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The use of alcohol by patients with epilepsy as this affects their social treatment and rehabilitation.

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Boston University
THE USE OF ALCOHOL BY PATIENTS WITH EPILEPSY
AS THIS AFFECTS THEIR SOCIAL TREATMENT AND
REHABILITATION

A thesis

Submitted by
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In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1955
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CHAPTER I

INTRODUCTION

Purpose

This study has grown out of an interest in the extent to which the use of alcohol interferes with the social treatment and rehabilitation of patients with epilepsy.

Epileptic patients are advised to abstain from alcoholic beverages as part of their program to help control seizures. However, some patients claim to find release from emotional tension by the use of alcohol, thus hindering their recovery. It is also advised that the patients keep alert physically and mentally since activity itself wards off seizures. There is no "personality type" prone to alcoholism or epilepsy but a low toleration of tension is characteristic of the first while the social environment of the second tends to be tension producing.

It is the purpose of this study to answer the following questions about a group of epileptic patients whose rehabilitation was complicated by their use of alcohol.

1. In what areas and to what extent do these patients experience tensions?

2. What is the pattern of use of alcohol for these patients, and how is it related to the tensions they experience?
3. What is the role of the social worker with patients whose rehabilitation is hampered by the use of alcohol?

Scope and Method

The subjects studied included sixteen patients of the National Veterans Epilepsy Center of the Boston Veterans Hospital. All social service cases active in the unit in 1953 were reviewed. All patients having an alcoholic problem mentioned in the social service records were identified. Among these only patients within the normal range of intelligence and with a primary diagnosis of epilepsy were chosen for the study. They were without psychosis and were not considered to be neuro-psychiatric patients. None had other physical diseases and only five had a secondary diagnosis of alcoholism. Three had been treated at the National Veterans Epilepsy Center at Cushing Veterans Administration Hospital previously and had been transferred from Cushing Veterans Administration Hospital to the Boston Veterans Administration Hospital for medical and social service follow-up studies. Thirteen were referred for social histories for diagnostic purposes or for help regarding vocational rehabilitation.

Information was taken from medical and psychological reports as well as from social service case summaries. A schedule was used in reading the cases on which information pertinent to this study was recorded. (See schedule in
appendix.)

**Limitations**

The 1953 contacts with social service were limited to two or three interviews. These were geared to the purpose for which referral was made, for the most part diagnostic, and therefore were sometimes limited in information pertinent to this study.

Except in the five cases of a medical diagnosis of chronic alcoholism the ratings of symptomatic drinking and the phases of addiction are the writer's own based on material presented in the records. Therefore in this aspect the study is limited by the writer's reliance on case recording rather than direct contact with the patients.

The discussion of the use of alcohol is limited to the emotional and social aspects. The physiological effects of alcohol on epileptic patients is beyond the scope of this study.

The results of this study are applicable only to the epileptic patients who had a problem with alcohol and who were referred to social service at the Boston Veterans Hospital during one year. While the findings fit this specific group in this particular setting they include some general ideas and leads on which further studies can be based.
CHAPTER II

THE SETTING

Boston Veterans Administration Hospital

On July 27, 1952, the Boston Veterans Administration Hospital was formally dedicated to the care and treatment of the veterans of all wars who live in the Boston area. To this end many organizational units merged into the three important functions of any general hospital for the general medical and surgical treatment of the sick: service to the sick, education of all those engaged in medical and allied activities, and research.

To meet the eligibility requirements for hospitalization, the veteran patient's disability or illness may be either service connected or non-service connected provided that he was honorably discharged from the armed forces of the United States. Patients having a service connected disability are given priority over non-service connected patients who are granted admission according to their signed statement of their inability to pay for similar services and treatment elsewhere. The veteran with a non-service con-

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1 The information for this chapter has been compiled and condensed from agency manuals, discussions with the Chief of Social Service and doctors in the National Veterans Epilepsy Center.
nected condition is not eligible for outpatient care through the Veterans Administration.

It was necessary to put the Boston Veterans Administration Hospital into active use as rapidly as possible because of the closing of the West Roxbury Veterans Administration Hospital as a general hospital and the reduction of beds at Cushing General Hospital preparatory to transfer of that unit from the Veterans Administration to the Department of Defense. To this end the majority of staff was drawn from the West Roxbury and Cushing Hospitals and combined with other professional and lay personnel so that a large number of patients could be adequately handled.

The 923 bed hospital is staffed by 1200 employees, approximately fifty of whom are engaged in special medical research programs, the remainder directly concerned with the care and treatment of patients and the administration of the services of the hospital. These services include the following: medical, surgical, neuropsychiatric (with special aphasia and epilepsy centers), physical medicine and rehabilitation, radiology, nursing, dietetic, dental, special services and social service.

Each service is supervised by a chief of that unit who is, in turn, responsible to the Chief of Professional Services who is directly responsible to the Manager. The individual professional services are co-ordinated to function as a well
integrated single hospital. The two services considered in this study are the National Veterans Epilepsy Center and the social service department.

**National Veterans Epilepsy Center**

In 1947 at the Cushing Veterans Administration Hospital in Framingham the epilepsy unit was established under a government grant which provided for a center for research into the causes and treatment of epilepsy; prognosis, treatment, and rehabilitation of veteran epileptic patients; and the nationwide education of all those who might be concerned with the handling of epileptic veterans so that they might receive the benefit of the best medical care available.

The unit at the Boston Veterans Administration Hospital carries on the tradition started at Cushing. It accommodates thirty-six ward beds and an out-patient clinic for approximately one-hundred and fifty patients. Patients may be transferred from any part of the country for study, diagnosis and treatment if adequate diagnosis or control of seizures has not been established in other hospitals.

There is an extensive research laboratory headed by persons who are studying not only the problems of veteran patients but are carrying on research. Problems under study include diagnostic methods and treatment techniques including various drugs, and fundamental research in the basic physiology of convulsive seizures. The veteran patients have the
advantage of the best that is known about this disease from experts who are in the forefront of knowledge. The unit is supervised by the chief neurologist. Other neurologists, neuro-surgeons and psychologists who are expert in the study of epilepsy comprise the unit which also has the services of a psychiatrist and a social worker. Dr. Lennox, one of the leading authorities on the subject of convulsive seizures, is a consultant who visits the unit regularly to help at case presentations.

A social service worker is a member of the team. She aids the doctor by obtaining social histories for diagnostic purposes and she assists the patient to make full use of the rehabilitation and vocational counseling services available to him.

Social Service Department

At the Boston Veterans Administration Hospital the social service department consists of a chief, a psychiatric and a medical case work supervisor, four psychiatric case workers, four medical case workers, four psychiatric case work students, three medical case work students, two secretaries and two clerical volunteers.

The department has four major functions: 1) direct case work with the patients and/or their families; 2) teaching (formal and informal) to members of other disciplines and to
social work trainees; 3) participation in hospital administration and policy making; and 4) participation in research projects.

The direct case work with the patients is focused on helping the patient with those emotional and social problems which his illness creates for him and with the obstacles which prevent him from deriving the greatest help from medical treatment and the hospital experience. Every patient may take advantage of the services given by the department. Each full time worker is responsible for all referrals on her own ward. These may come from many different sources, principally from the physician on the ward, the nurses, therapists, relatives or friends and from the patient himself.

In responding to referrals the social worker's main areas of work include: helping the patient and/or family accept his illness, helping the patient to express his feelings about problems with the idea of reaching a better solution, obtaining background material to aid the doctor in his diagnosis, evaluating the family's attitudes regarding the patient's illness, discharge planning including use of community resources such as the visiting nurse, medical and psychiatric clinics, nursing homes, public and private agencies.

Regardless of the source of the referral the worker confers with the ward doctor in making any plans with or for
the patient. The team approach is used in the treatment of the patient. Ward conferences, medical-social ward rounds and informal meetings with other members of the team are means used to help the different disciplines work together for the best interests of the patient.

These same medical-social ward rounds and other types of conferences at which the various clinicians participate provide good opportunities for the social worker to practice her second function, that of teaching. This particular teaching is in no way formal but is rather a means of interpreting the role of the social worker to the other professions as well as an opportunity to discuss the social implications of the illness being discussed and the social service problem which the illness creates for the patient. When asked, the department assists in the formal teaching of other professional groups, such as nurses, psychologists, etc.

The training program for student social workers includes students from two schools of social work in the vicinity. The students participate fully in the various training programs of the hospital and are given orientation and training by the chiefs of the various hospital departments and services. They are supervised weekly by case workers in their special sequence (medical or psychiatric) and have the opportunity to carry cases on both medical and psychiatric wards. They have special weekly psychiatric consultation to help
them better understand the dynamics of their patients. They present cases at staff conferences and have weekly group meetings with the Chief of Social Service.

For administration and policy making there are regular staff conferences held with the chief acting as liaison person between the social service staff and the hospital management. She attends regular meetings with other department chiefs and is responsible for communication between the Chief of Professional Services and her department.

The last function of the department includes sharing in research projects. This may be done by evaluating various methods of social service, types of referrals or by reviewing various aspects of the social work program. This research may also be done in conjunction with the medical staff. An example of this was the intensive five year study started by the staff of the National Veterans Epilepsy Center at Cushing Hospital and continued at the Boston Veterans Administration Hospital.

Each department and service of the hospital acts on the principle of the "patient as a person" and every effort is made to see that the veteran patient receives the best possible comprehensive medical care.

A more comprehensive treatment of the role of the social worker is presented in Chapter VII.
CHAPTER III

MEDICAL AND SOCIAL PROBLEMS OF PATIENTS WITH EPILEPSY

Convulsive seizures have been discussed for more than twenty centuries. The superstitions, half truths and prejudices which have accumulated through the ages do not give way easily. Dozens of names have been used for convulsive seizures. Among the most common are "the sacred disease," "the demon disease," "falling sickness" and "fits." The words themselves bring to mind many wholly unjustified ideas of an incurable disease, a public menace, a family disgrace, etc. There is a dramatic impact in the name epilepsy and that impact is sometimes able to cause more hardship to the sufferer than the disease itself. Although more has been learned about epilepsy in the past thirty years than in all the preceding years, convulsions still tend to be regarded with dismay and shame. Not many people understand the full meaning of the disease to those who suffer it.

Epilepsy is the Greek word for seizure. Seizures have great variety but some common characteristics are loss of consciousness, involuntary muscular movement and disturbances of the sympathetic nervous system. It has been defined by various authorities as "a sudden, excessive and un-
ruly discharge of neuronal cells, ¹ "a chronic disease of the brain manifesting itself by a sudden loss of consciousness which may or may not be accompanied by convulsions,"² "a cerebral dysrhythmia."³

Some patients have a warning before a seizure which is called an aura. This usually consists of a tingling of an arm or leg, a "sinking" feeling in the stomach or other ill defined symptoms like smelling a peculiar odor, having a peculiar taste, a queer feeling, etc. Sometimes the patient himself notices nothing but someone with him may detect an unusual appearance such as pallor or dilated pupils.

There are several types of seizures; the three most common will be discussed here.

The grand mal attack is the most spectacular and distressing to observe. It is characterized by a sudden attack of unconsciousness and a generalized convolution with rigidity of all muscles. During this phase the patient becomes blue in the face and breathing stops. There is salivation and sometimes biting of the tongue or cheek. There may be loss of control of the sphincters. After this phase there is a rhythmical jerking of the arms, legs and head. Respiration and color become more normal and in a short time

¹ Hughlings Jackson, quoted by F. A. Dunsworth in a paper presented at Staff Meeting, Camp Hill Hospital, 3/11/47.
² Albert Bing, quoted by F. A. Dunsworth in a paper presented at Staff Meeting, Camp Hill Hospital, 3/11/47.
the jerking ends. The patient lies exhausted, bathed in sweat. He may sleep for minutes or hours and is muscle sore and depressed when he "comes to" often with a severe headache.

The petit mal attack, on the other hand, often goes unnoticed. It is not just a mild or brief seizure but is something altogether different. It is characterized by a very brief loss of consciousness (seldom more than a few seconds), without muscular movement other than a rhythmical twitching of the facial muscles. Great frequency, short duration, abrupt onset and termination are the distinguishing features of the petit mal attack. The patient may appear momentarily dazed, may continue whatever he was doing or saying without any confusion or apparent recognition of a time lapse. These symptoms do not seem too severe and are not so hard on the observer as are the grand mal attacks but they are apt to recur very frequently during a day and the patient's life can be made miserable by them.

Psychomotor attacks are characterized by a period of amnesia with or without contortion of the trunk muscles. The patient may suddenly become unreasonable or he may perform some purposeless act. There is extreme variety in the form these attacks may take. The degree of awareness which the patient has is variable. He may walk about and answer questions but afterwards he will have no recollection of what he
did or even that he had a seizure.

There are two major classifications of epilepsy: symptomatic and idiopathic. If the cause of the seizures is known the classification is symptomatic. Some causes are infections like meningitis or encephalitis, tumors, brain deterioration, or scars on the brain caused at birth or later in adult life as the result of a head injury with or without a skull fracture. These last mentioned are called post traumatic. Certain drugs will bring about convulsions. "Probably the most common chemical convulsant is alcohol."[1] One or several convulsions from any of the above causes would not constitute a diagnosis of epilepsy. It is the recurrence of convulsions which puts them into the symptomatic epilepsy classification.

If there is no known cause for the seizures the attacks are classified as idiopathic. There is very little to say about idiopathic epilepsy in this paper except that it is supposed that there may be a predisposition which is presumably functional and it appears to be hereditary to a large extent. No constant abnormalities are found in patients subject to these seizures.

Treatment

To the average patient treatment means drug therapy.

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There are five medicines currently in use and one which is
newer and still not used so generally. Historically the first
are the bromides. They were first used in 1857 for the relief
of seizures and are still in use but should be restricted.
They are not considered in any of the cases used in this
study. Next is phenobarbital (luminal) which has been effec-
tively used since 1912. This drug is most frequently used
with success in the motor type of seizures. Dilantin sodium,
introduced in 1937 by Dr. Putnam and Dr. Merrett of Boston,
is most effective against grand mal and in psychomotor attacks
is more effective than phenobarbital. Benzedrine and tri-
dione are often helpful in petit mal while the newer drug,
mesantoin, has been used by patients who did not respond well
to other forms of therapy. It has been most effective in
grand mal and less in psychomotor.

The purposes and limitations of drug therapy should be
well understood by the patient and his relatives. The
patient's cooperation with his doctor is of the greatest im-
portance because only the doctor who can see the patient and
follow his symptoms is competent to say what medicine should
be taken, for how long and in what dosage. Some patients
should take no medicine (two in this study did not). Not all
forms of seizures are helped equally by a given medicine and
the prescriptions should be tailor made for each patient.
Seizures are subject to great natural fluctuations. Attacks
may increase in frequency or may stop altogether without any apparent cause. An accurate record kept by the patient of the days when seizures occur and of the medication taken helps the doctor to regulate the amount and kind of drugs best suited to the patient's needs.

Overdosage must be guarded against because some of the drugs taken to excess cause harmful symptoms. Bromides and phenobarbital are sedative drugs. In large amounts they slow the activity of the body and of the mind. Bromides cause stomach irritation and thirst, and a rash of pimples and boils. Phenobarbital causes dizziness and confusion of ideas and sometimes a rash less irritating than the bromides but unpleasant. In huge doses this sedative can cause death. Symptoms of overdosage of dilantin include stomach distress, dizziness, difficulty in focusing the eyes and sometimes excitement and confusion of thought. There is very little danger of overdosage if the patient reports any unpleasant symptoms to his doctor immediately.

The important point to be stressed regarding drug therapy is this: the patient or his family must assume responsibility for keeping a daily record of seizures, must take the responsibility of reporting any unusual symptoms and must be patient during the sometimes long process of discovering the correct combination and amount of medicines to be taken. "The patient needs to take his daily dose as a habit,
and not miss a single day unless told to. 5 This imposes the heaviest responsibility on the patient and is one of the main considerations of this study.

The surgical treatment is less common and is indicated when there is a lesion which can be approached with safety. To justify the surgical risk, the attacks should be frequent and severe and the operation should not cause an important disability. None of the patients considered in this study have had surgery.

Social problems and treatment

Assuming that seizures have been controlled to the extent that they do not recur frequently the patient is still faced with problems from two sources; an unenlightened public and himself. The real problems of vocational handicaps are well known and will be only briefly reviewed here. There are certain positions which the epileptic patient is advised to avoid for his own protection. These include work at heights, near unprotected machinery, etc. Other positions should not be taken which involve the safety of others, like driving a taxi or a truck, or performing surgery. Other positions depend largely on public opinion; these include preaching, acting, or other professions which require that one appear

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before groups of people. Taking all this into consideration there are still many occupations which would appear to be available and suitable for the person with epilepsy. However, public prejudice and negative attitudes of employers are still more widespread than they should be. Faced with these vocational hazards the epileptic patient is apt to conceal the fact that he is subject to seizures and then lives in fear of having one on the job.

The same fear of rejection which the patient feels regarding employment is with him in his social contacts as well. The weight of public prejudice and ignorance is heavy. The patient may be tempted to withdraw rather than face meeting condescension and repulsion.

Within himself the patient may develop some of the traits characteristic of many chronic diseases such as:

dependence, limitation of horizons, rigidity in habits, and a feeling of insecurity and anxiety in unfamiliar surroundings. To these are often added the special burdens which the peculiar nature of the convulsive state imposes—the fears of dropping out of the world at any time, of bodily injury or humiliation and the weight of public prejudices and ignorance about the condition.\(^6\)

Concurrent with a medical regime a certain social regime should be followed. This is not just something that would be good to do but is considered an integral part of treatment.

Most urgently stressed by some doctors is the desirability of an interesting hobby or some personally creative work to form a state of mind which is helpful in actually preventing seizures. Dr. Lennox prescribes:

activity which affords a combination of muscular exertion, intellectual interest and pleasure. The lactic acid manufactured by sweat producing labor is an excellent sedative. 7

It is agreed that the worst thing a patient could do under any circumstances is to sit around and wait for the next seizure. When the patient is off guard, resting or just doing nothing an attack is more apt to occur.

Simple as these suggestions seem to be there are so many factors involved that the patient needs help in keeping his poise and balance. It is in this area that the social worker can be of real help to the patient. It is very well to advise that the patient's associates consider him mentally and somatically normal but the fact remains that when one witnesses a seizure very often common sense gives way to primitive feelings and behavior. If associates shun the epileptic patient his activities become contracted, his interests narrow and he finds it easier to give in to inertia than to seek the activities recommended above. This inertia with its attendant feelings of depression is relieved temporarily for some patients by the use of alcohol.

CHAPTER IV

ALCOHOLIC PROBLEMS OF EPILEPTIC PATIENTS

In the 2000 years during which convulsive seizures have been discussed, a confusing variety of opinions about their cause and treatment has been advanced. Unanimity of opinion, however, has prevailed at one point; namely, the harmful effect of alcohol. Light wine in moderation was often prescribed, but any excess was uniformly decried.¹

The unanimity still prevails. In every reference used in this study the advice was the same. Although different words and emphases were used the meaning was clear. Epileptic patients should not drink. The primary reason for this was stated in the preceding chapter and can bear repetition: "Probably the most common chemical convulsant is alcohol."

Some epileptic patients can accept abstinence or extreme moderation without difficulty. Three patients in this study abstained completely. If a patient prefers to take his chances on having a seizure because he wants to take a drink is he to be considered an alcoholic?

Before an attempt is made to answer that question in the following chapters a review of some of the current thinking on the use of alcohol is in order. Normal, symptomatic and addictive drinking will be discussed.

Normal or social drinking is based in part on the culture of which a person is a member. Of the many reasons given for drinking only a few will be mentioned here. Moderate drinking gives most people a pleasant feeling of well-being, of euphoria. For some, drinking is a customary part of their regular meals, others drink because it provides an opportunity to associate with convivial friends or because it is a traditional part of a social ceremonial. Occasionally a social drinker may imbibe to excess but if he does it does not seriously interfere with his mode of living.

Symptomatic drinking and its development into addictive drinking are described as follows:

For the purpose of the present discussion the expression 'symptomatic drinking' will be limited to the predominant use of alcoholic beverages for the relief of major individual stresses.

The 'occasional symptomatic excessive drinker' tends to take care of the stresses and strains of living in socially accepted, i.e., 'normal' ways, and his drinking is most of the time within the cultural pattern. After a long accumulation of stresses, however, or because of some particularly heavy stress, his tolerance for tension is lowered and he takes recourse to heroic relief of his symptoms through alcoholic intoxication. No psychological abnormality can be claimed for this type drinker, although he does not represent a well-integrated personality.

Nevertheless, within the group of apparent 'occasional symptomatic excessive drinkers' there is a certain proportion of definitely deviating personalities who after a shorter or a longer period of occasional symptomatic relief take recourse to a constant alcoholic relief, and drinking becomes with them a 'mode of living'. These are the
'alcoholics' of whom again a certain proportion suffer 'loss of control', i.e., become 'addictive alcoholics.'

Several points in this description must be borne in mind particularly in reference to epileptic patients. The pattern described is based on the fact that occasional symptomatic excessive drinkers do not represent well integrated personalities although no psychological abnormality can be claimed for them. Epilepsy itself for some individuals may constitute a "particularly heavy stress" and the continued vocational and social frustrations discussed in Chapter III, if they exist, may constitute "a long accumulation of stresses" for which the patient seeks "heroic relief...through alcoholic intoxication." How many of the epileptic patients studied come under the classification of "definitely deviating personalities" is difficult to determine. "Loss of control," however, can be studied from the records.

Dr. Jellinek makes a distinction between excessive symptomatic drinkers and "addictive alcoholics" and bases that distinction on "loss of control." He has prepared a chart of the phases of addiction. This chart is based on a study of more than two thousand drinking histories of male alcohol addicts. Not all symptoms appear in all addicts nor

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do they appear in the same sequence. However they do represent what may be considered an average trend. The chart itself is not necessary for this discussion but it is important to note some of the characteristic behaviors in the various phases as Dr. Jellinek has arranged them.

In the pre-alcoholic phase alcohol provides especially rewarding relief of tension for many. There are more drinking episodes and more alcohol is consumed at each episode.

In the prodromal phase the following kinds of behavior are characteristic: black-outs, pre-occupation with alcohol, drinking for the effect of alcohol per se, defensive reaction to the mention of alcohol.

A person in these two phases is not considered an addictive alcoholic. It is the inability to stop drinking that implies addiction. When the alcoholic seriously tries to drink moderately he always fails.

The third phase, called crucial, does not appear in non-addictive excessive drinkers. The first and most important characteristic differentiating it from the preceding two, is "loss of control" which means that the person always drinks to intoxication. Some of the other characteristics are rationalization and alibis, solitary drinking, marked self pity, geographic escape, unreasonable resentments, narrowing range of interests, etc.
The chronic phase of alcohol addiction includes ethical deterioration, reversible deterioration in thinking, persistent tremors, convulsions, hallucinations, alcoholic psychosis, involuntary commitments, collapse of the rationalization system and admission of the condition and personal defeat.

The distinction between non-addictive alcoholics and addicts is an important one because while there is no denying that the first is a sick man his sickness is not the drinking itself but rather other difficulties, psychological and/or social, from which intoxication provides relief. For the second the "loss of control" is a disease condition per se. There is some disagreement regarding the disease concept but the writer feels that it is justified because the professions of medicine and psychiatry see in the alcoholic a condition which deserves to be called a disease. At present it belongs to the "functional" group but some scientists believe that there is a physiological basis for the alcoholic's abnormal drinking and that once he has become an addict further physiological changes have occurred which prevent him from ever becoming a normal drinker.

It seems to the writer that it is as important for the person who plans to treat patients using alcohol, to know as much about the diagnosis of normal drinking, symptomatic drinking, and addictive drinking, as it is for the person...
who is treating epileptic patients to know the difference between grand mal, petit mal and psychomotor seizures. It is not enough to say "he has epilepsy," "he is an alcoholic."
CHAPTER V

THE PATIENTS AND THEIR ILLNESS

The data presented in this chapter were gathered from the social service case summaries, psychological records and medical charts of sixteen veterans of the epilepsy unit of the Boston Veterans Administration Hospital during 1953. Thirteen of the veterans were first admission patients at the hospital at the time they were referred to social service. Three of the sixteen had been treated for epilepsy at the Cushing Veterans Administration Hospital and were among several patients of an intensive five year study by the National Veterans Epilepsy Center team. They had returned to the Boston Veterans Administration hospital in 1953 for their last evaluation. All came from various places in the United States with the majority from the Boston area.

Background of Patients

Twelve of the patients studied were between the ages of twenty and forty. The largest number (six) was within the twenty six to thirty age group. This is not surprising since fifteen were veterans of World War II. The oldest patient studied (fifty one) was a veteran of World War I. The ages of most patients, twenty to forty, are considered the most productive years.
### TABLE I

**AGES OF PATIENTS**

<table>
<thead>
<tr>
<th>Years</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25</td>
<td>2</td>
</tr>
<tr>
<td>26-30</td>
<td>6</td>
</tr>
<tr>
<td>31-35</td>
<td>2</td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
</tr>
<tr>
<td>41-45</td>
<td>1</td>
</tr>
<tr>
<td>46-50</td>
<td>2</td>
</tr>
<tr>
<td>51-55</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

### TABLE II

**NATIONALITY BACKGROUND OF PATIENTS**

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish American</td>
<td>6</td>
</tr>
<tr>
<td>Scotch</td>
<td>3</td>
</tr>
<tr>
<td>Italian</td>
<td>2</td>
</tr>
<tr>
<td>Swedish</td>
<td>2</td>
</tr>
<tr>
<td>French</td>
<td>1</td>
</tr>
<tr>
<td>English</td>
<td>1</td>
</tr>
<tr>
<td>American Negro</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>
Seven different backgrounds were represented among the sixteen patients. The largest group (six) was of Irish descent; Scotch descendants were exactly half this number. Italian and Swedish backgrounds were represented by two each. The remaining three represented one each of French, English and American Negro backgrounds.

All those of Irish (six), Italian (two), and French (one) descent as well as one of Scotch and one of Swedish descent were Catholics. Two of Scotch descent and one each of English, Swedish and Negro backgrounds were Protestants (five). Religion was discussed in only one instance. The Swedish Protestant World War I veteran who had given up the practice of his religion in his youth returned to it at the time that his illness was first diagnosed and found it to be a very positive, meaningful influence in his life.

Most patients were members of small families. Six were only children while eight were either the youngest or next youngest in their families. One was the oldest of two siblings and the twin was the seventh child in a family of eleven. Four were deprived of both parents before they reached maturity. Three were deprived of their fathers only. One was deprived of his mother only.

One patient was illegitimate. He was born when his mother was fourteen and was brought up by his paternal grandparents. The parents of one patient were living together but
for some reason which the patient never understood he was placed in foster homes from the age of four to eleven.

TABLE III
PATIENT'S POSITION IN THE FAMILY
AND AGE AT WHICH DEPRIVED OF PARENTS

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Position in Family</th>
<th>Age when deprived of mother*</th>
<th>Age when deprived of father*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>only child</td>
<td>shortly after birth</td>
<td>father never known</td>
</tr>
<tr>
<td>2</td>
<td>only child</td>
<td>from 4 to 11 years</td>
<td>from 4 to 11 years</td>
</tr>
<tr>
<td>3</td>
<td>only child</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>only child</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>youngest of 3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>youngest of 5</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>7</td>
<td>second of 3</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>oldest of 2</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>9</td>
<td>only child</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>next to youngest of 4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>youngest of 4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>second of 3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>youngest of 5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>youngest of 3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15</td>
<td>only child</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16</td>
<td>seventh of 11 (twin)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* No entry is made in table if parents were in the home until patient's maturity.

It is of interest to note that four of the six only children were deprived of one or both parents before they reached maturity. Three of these four were brought up by
relatives and in one case by foster parents. The one who was deprived of his father at four remained with his mother who remarried when the patient was ten but the stepfather also deserted within a period of two years. The age at which these patients lost their parents is significant in terms of their emotional development. Most were either at the oedipal stage or at puberty.

Of the eight whose parents were living and well at the patients' maturity two were said to be the mother's favorite child, one other had a "soft hearted" mother and a "strict" father. No pertinent information was found about the parental relationships of the other five patients.

TABLE IV

EDUCATION OF PATIENTS

<table>
<thead>
<tr>
<th>Education</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>College graduate</td>
<td>1</td>
</tr>
<tr>
<td>High school graduate</td>
<td>5</td>
</tr>
<tr>
<td>Completed part of high school</td>
<td>7</td>
</tr>
<tr>
<td>Completed grammar school</td>
<td>1</td>
</tr>
<tr>
<td>Completed part of grammar school</td>
<td>2</td>
</tr>
</tbody>
</table>

Total 16
According to Table IV the greatest number of patients studied (thirteen) had at least partial high school training. Among those who failed to complete high school two left because of scholastic failure, two left to go to work and three left to join the service. The one college graduate completed his education after his return from service. The two who failed to complete grammar school were scholastic failures in the seventh grade. The four scholastic failures, two in high school and two in grammar school, cannot be explained by lack of intellectual capacity since all the subjects of this study had normal to bright I.Q.'s according to tests administered at the hospital.

**TABLE V**

YEARS IN SERVICE

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>2</td>
</tr>
<tr>
<td>Two</td>
<td>6</td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
</tr>
<tr>
<td>Four</td>
<td>3</td>
</tr>
<tr>
<td>Five</td>
<td>2</td>
</tr>
</tbody>
</table>

Total 16

Twelve of the patients studied served from two to four years in the armed forces. Service was equally divided between the Army and the Navy. Nine entered service directly
after their educational training before they were twenty. As noted above, some left high school to enlist. These nine did not have regular employment experience nor were they married at the time of enlistment. Seven joined the service later, between the ages of twenty five and thirty. Of this group some had been married and all had been gainfully employed prior to enlistment. Only one had a service connected disability for epilepsy and received a medical discharge.

**Illness**

**TABLE VI**

**MEDICAL DIAGNOSIS OF PATIENTS**

<table>
<thead>
<tr>
<th>Medical diagnosis</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy, grand mal</td>
<td>9</td>
</tr>
<tr>
<td>Epilepsy, petit mal</td>
<td>3</td>
</tr>
<tr>
<td>Epilepsy, psychomotor and grand mal</td>
<td>2</td>
</tr>
<tr>
<td>Epilepsy, psychomotor and petit mal</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

Nine patients studied had grand mal seizures only, three had petit mal seizures only and four had psychomotor combined with one of the other two.
History

According to information given by the patients or relatives there was no known history of epilepsy or nervous disorders of any kind in the families of any of the group. Eight patients had symptomatic, post traumatic epilepsy. In all these cases this was the result of accidents which occurred during or after service. Some examples are: the patient was struck by a street car; the patient fell from a roller coaster in motion; the patient was struck by a part of an airplane as he bailed out over enemy territory. Eight had idiopathic epilepsy with a question of alcoholism as the precipitating factor in five.

Of the three in the five year study onset of epilepsy occurred in 1943 in two cases, in 1945 in one case. These three were considered controlled. Four patients had their first seizure in 1946, seven years before treatment at the Boston Veterans Administration Hospital, one each in 1945, 1947, 1948, 1949, 1952, 1953. Three had their first seizure in 1951. These were considered not controlled. The onset of seizures in twelve cases was precipitated in some way by the use of alcohol. Some of the accidents occurred while the patients were intoxicated. Ten patients had been drinking excessively prior to their first seizure.

Treatment

Medical treatment consisted of dilantin only in eleven
cases, dilantin and phenobarbitol in three, no medication in two. All but three of the patients had been treated by other physicians before coming to the hospital. Medical treatment had been hampered in twelve cases. This means in all cases, excluding one of the patients of the five year study and three patients who had not been treated previously for epilepsy, the patients had been irregular in taking medicine and had neglected to keep a record of seizures and the medicine taken at the time. One patient admitted that he had experimented with his medication himself. In all these cases the use of alcohol was one factor which contributed to the irregularity and experimentation.

**Attitudes Toward Illness**

Thirteen patients expressed strong negative feelings regarding their illness. The feelings of insecurity, inferiority and shame were general, the intensity varied from individual to individual. One attempted suicide when he learned his diagnosis several years ago; one said that his seizures frightened his nieces so he could not live with his brother; two considered that the seizures "have ruined my life." One claimed that "it doesn't bother me any more." His seizures had been controlled for three years. In two records no expression of feeling about seizures was found. These two patients were primarily concerned with their other difficulties which seemed more distressing to them than their seizures.
CHAPTER VI

CURRENT SITUATION, EMOTIONAL PATTERNS AND DRINKING BEHAVIOR

In considering the current way of life of these sixteen patients the writer has explored the areas of living arrangements, work, emotional patterns and use of alcohol.

Living Arrangements

TABLE VII

MARITAL STATUS

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>3</td>
</tr>
<tr>
<td>* Married</td>
<td>7</td>
</tr>
<tr>
<td>Separated</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

* One listed as married was married and divorced once before this marriage.

From Tables VII and VIII it can be seen that the largest number of patients either were married or had been married and were separated. Only three of the sixteen had never been
married. The seven married patients lived with their families.

TABLE VIII

PRESENT LIVING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Living arrangements</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived with wife</td>
<td>2</td>
</tr>
<tr>
<td>Lived with wife and children</td>
<td>5</td>
</tr>
<tr>
<td>Lived with relatives</td>
<td>4</td>
</tr>
<tr>
<td>Lived alone with private family</td>
<td>1</td>
</tr>
<tr>
<td>Lived alone in rooming house</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

Two owned their own homes, five rented tenements. The wives of these seven patients showed their genuine interest and concern for their husbands' welfare by cooperating to the best of their ability with the medical staff and with the social worker. Four patients were married before the onset of seizures. They had all established good marital relationships before their diagnosis of epilepsy. Most of the wives appeared to be frightened by the seizures and needed support and interpretation from the social worker. In one case the worker observed in the record that "Patient and his wife get along well maritally. I would say he had made a good adjustment in relatively happy surroundings." In another record: "Patient
appears to have a better home life now than he has ever had...there seem to be no specific problems." Another observation: "His wife has learned to accept his seizures. They get along well maritally." The worker's comment on the fourth is: "Both the patient and his wife seem intelligent and maintain good standards at home." Of the three whose wives knew of their condition before marriage one wife said that "the mere thought that he may have to go through life with these things upsets us both." According to her statement she and her husband had been happy together. Another wife, a nurse, seemed to show extraordinary understanding of the meaning of her husband's illness to him. This understanding was evident in a letter which she wrote to the worker at the latter's request. Concerning the last patient in this group the worker commented: "Neither patient nor his wife seem very highly endowed intellectually but are emotionally well adjusted to seizures..."

As can be seen from the above the married patients had formed good relationships with their wives who gave them emotional support in varying degrees.

The three single patients lived with relatives as did one who had had a brief forced marriage and divorce. The first three continued to live with the relatives who had brought them up. These patients told the social worker that they did not feel welcome in the homes of the relatives. One
discussed the possibility of taking a job in a distant country in order to "escape" from the home situation which he felt to be intolerable. Another expressed the feeling that his relatives considered him to be a malingerer. He said that they did not understand why it was so difficult for him to find suitable employment since he was a college graduate. After interviewing these relatives the worker commented in the records that they appeared to be rigid people, lacking in understanding and real affection for the patients. The third (a chronic alcoholic) did not want his relatives "disturbed" by the social worker. According to him his seizures were more upsetting to the relatives than was his drinking pattern. The patient who had the forced marriage was himself illegitimate. His relatives were in another state and were not seen by the social worker. His own comments indicated that his maternal aunt and uncle, with whom he had lived for several years, were people who made him feel "at home" with them. According to him they tried to understand the limitations imposed by his illness.

Five who were separated from their wives lived alone. One patient who lived alone with a private family had told no one of his seizures. They had been controlled for three years. He had no close relationships and at his request no contact was made with any relatives. The four patients who lived in rooming houses had no one close enough to them to be contacted.
Of the seven married patients four had married during or after service. These four were included in the group of nine who entered service before reaching the age of twenty. The three single patients, the one divorced patient, and the one who lived alone with a private family also belong to this group. This last patient is the World War I veteran who entered service at seventeen.

Three married patients entered service late. They were married at the time. Two of this group had no children. All those who lived in rooming houses had been married before they entered service. They had been separated during or shortly after service. Two of this group had owned their own homes. One had a grown daughter whom he rarely saw.

Work

Four of the young married group had had good work histories as skilled laborers before their seizures. They were currently working below their capacities due to their diagnosis of epilepsy. Three were insecure and unhappy in their work as unskilled laborers. Their employers did not know of their seizures since they were afraid of losing their jobs if they revealed their illness. The one exception to this dissatisfaction was a laborer for the city. He enjoyed his outdoor work and was supervised by his father who was understanding of his illness.
Of the three older married patients (who entered service after twenty three) all had good work histories prior to service, one as a watchmaker, one as a recreational director and one in different business positions. Two were currently employed, one as a postal clerk, the other as a laborer. Neither was happy or financially satisfied with his position which was not compatible with his superior intelligence and training. Neither employer knew that the patients had epilepsy because they had not dared to disclose this fact. The current positions were the last of a series of unrewarding ones which the patients had taken since their diagnosis. Sometimes they had had seizures on previous jobs but not on the current one. The third patient (watchmaker) had not worked steadily since his discharge from service several years before his diagnosis of epilepsy. He kept house while his wife worked.

Of the four who lived with relatives three belonged to the young group; one to the older group. All were currently unemployed. Two had had excellent positions after discharge from service and before their diagnosis of epilepsy. Since diagnosis one had several jobs, none of them compatible with his intelligence or training. He was a college graduate of superior intelligence. He did not tell his employers about his seizures, nor did he have seizures on the job. He drank to "ward off" seizures and was discharged because of irregu-
lar working habits and the odor of liquor on his breath. It is interesting that he seemed to prefer to be discharged for drunkenness than to explain about his epilepsy. Another had grandiose plans without realistic basis. He also had superior intelligence. His epilepsy resulted from an accident at work and because of this he was given training for another position with the same firm. His employer was sympathetic and understanding but the patient did not choose to keep this position at the time of his hospitalization. The third member of this group with less intellectual capacity had been trained as a barber and had been successful until he had to give up this work because of his seizures. Since then he had been unsuccessful in holding satisfactory employment. The patient who belonged to the older group had been a tree surgeon before he entered service but had not been regularly employed since his discharge. He was a chronic alcoholic whose onset of seizures was recent and was not a contributing factor to his continued unemployment.

Of the five who lived alone two belonged to the young group. One had always had a good work history and since his seizures had been controlled he made an excellent work adjustment, was happy at his work and supervised six men. However, he did not feel secure enough to tell his employer of his condition. The other had a poor work history. Although he had bright-normal intelligence he had never held a job more
than seven months. He was currently unemployed. His poor work record preceded his diagnosis of epilepsy.

None of the other three had had good work histories for many years. All were currently unemployed. Although one had superior intelligence and the other two had high average intelligence they did not adjust to work after they returned from service. At one time they had been capable of making an adequate living, although even then their employment did not seem compatible with their capacities. One had worked for the highway department for eight years, another had been a shipping clerk for several years and the third had been an "office boy" for several years. Their poor work records preceded their diagnosis of epilepsy.

Of the eight employed patients two were satisfied with their current employment. One of these two worked in the protected environment of his father's supervision. None of the others told their employers of their illness. Epilepsy was seen by the patients as the cause of unsatisfactory positions in six cases and for unemployment in three. In five instances the unemployment preceded the seizures.

Emotional Patterns and Drinking Behavior

The patients' use of alcohol and their emotional

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1 Material on the emotional patterns was taken from psychological reports and from the worker's observations in the case record.
patterns were considered together since they were so closely related. For purposes of this study the writer has classified the patients' use of alcohol into three groups: the abstainers, the symptomatic drinkers and the addictive drinkers. The emotional patterns of the patients will be considered under these classifications.

**TABLE IX**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstainers</td>
<td>4</td>
</tr>
<tr>
<td>Symptomatic drinkers</td>
<td>7</td>
</tr>
<tr>
<td>Addictive drinkers</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

As can be seen by Table IX, the patients studied were almost evenly divided among the abstainers, the symptomatic and the addictive drinkers with the greatest number in the symptomatic group.

A. **Abstainers**

Two of the four abstainers were deprived of their parents before they reached maturity. Three were married, one was separated. All were employed and had good employ-
ment records. Three were dissatisfied with their current employment. Three were of the group who entered service after age twenty. Two were members of the five year study. Their seizures were controlled. One had had medical treatment elsewhere and one had just had his condition diagnosed as epilepsy.

These patients were all described as alert and cooperative, all had very few close relationships. All found it difficult to express feelings. Three had "many emotional strengths" which were not otherwise described. These strengths enabled the patients to make good adjustments. One showed "conspicuous overt anxiety and tension," another showed "very little confidence in himself, many feelings of inferiority especially about mental ability."

Three patients were described as moderate social drinkers before their diagnosis of epilepsy. These three stopped drinking when they realized that their seizures followed their drinking. One patient described himself as having been an "alcoholic." According to the patient himself he had started to drink heavily while in service, and stopped three years after the onset of his seizures. He had been an abstainer for five years, the period of the study of which he was a member.
B. **Symptomatic Drinkers**

Three of the seven symptomatic drinkers were deprived of parents before maturity. Three were married, two were single, two were separated. Five had good work adjustments before seizures. Three were currently employed but dis­satisfied. One was employed and satisfied. Three were unemployed. One employer knew of seizures. One was a member of the five year study. His seizures were considered controlled. Five were of the group who entered service before age twenty.

The outstanding trait of four patients was their lack of affect. The chief defenses of all were isolation and intellectuallyization. Hostility, depression, evasion, apprehension and anxiety were the words most commonly used in reference to six of the group. One was described as sluggish and lethargic.

Six patients of this group expressed the feeling that their use of alcohol was no problem. They said that they could "control" their drinking and they showed no desire to abstain. One saw his use of alcohol as harmful and requested help. Three verbalized that they drank to relax and to feel better. One also said that he drank to "ward off seizures." All said that they began to drink heavily in the service. Six exhibited some behavior described under "crucial phase of addiction" in Chapter IV. From the
records it seemed that whenever they drank they drank to intoxication, they exhibited marked self-pity and unreasonable resentments. One patient showed a definite wish to change geographic location in spite of the opportunity to work in a protected environment.

The writer feels that these patients did not represent well-integrated personalities and that the heavy stress of the disease, epilepsy, with its attendant accumulation of vocational and social stresses, could be a factor in the patients' "loss of control." Their rehabilitation was complicated by their symptomatic drinking which showed some tendency toward addiction. These patients did not have a secondary diagnosis of alcoholism.

C. Addictive Drinkers

Five patients had a secondary diagnosis of chronic alcoholism which was considered to be a precipitating factor in their convulsive seizures.

Two patients in this group were deprived of their parents before they reached maturity. One was single and lived with his mother, one was married and lived with his wife, three were separated and lived alone in rooming houses. These last mentioned lost their wives because of their inability to stop drinking.

All had had trades for several years prior to excessive drinking. All were currently unemployed and had had poor
employment histories for several years. All were of the group who entered service late in life.

These patients were described as passive dependent or passive aggressive characters who showed little affect and whose chief defenses were avoidance and denial.

One of the group had used alcohol constantly for twenty six years. Three others had been drinking heavily for ten years. One dated his problem with alcohol from 1948. Their "mode of living" consisted of drinking and was completely contrary to the way of life recommended as treatment in Chapter III. They exhibited many characteristics of the chronic phase of addiction excluding alcoholic psychosis.

Summary

The emotional patterns of the abstainers were positive with strengths mentioned more frequently than weaknesses. They found it difficult to express feelings and tended to withdraw from new relationships. One patient, who at the time of his diagnosis of epilepsy suffered acute anxiety and many negative feelings, seemed to have made an adjustment through faith. His own statement was, "I believe I wandered too far from God when I was a boy. I should have had faith in Him and myself. I am much less tense than formerly." The worker's comment was, "I think this patient has made a relatively good adjustment. If nothing traumatic, physical or emotional happens to him he probably will
go along all right as he has enough insight and enough strength of faith to keep him going in areas which give him satisfaction."

Two others showed that they compensated for their feelings of inferiority by maintaining good relationships with people in their employment and by establishing happy family lives for themselves. One who described himself as a former alcoholic became more short-tempered and withdrawn after he abstained.

Among the symptomatic drinkers it was difficult to evaluate the extent of their drinking problems because of their defenses of isolation, intellectualization and rationalization. None had well integrated personalities. They relieved, through alcohol, symptoms of their underlying personality conflicts. All exhibited marked tendencies to be tense and depressed, perfectionistic, quietly stubborn, egocentric, and all seemed to have feelings of superior worth while at the same time they seemed oppressed with a sense of inferiority and loneliness.

The chronic alcoholics used denial and withdrawal as their major defenses. One had withdrawn from reality to the extent that the major activity of his daily life was drinking. The others had regressed from the adult responsibil-
ities of marriage and work to the extent that their major satisfaction was drinking. They used intoxication to deny some unwelcome features of reality.
CHAPTER VII

ROLE OF THE MEDICAL SOCIAL WORKER
IN THE EPILEPSY UNIT

The social worker's special contribution to the clinical team is her interpretation of the specific manner in which a given patient in a particular social environment deals with his problems. As the social worker visualizes the epileptic patient against the background of his family, occupation and social environment she is able to present a comprehensive picture of interrelated facts and to clarify for the doctor those social factors which contributed to the patient's illness, the problems which his illness created for him as well as for his family, and those hurdles which stood in the way of his being able to accept and use medical advice.

Regardless of the source or the reason for referral the medical social worker uses her specific skills in interviewing to establish a positive relationship. With the individual patient her approach is of a combined medical social nature. The interview is used for securing information about the person as well as his illness, including his relationships with other persons in his social environment. The various pressures society exerts on the patient and his reactions to these are important since an individual's particular state of emotional distress is the result of both
internal and external factors.

The worker must rely on her knowledge of the dynamics of personality and her experience with ill persons to evaluate the various life experiences in the light of their effect on the present situation. "The life history assists in highlighting the particular danger points where the patient characteristically fails."¹

Interviews with relatives aid the worker in getting the history and description of seizures which are so helpful in making a diagnosis of epilepsy. These interviews are also used by the social worker to explain the nature and extent of the patient's illness. In this way she aids the relatives to help the patient accept his epilepsy and the limitations which it imposes.

Before she makes a referral to a community agency it is necessary for the social worker to have a satisfactory working relationship with the patient and to have a real appreciation of his needs. The patient deserves a careful explanation, including the need for referral to a new agency and the reason the new agency is more appropriate than the hospital for the attainment of his goals. The outside

¹ S. Mouchly Small, M.D., Psychoanalysis and Social Work, p. 283.
agency needs information in the nature of a report from the worker containing pertinent background material about the patient and the treatment which he has received.

In 1953 The National Veterans Epilepsy Center in Boston received total coverage by the social service department. This meant that each patient was referred to the social worker of the unit. The social service department has a card which classifies the status of the patient at the time of referral, the length of service, whether immediate or continued, the persons other than the patient to whom services are rendered, the major focus of social services which includes, among others, diagnostic social study, attitude toward and adjustment to illness, financial problems, employment problems, collaboration with other services and resources, research in either the social service department or in multi-discipline projects, etc. Nine social work techniques used to achieve goals are listed. These are: 1) supportive relationship; 2) exploration; 3) manipulation; 4) explanation; 5) ventilation; 6) universalization; 7) clarification; 8) interpretation; and 9) synthesizing.

All the referrals included in this study were made by the physicians of the epilepsy unit. The status of thirteen patients at the time was new. This means that this was their first social service contact at the hospital. These were hospital in-patients. One of these patients was later
seen on an out-patient basis. The three patients included in the five year study had been "active" for the five years. They were seen on an out-patient basis for medical and social follow-up. The length of service in all cases was "continued" although the 1953 contacts were limited to less than five interviews for each case. Social service was offered to the patient in all cases, and to the relative and patient in eight cases.

TABLE X

PURPOSE OF REFERRALS TO SOCIAL SERVICE

<table>
<thead>
<tr>
<th>Referral for</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social study only</td>
<td>4</td>
</tr>
<tr>
<td>Social study for case presentation</td>
<td>3</td>
</tr>
<tr>
<td>Social study and description of seizures from wife or relative</td>
<td>3</td>
</tr>
<tr>
<td>Social study for employment and rehabilitation</td>
<td>3</td>
</tr>
<tr>
<td>Social study in relation to 5 year study</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

As can be seen from Table X the purpose of the referrals to social service was social study. In the referrals particular emphasis was laid in four areas. The referrals in the first three categories in the table had for their primary focus diagnosis. Those which included work histories had as
their primary focus vocational rehabilitation, and those which included evaluation of the patients of the five year study focused on the results of previous treatment or research. These focuses were those of the doctor who made the referral. To those the worker added some of her own in the course of the case work contacts.

The major focus during the social study was on the patient's attitude toward and adjustment to illness. As has been stated in previous chapters the patient's adjustment was adequate in two of the three cases of the five year study. In three cases the diagnosis of epilepsy was made for the first time. These patients had not had time to adjust to their illness and needed support and explanation in this phase of their treatment. Twelve patients had had a diagnosis of epilepsy before coming to the National Veterans Epilepsy Center and either had not been able to accept their diagnosis or had hampered treatment because they could not make a satisfactory adjustment to it. Helping these patients in this area was a major focus of the worker and required skill in the use of the techniques of a strong supportive relationship, explanation, exploration, and clarification. The worker gave the patients an opportunity to ventilate their feelings about their illness in an accepting environment.
Another major focus centered around personal and family relationships. In eight cases this meant offering services to the wife or relative as well as to the patients themselves. Personal and family relationships constituted a major problem for those patients who lived with relatives whom the patients saw as rejecting. It was also a problem for those addictive drinkers who had lost any close relationships by their constant and continued use of alcohol. As has been indicated earlier this did not constitute a major problem for the married patients or for one patient who lived alone and had his social relationships to compensate for his lack of family ties. While focusing in this area again the technique of a supportive relationship was basic to the use of the other techniques of manipulation, clarification and ventilation.

The financial and employment problems of the epileptic patient present a challenge to the social worker. Eight patients were employed, only two satisfactorily so from their own point of view. The worker had to evaluate to what extent the illness prevented the patient from finding suitable employment and to what extent the illness was used as an excuse for poor work. Her goals and techniques were dependent on her social diagnosis. In two cases the worker referred patients to the Vocational Counselling Service at the hospital. In one case a referral was made to a voca-
tional counseling service in the patient's home city. In another instance she noted: "It was worker's estimation that patient is probably doing as well as he can under the present circumstances. If it was possible to help him accept his illness it might be that one could move on to helping him in his job." In each case which presented employment problems and was not referred elsewhere the worker allowed the patient to ventilate his feelings about his illness and the relationship which it had with his employment. She used the technique of clarification to help the patient accept some of the limitations imposed by his illness and also talk about some of his fears concerning his work. In no case did the worker contact an employer.

The use of alcohol in relation to seizures was not treated as a major focus of social service, but was recognized by the worker as a factor in other areas. In two cases the worker explored this relationship with patients with positive results. One asked for help with his drinking problem and was referred to a family agency in his community. Another came to recognize the relationship and at the time of his last interview as an out-patient he had voluntarily stopped drinking. Discussion of drinking was recorded in eight cases; two abstainers, five symptomatic drinkers, and with the wife of one addictive drinker. In three cases the worker commented that the patient was not ready to discuss his drinking as
a problem. In one instance the patient said that he drank "a little." His wife gave evidence that she considered his drinking to be excessive and that it interfered with his way of life. From the records it appeared that six of the seven symptomatic drinkers did not admit that there was a relationship between drinking and seizures. The worker observed and noted resistance in this area but she could not go beyond that in treatment. Discussion of the relationship between seizures and drinking was conspicuous by its absence in the records of the chronic addictive drinkers. The reason for this is not clear, but one of the characteristics of alcoholics is their reluctance to discuss their use of alcohol.

From the description given above it can be seen that several different social services were offered to the patients included in this study. The social worker obtained social histories, formulated social diagnoses and gave emotional support in sixteen cases. Her areas of greatest activity were those of social diagnosis, vocational help, and collaboration with other services in research. Her major focus in these cases centered around: 1) the patient's attitude toward and adjustment to his illness; 2) personal and family relationships; 3) financial and employment problems. The patient's use of alcohol as it affected these three was recognized and noted by the worker but in most instances little attempt was made to work through this
particular problem.

The techniques most commonly used were all based on a supportive relationship and included explanation, exploration, clarification, manipulation and ventilation.

Case work services were given to the patient's wife or relative in eight cases. Referrals were made to Vocational Counseling in the hospital in two cases and to community agencies in two cases.

All the social work contacts were limited to fewer than five interviews and were not intended to provide long term social case work treatment.
CHAPTER VIII.

CONCLUSION

This thesis included the cases of sixteen epileptic patients referred for brief contact with the social service department of the Boston Veterans Administration Hospital during 1953. All these patients had used alcohol to some extent before referral. The writer has studied the records of these patients in an effort to show how the use of alcohol affected the social treatment and rehabilitation of the patients. Questions posed for the purpose of this study were: In what areas and to what extent do these patients experience tensions? What is the pattern of use of alcohol for these patients, and how is it related to the tensions they experience? What is the role of the social worker with patients whose rehabilitation is hampered by the use of alcohol?

In Chapter II the setting of the study was described. In Chapter III the writer explored some of the problems of the illness itself, the social and vocational tensions which accompanied the illness and the suggested medical and social treatment. In Chapter V it was found that all the patients studied experienced these tensions to some extent. Six patients experienced marked tension in the vocational area while eight others were currently unemployed. Epilepsy was
seen as a contributing factor in the unemployment of three of these patients.

In Chapter IV the writer described three possible drinking patterns and in Chapter VI showed how the patients used these patterns. Three patients had been social drinkers. These three plus one other abstained without the help of outside agencies after their diagnosis of epilepsy. Seven had backgrounds and personalities which gave them a low tolerance for tension. The stress of epilepsy and its attendant stresses gave these patients great difficulty with the result that they seemed to have lost control over the amount they drank. This apparent loss of control further complicated their treatment for epilepsy and their rehabilitation. Five patients had passive aggressive or passive dependent personalities and had had the pattern of chronic alcoholism before they experienced seizures.

In Chapter VII the writer presented the role of the medical social worker in relation to other members of the clinical team working with these patients. In the brief social service contacts the worker was concerned primarily with obtaining social histories for diagnostic rather than for treatment purposes. While obtaining these histories she used her professional skills and techniques to help the client accept and adjust to his illness, to explore and clarify with him some of his financial and employment prob-
lems and to interpret the meaning of the illness to the wife and relatives in order to prevent or lessen strains in the patient's personal and family relationships.

The writer feels that the familiarity with the drinking patterns outlined in the text would have been helpful to the worker in her diagnostic evaluation of the patients whose use of alcohol interfered with their treatment and rehabilitation.

It can be seen from this study that the use of alcohol added tensions to those already caused by the social and economic hardships encountered by many epileptic patients, and that the attitude of the patient toward his illness helped to foster patterns of isolation, rationalization, secrecy and dependency.

This thesis has also shown that in this group of sixteen patients there were no moderate, social drinkers. They were either abstainers or they had underlying emotional conflicts and personality disorders which had laid the groundwork for excessive drinking before they had a diagnosis of epilepsy. The use of alcohol was a real hindrance to the social treatment and rehabilitation of these patients with epilepsy.

The social treatment and rehabilitation of patients with epilepsy involves much more than case work. It is a challenge to all the "helping" agencies including social work, education, vocational rehabilitation, and religion. Interpretation of the medical diagnosis and treatment must
be done for groups as well as for individuals. When this social treatment is further complicated by the use of alcohol the problem requires a more concerted effort if it is to be solved. In spite of the heroic efforts of individuals like Dr. William G. Lennox and organizations like the International League Against Epilepsy and the Laymen's League Against Epilepsy as well as the equally heroic work of others like Marty Mann, Alcoholics Anonymous, the National Committee on Alcoholism there is still much public ignorance and misconception surrounding both epilepsy and the use of alcohol.
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Books:


Periodicals:


Unpublished Material:

APPENDIX

SCHEDULE

I. BACKGROUND

A. Age
B. Family position
C. Religion
D. Nationality
E. Education
F. Branch of service: Dates, Rank, Discharge
G. Marital Status

II. PRESENT LIVING ARRANGEMENTS

A. Members of household
B. Patient's relationship to others in household
C. If married, did wife know of seizures and/or drinking pattern before marriage?
D. Did seizures start before or after marriage?
E. What is wife's attitude toward patient?
   Seizures? Drinking?
F. If single, what is the attitude of near relative or friend to the above? State role of this relative or friend.
G. If divorced or separated, under what conditions?
III. MEDICAL INFORMATION

A. Type?
B. Kind?
C. History?
D. How does he regard epilepsy as it affects him?
E. How does he see others' reaction to his illness?
F. Other comments.

IV. USE OF ALCOHOL

A. Was and is he a social drinker? Explain.
B. Did he and/or does he now exhibit behavior which would place him in one of the following phases of addiction:
   Pre-alcoholic: explain
   Prodromal: explain
   Crucial: explain
   Chronic: explain
C. Is he an habitual symptomatic drinker? Explain
D. Is he now an abstainer? Explain
E. How does he correlate his seizures with his drinking?
F. Other comments.

V. EMPLOYMENT

A. What is his present work adjustment?
B. What are his qualifications and training for his
present work?

C. What kinds of employment did he have in the past?

D. How long did he hold these positions?
   Have his employers known of his seizures? His drinking?
   Does he attribute his leaving to his seizures? Drinking?
   Other?

E. Has he had vocational guidance or training?

F. Other comments.

VI. EMOTIONAL STATE

A. Distinguish between his evaluation and that of others in the following:
   1. How does he take responsibility for his actions?
   2. How does he work out his hostile feelings?
   3. How does he relate to others?
   4. In what ways is his behavior different from what it was before seizures?
   5. How does he express his feelings to worker?

B. Other comments.
VII. ROLE OF SOCIAL WORKER

A. What is social worker's role in her contacts with the patient and/or his family?
   1. In regard to referral?
   2. In regard to case work developments?

B. How does she discuss drinking with patient or family?

C. How does she use her knowledge of the patient's drinking in her case work treatment?

VIII. WORKER'S EVALUATION AND COMMENTS ON THE USE OF ALCOHOL IN RELATION TO ILLNESS.