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A study of the role of the social worker in the treatment of epileptics at a State Mental Hospital.

Wilson, Robert B

Boston University

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Boston University
BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE ROLE OF THE SOCIAL
WORKER IN THE TREATMENT OF EPILEPTICS
AT A STATE MENTAL HOSPITAL

A thesis

Submitted by
Robert Brogden Wilson
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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II. Background Information</td>
<td>6</td>
</tr>
<tr>
<td>III. Case Studies</td>
<td>20</td>
</tr>
<tr>
<td>IV. Summary and Conclusions</td>
<td>33</td>
</tr>
<tr>
<td>Bibliography</td>
<td>47</td>
</tr>
<tr>
<td>Appendix</td>
<td>49</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The psychiatric case worker in the social service department of a state mental hospital is responsible for dealing professionally with many different types of mental illness. Generic case work techniques are employed in working with any of the diagnostic categories. In addition, there are specific problems which are peculiar to each individual category.

This study is concerned with the diagnostic category, "convulsive seizures-epileptic type". The purpose of this study is to investigate the role of the social worker in the treatment of epileptic patients at a state mental hospital.

The importance of such a study is obvious when it is noted that approximately 37,500 epileptics are cared for in mental hospitals in this country. The cost of caring for these patients is estimated at $15,000,000.00 annually. Most of these patients have been committed to mental hospitals, because they have been unable to make an adequate adjustment to the social demands on the outside. In society, they are often the target of ridicule and rejection.

There are many frustrations facing the epileptic. When his defenses, which may have been weak to start with, no longer prove adequate, institutionalization may be the only solution.

During the patient's stay in the hospital, the doctor uses his unique skills to help him on the road to recovery. The doctor's role may be simply prescribing the correct medication for the control of the seizures. It may require some type of psychotherapy. Whatever treatment is given by the doctor, when the patient is ready to go out of the hospital again to become a member of society, the unique skills of the social worker are often utilized to help make the adjustment an adequate and lasting one.

The social stresses which precipitated his commitment may be waiting to greet him. His family may still be there to contend with. He must earn a living, and obtaining employment is a very realistic concern to the patient. Perhaps he needs help in accepting his epilepsy, its implications and its limitations. These problems and their solutions can make the difference between a successful re-adjustment or a necessary re-admission to the hospital. This is the general area in which the case worker operates.

PURPOSE

This is a study of patients in a mental hospital who have been diagnosed as psychotic with convulsive disorders. The purpose is to investigate the role of the social worker
in the treatment of these patients.

The questions for which answers are being sought are:

1. What are the presenting problems in the referral of the patient to the social service department?

2. What are the actual problems as seen and treated by the social worker?

3. What techniques are employed by the social worker in working with the epileptic patient?

METHOD AND SCOE

The procedure used in this study involves a qualitative survey of five cases referred to the social service department of a state mental hospital between January, 1952 and January, 1953, inclusive. These five cases were chosen from a total of fifteen such referred during this period. The writer read these fifteen case records and selected the five used in this study because they were the most representative of the case work being done at the hospital. They demonstrate the roles and the techniques of the social worker who works with epileptics in this setting.

The data for the study were obtained from the records of the social service department. In cases where the recorded material was inadequate, the writer obtained supplementary information by interviewing the social worker who carried the case.

Current literature was read to provide a broader background and to give the study a comprehensive, intelligent perspective.
The scope of this study is focused on the role of the social worker in the treatment of epileptics at this hospital. The referral of the patient may be made at any time during the patient’s connection with the hospital. He may be in the hospital or he may be out on trial visit. He may be living in the hospital during the day or night but working out of the hospital the rest of the time. This latter arrangement is used when a protective environment is considered still necessary or if the patient has no suitable place to live.

**LIMITATIONS**

Because of the small number of cases used, the validity of this study is limited to the setting involved. Due to the uniqueness of the setting, the findings would not necessarily be applicable to work with epileptics in a setting other than this mental hospital.

**SETTING**

This study was carried out in the social service department of a state mental hospital. The function of the hospital is the care and treatment of persons who are found to be psychotic. It has a patient population of approximately three-thousand. The length of the patient’s stay varies from a few days to several years, depending on the nature of the illness and the type of treatment required. When the patient is considered well enough to leave the
hospital, he is not discharged immediately. He is allowed to leave on a "trial visit" basis for one year. If at the end of the year he is adjusting adequately, he is discharged completely, and the hospital no longer has any legal connection with him. During this year, if the adjustment is not adequate, the patient may be re-admitted for further treatment without going through the legal process of commitment.

**ROLE OF THE SOCIAL WORKER**

The social worker may be asked to work with a patient to help him prepare for trial visit. He may have to work with the patient's family or parents to help them work through their feelings and misconceptions about the patient and epilepsy. The worker operates in the area of employment and employment planning. This includes preparing the patient to obtain and keep a job and also interpreting the patient to the employer. Another area in which the worker treats the patient is that of the patient's personal and emotional problems. These activities are done both before and after the patient leaves the hospital.

The social service department is staffed by one director, one head worker, nine psychiatric case workers, and ten student social workers from three different schools of social work.
CHAPTER II

BACKGROUND INFORMATION

HISTORICAL CONSIDERATIONS

In order to gain the proper perspective of the present day feelings and problems surrounding epilepsy, it is necessary to consider it from the historical viewpoint.

Beginning with the Hebrews and the Arabs, ancient medical writers recognized the seriousness of seizures and had much to say about them. The earliest full discussion, and one of the most interesting of all, is by Hippocrates, the "father of medicine", written from Greece about 400 B.C. The popular misconception dating from that time was that epilepsy was a supernatural phenomenon caused by gods who possessed men's bodies with demons and made them unclean. Treatments for epilepsy which were used in those days included making an opening in the skull to allow the demons to escape. The disease was most often associated with feeblemindedness.

This supernatural interpretation continued until the eighteenth century when leading European physicians abandoned their belief in demon possession.

2 Ibid, p. 20.
Attempts were then made to differentiate between epilepsy and mental disease. However, it was not until the twentieth century that new hope really came. In the last two decades, there has been great progress toward solving the ancient problem of the "demon disease", "the sacred disease" - epilepsy.

This brief historical picture indicates the superstition and ignorance which have plagued victims of epilepsy for centuries. The "instinctive" fear of a convulsion may well have its roots in these ancient superstitions.

THEORETICAL CONSIDERATIONS

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

Approximately one half of the epileptics regularly have a warning. The medical term is "aura", and the symptoms which comprise an aura are extremely diverse. A group of

4 Lennox, op. cit., p. 17.
5 Herbert Yahraes, Epilepsy--The Ghost is out of the Closet, p. 3. New York City: Public Affairs Committee.
750 patients who described their aura used 327 different terms. These included: "a queer feeling", "dizziness", "numbness", "sickness", "fear", and "a feeling of gas or nausea".

The nature of the seizures is varied, and the contributing factors are complicated. However, for diagnostic purposes, four main categories are generally accepted by the medical profession. These categories are: grand mal, petit mal, psychomotor, and Jacksonian.

Grand mal: In the grand mal convolution, there is complete loss of consciousness accompanied by a muscular spasm. There may be an aura. The person falls, and the muscular spasms continue for from one minute to one half hour. He may groan or cry out, although he will not remember pain. Saliva appears on his lips; his color becomes dusky. When this phase is over, and the jerking movements stop, the person lies relaxed, breathing heavily, sweating profusely, and is insensitive to pain. During this seizure, he may have been incontinent of feces and urine. After the seizure, he may sleep heavily for hours or get up but feel dull for a short period.

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6 Lennox, op. cit., p. 25.
7 Ibid, the following classifications and descriptions are paraphrased or quoted from this source, pp. 24-32.
**Petit mal**: The petit mal seizure may often be overlooked, because it lasts only a few seconds, and the symptoms are so slight. It is the most frequent type of seizure. It may occur from one to several hundred times in one day. Unlike other forms, there is no preceding warning. It consists merely of a loss or impairment of consciousness which comes abruptly and leaves quickly. Usually, there is a little rhythmic twitching of eyelids or eyebrows.

**Psychomotor**: This type of seizure is hard to describe, because the appearance and actions of the patient are so diverse. Instead of losing consciousness completely, he is in a state called "amnesia", in which he acts as though he were conscious but afterward has no memory of what took place. He may mumble incoherently, make chewing motions, or walk about aimlessly. He may behave oddly and may commit a criminal act. The seizure usually lasts only a few minutes but may last for days.

**Jacksonian**: In this convulsion, the patient usually retains consciousness and can watch the convulsive activity as it spreads over his body, but he cannot stop it. It is usually confined to one side of the body and spreads upward from the extremities. This indicates that a certain portion of the brain is being irritated by something, perhaps a tumor or a scar. This is a distinct aid in mak-
ing the diagnosis and in treating the case. This seizure usually lasts only a short time.

The fundamental cause of epilepsy is now presumed to be an inherent "cerebral dysrhythmia" or a predisposition to seizures. This theory has evolved through the study of records made of the electrical waves of the brain with the electroencephalograph. This predisposition was present when the patient was conceived and presumably will remain with him throughout life. It is caused by a peculiar electro-physico-chemical reaction of nerve cells in the brain.

This predisposition does not necessarily mean the person will have seizures. It is estimated that ten percent of the population has this cerebral dysrhythmia, but only one out of twenty of these persons ever has a seizure.

Many factors can precipitate the onset of seizures in a person predisposed to them. Organic brain damage is an important cause. This may be congenital or the result of trauma occurring after birth. It may be a brain tumor. Infections in the brain or its covering may leave scars which later produce seizures. Disorders of body function may result in toxic substances in the blood stimulating seizures in the brain.

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8 Ibid, pp. 65-70.
Emotion, as a causal factor, is still questioned by some people. The fact is that many epileptics have seizures following or during emotional experiences. The confusion enters because of the frequent difficulty in differentiating cause from effect in these situations. It is agreed that emotional problems are important in the total clinical picture.

CONTROL

In studying epilepsy, it is important to consider the medicinal control which is available to the patient. In contrast to the old fashioned treatment of powered human skull or gall fried in urine, medicine is now available which can control most seizures. The treatment must be on an individual basis, because a medicine which helps one person may harm another.

The grand mal seizure is the best understood and the easiest type to treat. Phenobarbital, dilantin, and mesantoin are highly effective with this type. Tridione and paradione are two new drugs which have been successful in treating psychomotor seizures and also grand mal and petit mal.

These medicines must be taken under skilled medical supervision, because the side effects may contraindicate the

use of the medicine. The patient may form a rash or may become stupified by the sedative effects. With careful supervision, the proper medicine and dosage can be ascertained. This is, however, only one of the tools used in treating epilepsy. It may succeed in arresting the symptoms, but it would be misleading to state that it can cure epilepsy. It cannot. It therefore becomes obvious that the patient must be impressed with the long term nature of the total treatment plan.

THE EPILEPTIC

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

Opposed to this belief is Dr. William Lennox's observation that epileptic patients seen in clinics or offices

10 Lennox, op. cit., pp. 148-158.
are no more peculiar than the general run of the population. Epileptics have psychological traits which any chronic disease is likely to produce - dependance, feelings of insecurity, limitation of horizon, and rigidity of habits.

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

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

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

3. The unpredictableness of the attack. Fortunate are those patients whose attacks are nocturnal.

4. The dependent attitudes created in the patient, sometimes on a realistic basis. Where seizure control is poor or only fair, patients do not go out unaccompanied. It is common to find grown men and women followed by aged parents. Unfortunately, this attitude may be fostered by families and may persist in the patient after improved
seizure control no longer makes such limitations necessary.

The epileptic must cope with realistic problems in four major areas of his life: family relationships, social relationships, education, and employment.

In the family relationships, the parents' ability to help the epileptic child feel secure is vital. To any handicapped child, it is important to be loved, accepted, and understood. If the parents adopt the attitude of being ashamed, afraid, and disgraced, the child will reflect this.

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

Working with the epileptic's parents and family is an important area for the social worker. He can work toward correcting their misconceptions and superstitions. He can help them work through their feelings so that they no longer need to be overprotective or rejecting and can replace

13 Ruth Gerofski, op. cit., p. 162.
these with realistic, constructive attitudes. If the parents can be helped to be more realistic in their relationship with the patient, the patient will be better able to adjust realistically to his handicap.

Social relationships present a challenge to any handicapped person, but the epileptic's situation is peculiarly difficult. He is never sure he will not have a seizure and create an embarrassing public spectacle. Because of this, feelings of self-confidence and security may be replaced by feelings of insecurity, self-depreciation, and guilt. He may feel he is not accepted or not wanted by his friends, group, school, or employer. To avoid these disturbing situations, the epileptic may withdraw from his activities into a more comfortable, egocentric shell. If he continues in this way and is not given help to correct it, his behavior may grow progressively worse. Institutionalization may have to be the ultimate result.

The epileptic, like anyone else, should have social outlets if he is to have a healthy personality. In our society, because of prevailing prejudices and misconceptions, the available outlets are seriously limited. Rather than expend the effort required to overcome these difficult obstacles, the epileptic may not even make the attempt.

In addition to these more casual, public social contacts, the epileptic faces emotional conflicts in the areas of love
and marriage. Some states still have laws forbidding epileptics to marry, and others require eugenic sterilization of those epileptics who do marry. In practice, these laws are rarely put into effect, but they are available and can be used. Aside from the legal aspects of marriage, there are emotional problems arising from this intimate inter-personal relationship. Also, the question of the hereditary nature of epilepsy plays an important part. The evidence indicates that a predisposition to epilepsy is hereditary. It does not follow that seizures, themselves, are hereditary. Inspite of this, the fear of the hereditary aspects of the disease and the effect on the children is a source of anxiety for the epileptic.

Obtaining an education presents many problems for the epileptic. The problems related to social adjustment are increased in the school setting. The epileptic's attempts to receive an education may be frustrated by his teachers and fellow students. They may be afraid of him, be hostile toward him, and reject him. If the patient has petit mal seizures he may be accused of inattentiveness. Grand mal seizures are often considered indicative of feeble-mindedness. He may actually be asked to leave school. If he is not asked to leave after having a seizure, his adjustment may then be tenuous at best. This threat of terminating his

15 Ibid, P.114.
formal education is a traumatic experience in the patient's life. It is frequently not an isolated instance of failure and rejection but one of a series. This is a failure in one of his major encounters with the outside world. In addition, he has lost the opportunity for an education which is essential for a handicapped person. This jeopardizes his chances of competing with more skilled workers in the field of employment. In our competitive society, it is vital for the handicapped person to have training and skills which enable him to compete with others on an equitable basis.

With full recognition of these other very real problems, the area of employment and making a livelihood offers the adult epileptic the greatest difficulty and frustration. The epileptic seeking employment should be allowed to compete with other employees on the basis of skill, experience, and productivity. Undoubtedly a waste of manpower results from the bias about epilepsy. More important is the psychological toll on the individual who is denied work. In a study made in 1948 of 178 epileptic patients, of forty-four men who were employed, only eleven, or 25 per cent, were engaged in some form of skilled or semi-skilled labor. Three of these were already established in their trades before their seizures began. With one exception, the men had not told their employers about their seizures when they
obtained their jobs. A necessary factor for those who had
had seizures on the job was an understanding employer.

In this study, the remaining 75 per cent of the employed
men were in unskilled jobs. Holding a job one month, they
would have a seizure the next month and be fired. Theirs
is the recurrent tragedy of trying to decide whether to
hide their illness or to give up any attempt to work.

The problem of discrimination against employing epi-
leptics is an area in which the social worker must work
actively. Interpretation of the illness to the employer
and explaining the attending limitations and capabilities
is an aid. Helping the epileptic to understand his own
illness and its implications is another aid. This will
enable him to be more realistic and selective in his emplo-
ment aspirations.

Objectively, the employment of an epileptic should be
no different from any other person. He has certain lia-
ibilities and assets. He has certain characteristics, skills,
qualifications, and limitations and should be judged and
hired accordingly. Obviously, it would be unwise to employ
epileptics where they must be near dangerous machines or
work at dangerous heights. However, one of the consequences

16 Elbael L.C.L. Davidson and Joan Thomas, "A Social
Study of Epileptics", Journal of Social Case Work 30:361,
November, 1949.
of the discrimination in employing epileptics is that some of them conceal their illness and take jobs which they cannot safely hold. This may imperil the lives of the epileptics and those around them. It also makes it more difficult for those whose seizures are better controlled or who have more appropriate jobs. Jobs are available which epileptics can do adequately. However, without the opportunity for proper, unbiased job placement, he may have no alternative but to take any available job and try to conceal the fact that he is subject to seizures.

The numerous problems facing the epileptic seem to be based on irrational prejudices. It is apparent that the epileptic must be considered as an individual, and his conflicts and problems must be worked with as they affect his total being. The role of the social worker in relation to the epileptic begins to evolve as these factors are considered in relation to their effect on the individual's total adjustment to his society.
CHAPTER III

CASE STUDIES

This chapter presents the five cases studied from the social service records of a state hospital. It shows the reasons for which cases were referred for social service help, problems facing the epileptic who is in this setting, and techniques used by the social worker to help him.

The epileptic in a state mental hospital presents problems which are similar to those of any other epileptic. In addition, there is the additional factor of being psychotic and committed to a mental hospital. This is a multiplication of social stigmas which result from social prejudices and misinformation. In two of the five cases, the fear of being considered a mental patient was greater than the fear of being considered an epileptic.

The major difficulty facing the social worker in working with these patients was getting them to relate on a casework basis which would be conducive to positive movement. Three of the patients looked at the worker solely as the person who was to get them out of the hospital. Initially, they were unable to utilize the attempts made to prepare them for release. This prolonged the case work process.

The second major difficulty was found in working with the patient's parents and adverse parental attitudes. In
two cases, work was attempted with the parents but with very little success. In all cases, adverse parental attitudes were operative. If they were not operating in the current situation, the current influence of past attitudes was still operating.

This resulted in the workers setting one goal throughout each case. The worker attempted to counteract these adverse parental attitudes by giving the patient a corrective experience with an accepting and understanding person. This was obviously beneficial in four cases and less beneficial in one.

If a social worker is to work successfully with epileptic patients, he must possess great skill and sensitivity. He must consider the patient as an individual and be able to recognize his individual needs and his modes of expressing them. The problems met by the worker and the techniques used to cope with them will be seen in the following five cases.

Three of these cases involve mentally deficient patients. They have had little education and possess no specialized skill or profession. This made it difficult for the worker to help with employment planning. The other two cases had normal intelligence. One of these was a skilled worker in the plastics industry. The other one had worked at numerous odd jobs but had no special skill. Their ages, at the time
of their referrals, ranged from twenty-three years to forty-two years. Three of them were in their early twenties, one was thirty-three years old, and one was forty-two.

Case A

The case of Jane B. illustrates how the social worker works with the problems of a feeble-minded epileptic female whose family openly rejects her.

Jane was admitted to this hospital on November 3, 1930, at the request of her parents. She had been having frequent seizures accompanied by hallucinations and had been a disturbing element in the home. On admission, she was twenty-four years of age. She was diagnosed as having a chronic brain syndrome associated with convulsive disorders. She is the third of five siblings in a family of lower socio-economic status. The parents are uneducated and careless in speech and dress. One of her younger sisters is married, and the other one is still in the home. Her two older brothers are not married but live away from home.

Jane was born unexpectedly while her mother was looking out of a window. "She just dropped out and landed on her head." She was a frail infant who was always hungry. She could never get enough to eat. Her development was retarded. She was toilet trained at about two years, walked at three years, and talked at four years. When she was six years old, a playmate pushed her against a pole, and she struck her forehead. Her mother says that Jane's difficulty stems from this, and that she has acted peculiarly since that time. Jane states that her seizures began when she was eighteen.

She failed the first grade in school, and her parents withdrew her from school. She has never learned to read or write. At the hospital, her I.Q. was found to be 35. From the time Jane was withdrawn from school until she was admitted to
the hospital, she was kept in her home by her parents. She had little opportunity to make friends and has always had difficulty in relating to other people. There is an indication of strong rivalry between Jane and her siblings. She had always demanded a lot of attention. When she was denied this, she would display a violent temper. She has assaulted her sisters on several occasions when they have made fun of her.

Jane is subject to epileptic seizures of the Jacksonian type. When they begin, she has no warning aura, and her left hand shakes. The shaking moves up her left arm, and her entire body soon convulses. She falls to the floor unconscious, her eyes roll, and she is incontinent of feces and urine. She sometimes has hallucinations during these seizures. When she regains consciousness, she has a headache and will sleep for hours.

When Jane was referred to social service, she had already left the hospital to begin her one year of trial visit. The referral from the doctor requested help in facilitating her adjustment to her home and the community.

The case was assigned to a female worker. This worker found Jane to be very willing and cooperative but rather demanding of her time and attention. Her seizures, which had been controlled by dilantin while she was in the hospital, had begun again since her return to the home. This was in spite of the fact that she continued to take her dilantin regularly. The parents were extremely rejecting, showed no interest in helping Jane, and would not cooperate with the worker. Because of this, another worker was assigned to work with the parents. The parents cooperated superficially with this worker but not in a meaningful way. They would verbalize understanding and interest, but their action with Jane denied the reality of this.

Jane felt her seizures were related to her being home and asked for the worker's help in
getting out of the home. The worker responded by trying to get her employment which would get her out of the home and give her an outside interest. The parents discouraged any plans in this direction, and the plan failed. They told her that she might as well give up, because she could never get a job or do anything else right.

Because of the very negative home situation, it was decided that Jane should be referred to the Department of Mental Health, Division of Mental Deficiency. This would be for a community commitment and would remove her from the home. She would be put into a community placement where she would be under the protective custody of the Department of Mental Health. They would help her in her living adjustment and also with vocational planning. This referral was made just before Jane was to be discharged.

Between the time of discharge and the completion of the referral, Jane suddenly married another mental defective. The worker was not consulted and discovered this only when she contacted the family. The parents were then seen, and they expressed great relief at having Jane out of the home. They showed no concern for or interest in her marriage.

Because Jane was discharged from the Hospital her relationship with the worker had to be terminated. Her status at the present time is unknown.

Interpretation

This case points up the desirability of having the cooperation of parents or other significant figures in the patient's environment. These parents were ashamed of their epileptic daughter. They withdrew her from school and kept her home. This was overprotection motivated by guilt.
and shame. They wanted to be rid of her but did not want her out where she would be seen as a reflection on them.

Because of this Jane had little opportunity to learn how to relate to other people. Unfortunately, she was out of the hospital and in the home before the referral was made to social service. As a result, the worker did not have the usual opportunity to establish a positive relationship with her prior to her return to the negative home environment. Also, there was no chance to consider alternative plans for Jane. Because of her parents' interference and the lack of a supporting, positive relationship, Jane failed to relate meaningfully on a case work basis.

In the doctor's referral, the worker was asked to facilitate the patient's adjustment in the home and the community. Other problems, implicit in this referral, arose immediately. The uncooperative parents had to be worked with. Assigning another worker to them did not make any appreciable difference.

Jane's worker tried to relieve her home situation by accepting some of her dependency needs and her hostility. This helped, but the transference was not strong enough to counteract the parent's influence. Then it was apparent that these supportive techniques were of such limited value, it was decided to use community resources as a means of alleviating the home situation and helping Jane to make a more ade-
Case B

Sam B. is another case of a feeble-minded epileptic who has suffered almost total rejection from his family all of his life.

His developmental history indicates that he was born normally when his mother was thirty-five years old. He was the fourth of five siblings. His development was uneventful, but it was slower than normal. He failed the first grade and his parents put him in an institution as a mental defective. He was then seven years old, and he remained there until he was nineteen years old.

His adjustment at the school was considered poor. He was uncooperative, assaultive, and generally maladjusted. Sam will not talk much about these twelve years of his life. He describes it as an unhappy experience which he would rather forget.

When he was released from the school, he went to live with his father. His parents had been divorced while he was in the school, and his mother had re-married. Sam lived with his father and his father's housekeeper. He held occasional jobs as a bus boy and dishwasher. These jobs were often in restaurants where his father worked as a dishwasher.

During the early part of this period, Sam developed his first epileptic seizures. These were of the grand mal type. He sometimes has a warning sure which he describes as a "funny feeling" in his stomach. The convolution then begins and engulfs his entire body. He falls to the floor unconscious and is incontinent of feces and urine. When he awakes, he feels depressed and likes to sleep for hours. He is easily irritated before and after his seizures, and he has been known to assault people at these times.
Sam was admitted to the state hospital when he was twenty-one years old, because he threw a chair at his father after coming out of a seizure. His diagnosis was psychosis with convulsive disorders (ideopathic epilepsy). Since being in the hospital, he has escaped three times and gone to live with his father each time. This has been followed by a seizure, and his father calls the police to return him to the hospital.

Sam was referred to social service after he had been in the hospital for two years. The referral was to pre-discharge planning for employment. The male worker assigned to the case took him to employment agencies and finally located a job for him in a boarding home as a general helper for five dollars per week. Sam kept this job one week and then quit. He felt his employer was not paying him enough. He then found a job as a bus boy and went to live with his father. In a few weeks, he had a seizure on the job and was returned to the hospital. This same pattern occurred three times. Sam did not maintain contact with the worker on any of these escapes. After the third escape, he was kept in a locked ward of the hospital and not allowed out. The worker had attempted to establish a case work relationship with Sam but found it impossible. He looked at the worker as a person who could help him get out of the hospital. He cooperated only to the extent required to get out.

Three months later, the case was again referred to social service and assigned to another male worker. This referral requested the worker to establish a relationship with Sam and work toward employment planning.

This contact lasted for five months and involved twenty-four interviews. Sam was again able to relate only on a superficial basis. It became apparent that his parents had rejected him all of his life. They wanted to have nothing to do with him. They were frightened by his seizures and felt he was a "strange boy". Sam had much repressed hostility toward them but could not release it. The worker attempted to help him abreact his hostility by focusing it on the worker, but this did not work. Sam could express no hos-
tility toward anyone or anything, except his ward. He hated the ward he was on.

Sam's attitude was always one of self-assurance. However, he conveyed his fear of having seizures and of being a mental patient in subtle ways. He would never admit these feelings openly. He would make unrealistic plans and claim that God would help him, if he could only get out of the hospital. He felt that God could cause him to have a seizure any time he wanted to.

Sam tried to use the second worker much the same as he did the first— as a means of getting out of the hospital. However, he did verbalize understanding of the plan to work things through that were necessary before he could be released. After five months of intensive case work, the worker and the doctor decided that Sam had progressed enough to warrant going out one day at a time to look for work. His seizures were fairly well controlled, although he had one about every six weeks. It seemed that emotionally disturbing situations precipitated the attacks, so the worker planned close, supportive supervision.

With the help of the worker, he got a job as a bus boy in a cafeteria. He worked there one week and then quit, because the work was too strenuous. However, he maintained contact with the worker by telephone. He then looked for employment in several hospitals, because he thought that would be an understanding environment. He was turned down each time when he told them he was an epileptic.

Because of his good behavior in returning to the hospital every night and maintaining contact with the worker, Sam was allowed to have a weekend pass. Unfortunately, and without notifying the worker, he went to his father's home to stay. At this time, his niece died, and he and his father and a cousin went to the funeral. After the funeral, they had a few drinks and went home that evening. After Sam and his father got home, he stabbed his sleeping father to death. The reason he gave for doing this was that his father was not happy. He killed him to put him out of his misery. The worker was not allowed
to see him after this incident. At the time of this study, Sam is awaiting trial by the Grand Jury.

Interpretation

This mentally defective epileptic had been in institutions for fourteen of his twenty three years. His rejecting home life followed by an unhappy experience at an institution established this pattern of behavior. In the state hospital, he retained his established pattern of not relating to authority figures in a positive way. The two workers were authority figures, and a case work relationship was difficult to develop.

Sam was both ashamed and afraid of his epilepsy. He would sometimes deny that he had had a seizure. He would never admit any doubts or fears concerning the attacks. His unrealistic planning was probably an extension of his long fantasy life which institutional life had activated.

In spite of the wall Sam put between himself and the workers, the relationship became strong enough so that he maintained contact with the second worker when he was out of the hospital and did not try to escape. This was an encouraging improvement over past relationships. Unfortunately, the events of the weekend proved too much for him. His niece died; he went to the funeral, which is an emotional experience; he drank, and alcohol often results in seiz-
ures for an epileptic; and then he was left alone with his rejecting father. This illustrates the realistic limitations of case work.

**Case C**

Paul is another feeble-minded epileptic. He was admitted to the state hospital in August, 1951 for behaving peculiarly in connection with trying to help a nurse. She claimed she did not need his help and that he was annoying her, so she called for the police. Paul was twenty-four years of age when this happened. His diagnosis was psychosis with convulsive disorders (ideopathic epilepsy).

Paul was born with a congenital ear defect which required several operations when he was a baby. He developed slowly and did not talk until he was five years old. He was backward in school, and his parents withdrew him from the second grade to keep him home. He can neither read nor write very well.

Paul's seizures began when he was nine years old and were of the grand mal type. He has never had a full time job, and his parents do not encourage him to work at all. He had a few part-time jobs—usually as a paper boy. His parents wanted him to stay in the home, because they were afraid of the shameful scenes caused by having a seizure in public. Paul had a seizure while he was out with his mother several years ago, and she was so ashamed that she could not forget it. Paul spends most of his time sleeping, listening to the radio, watching television, and reading comic books.

Paul says he is always trying to help others. He has a very active fantasy life and trusts everybody. When he is frustrated in his attempts to help somebody, or when somebody he trusts disappoints him, he becomes very moody and stubborn... He impresses one as very immature, inadequate, and dependent.
When Paul was referred to Social Service, he was already on trial visit and living with his parents. The referral was for employment planning and emotional stabilization. A male worker was assigned as a means of helping in Paul's masculine identification. The worker found him to be very dependent. He wanted the worker to do many things for him, including finding a good job for him immediately.

The worker attempted to stabilize Paul emotionally and help him to be more realistic in his relationships and his thinking. Work with the parents was also attempted but was not successful. They were simultaneously overprotective and rejecting. They kept him home but did not want to have much to do with him while he was home. His mother would not call him in the morning when he had an appointment to look for a job or to see the worker. She felt that the longer he slept, the less she would have to have him around her. He tried to help her around the house, but she would not let him, because he made her nervous. He would react to this rejection by feeling guilty and depressed. When he would try to show some initiative towards doing anything, his mother would discourage him. Paul would show his resentment and hostility by being messy around the house. He left his clothes in the middle of the room and threw magazines around the house.

The worker at first accepted Paul's dependency in order to establish a relationship. Gradually, limits were set for him so that the dependency could be more controlled. This was done by regulating the frequency of the contacts and insisting that Paul be punctual for his appointments. This plan met resistance but slowly succeeded. The worker also made it a point to compliment him on his dress and appearance, and Paul slowly took pride in dressing properly.

Paul was very discouraged about his being an epileptic. Actually, mesantoin had successfully controlled his seizures for four months, and the prognosis was considered good. The worker gave him support in this to counteract
the parental influence. He also supported him in his strivings for independence from his parents and in his desire to get a job.

His year of trial visit was completed on January 18, 1935, and he had to be discharged. The worker felt he still needed help. A referral was made to a vocational guidance agency for help with employment. He was also referred to a Nerve Clinic for case work services and continued help with his epilepsy. Paul took the separation from the worker very hard, but it was worked through satisfactorily. Paul made the transfer successfully, and the two agencies are now working with him.

**Interpretation**

In spite of the handicaps of epilepsy, feeble-mindedness, and a negative home situation, Paul was able to benefit from the case work offered to him. Through the support of the worker, Paul was able to become more independent and see himself more as an individual. His ego was strengthened.

He received no encouragement at home, and he reflected his parents feeling of guilt about the disease. His desire to help others would seem to be a result of this guilt. His strong dependency needs were first met and then controlled by the worker. This was difficult but essential in helping Paul to move forward.

Paul had positive factors to work with, and this helps account for the success in this case. He wanted to be more independent, and he recognized the negative aspects of his home environment. With this as a found-
ation, the worker was able to accent these positives and try to counteract the negatives.

The referral to community agencies at the time of his discharge was accomplished with good timing, and there was no lapse between the supervision of the hospital and the agencies to which he was referred.

**Case D**

Frank S. was committed to this state hospital on August 7, 1952. He had been found drunk and was kicking in a door. He thought he was the devil, and he was looking for his wife. In addition to his drinking, he is subject to epileptic seizures of the grand mal type. His intelligence tests at bright normal. His diagnosis was acute brain syndrome associated with convulsive disorders.

Frank was the youngest of eight siblings. The family was in the lower socio-economic stratum. His parents both died while he was in early adolescence. Because of this, he was sent to California to an older sister. She could not care for him, so he was sent to a school for boys. After two years in this school, he entered the Merchant Marine and has been with them intermittently since that time. During World War II, he was in the Navy for four years.

While in the Navy, he married a girl whom he had met casually while on leave. He had to go back to the ship after the marriage and did not see his wife for a year. During this year, he was hit on the head with a club and knocked unconscious. His seizures date from that episode which took place when he was twenty-two years old.

When he was discharged from the Navy, he lived with his wife for six months and then went back into the Merchant Marine. His wife felt he had changed from the wonderful man she had married.
He had become irritable, moody and suspicious of her. He has tried to strangle her twice when he has been drinking.

This marriage lasted for eight years and three children resulted from it. Frank and his wife are now separated, but he is still devoted to the children. In the early part of their marriage together, he was very conscientious about supporting his family. Since being in the hospital, he has expressed the desire again to be in the position to provide for them.

In his employment history since his first seizure, he has held several jobs as a seaman with different oil companies. On these jobs, his seizures have caused him either to be fired or he has quit because of the embarrassment he feels. He did not take his medication regularly, and this is partially to blame for his seizures.

While still in the hospital, he was referred to social service for help in changing his vocation, because it was felt that working on a ship was dangerous for an epileptic. In the course of the case work contact, Frank expressed shame and guilt about having seizures. He had serious doubts about his ability to function as a man, because of his many employment failures and his unsuccessful marriage. He felt he never should have married his wife - "she drinks like a fish and runs around too much".

Frank was anxious to cooperate with the case worker and was able to benefit from talking to an understanding and accepting person. The worker's main activity was to support this dependent, insecure man and let him talk about his problems. This catharsis was the main therapy for Frank. Through having the worker encourage him to take his medication regularly and with emphasis on the importance and necessity of it, he brought his seizures under control. Through suggestion and encouragement to take part in patient activities, he began to feel more like a man. He became president of the patient government in his building and did very well at it.

With such encouraging improvement, he was
referred to the Office of Vocational Rehabilitation. He was accepted for training by them and is now studying at an electrical and technical school. His seizures are controlled by dilantin and he is adjusting extremely well.

**Interpretation**

Frank was able to benefit from the case worker's help. His seizures had begun late in his life and there was not yet a difficult pattern of defenses that the worker had to work through before progress could be made. He was intelligent. He wanted help with his problems and accepted the worker in a beneficial case work relationship. The worker helped strengthen his ego to the point where he could accept the responsibilities and opportunities of training for a new, or more appropriate type of employment. The worker's support enabled him to carry out this plan. The worker then made the necessary referral so that he could get the desired training. His prognosis can be considered good.

**Case E**

Jim V. was admitted to this state hospital on October 5, 1950 for being excited, noisy, violent, and assaultive. He is an alcoholic epileptic with a normal I.Q. He says he has been drinking for fifteen years and drinking heavily since his mother's death ten years ago. He has been hospitalized for delirium tremens several times. There is some indication of organic brain damage but no mem-
cry loss. His diagnosis is alcoholic psychosis with convulsive disorders.

Jim's birth and development were normal. He was the eldest of five children born to parents who were both alcoholic. He completed the eighth grade and then withdrew from school to go to work when his father died. As an adult, Jim spent five years in the Merchant Marine. He then began working in plastic manufacturing plants and continued in this industry for nine years. He is considered a skilled plastics worker. In the course of these nine years, he has held several jobs and lost each one of them because of having a seizure or drinking.

Jim lived with his mother until she was killed by an automobile in 1941. She died in his arms. He had a strong attachment for her and felt a great responsibility for caring for her. He was the only child to remain with her in spite of her being an alcoholic, and her death was an extremely traumatic event in his life. He feels he "cracked up" when it happened. He had been drinking for five years prior to her death, but he drank heavily after her death and until his admission to the state hospital.

Jim's epilepsy began in his childhood, but the seizures were not a serious handicap until he began to drink in his middle twenties. The seizures were of the petit mal type at first, but drinking brought on grand mal seizures. He says he only drinks when he gets lonely, but he gets lonely very often. When he began taking Dilantin and was not drinking, he had no seizures. However, he has been very lax in taking his medication, and he has never stopped drinking for long. He finally began having paranoid ideas and thought his Dilantin had been poisoned, so he stopped taking it. He suspected his landlord of wiring his bed so he could electrocute him. His seizures increased, he grew more assaultive, and he finally had to be admitted to the state hospital.

When he recovered from his psychotic episode, he was referred to social service for help in finding employment and a place to live. A male worker was assigned to the case. The worker found Jim to be a dependent person who felt that the worker
should get him a job immediately. He grew hostile toward the worker when he did not find a job. The worker accepted his hostility. After this reality testing, Jim was able to accept the case work relationship. He was helped to accept the realistic limitations of his epilepsy and employment plans were made accordingly. Jim had been afraid and ashamed of his seizures and had tried to deny these feelings. The worker felt progress had made in Jim's attitude by supporting the positive factors in his situation and being realistic about the negative factors without emphasizing them.

Jim was ambivalent about his dependency needs. The worker encouraged his masculine strivings and played up his successful achievements. He responded to this and also accepted the strong emphasis put on the necessity of his taking his medication.

After thirteen weekly interviews, Jim was allowed to go out to look for work and return to the hospital at night. He soon found a job in a plastics plant. His Dilantin has controlled the seizures for five months, and he has not drunk since his admission to the hospital. He claims that his psychotic episode and the resulting admission to a mental hospital have cured him from drinking. He is still holding the job and is making a good adjustment. He still lives in the hospital but will be allowed to live out soon. His greatest fear, and one which he still has, is that it will be discovered that he has been in a mental hospital. The worker is helping him with this and it is being worked out as he discovers that he is actually accepted by his fellow employees. The worker continues the contact on a weekly basis.

**Interpretation**

Jim's epilepsy was not a critical problem until he began to drink. His attachment to his mother was unusually strong, and his drinking began while he was caring for her. Her death marked the beginning of
his heavy drinking. It seems that their relationship was neurotically tinged. This area of his feelings was not worked with directly by the worker, and this did not seem advisable. His epilepsy, which was aggravated by his drinking, was a problem which he attempted to deny. This was unsuccessful and proved to be a handicap in his employment. His failures and rejections in his work probably increased his feelings of guilt and frustration. The paranoid condition began when his other defenses began to be less effective. He finally was institutionalized as psychotic.

The worker helped him express his feelings, fears, and guilt. Jim was able to achieve a more masculine identification. His ego was strengthened to the point where he could operate as an independent man. It is too soon to judge the permanence of Jim's adjustment, but the prognosis looks hopeful as of now.
CHAPTER IV

SUMMARY AND CONCLUSIONS

The purpose of this study was to investigate the role of the social worker in working with epileptic patients at a state mental hospital. In carrying out this investigation, three questions were considered:

1. What are the presenting problems in the referral of the patient to the Social Service Department?

2. What are the actual problems as seen and treated by the worker?

3. What are the techniques employed by the social worker in working with the epileptic patient?

Background information was presented in order to achieve an understanding of the disease and of the worker in the setting in which the study was made.

A brief historical survey of epilepsy and the superstitions and beliefs surrounding it was given so that present-day ideas might be better understood. It was noted that much progress has been made in the medical treatment available for epileptics. It was also noted that the attitude of society has changed very little over the passing centuries. The public is still superstitious and uninformed about epilepsy.
The four major classifications of epileptic seizures were described. These were: grand mal, petit mal, psychomotor, and Jacksonian.

Basic to these four types of seizures is the inherent predisposition to seizures. This is the fundamental cause of epilepsy. It is described as a peculiar electrophysicochemical reaction of nerve cells in the brain, and it is called a cerebral dysrythmie.

Medicinal control of most seizures is now possible, but this does not mean they can be cured. The drugs used to achieve this control are phenobarbital, dilantin, mesantoin, tridione, paradione, and phenurone. These must be taken under medical supervision.

The epileptic as a person was discussed. The epileptic's personality was discussed. Epileptics do have psychological traits which any chronic disease might produce.

Problems facing the epileptic were discussed in general. Major areas of difficulty in the epileptic's life are: personal or emotional problems, family relationships, social relationships, education, and employment.

Five case studies were presented. The five patients studied included four men and one woman. Only one of these patients had married, and that ended in a separation after eight years. The separation was attributed to the patient's irritability and suspiciousness. One feeble-minded patient
was married after her discharge from the hospital. She married another feeble minded person. Two of the three who were not married expressed the desire someday to marry. The other one saw no point in marriage and felt that what he would want out of marriage could be easily purchased.

One of the patients was an only child, and his family were overprotective and rejecting. Three of the patients had four siblings, and one had seven. In no case was there a close feeling between the patient and his or her siblings. In those cases with numerous siblings, the parents rejected the epileptic and favored the other siblings. One exception to this was the alcoholic, Jim. He seemed to have assumed the role of his father and had a close relationship with his mother.

The educational picture was consistent with findings of other studies. Three of the patients were withdrawn from school because of parental feelings about their having had seizures in school. One went as far as the third grade, one went to the second, and one went to the first. However, the factor of the feeble-mindedness of these three patients is important in understanding the reason for the withdrawals. The other two patients had normal intelligence. One completed the eighth grade, and one the tenth grade. Their leaving school was not due to epilepsy. It was due to other factors.
The three feeble-minded patients had no employment history on which to build a vocational program. The female patient had never been allowed to work. The other two had held several jobs of a menial and temporary nature. They did not inform their employers of their epilepsy, and the jobs were usually terminated because of seizures. This is a pattern which has been found to be typical in other studies. The two oldest patients, who did have a work history, were able to benefit from vocational planning. One was able to enter a trade school to learn a new, appropriate vocation. The other obtained a job in his former industry of plastics, but in a position which was not hazardous for him.

As to the seizures, themselves, three of the patients had only grand mal seizures. One had Jacksonian, and one had both grand mal and petit mal.

The age of onset of the seizures varied from childhood to twenty-three years of age. This factor seemed to have no consistent bearing on the course of the patient’s life. The patient whose seizures began in his childhood had the best employment history and had a specialized skill in plastics. The patient whose seizures began when he was twenty-three years old also had an acceptable work record. Here again, these two men had normal intelligence, and the other three did not.
**REFERRAL PROBLEMS**

Regarding referrals, four of the five referrals were for employment planning in preparation for discharge. Two of these also involved emotional stabilization and help in planning and thinking more realistically. The fifth referral was for help in her home and community adjustment.

**ACTUAL PROBLEMS**

After the worker began to work with the case, other problems became apparent. In every case, a major problem was that of getting the patient to relate on a case work basis. Due to defense patterns which were well established, or strong dependency needs, it was difficult to reach the patient. In two cases this was never successfully done. The other three were difficult but successful.

The patients were in various stages of emotional readiness for employment or home adjustment. This necessitated helping the patient prepare to accept and hold a job. The patients also required help in understanding and accepting their epilepsy and its implications. This appears to be a fundamental factor in working with epileptics, and it is essential that this phase of the contact be adequately handled.

In two cases, it was necessary to work with the parents. These parents were both overprotective and rejecting and did not cooperate with the worker's attempts to help the
patients. In one of these cases, a separate worker was assigned to the parents, but it helped very little. In another case, the parents wanted nothing to do with the patient and would not enter the case at all.

TECHNIQUES EMPLOYED BY WORKER

The role of the social worker involved working in three major areas. The first was that of the personal or emotional problems of the patient. This includes the emotional involvement in accepting their epilepsy. The second was the area of inter-personal relationships, including the patient's relationship with his parents and family. The third area of the worker's activity was in the patient's environment. The latter included primarily employment planning and living arrangements.

In working in these three areas, a goal was to give the patient a corrective experience with a positive, accepting, understanding person. In this role, the worker gave the patient the experience of being accepted as a person - not a rejected, handicapped epileptic. This approach was used in each case. Implicit in this were the supportive attitudes of the worker, strengthening the patient's ego so that he could move with the worker's planning.

Manipulation was attempted in three cases. One such effort in the home was too late to be of help. Two cases were successful in that they were able to go ahead with
employment which was suitable for them with their epilepsy. The worker knew of vocational resources and was able to help the patients see the desirability of the proper employment. A knowledge of available community resources which can be used to advantage is a necessary tool of the social worker.

The person with epilepsy has the same needs, desires, feelings, hostilities, and emotions as any other human being; his situation becomes enormously complicated because of the nature of his illness and the stigma attaching to it as far as society, his family, and he, himself, are concerned. The feelings and emotions which patients show must be accepted and understood. The meaning which the illness had for the patient must be understood. This may or may not be verbalized by the patient. The epileptic is an individual and must be considered and treated as such. By doing these things, the worker helps to integrate the epileptic's ego into a more meaningful, productive whole.

Besides helping the individual epileptic, the social worker can contribute to the growing literature on the subject. This study is an attempt to do this. The limited sample involved precludes any specific applicability to the epileptic population in general. Also, the fact that these patients are in a mental hospital indicates the severe extent of their maladjustment. The well adjusted
epileptic would not be found in this setting to receive the type of treatment given here. These cases point up the very complicated problems involved in social planning for epileptics; but also that even severely disturbed ones can be helped to make a limited adjustment. This emphasizes the necessity of being realistic in the planning and the establishment of goals.

In working with the epileptic's environmental problems, the social worker has a unique opportunity to interpret epilepsy and epileptics to the public. Through contacts with employers, vocational schools, relatives, community agencies, and other resources which are utilized, the worker can present the factual side of epilepsy. He can help combat the prejudices, ignorance, and superstition which thwart the epileptic in his attempts to be accepted as an individual.

Approved: 

\[Signature\]

Richard K. Conant
Dean
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BOOKS


PERIODICAL REFERENCES


APPENDIX

SCHEDULE

I. INFORMATION ABOUT PATIENT

A. Name
B. Age
C. Sex
D. Marital status
E. Siblings
F. Family problems and adjustment
G. Education
H. Employment history

II. INFORMATION ABOUT PATIENT'S ILLNESS

A. Date of admission to hospital
B. Diagnosis
C. Type and frequency of seizures
D. Age at onset of seizures

III. INFORMATION ABOUT REFERRAL TO SOCIAL SERVICE

A. Reason for referral
B. Problem as worker saw it
C. Role of worker
   1. Areas in which worker operated
   2. Techniques used by worker