclined to wonder.

Having examined the difficulties which epilepsy presents to the fourteen children and their parents, it seems appropriate to now consider the help provided for them. The following table is presented to indicate the kinds of referrals which were made to the medical social worker in the seizure clinic.

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social history requested</td>
<td>7</td>
</tr>
<tr>
<td>Interpretation of epilepsy to parents</td>
<td>4</td>
</tr>
<tr>
<td>Interpretation of epilepsy to patient</td>
<td>1</td>
</tr>
<tr>
<td>Help parents accept institutional care for patient</td>
<td>1</td>
</tr>
<tr>
<td>Help parents accept medical treatment</td>
<td>1</td>
</tr>
<tr>
<td>To familiarize the school teacher re patient's condition and the kind of help he required</td>
<td>1</td>
</tr>
<tr>
<td>Help mother in the disciplining of her child</td>
<td>1</td>
</tr>
</tbody>
</table>

Table I

The figures in this table, although insignificant in terms of numbers, nevertheless bring to light several interesting points. Note that the numbers do not add up to fourteen. In some instances, the physician stated more than one reason for requesting help for the patient. Note also that the largest number
of referrals was based upon a desire for information about the patient. This suggests that the medical social worker received most recognition as an "investigator". While this may have been true when the clinic first began, it is not so today. As the medical social worker gained knowledge of both the medical and sociological aspects of the illness, her function in the clinic gradually changed. Too, as the physicians became more familiar with the kinds of help provided by the medical social worker, there were changes in the nature of their referrals. Regardless of the type of request made, the help given depended upon the particular needs of the patient, the skill of the medical social worker, and the ability of the patient and his parents to use the service available.

Direct help to the children in the sample has been extremely limited. Some help is provided for the older children in meeting their environmental needs. Also, whenever possible, they are encouraged to discuss their feelings toward their handicap and any other problems they may have. However, because many adolescents are extremely secretive and suspicious of the motives of others, establishment of a case work relationship which would eventually lead to a discussion of attitudes and feelings, has been extremely slow. Also, the majority of the older children in this group are intellectually handicapped and could in all probability gain little from this type of discussion. Since young children are rarely able to verbalize their feelings, indirect methods must be used, both to discover their conflicts and to help
them with these. This can be accomplished in a play situation by a therapist who has been trained to understand the symbolism of a child's play. In some clinics, the therapist is a social worker whose training has been directed along these lines. Whenever this type of case work service is offered, provision is made for the social worker to consult with a psychiatrist who is equipped to guide the therapist. Following the establishment of a diagnosis of the child's conflicts, the therapist can, by means of play, help the child work through his difficulties. The social worker in the seizure clinic is not equipped to provide this type of help to emotionally disturbed children. Also, psychiatric consultation for play therapy is not available to the social worker. For these reasons the emphasis in working with these children has been directed toward relieving environmental pressures and modifying parental attitudes. Janey's case is an example of the type of help which has been provided for children.

(a) Janey was first brought to the Health Centre for Children by her elder sister who sought advice regarding Janey's seizures and also her "strange behaviour". The seizures which first appeared two years ago and had been controlled by phenobarbital, reappeared when Janey stopped taking her medication. She was described as a sullen youngster who refused to play with other children and who fabricated reasons for not leaving the house. She locked herself in the bathroom for three hours to avoid having to keep her clinic appointment. On several occasions as she and her sister travelled over one of the Vancouver bridges, she spoke of wanting to jump off the bridge. She could give no explanation for wanting to do this other than that she had an urge to do so. Following the initial examination, it was decided that Janey should be placed on the psychiatric ward for purposes of observation. It was at this point that a request for a social history came to the medical social worker. There followed a
succession of interviews with Janey, her sister, and both her parents.

It was learned that Janey, the second youngest of four daughters, was a product of a broken home. When she was approximately four years of age, her father joined the armed services and since that time has been absent from the home. Janey's mother is living in a common-law relationship with a man who has refused to accept the financial responsibility of the children. Since the two older daughters are married, Janey's mother has been able to provide for the necessities of the two younger daughters by holding a part time job. Janey's mother speaks quite freely about her preference for Janey's younger sister. She describes her as a more likeable, outgoing youngster who is less of a worry to her. She states that Janey has always been a strange child. When she was very young she refused to play with other children and spent much of her time playing in her own little world of make-believe. As she grew older, she continued to have difficulty in her relationships with others. The onset of seizures seemed to reinforce this pattern. She was in constant fear of having a seizure in the presence of others. She apparently stopped school for this same reason. The plan for her to help her mother with the housework did not prove satisfactory. Janey resented instruction but was not capable of carrying out her responsibilities without constant reminders. Most of her time was spent day-dreaming or reading comic books. Shortly before her admission to the hospital, she went to live with her older sister with the understanding that she was to help her with the housework.

Janey's three week stay in the hospital seemed to be a pleasurable experience for her. She made friends easily and at times was quite outgoing and aggressive. She seemed to thrive on the attention she was getting. There were few indications of her tendency to daydream, although the occupational therapist noticed that her attention span was brief. She seemed quite contented in her protected environment and continued her pattern of refusing to face the outside world. Upon discharge from the hospital, plans were made to have Janey placed in the Crease Clinic for a temporary period.

The medical social worker's contribution to the treatment programme for this patient took various forms with a minimum amount of direct help to Janey. The social history contributed to the doctor's
understanding of Janey's total situation. It was quite evident that there was no one in the family who could give her the understanding and help she required. Due to the lack of facilities in the hospital, the medical social worker acted as the resource person in arranging for psychological tests to be done at the Child Guidance Clinic. She acted as liaison between the hospital and the district social worker who was to do the follow-up of the case and see to it that plans for Janey's admission to the Grease Clinic were carried out.

Direct help was given to Janey on a superficial level. Discussions regarding admission to the hospital, the routine of the ward, the psychological tests, discharge plans and eventual placement in the Grease Clinic probably served a therapeutic purpose. The worker visited Janey frequently and took her out for walks on the hospital grounds. Her conversations consisted primarily of descriptions of her numerous, and probably make-believe, boyfriends. On only one occasion did she casually mention her feelings regarding her illness. She talked about it in connection with wanting to stay in bed in the mornings since most of her seizures occurred at that time. She added that she worried about having seizures in front of others. At this point the benefits of medication were explained to her with the intention of helping her realize that control of the seizures might help her overcome her fear of meeting people. Recognizing that the pattern existed prior to the onset of seizures, there is some question about her ability to benefit from this discussion.

During her entire stay in hospital, Janey failed to express her feelings toward her younger sister or her mother. She spoke of them only in pleasant terms and at times seemed to be fantasizing about her status in the home. It seemed impossible to establish anything other than a superficial relationship with her since she frequently appeared to be out of touch with reality. Although Janey enjoyed her stay in hospital, the extent to which she benefitted from her experience, other than to gain control of her seizures, is questionable.

Janey's case illustrates the way in which medical social work can provide a service which is indirectly beneficial to the patient. Background information of the patient's social situation
adds to the physician's understanding of the patient as a person, thus enabling him to use the psychosomatic approach not only in establishing a diagnosis, but also in carrying out treatment.

The medical social worker's awareness of community resources, provides another form of indirect help. In Janey's case, one agency in the community provided a service which helped establish a diagnosis, and a second agency contributed by seeing to it that the physician's recommendations were carried out. There are numerous examples in this sample, of agencies such as the Children's Aid Society, the Metropolitan Health Committee, and the Vocational School, contributing to the treatment programme of the children.

The medical social worker who is familiar with both the truths and also the common misconceptions regarding epilepsy can do much to modify parental attitudes toward it. The well-informed parent has fewer fears and as a result is more able to help the seized child develop healthy attitudes toward his handicap. In the seizure clinic, numerous methods have been employed to educate parents. Pamphlets, obtained from the National Epilepsy League of America, are distributed among the parents. Books are made available for their use. The following case illustrates how an epileptic child can benefit from increased understanding on the part of his parent.

(a) When Tony was first referred to the Health Center for Children for medical treatment, his mother was extremely concerned about his health. Since she was separated from her husband, the responsibility of the illness was hers alone. Although she seemed an intelligent woman, she believed that epilepsy appeared
in seven year cycles, and that once it appeared, nothing could be done until the seven years were completed. She was convinced the medication Tony was taking was harmful and she blamed it for his increasing difficulty in school. Because of the frequency of his attacks, she considered it necessary to restrict his activities. Tony was a most unhappy youngster. He was extremely quiet and shy in school, but acted out his hostile feelings at home.

As changes were made in the medication, the frequency of the seizures decreased and gradually stopped. Tony's mother then became more able to discuss his illness on an objective, rather than an emotional basis. She received an explanation of the different kinds of anti-convulsant drugs used in the treatment of epilepsy and the side reactions which could be expected. Changes in medication were explained both to Tony and to her. She was made to feel that her help was required in the treatment, and also that others were interested in helping her share the responsibility of her son's illness.

From the evening group discussions she learned how other parents felt about epilepsy. Some of her own fantastic beliefs, expressed by some members of the group, were discounted and ridiculed, not by the professional people present, but by other parents. The idea of treating Tony as a normal child was planted in her mind. Also, from comments made by parents, whose grown up children receive treatment for epilepsy, she recognized the importance of planning for his future.

As her understanding of epilepsy and its problems became clearer, her attitude toward Tony changed considerably. She is now trying to see him as a well child whose potentialities must be explored to the fullest in order to make up for his handicaps. Formerly, it was her ambition for him to enter the priesthood. For this reason she placed too much emphasis upon the attainment of marks which were beyond Tony's capabilities. The tension resulting out of this was a negative influence upon him. When the results of the psychological tests were explained to his mother, she commented that there did not seem to be any point in pushing Tony beyond his capabilities, and that it would be best to direct his training along the lines which were best suited for him.

In a recent conversation, Tony's mother commented on the change in his attitude. He is doing better work
in school and plans to continue for as long as he is able. He participates in numerous school activities, is less moody and appears to be happier in every way. It seems likely that the chances of happiness in adulthood for Tony, are greater now than when his mother first brought him to the Health Centre for Children.

From the material presented in this chapter, it may be concluded that the children in this study, have more than the average number of difficulties. There is evidence also, that their medical condition is not solely responsible for the extent of their problems. Financial insecurity, unsatisfactory relationships between parents, and parental ignorance of the basic needs of children may be contributing factors in this particular sample. In some instances, the illness presented difficulties in terms of parental attitudes toward epilepsy and the seizure child, parental attitudes regarding the acceptance of free medical treatment and also, ability of parents to intelligently participate in the treatment. Examination of the cases reveals that with help from the physician and the medical social worker, over prolonged periods of time, parental attitudes could be modified to the extent where some parents could probably contribute a great deal toward the achievement of happiness and maturity in adulthood, for the seized child.
Chapter IV

CAN THE MEDICAL SOCIAL WORKER HELP
THE ADULT WHO IS SUBJECT TO SEIZURES?

Is happiness, and maturity in meeting the responsibilities of adulthood a reality for the person with epilepsy? For many the answer is "no", for some "yes", and for others, "perhaps". Although there may be some truth in the current belief that persons with epilepsy are incapable of becoming and remaining worthwhile members of a community, examination of the social situations of the thirty-nine adults in this study, clearly illustrates that blanket statements regarding "epileptics per se", are not applicable. Indeed, because of the individualistic characteristics of the members of the group, attempts at analysis of clearly defined categories of patients proved unproductive. For this reason, this chapter is not to be a statistical study of the adults in this group, but rather a general description of problems which epilepsy presents to the adults who seek medical treatment at the seizure clinic of the Vancouver General Hospital. Also, because of this individualistic quality, no attempt has been made to present a statistical evaluation of the results obtained from the help provided by the medical social worker in the clinic. Again, with the help of case illustrations, the description is to be general.
Examination of the case material revealed that although there were problems common to all adults with epilepsy, those of the single persons differed in many respects from those of the married group. Therefore, the problems which epilepsy presents to adults shall be discussed in terms of these two categories.

Diagram 2

Diagram 2 indicates the marital status of both the men and women in the sample. Since 68% of the single persons in this group are between the ages of seventeen and thirty years, it is possible that a number will marry in the future. However, the statistics would probably still suggest that the largest portion of epileptic persons do not marry. Assuming that the women who are at present engaged to be married, shall marry, and the men who are separated from their wives are not likely to marry, the statistics indicate
that a higher percentage of men than women remain single.\(^{17}\)

Of the four men who are married, all but one developed epilepsy following marriage. In the case of the eight women, only one developed epilepsy following marriage. The financial aspects of marriage may be responsible for this. In our present society, the male is expected to assume the financial responsibilities of the household. Therefore, the handicapped male, who is in a constant dilemma about the permanency of his job, is unlikely to assume the responsibilities of marriage. The women, on the other hand, may see marriage as a solution to their employment problems. The placement officers of the National Employment Service have observed that men are more willing than women, to accept a fellow employee who has epilepsy. This suggests that men are less distressed by the sight of a seizure, than women. Whether or not this influences the development of social relationships which eventually lead to marriage, is difficult to ascertain. Prior to a discussion of the problems which epilepsy presents to the married person with epilepsy, let us examine the social situations of the single members of this group.

The single person encounters the greatest number of difficulties in terms of social relationships and employment. Parental attitudes have been discussed at great length in chapter three and therefore require no further elaboration. However, their

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\(^{17}\) The three single girls who are engaged to be married have been included in the group of married epileptic persons. Analysis of the cases indicated that the problems which epilepsy presents to them are similar to those of married persons whose seizures began prior to marriage.
influence upon the establishment of healthy attitudes toward employment and the development of social relationships must not be discounted. The child who has lived in an environment of overprotection and dependency, is ill-equipped, as an adult, to seek out friendships. Nor can he meet the frustrations of the business world. The child who is the product of a cold and rejecting environment, becomes a suspicious and antagonistic adult. His ability to accept the less desirable, as well as the desirable qualities of his friends, is limited. Failure on the part of friends to fall in with his way of thinking is immediately interpreted as an indication of their dislike for him. Also, this group experience difficulty in accepting direction from employers. Again, criticism is interpreted as an indication of dislike and unfairness. In short, the person who has lacked sympathy and understanding in childhood, seems unable to view the behaviour and motives of friends, fellow employees, and employers, on a realistic basis.

For the single persons in this study, difficulty in social relationships reveals itself in the following ways.

(a) The person spends all his time at home with his family because he feels that no one who knows about his handicap will want to be his friend. His attitude is frequently the result of former unpleasant experiences.

(b) The person establishes friendships but these are not lasting. He is somewhat negativistic with the result that few people want to carry on with the friendship. Also, because of his suspicion and impatience with others, he sees no point in continuing with the friendship. There is also the group of people who have not been in any one place long enough to acquire lasting friendships. Because
of employment difficulties, they are constantly on the move.

(c) The person is unable to share friends. Because of his difficulty in finding people who understand and accept him, he is inclined to "latch on" to the person who shows him friendliness. Frequently this leads to a dissolution of the friendship.

Although all of the twenty-eight persons appear to be experiencing difficulty in their social relationships, in ten cases, these difficulties do not appear to be particularly associated with their medical condition. For example, one boy who stutters severely, is extremely backward about placing himself in a situation where he will be meeting new people. Another member, who feels that her family is looked down upon by members of the small community in which she lives, refuses to make any attempts to seek new friendships. The implications of the illness seem less distressing to this group of ten patients, than to the remaining eighteen. There are those who are less inclined to concern themselves with their handicap because their seizures are now more or less controlled. Four persons are employed, and two remain at home. They each have their acquaintances, many of whom are unaware of the fact that they have epilepsy. The four whose seizures have not been as well controlled, do not appear to be particularly perturbed by the effect of their seizures upon either their social relationships or employment. The following case is illustrative of the patient who has made his own peculiar adjustment to his handicap.

(a) Mr. R, who is forty-four years of age has had epilepsy since infancy. Although his major seizures occur as frequently as four or five times a month, he is lax about taking his
medication. He also accepts alcohol whenever an acquaintance consents to buy him a drink. Twenty years ago, Mr. R. was told by the doctors in the Mayo Clinic at Rochester N.Y., there was nothing which could be done for him. It was suggested, according to Mr. R., that he limit his activities and plan not to work for the remainder of his life. Mr. R. has followed the advice of the doctors. Despite the fact that a greater measure of control of seizures has been achieved, Mr. R. is convinced that nothing can be done for him. Since his material needs are sparingly supplied by the social assistance cheque he receives, and his social needs seem to be met, Mr. R. is content.

Difficulties in social relationships seem to be more distressing to the remaining eighteen single persons. Some are unable to make any attempts in establishing social relationships. They have completely withdrawn from society. Another group can speak about their feeling of "not belonging", and following one or two unsuccessful attempts, refuse to exert themselves further. The third group consists of outgoing persons who made attempts to make friends, but are not liked by others because of their aggressive behaviour.

The first group consists of eight persons who are similar in only one respect. They seem to have adopted an attitude of, "Nobody likes me or wants to be my friend." The basis for this feeling seems quite different in each. A number of the persons in this group are mentally retarded and have as children, been subject to a great deal of teasing. Withdrawal is a suitable escape. Also, because of their intellectual handicap and the frequency of their seizures, parents have kept them close by their side. Consequently, they lack confidence in their ability to meet the outside world. One patient has completely withdrawn from reality
and lives in a fantasy world. Another two have been committed to the Provincial Mental Hospital in states of depression. The others remain at home, complain of their loneliness, but are unable to do anything about it. The following case describes the loneliness characteristic of this group of adults.

(a) Miss S. is an attractive twenty-six year old girl who was first introduced to the social worker approximately two years ago. At that time a request was made to help Miss S. find employment. Several months later, when Miss S. was brought into the hospital, having attempted suicide, greater effort was exerted in attempting to understand Miss S.'s total situation.

It was learned that Miss S. is the eldest child in a family of two. The other child is a boy, four years her junior. Her parents are elderly people who seem quite rigid in their ideas. Miss S. was a sickly child and as a result encouraged to remain close to home. Even prior to the onset of major seizures, at the age of thirteen, Miss S. had few friends. She was inclined to be backward and shy. Following the onset of seizures, some of her classmates considered her mad and resented her presence in school. However, she continued her studies, ranked in the upper half of the class and completed her grade eleven examinations. By this time a greater measure of control of seizures had been achieved.

The family then moved and Miss S. obtained a position as a salesclerk in a ladies' clothing store. Since she had a fairly lengthy warning prior to the onset of a seizure, she was able to remove herself to the back of the store on the rare occasions when a seizure occurred. Her employer, though sympathetic and understanding encouraged her to stop working and when the family moved again, seemed to welcome Miss S.'s departure. Miss S. then obtained a position as a clerk in one of the department stores. Several months later she was asked if she would like to work as a cashier. Miss S. was successful in this job and from her mother's description, seemed quite happy and content. Miss S. was free of seizures for three years when she stopped taking her medication upon the suggestion of a man who was living in their home. He said he was a herbalist and that the herbs he would give her would be less harmful to
her than the "dope" she was taking. They would also bring about a cure. Miss S. was at work when the first seizure in three years occurred. She was asked to give up her job.

Her medical condition was again soon under control. However, the damaging effect of this experience upon her personality development, could not be as easily repaired. As Miss S. experienced more and more difficulty in obtaining employment, she became more reluctant to apply for jobs. She became increasingly despondent and preferred to remain in her room, sewing or staring into space. Since she was convinced that no one liked her, she refused to go anywhere, where she might meet young people.

This case illustrates the difficulties in social relationships which are both directly and indirectly caused by an illness. With this girl, it seems likely that the illness merely increased the magnitude of an already existent problem. Parental attitudes have contributed much to this girl's present difficulties. The mother has been extremely overprotective and has unconsciously reinforced the idea that people are fearful of becoming friends with persons who have epilepsy. Encouragement in helping her overcome these feelings, would have been more constructive. The details of this case have been presented to illustrate many of the other problems associated with epilepsy. The negative influence of parental attitudes has already been mentioned. The damage done by Miss S.'s school experience cannot be discounted. Acceptance of one's school-mates and the feeling of being "one of the gang" is important to an adolescent girl. The effect of having to give up a job, despite one's capabilities, is distressing to a young girl. Heart-breaking also, is the fact that, regardless of their experience with this illness and the
success which has been achieved in medical treatment, both the parents and the patient are so willing to take the advice of any "quack" who offers them a "cure".

The second group of patients are those who seem to have expended more effort in establishing friendships, and have achieved a measure of success. However, they cannot be described as happy, contented, out-going persons. The following cases illustrate the difficulties in social relationships which this group meets.

(a) Miss X. is a twenty-seven year old girl whose seizures began in infancy. As a child she lived in an extremely protected, and at the same time, rejecting environment. Later, she spent several years in a mental institution because her parents, who were separated, refused to care for her. Following her discharge from the hospital, she came to Vancouver and since that time has held several jobs as a messenger girl. Periodically she loses her job because of seizures.

Miss X. cannot comfortably participate in group activities, because she feels "different". However, she does have one or two close friends. Since she has had little experience in establishing casual friendships, she tries too hard to acquire the friendship of the few people whom she thinks are accepting her. She states herself, that she does not like to share her friends.

(b) Miss L. is a twenty-seven year old Chinese girl whose seizures began at the age of sixteen years. Prior to the appearance of the seizures, Miss L. had poliomyelitis which left her with weakness in her left leg and hand. Although Miss L.'s seizures are now controlled, she is most concerned and ashamed of her illness. Her culture partly explains this. Epilepsy is viewed with horror by the Chinese people, who consider isolation and ostracism the only method of coping with it. Miss L. herself, has many superstitions about it. For example, she believes that anything or anyone who is associated with her is destined for destruction. She attributes the death of two of her teachers, to the fact that they took a sincere interest in her.
Miss L. is a most ambitious girl. Despite her handicaps, she has held a job as a clerk in a grocery store, studied her English public school grades by correspondence and is now taking a business course. She is kept busy working and studying and states that she has no time for recreation. However, she does have some friends and in the past has had several boyfriends, none of whom know about her epilepsy.

(c) Miss J., who is thirty-one years of age has had epilepsy since infancy and has been free of seizures for approximately two years. As a child she lived an extremely sheltered life and was not permitted to leave the home without being accompanied by a member of her family. As an adolescent she had no friends other than a former school teacher who was many years her senior.

In more recent years, as the frequency of seizures decreased, Miss J. was encouraged to seek the friendship of others. She joined several clubs, such as the Y.W.C.A. and the Weaver's Guild. Although she attended religiously, and people were pleasant, she acquired the friendship of none. She was looked upon as being different from the others. In her search for friendship, she began frequenting the neighborhood bowling alley and dance hall. She has made several acquaintances which her parents do not consider desirable. Although she is anxious to satisfy her need for social relationships, she distressed by the constant "nagging" of her parents.

The third group of persons who experience difficulty in social relationships are those who are not liked by others because of their aggressive, negativistic attitude. Mr. F.'s case is illustrative of this pattern.

(a) Mr. F. is now twenty-six years of age. His major seizures began at the age of six years, and although he has been free of seizures during fairly lengthy periods throughout his life, complete control of seizures has not been achieved. Mr. F. was subject to a great deal of teasing and abuse during his school years. He refused to attend school because of this, upon the completion of the fifth grade, He experienced rejection at home.
His immediate reaction to any form of frustration, took the form of a temper tantrum. This pattern persists and as a result Mr. F. has few friends. His attitude seems to be one of, "Nobody likes me or shows me any consideration; therefore, why should I be considerate of others."

The cases used to illustrate the difficulties encountered in social relationships, point out the individual quality of these difficulties. Although similar characteristics of withdrawing from society, or the development of negativistic attitudes may appear in a number of cases, the basis for the development of these patterns is rarely similar. Handicaps other than epilepsy, parental attitudes, experiences in school and employment, cultural patterns, and the type and frequency of seizures, all seem to be determining factors. The material suggests also that the older members of the group who have been subject to seizures for many years, have to a greater extent accepted their handicap and made an adjustment to it. The majority of the persons in this group nonetheless, are extremely unhappy about their lack of friends.

Employment for the epileptic persons in this group, constitutes a major problem. Of the twenty-eight single persons in the sample, only five have been fairly steadily employed. But even they have experienced periods of idleness during the past two years. A sixth person whose parents recently received money for oil rights, is now engaged in a business of her own. Eight people have worked spasmodically and thirteen have not worked at all during the past two years. The men who have been employed have had little training for specialized jobs. The majority have worked as labourers. Others have been employed as a hardware clerk, hotel
clerk, waiter, logger and porter on a boat. The positions of
factory worker, messenger girl, sales clerk, ward aid and house
maid, have been held by the women who have worked. In most
cases, dismissal accompanied the occurrence of a seizure. In
other situations, seasonal lay-offs, which are frequent in the
unskilled employment field, were responsible for the dismissal.
In some instances, dissatisfaction with the job, resulted in the
patient's refusal to continue with it. In the group of thirteen
patients, who have not worked during the past two years, ten do
not know what it means to work or to be financially independent.
A partial explanation for this is that nine of the ten patients
are intellectually handicapped. There are few facilities in
British Columbia, for the employment of mentally retarded persons.
Miss Y, the tenth person, is not intellectually handicapped, but
she does not have the use of her left side and has been treated
as an invalid for many years. Six of the ten persons are still
subject to frequent seizures. This has also been a determining
factor in their inability to undertake or find employment. The
three people who at one time experienced financial independence
are at present unemployed for reasons other than mental retard-
ation and frequency of seizures. One, due to a medical condition
other than epilepsy, is considered physically unfit for employment.
The second whose seizures are now controlled is so unsure of
himself, that he makes an unfavourable impression before employers.
In addition to his own efforts, the efforts of the National
Employment Service, have proven unproductive. The third case
presents an interesting employment problem.
(a) Mr. C. has been unemployed for a period of four years, following brain surgery done on an emergency basis. Shortly afterwards, the first seizure occurred. Mr. C. had previously held jobs as a clerk in a hotel and waiter in a beer-parlour. He was considered a capable employee.

At present Mr. C. receives social assistance amounting to $40.00 per month, lives in a third rate hotel, and eats most of his meals with his sisters. In many respects he seems quite content with his lot. He speaks of his fears of undertaking the kind of work he has always done, because of the risk of having seizures in public. Periodically, when he has been free of seizures for two or three months, he begins to wonder if he is well enough to undertake a job. On several such occasions, on his way to apply for a job, Mr. C. has had a seizure. The anxiety associated with employment seems to bring on seizures.

Examination of the employment experiences or lack of experience of this group of patients, indicates that a large number who are unemployed could work if given the opportunity. There are those who, because of their limited intellectual ability, the frequency of seizures, their lack of training, their feelings of insecurity in meeting the outside world and their lack of faith in their ability resulting out of repeated failures, cannot be employed in the regular labour market. These then, are the difficulties which epilepsy presents to the single persons seeking employment.

Prior to a discussion of the problems which epilepsy presents to married persons, perhaps a description of the feelings of the single persons toward marriage would be in order. A large number of both male and female patients express their desire to be married. The men, more than the women, speak of the improbability of this. Although they talk about wanting to marry and to
"settle down the way other people do", they cannot see themselves ever accomplishing this. Their inability to hold a steady job or to find a mate who will be understanding and accepting of their medical condition, are mentioned as hindering factors. It should perhaps again be noted, that the setting from which the patients for this study were selected, has influenced the nature of the sample. There would seem to be a preponderance of persons who are more likely to be unemployed, and less able to assume the responsibilities of marriage. The girls seem more hopeful about their chances of marriage, but there are some who wonder if it is fair to expect another person to share the responsibilities of their handicap. Those whose seizures are controlled, have the problem of deciding when and how to discuss their medical condition with members of the opposite sex who have shown an interest in them. Miss L., whose situation was described on page 53, had this problem to work out. Because of her understanding of the feelings of chinese people toward epilepsy, she decided not to inform her male friends about her illness and simply refused their proposals of marriage. Most of the patients with whom this point was discussed agree that the prospective mate must be informed, regardless of the risk of their refusal to accept the responsibility of the illness. In summary, it may be concluded that the majority of the single persons in this study would like to be married. However, some question its advisability and others seem to have accepted its improbability. Authorities in this field agree, that marriage for the person with epilepsy must be decided on an individual basis.
Examination of the case-histories of the married persons in this study suggested discussion of the difficulties which epilepsy presents to: (a) those persons who were subject to seizures prior to marriage, and (b) those persons whose seizures first appeared after marriage. The first group consists of eight persons and includes three single girls who are engaged to be married. There is only one man in this group. The second group consists of four persons and includes only one woman. The very fact that there is a preponderance of men in one group and of women in the second group suggests that the difficulties encountered by these two groups are in many respects dissimilar.

The mature persons in the first group probably realized that happiness and success in marriage was to a large extent dependent upon the attitude of the prospective mate, toward the handicap. Since the majority of persons in this group are women, let us consider some of the questions the epileptic woman might ask herself before deciding upon marriage with a particular person.

(1) What does my future mate know about epilepsy? What does he feel about it? Will the occurrence of a seizure be upsetting to him?

(2) Can he, and is he willing to assume the financial responsibility of my illness?

(3) What does he think about having children? Will he be fearful about taking the risk of producing an epileptic child? Does he consider my seizures sufficiently well controlled to enable me to care for a child?

Analysis of the case histories of the eight patients suggest that little discussion regarding the handicap occurred prior to the marriage. The following cases are presented to illustrate some of
the difficulties which can result out of this.

(a) Mrs. J. married an American soldier at the age of twenty-one years. She has been married for approximately three years and has lived steadily with her husband for less than a year, since his discharge from the army. Although she has not openly expressed dissatisfaction with her marriage, there are indications of unhappiness. Examination of her developmental history suggests that Mrs. J. was probably not ready to assume the responsibilities of marriage.

Mrs. J. is the second youngest of a family of four children who were raised by a widowed mother. There is a long history of illnesses in the family. At the age of thirteen, Mrs. J. developed epilepsy and because of the side reactions of her medicine stopped school at that time. She states that she remained at home, because of the frequency of seizures, during the greater part of her adolescence. Her mother was her chief companion. Occasionally, her young brother took her to a movie or a dance. As she approached her twenties, a greater measure of control of seizures was achieved and she was able to find a temporary job. She also made more attempts to mingle with young people. It was at this time that she met her husband.

Since Mrs. J. has not spoken about her reason for marrying her husband, there is no way of knowing this. The fact that she had few friends, the glamour of a uniform, the security of financial support, may have been determining factors. She speaks of her husband as an easy-going, cheerful, good-natured person. Her mother however, describes him as selfish and irresponsible. In her opinion he has indicated his irresponsibility in his handling of financial matters, his attitude toward her daughter's illness, and his behavior toward his child. She states that he has discussed plans for divorce with friends, but has not mentioned it to his wife.

Prior to the marriage, Mrs. J.'s illness was explained to Mr. J. by her doctor. Mr. J. indicated that, superficially at least, he understood and was willing to assume the responsibilities associated with it. Mrs. J. comments that the seizures, which now occur approximately once a month, do not seem to cause him any anxiety. However, Mrs. J. is herself quite disturbed about them because of the
difficulties she is encountering with her sixteen month old daughter. Since the child becomes most upset when a seizure occurs, Mrs. J. is anxiously awaiting the time when the child will be old enough to understand and accept an explanation of the illness. It seems possible that Mrs. J. feels guilty about having had a child since she arranged to be sterilized immediately after its birth. Her attitude toward the youngster is also suggestive of this. She worries excessively about the youngster's health and seems to need reassurance that she has not produced an imperfectly endowed child. There is no evidence to indicate that either Mr. or Mrs. Jones thought about the implications of the illness upon their offspring. Nor was too much thought given to the significance of the illness in relation to their own happiness.

Mrs. J. may have seen marriage as a solution to the difficulties she encountered as a single person. The extent to which this has proven successful is questionable. Since her husband's discharge from the army, he has not been able to find steady employment. Nor is he able to take her with him to the United States and thus benefit from the gratuities made available to him from his war experience. Immigration regulations prevent her entrance into the United States. Consequently, her search for financial security has not been met. Although she has the companionship of her husband, she has few friends. Her earlier experience has not taught her the art of getting along with others. Nor is her husband a particularly sociable person. She has the added responsibility of a child, who at times causes her a great deal of worry. Also, the sharing of responsibilities, which she probably expected in marriage has not materialized. She has therefore regressed to her former pattern of depending upon her mother. In short, marriage does not seem to have met Mrs. J.'s needs. She seems to have made little progress in her ability to meet the problems of adulthood.

(b) Mrs. I. who is now twenty-three, has had both major and minor seizures since she was ten years of age. She spent five years of her life in the Provincial Mental Hospital and when she was successful in escaping from the institution, she determined to marry. It should be noted that she was institutionalized because of her seizures and not her mental status.
Considering Mrs. I.'s background and her present emotional status, it seems likely that the only type of person to whom she would appeal, would be a person who was himself immature. Mrs. I. married a man who has had a "nervous breakdown". He has always had difficulty in obtaining employment and as a result cannot provide for the basic necessities of the household.

When Mrs. I.'s child was born, she stated she always wanted a child, "of my very own, so that I might give it the things I missed as a child". Because of the financial insecurity in the home, the immaturity of both the patient and her husband, and the frequency of Mrs. I.'s seizures, one would question the likelihood of any child obtaining the security which is its right. It seems probable that in this particular case, the patient has been intent upon meeting her own emotional needs with little consideration of the responsibilities of adulthood or parenthood.

More emphasis has been placed upon pointing out the implications of the illness to the three girls who are engaged to be married and the one girl who married within the last year. Miss F. who is engaged to be married has given some thought to the implications of her illness. Although there is no way of knowing how this will affect her marriage, it seems probable that the chances of happiness in marriage are greater for her than the two persons whose situations have been described.

(c) Miss F. has known her fiance for approximately a year and has been engaged for two months. She has not made definite plans for her marriage since she is waiting to see the measure of control which can be achieved with the new medication which is being tried. She and her fiance have discussed the financial responsibility of her illness and he feels that he is able to assume this responsibility. In discussing the advisability of having children they agreed that they wished to have children despite the risk of producing an epileptic child. They recognized that since her ability to look after a child would depend upon the frequency of her seizures, they would be wise to be sure about this before planning for a child.
Arrangements have been made for the fiance to discuss Miss F.'s condition with her physician and also for him to have an E.E.G. test. The results of the test will be helpful to the physician in advising them regarding having children. Miss F.'s fiance has read several books, and is planning to attend the evening meetings in order to familiarize himself with the facts about epilepsy. He seems fond of Miss F. and sincerely interested in doing what is best for her.

The material in this sample does not provide conclusive evidence regarding the advisability of marriage for persons with epilepsy. Financial problems are present in varying degrees in each of the eight cases. However, this is to be expected in this sample. Maturity and readiness to assume the responsibilities of marriage seems lacking in the majority of the members of the group. Consideration for the responsibilities associated with the illness seems also to be lacking. However, measuring the lot of the married epileptic persons against that of the single persons, it seems likely that the former group have achieved a greater degree of happiness.

The person who develops epilepsy following marriage, experiences the fears and prejudices well known to the single epileptic person. However, his problems are somewhat different. His mate is there in some cases to help share his difficulties and in others to magnify them. In the case of a man, meeting the

18 Persons who do not present clinical symptoms of seizures, may nevertheless have an abnormal E.E.G. tracing. Since both parents contribute to the inherent qualities of an offspring, it is advantageous to know whether both parents, or only one may be transmitting to the child, the predisposition to seizures.
financial responsibilities of an established household is a very real concern. The attitudes of children toward the handicapped parent can also be disturbing. The following cases are presented to illustrate these points.

(a) Mr. L., who is thirty-six years of age developed epilepsy at the age of twenty-seven. Prior to the development of seizures, he was employed as a civilian telegraphist in the R.C.A.F. Despite frequent petit mal seizures, he was able to carry on with his job for some time. However, when the major seizures began, he was compelled to give it up. Mr. L. has had extensive surgery since that time and as a result has a visual handicap in addition to the epilepsy. Obtaining employment has been most difficult. His wife holds a part-time job to supplement the help they obtain from Mr. L.'s parents.

Mr. L.'s wife is a sympathetic, understanding woman who has given her husband the encouragement and support he needs. Although he appreciates it, at the same time he resents the extent to which he must depend upon her.

(b) Mr. A., who is forty-six years of age, had his first seizure two years ago during a period of financial stress for the family. Since that time seizures have occurred only when he was worried, or when he let himself run out of medication. Although he has been free of seizures for a period of eight to nine months, he has not been able to find work. The family continues to receive social assistance.

The attitudes of Mrs. A. and the children have been detrimental to Mr. A.'s general feeling of well-being. Mrs. A. knows little about epilepsy and unfortunately is more prone to believe the folk-tales associated with it, than the truth. Both she and the children fear the seizures and have succeeded in making Mr. A. feel that he is a strange being who is not possessed of all his senses. In the past, Mrs. A. has insisted upon managing the affairs of the family. Consequently, Mr. A. who was basically a dependent person, depended upon her perhaps more than the average husband depends upon his wife. As a result, Mr. A. has found his wife's present attitude toward him distressing and beyond his comprehension.
Mr. B., thirteen years ago, at the age of thirty, had his first major epileptic seizure. He had been married for several years and had a three year old son. Having completed a university course in agronomy, he was employed as a school teacher in a small town in the interior of British Columbia. Since the seizures first appeared only at night, he was able to carry on with this job for several years. He was in constant fear that someone would find out about his illness. The first occurrence of a seizure in the class-room resulted in his discharge. From then on, a series of jobs and periodic dismissals followed. As the number of dismissals increased, Mr. B.'s personality became increasingly unpleasant. Consequently some of his dismissals were not the result of seizures, since there were times when he was free of seizures for a lengthy period, but rather his negativistic manner. The fear of discovery and also his feelings regarding taking jobs which he considered beneath him, in part explain his behaviour.

Mr. B.'s wife although understanding of her husband's illness, is quite naturally distressed about it. Prior to the birth of their second child, she was particularly anxious about the heredity aspect of the illness. At the age of three, the youngster had a seizure during an illness. Although disturbed by it, she refused to accept the possibility of a diagnosis of epilepsy. In addition to this worry, and concern about their financial insecurity, Mrs. B. has the added responsibility of explaining the implications of the illness to the children. They do not understand their father's frequent periods of irritability, or the reason why their parents live a restricted social life. They are constantly reminded of the influence of their behaviour upon their father's health. Consequently, the tension in the household seems to be at a high pitch at all times.

These three cases clearly illustrate the unhappiness which epilepsy brings to families. For some families, its appearance introduces serious problems. For others, it merely intensifies the seriousness of existing problems.

Presentation of the social situations of the single and married persons in this study, has indicated the magnitude and the
diversity of problems which present themselves to epileptic persons. The reactions of the members of this group to their handicap, is so varied, that it seems logical to assume that the help they are given must be provided on an individualistic basis. Examination of the kinds of requests for help which have come to the medical social worker in the seizure clinic, and the help provided verifies this assumption. Table 2 indicates the kinds of requests for help made to the medical social worker.

<table>
<thead>
<tr>
<th>Request</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social history requested</td>
<td>17</td>
</tr>
<tr>
<td>Help patient with emotional problems</td>
<td>12</td>
</tr>
<tr>
<td>Help patient find employment</td>
<td>8</td>
</tr>
<tr>
<td>Interpret epilepsy to parents or relatives</td>
<td>3</td>
</tr>
<tr>
<td>Help patient obtain financial help</td>
<td>2</td>
</tr>
<tr>
<td>Medical help for patient requested from social agency in the community</td>
<td>2</td>
</tr>
<tr>
<td>Follow up of patient upon discharge from hospital</td>
<td>2</td>
</tr>
<tr>
<td>Help patient accept medical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Help patient find recreational outlets</td>
<td>1</td>
</tr>
<tr>
<td>Help children understand parent's illness</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2

With this group of patients, as with the children, the greatest number of referrals were made in terms of requests for information about the patient. In many instances it served as the initial step in establishing a casework relationship which resulted
in the provision of various kinds of help to the patient. The emotional problems of the twelve patients for whom help was requested, were varied. Parental attitudes, feelings regarding the illness, and an unsatisfactory marital situation were frequently the reasons for the patient's anxiety. With this group, as with the children, help has been provided on the basis of the patient's need, the resources available to meet these needs, and the patient's ability to use the service available. The casework relationship with ten of the thirty-eight patients was concluded following the initial diagnostic interviews. It was decided that the service given had met the patient's immediate need and also that the patient could probably gain little from a continuing casework relationship. The extent of the patient's deterioration, his satisfaction with his situation, and the length of his illness were determining factors. Service to this group of people consisted of:

(a) Obtaining a social history for the use of the physician.

(b) Acting as liaison between agency in the community and the physician ... i.e. Children's Aid Society, National Employment Service, City Social Service Department.

(c) Arranging for patient's committal to the Provincial Mental Hospital ... discussing plans with relatives who were disturbed by the necessity of such planning.

(d) Enabling patient to verbalize his feelings about a specific problem which presented itself and helping decide upon the alternatives available to him in meeting the difficulty.

(e) Discussing epilepsy with patient's relatives, thus alleviating some of their anxieties about the patient's condition.

The following case is one which was followed by the
medical social worker, only long enough to establish a diagnosis of the patient's social situation.

(a) Mr. K., whose seizures began at the age of eighteen, is now forty-one years of age. He left home shortly after the onset of seizures and since that time has wandered. He states that he has to have a seizure about twice a year, "in order to relieve the pressure in my head." Well in advance, he is aware of when this is likely to occur and gives up his job to prevent having the seizure on the job. He is not conscientious about taking his medication and is reluctant to give up alcohol. He has been advised by the physician, that the seizures could be completely controlled if he could be co-operative about the medication and the alcohol.

Following several discussions with Mr. K., it was obvious that although he blames the seizures for having to constantly seek out new jobs, he works at a job only long enough to meet his immediate needs. He enjoys alcohol and also his wandering life. Control of seizures would necessitate changes in the pattern of life which he has established for himself. He does not seem prepared to do this at this stage of his life.

In this case, the medical social worker contributed to the treatment by bringing to the physician, information which increased his understanding of Mr. K.'s total situation. Since Mr. K. is quite content with the adjustment he has made to his handicap, it seems possible that efforts to control the seizures, would be more distressing to him than to let him have his seizures.

The following cases are presented to illustrate the variety of services made available to the remaining twenty-eight patients.

(a) Mr. B.'s situation is briefly described on page 65. The physician, in referring Mr. B. to the medical social worker, suggested that efforts be made to find employment for Mr. B. Following a two month waiting period, during which time Mr. B. was able to obtain temporary employment, he was finally placed in a job by the special placement division of the National Employment Service. Mr. B. was relieved to learn that although his employer was informed of his handicap, he was nevertheless
willing to accept him. Except for the initial interview, there were few opportunities to talk with Mr. B. since he was employed or busy seeking employment.

Mrs. B., who was taking her young daughter to the Health Centre for Children was interviewed on numerous occasions. She commented on the help she experienced out of being able to discuss her husband's illness with another person who seemed to understand. The few acquaintances they have, know nothing about her husband's illness. In the past she found herself telling "white lies" in order to be sure that no one found out about it. Because discussion of epilepsy is upsetting to Mr. B., she has kept her thoughts to herself. At times she felt the burdens of his illness were more than she could endure. On one occasion she commented that, "It is a nice feeling to know there are others who are interested and willing to share the responsibility with you."

Steady employment for Mr. B., attendance at the evening group meetings, together with the reassurance Mrs. B. obtained out of the discussions with the social worker, have brought about a change of attitude on the part of Mrs. B. She herself states, because she is less anxious about keeping her husband's illness a secret, and also about the possibility of her children developing epilepsy, the general atmosphere at home has improved.

In this case the medical social worker provided direct help to the patient by obtaining the service of an agency in the community. Indirectly, Mr. B. benefitted from the change in attitude on the part of his wife. Interviews with the social worker not only served to increase her understanding of epilepsy, but also to serve as a safety-valve for her pent-up feelings.

(b) Miss J.'s situation is described on page 54. When Miss J. was first introduced to the medical social worker, she was a withdrawn, and resentful person who was completely dominated by her family. Several interviews occurred before Miss J. felt sufficiently confident in the social worker to verbalize her feelings about her handicap and the protective attitude of her parents. She was encouraged to think of ways she might enable her parents to understand her need to be more independent. When an opportunity presented itself, the social worker explained to the parents how many
handicapped persons needed encouragement in trying to meet the problems of adulthood with limited help from others. She added that in chronic illness, patients were inclined to cling to others for support, because of their lack of confidence in their own ability. Throughout the months that followed, both Miss J. and her parents required reassurance about Miss J.'s attempts at independence.

Miss J. has become a different person. Formerly, she was withdrawn, subservient, and inwardly resentful. At present, she is outgoing, aggressive and at times openly hostile. In many respects she is a happier person. However, she requires help in meeting her difficulties with a greater measure of objectivity and calmness. Formerly, by remaining at home, she rarely had occasion to face an uncomfortable social situation. Now she must learn to cope with such a situation without becoming discouraged or openly hostile. Also, since her parents are elderly people who probably are limited in their ability to change, Miss J. requires help in deciding what concessions she will have to make if she is to live comfortably in their home.

This case illustrates the way in which the medical social worker, although providing little in the way of material or environmental help to persons with epilepsy, can nevertheless give them the encouragement and support necessary to help them help themselves. This particular patient benefited from the medical social worker's attempts to help the parents gain more understanding of the patient's needs. This case also illustrated how a long term relationship must be carried on if satisfactory changes in attitudes are to occur. Miss J. has gone from one extreme to the other and it may take months and perhaps years before she is able to adopt a "middle way".

(c) Miss F.'s plans for marriage are described on page 62.

A year ago, when Miss F. who had attempted suicide, was brought to the psychiatric ward of the hospital, her physician requested the medical social worker's help in obtaining the co-operation of both the patient and her parents. He had known them in private practice for approximately six years, and found it impossible to gain their intelligent participation in treatment.
The initial interviews with each of the parents was explained on the basis of wanting to discuss with them, the way in which the doctor, the medical social worker and they could help their daughter become a happier person. Discussion with the parents revealed the following information regarding the patient's background.

Miss F., the eldest of three daughters was raised in a home where tension arising out of an unsatisfactory marital adjustment, existed for many years. As a small child, Miss F. was considered very grown up for her years. She was extremely tidy about herself and extremely willing to help with the household tasks. Just before the onset of both major and minor seizures at the age of thirteen, Miss F. vowed that she would do nothing for anyone in the household. Both her parents were working and seemed to be depending upon her to do the house-cleaning. Miss F. felt that the mother favoured the sister, two years her junior. She was considered to be capable, attractive and more likeable. The tension existing in the home was magnified manyfold by the onset of Miss F.'s seizures.

Despite the attempts of the physician, neither Miss F. nor her parents could be convinced of the benefits derived out of the medication. The seizures persisted and Miss F. began experiencing more and more difficulty in school. Since the majority of her seizures were of the petit mal type, her teachers were not aware of her handicap. She preferred not to tell them anything about it. Finally following an argument with her school principal who was trying to discover the explanation for increasing difficulty, she decided to stop school. She then made several attempts to work, but was asked to leave after her first seizure occurred. The time she spent at home was devoted to listening to records, reading books or simply day-dreaming. She made fewer attempts to see her friends or to make new acquaintances. She became more and more convinced of her worthlessness and finally after a quarrel with her father, of whom she is extremely fond, she attempted suicide by taking an overdose of medication.

Miss F. had to first be convinced of the social worker's sincere interest in helping her, before she would permit herself to be anything but antagonistic. No attempts were made to impose
any sort of help upon her. It was not long before she was discussing her feelings regarding her illness, her parents, employment and social relationships. She could see herself as a liability rather than an asset to society and for this reason could see nothing but unhappiness for herself in the future. When her unpleasant past experiences were discussed at length, she was encouraged to think about the future. Discussion of the dissention between her parents, resulted in a realization on her part, there was little she could do about it, except to do her part in making the home as pleasant and comfortable as possible. Because the others were either working or going to school, she decided that she could contribute most by doing the house-keeping. This was to be her job until she could find employment out in the business world. Because the family was in financial stress, attendance at the Outpatient Clinic was discussed with Miss F. and her parents. Her own physician continued to see her on an outpatient basis. Relieving her parents of this obligation helped Miss F. feel that she was less a responsibility to her parents. Miss F. met some of the other girls who attend the clinic and in this way gained additional understanding of the way others adjusted to their handicap. She gradually realized that in some respects she was more fortunate than others.

When the group for patients was begun, Miss F. was keenly interested in its organization since she felt that girls like herself could gain a great deal by meeting and discussing common problems. She said she thought she could help other girls overcome some of the ideas she once had. As her understanding of epilepsy increased, she became more co-operative about taking her medication. This together with an increasing measure of happiness, resulted in a marked decrease in the frequency of petit mal seizures and complete control of major seizures. Despite Miss F.'s efforts, and that of the special placement division of the National Employment Service, suitable employment has not been found for her. This seems in part related to a lack of confidence in her ability to do the kind of work she would like to do, and her feeling that certain jobs are undesirable. However, she has decided to make every effort to find some form of employment prior to her marriage, to prove to herself that she can hold a job.

The medical social worker contributed to the treatment
programme for this patient by first helping the parents gain more understanding of their daughter's needs. Attendance at the evening meetings increased their understanding of epilepsy, and resulted in a greater willingness to participate in treatment. Mr. F., who at first was extremely antagonistic, periodically comments on the change in his daughter's outlook toward life. At one point he had commented that, "No doctor can tell me anything I don't know about epilepsy. I live with it twenty-four hours a day." It was he who suggested to Miss F.'s fiance that he discuss Miss F.'s condition with the doctor before their marriage. He also brought him to the evening meetings. The doctor, because of his understanding of the total family situation, has taken more time to explain the implications of the illness both to the patient and her parents. Consequently, success in treatment seems more likely than it was when Miss F. was first brought into the hospital.

This case suggests that medical social work can contribute to the treatment of epilepsy by:

(a) Gaining information for the doctor's use.

(b) Helping the patient express his feelings, thus enabling him to view situations more realistically.

(c) Giving the patient the encouragement and support he needs.

(d) Helping parents understand the illness and the patient in order that they might participate in treatment in a more intelligent manner.

(e) Giving the patient the environmental help he needs whenever community resources are available.

From the many cases illustrating the problems associated
with epilepsy, and the kind of help provided, it may be concluded that medical social work can help some epileptic persons achieve happiness and maturity in meeting the responsibilities of adulthood and in this way become and remain worthwhile members of their community.
MEDICAL SOCIAL WORK - AN ESSENTIAL FOR THE SUCCESSFUL TREATMENT OF EPILEPSY

Successful treatment of epilepsy, as previously described, "implies that the person subject to seizures has gained control of his seizures, is able to support himself and to meet life's frustrations with a measure of calmness and objectivity." (p. 20) The contribution of the social worker in achieving this goal lies in the relating of social factors to medical factors, and in the treatment of particular social problems associated with epilepsy. Basic to the exercise of medical social work in the treatment of epilepsy is, (a) knowledge of the medical aspects of the illness, (b) understanding of the social and psychological problems which the illness present, (c) knowledge of community resources which may be helpful to the patient and (d) skill in diagnosing the extent of the patient's difficulties and the kind of help he can best use.

No attempt has been made in this study to measure in statistical terms, the extent to which the medical social worker contributes to the successful treatment of epilepsy. For this reason, one might question the validity of the statement regarding the need of a medical social worker in a programme striving to achieve "success". The case histories which have been presented
give ample evidence. Given a fuller explanation of the terms "help" and "service", used so frequently in this thesis, little doubt can remain as to the contribution medical social work can make for that matter, not only in the treatment of epilepsy in the seizure clinic, but in any medical setting.

In epilepsy as in all illnesses, treatment of social factors is dependent upon the patient's medical condition. Therefore, the first responsibility of the medical social worker is to be aware of the patient's physical health and to work closely with the physician in enabling the patient to get the most out of medical treatment. The professional relationship between patient and social worker is different from that which exists between the patient and the physician. Society has placed the physician in an authoritative position; and regardless of the understanding displayed by the physician, many patients, and particularly those attending a "free clinic" are reluctant to question the physician about matters which are causing them concern. The social worker, whose status is much less authoritative, and who has more time to devote to the discussion of problems relating to the illness, frequently gains information which is helpful to the physician in carrying out the medical treatment. For example, the physician may in this way discover that a patient's negativistic attitude is the result of fears regarding routine tests, the diagnosis, medication or the prognosis. The physician can, by a simple explanation allay such fears, and therefore obtain greater co-operation from the patient. The patient in turn benefits more from the medical treatment.
The tendency on the part of several patients in the seizure clinic, to disregard the physician's advice regarding medication, is an excellent example of how lack of co-operation in treatment can be overcome when reasons for this pattern are understood. Only after a fairly lengthy period had elapsed, and patients were at last convinced of the social worker's sincere interest in helping them, would they verbalize their feelings regarding their handicap. At this time the reasons for this pattern became obvious. In some instances, neither the patient nor the parents could accept the diagnosis, and as a result saw no reason for taking the medication. Those patients who had previously attended chiropractors, and had been warned of the evils of "dope", had ambivalent feelings about taking medicine. Some patients had not been told that it was important to have a definite amount of medication in the blood stream at all times as a preventative against seizures, and therefore could not see the reason for regularity in taking the medication. Many patients did not understand the trial and error method involved in determining the amount of medication necessary to control seizures. Some felt that the physician did not know what he was doing and was merely experimenting with them. There were patients who were not aware of the newer medications available for the treatment of epilepsy and who, because of their earlier experiences with anticonvulsant drugs, were inclined to feel they were of little value. Marked improvement in attitudes toward medication was observed when explanations were made and reassurances given by the social worker and the physician who had become aware of the reasons for
the patients' delinquency.

The medical social worker, because of his relationship with the patient, has an excellent opportunity to give reassurance regarding medical treatment. Many patients, as well as relatives, expressed appreciation for having had the opportunity to talk with someone who appreciated their "mixed-up" feelings regarding treatment, permitted them to discuss these feelings, and at the same time reassured them about the future. For many, this was quite different from earlier experiences in their search for medical treatment of epilepsy.

Informing the physician of the patients' unwillingness to give up seizures - whether conscious or otherwise - is another way in which medical social work can contribute to medical treatment. Although most patients in the seizure clinic verbalized a desire for control of seizures, there were indications of fear as to what this would mean to some patients whose illness was of long standing. They had made their own peculiar adjustment to their handicap and control of seizures would mean giving up their dependency upon relatives and also the community. For the first time in their lives, they would be expected to behave in a manner befitting an adult. The physician's awareness of this fear in patients has resulted in concentration of effort upon the patients who were better able to use the service of the clinic. The others were permitted to "drift" in medical treatment until such time as they showed a more positive approach toward treatment. The physician also reinforced the social worker's efforts to enable
the persons who need their seizures, to see the benefits to be gained from independence. With encouragement and support, some patients are more able to give up seizures; and in this way they become more co-operative in medical treatment. All of these are ways in which medical social work can help patients receive the greatest benefit from medical treatment.

In addition to helping with medical treatment, medical social work is also concerned with the adjustment which patients make to their social situations. The case histories which have been presented illustrate the problems which epilepsy presents with regard to familial and social relationships, education and employment. The types of help given by the medical social worker in meeting these problems, have of necessity been influenced by the actual needs of patients, the kinds of help they seek, their ability to use casework treatment and the skill of the medical social worker. As stated previously both direct and indirect help have been given. For the children of this study, casework help has been primarily of an indirect nature. This has already been explained in terms of a lack of resources in using play therapy as a means of direct treatment of conflicts in children. Although casework methods employed in helping adult persons with epilepsy have been more direct, nevertheless it seems likely that the adults have also benefitted most from the indirect help given.

The following examples are presented to illustrate the methods of social casework as defined by Miss Florence Hollis.¹⁹

¹⁹ This and succeeding quotations are taken from - Hollis, Florence, "The Techniques of Casework," Journal of Social Casework, Family Service Association of America, June 1949, p. 235-244.
(a) **Modifying the environment.** This refers to "steps taken by the caseworker to change the environment in the client's favor by the worker's direct action ... It is undertaken by the caseworker only when environmental pressures upon the client are beyond the latter's control, but can be modified by the caseworker, or when such pressures are more likely to yield to change when handled by the worker than by the client himself."

In the seizure clinic, this method has been used a great deal, and particularly in relation to modifying the attitudes of parents toward epileptic offspring. The overprotective patterns of Miss J's parents have been modified to some extent as a result of the implementation of this method by the social worker (Chapter IV). Attempts to modify the environment by discussions with school teachers (Chapter III) and placement officers of the National Employment Service (Chapter IV) are other examples of this casework method.

(b) **Psychological support.** This is designed to "relieve anxiety and feelings of guilt, and to promote the client's confidence in his ability to handle his situation adequately. Also included in psychological support is the direct encouragement of attitudes that will enable the client to function more realistically as well as more comfortably."

This is achieved by "encouraging the client to talk freely and express his feelings about his situation; expressing sympathetic understanding of the client's feelings and acceptance of his behavior; indication of the caseworker's interest in the client, his desire to help; expression of the worker's confidence that a way can be found to improve the situation, confidence in the client's ability to solve his difficulty, to make his own decisions; indication of the worker's respect for and approval of steps the client has taken or is planning where these attitudes are realistically warranted."

Psychological support and also environmental support were
used by the social worker in helping Miss F. feel that life was worth living and that she could be an asset, rather than a liability to society (Chapter IV).

(c) **Clarification.** "The dominant note in clarification is understanding -- understanding by the client of himself, his environment, and/or people with whom he is associated ... This understanding may range in quality from a simple intellectual process of thinking through matters that are uncomplicated by strong emotion, to a deeper comprehension of attitudes and feelings of considerable emotional content."

"Sometimes the caseworker makes direct interpretations concerning the effect or significance of the client's actions or reactions or of those of others with whom he is associated. More often, the worker merely asks questions or comments on inconsistencies and inappropriate emotions. Always the effort is to help the client to think more clearly, to react more realistically, and to plan more wisely."

This method has not been used extensively by the social worker in the seizure clinic. Only a small number of patients seemed to have the ability or the desire for this understanding. However it was used with Miss F. (Chapter IV) and also Miss L. (Chapter IV) who, as a result have been able to see their situations more realistically and to plan more wisely.

In attempting to help Miss I. whose case was presented in part, this method was used but without success. Although Miss I. verbalized a desire to gain understanding of herself and the reasons for difficulties in interpersonal relationships and employment, the understanding gained has been purely on an intellectual level. She does not seem to have the ability to use the understanding gained, in coping with the frustrations she meets.
(d) **Insight.** "Insight development involves carrying understanding to a deeper level than that described in clarification."

"To achieve insight, current and past emotions must be relived in a therapeutic atmosphere in order that some of the affect may be discharged and in order that irrationalities may be brought so clearly to the surface that they can be recognized, at first in the safety of the treatment situation and later in real life. ..... the purpose of this development of insight is to increase the client's understanding of himself and his situation so that he can manage his life more realistically, with less anxiety and hostility, and less use of destructive defence mechanisms."

This method of social casework has only on rare occasions been used in the seizure clinic. A lack of desire on the part of patients for this deeper understanding of themselves, lack of skill on the part of the medical social worker, and the absence of psychiatric consultation are the reasons for this.

Examination of the problems which epilepsy presents to the persons in this study, and analysis of the help provided by the medical social worker associated with the clinic have resulted in the following conclusions regarding the role of the medical social worker in the treatment of epilepsy:

(a) The medical social worker has a contribution to make in helping the physician understand the patient's social situation as it affects his medical condition and his attitude toward medical treatment.

(b) The medical social worker can do much to help patients obtain the greatest benefit from medical treatment by correcting misconceptions toward the illness, by alleviating anxiety regarding treatment, and by encouraging patients regarding the future.

(c) The medical social worker has a responsibility in helping parents develop healthy attitudes toward handicapped offspring. Since people are less fearful of those things which they understand, giving parents
an understanding of epilepsy, is the first step toward the development of healthy attitudes in parents. Making them feel that the social worker and the physician are willing to share some of the responsibilities of the illness, decreases their burden with the result that they are more able to give the child the necessary encouragement and support.

It is essential, if difficulty in adulthood is to be minimized, to encourage parents to permit children to participate in most of the activities which are pleasurable to children who are not handicapped by seizures. Parents need help in realizing that overindulgence and overprotection can be as handicapping to a child as epileptic seizures. The parent who is well-informed regarding epilepsy, who does not fear it yet recognizes the problems which it presents, can do much to help a handicapped child develop healthy attitudes which will enable him to meet the responsibilities of adulthood with maturity.

(d) The medical social worker can contribute to the total well-being of the adult patient, by helping him understand and accept his diagnosis. Establishment of a warm and friendly relationship may help the patient first to verbalize his anxiety and his fears; and, in some cases, may eventually result in greater understanding of himself and his reality situation. Reduction of environmental pressures and inner conflicts may result in a decrease of the frequency of seizures.

(e) The medical social worker has a responsibility, not only in being aware of community resources, but also in familiarizing the community with the facts regarding epilepsy. The stigma associated with this illness can only be overcome, when it is better understood.

In conclusion, a few comments must be made regarding the function of the medical social worker in the particular setting of this study. The cases presented suggest that the majority of persons in this study have more difficulties than might be expected from patients who seek medical treatment from physicians in private practice. For them, attempting to meet the immediate needs of
food, shelter and employment is one of the major responsibilities of the social worker. Unfortunately, there are few community resources in Vancouver which can be used for these purposes. Perhaps, therefore, the social worker can provide the greatest service to the patients of this clinic, by striving to establish an educational programme about epilepsy. It seems likely that attempts at rehabilitation of persons subject to seizures will prove unproductive until the community becomes aware of the difficulties of this illness, the truths about its nature, and the success which can be achieved in medical treatment. For the majority of the adults referred to in this study, it seems likely that the chances of successful treatment are very small. For this reason it is the opinion of the writer that the greatest emphasis should be placed upon the treatment of both medical and social ills of the children. Early control of seizures, together with the development of healthy attitudes toward the handicap, will undoubtedly result in fewer difficulties in adulthood.

It was the wider purpose of this thesis to throw light on the function of the medical social worker in the treatment of epilepsy. Although cases were selected from a specific setting, there can no longer be any doubt as to the contribution medical social work can make to the treatment of epilepsy in any setting. Undoubtedly, epilepsy must be considered a social problem as well as a medical problem; and the combined efforts of many professional and lay persons will be needed if the many men and women subject to seizures are to become and remain useful members of the communities in which they live.
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