DOWNLOAD PDF SPECIAL SERVICES FOR PEOPLE WITH EPILEPSY IN THE 1970S

Chapter 1 : Formats and Editions of Special services for people with epilepsy in the s [calendrierdelascienc

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Associated issues[edit] Physical health issues[edit] There are many physical health factors associated with developmental disabilities. For some specific syndromes and diagnoses, these are inherent, such as poor heart function in people with Down syndrome. People with severe communication difficulties find it difficult to articulate their health needs, and without adequate support and education might not recognize ill health. Epilepsy , sensory problems such as poor vision and hearing , obesity and poor dental health are over-represented in this population. Mental health issues dual diagnoses [edit] Mental health issues, and psychiatric illnesses , are more likely to occur in people with developmental disabilities than in the general population. A number of factors are attributed to the high incidence rate of dual diagnoses: With this information psychological diagnoses are more easily given than with the general population that has less consistent monitoring. Access to health care providers: With consistent visits to health care providers more people with developmental disabilities are likely to receive appropriate treatment than the general population that is not required to visit various health care providers. These problems are exacerbated by difficulties in diagnosis of mental health issues, and in appropriate treatment and medication, as for physical health issues. Common types of abuse include: Physical abuse withholding food, hitting, punching, pushing, etc. Neglect withholding help when required, e. Psychological reactions to abuse were similar to those observed in the general population, but with the addition of stereotypical behaviour. The more serious the abuse, the more severe the symptoms that were reported. In addition to abuse from people in positions of power, peer abuse is recognized as a significant, if misunderstood, problem. Rates of criminal offense among people with developmental disabilities are also disproportionately high, and it is widely acknowledged that criminal justice systems throughout the world are ill-equipped for the needs of people with developmental disabilitiesâ€”as both perpetrators and victims of crime. Challenging behaviour Some people with developmental disabilities exhibit challenging behavior, defined as "culturally abnormal behaviour s of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities". A lot of the time, challenging behavior is learned and brings rewards and it is very often possible to teach people new behaviors to achieve the same aims. Challenging behavior in people with developmental disabilities can often be associated with specific mental health problems. This is especially the case where the services deliver lifestyles and ways of working that are centered on what suits the service provider and its staff, rather than what best suits the person. In general, behavioral interventions or what has been termed applied behavior analysis has been found to be effective in reducing specific challenging behavior. Until the Enlightenment in Europe, care and asylum was provided by families and the Church in monasteries and other religious communities , focusing on the provision of basic physical needs such as food, shelter and clothing. Stereotypes such as the dimwitted village idiot , and potentially harmful characterizations such as demonic possession for people with epilepsy were prominent in social attitudes of the time. Early in the twentieth century, the eugenics movement became popular throughout the world. This led to the forced sterilization and prohibition of marriage in most of the developed world and was later used by Hitler as rationale for the mass murder of mentally challenged individuals during the Holocaust. The eugenics movement was later thought to be seriously flawed and in violation of human rights and the practice of forced sterilization and prohibition from marriage was discontinued by most of the developed world by the mid 20th century. The movement towards individualism in the 18th and 19th centuries, and the opportunities afforded by the Industrial Revolution , led to housing and care using the asylum model. People were placed by, or removed from, their

families usually in infancy and housed in large institutions of up to 3, people, although some institutions were home to many more, such as the Philadelphia State Hospital in Pennsylvania which housed 7, people through the s , many of which were self-sufficient through the labor of the residents. Some of these institutions provided a very basic level of education such as differentiation between colors and basic word recognition and numeracy , but most continued to focus solely on the provision of basic needs. Conditions in such institutions varied widely, but the support provided was generally non-individualized, with aberrant behavior and low levels of economic productivity regarded as a burden to society. Heavy tranquilization and assembly line methods of support such as "birdfeeding" and cattle herding [clarification needed] were the norm, and the medical model of disability prevailed. Services were provided based on the relative ease to the provider, not based on the human needs of the individual. Their earliest efforts included workshops for special education teachers and daycamps for disabled children, all at a time when such training and programs were almost nonexistent. This book posited that society characterizes people with disabilities as deviant , sub-human and burdens of charity, resulting in the adoption of that "deviant" role. Wolfensberger argued that this dehumanization, and the segregated institutions that result from it, ignored the potential productive contributions that all people can make to society. He pushed for a shift in policy and practice that recognized the human needs of "retardates" and provided the same basic human rights as for the rest of the population. The publication of this book may be regarded as the first move towards the widespread adoption of the social model of disability in regard to these types of disabilities, and was the impetus for the development of government strategies for desegregation. From the s to the present, most U. Along with the work of Wolfensberger and others including Gunnar and Rosemary Dybwad, [28] a number of scandalous revelations around the horrific conditions within state institutions created public outrage that led to change to a more community-based method of providing services. In most countries, this was essentially complete by the late s, although the debate over whether or not to close institutions persists in some states, including Massachusetts. Services and support[edit] Today, support services are provided by government agencies, non-governmental organizations and by private sector providers. Support services address most aspects of life for people with developmental disabilities, and are usually theoretically based in community inclusion, using concepts such as social role valorization and increased self-determination using models such as Person Centred Planning. There also are a number of non-profit agencies dedicated to enriching the lives of people living with developmental disabilities and erasing the barriers they have to being included in their community. Special education Education and training opportunities for people with developmental disabilities have expanded greatly in recent times, with many governments mandating universal access to educational facilities, and more students moving out of special schools and into mainstream classrooms with support. Post-secondary education and vocational training is also increasing for people with these types of disabilities, although many programs offer only segregated "access" courses in areas such as literacy , numeracy and other basic skills. There are also some vocational training centers that cater specifically to people with disabilities, providing the skills necessary to work in integrated settings, one of the largest being Dale Rogers Training Center in Oklahoma City. See also Intensive interaction At-home and community support[edit] Many people with developmental disabilities live in the general community, either with family members, in supervised-group homes or in their own homes that they rent or own, living alone or with flatmates. At-home and community supports range from one-to-one assistance from a support worker with identified aspects of daily living such as budgeting , shopping or paying bills to full hour support including assistance with household tasks, such as cooking and cleaning , and personal care such as showering, dressing and the administration of medication. The need for full hour support is usually associated with difficulties recognizing safety issues such as responding to a fire or using a telephone or for people with potentially dangerous medical conditions such as asthma or diabetes who are unable to manage their conditions without assistance. The DSP works in assisting the individual with their ADLs and also acts as an advocate for the individual with a developmental disability, in communicating their needs, self-expression and goals. Supports of this type also include assistance to identify and undertake new

hobbies or to access community services such as education , learning appropriate behavior or recognition of community norms, or with relationships and expanding circles of friends. Residential accommodation[edit] Some people with developmental disabilities live in residential accommodation also known as group homes with other people with similar assessed needs. These homes are usually staffed around the clock, and usually house between 3 and 15 residents. The prevalence of this type of support is gradually decreasing, however, as residential accommodation is replaced by at-home and community support, which can offer increased choice and self-determination for individuals. Support to access or participate in integrated employment, in a workplace in the general community. This may include specific programs to increase the skills needed for successful employment work preparation , one-to-one or small group support for on-the-job training, or one-to-one or small group support after a transition period such as advocacy when dealing with an employer or a bullying colleague, or assistance to complete an application for a promotion. The provision of specific employment opportunities within segregated business services. Although these are designed as "transitional" services teaching work skills needed to move into integrated employment , many people remain in such services for the duration of their working life. The types of work performed in business services include mailing and packaging services, cleaning, gardening and landscaping, timberwork, metal fabrication, farming and sewing. Workers with developmental disabilities have historically been paid less for their labor than those in the general workforce, although this is gradually changing with government initiatives, the enforcement of anti-discrimination legislation and changes in perceptions of capability in the general community. They include heightened placement efforts by the community agencies serving people with developmental disabilities, as well as by government agencies. Additionally, state-level initiatives are being launched to increase employment among workers with disabilities. The Committee has been examining additions to existing community employment services, and also new employment approaches. Committee member Lou Vismara, chairman of the MIND Institute at University of California, Davis , is pursuing the development of a planned community for persons with autism and related disorders in the Sacramento region. Day services[edit] Non-vocational day services are usually known as day centers, and are traditionally segregated services offering training in life skills such as meal preparation and basic literacy , center-based activities such as crafts, games and music classes and external activities such as day trips. Some more progressive day centers also support people to access vocational training opportunities such as college courses , and offer individualized outreach services planning and undertaking activities with the individual, with support offered one-to-one or in small groups. Traditional day centers were based on the principles of occupational therapy , and were created as respite for family members caring for their loved ones with disabilities. This is slowly changing, however, as programs offered become more skills-based and focused on increasing independence. Advocacy[edit] Advocacy is a burgeoning support field for people with developmental disabilities. Advocacy groups now exist in most jurisdictions, working collaboratively with people with disabilities for systemic change such as changes in policy and legislation and for changes for individuals such as claiming welfare benefits or when responding to abuse. Most advocacy groups also work to support people, throughout the world, to increase their capacity for self-advocacy , teaching the skills necessary for people to advocate for their own needs. Other types of support[edit] Other types of support for people with developmental disabilities may include: Studies have been done testing specific scenarios on how what is the most beneficial way to educate people. Interventions are a great way to educate people, but also the most time consuming. With the busy schedules that everybody has, it is found to be difficult to go about the intervention approach. Another scenario that was found to be not as beneficial, but more realistic in the time sense was Psychoeducational approach. They focus on informing people on what abuse is, how to spot abuse, and what to do when spotted.

Chapter 2 : Exploring Epilepsy and Medical Treatment Options

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This is an open access article distributed under the Creative Commons Attribution License , which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. Abstract The purpose of this study was to present the evolution of views on epilepsy as a disease and symptom during the 19th and the 20th century. A thorough study of texts, medical books, and reports along with a review of the available literature in PubMed was undertaken. The 19th century is marked by the works of the French medical school and of John Hughlings Jackson who set the research on epilepsy on a solid scientific basis. During the 20th century, the invention of EEG, the advance in neurosurgery, the discovery of antiepileptic drugs, and the delineation of underlying pathophysiological mechanisms, were the most significant advances in the field of research in epilepsy. Among the most prestigious physicians connected with epilepsy one can pinpoint the work of Henry Gastaut, Wilder Penfield, and Herbert Jasper. The most recent advances in the field of epilepsy include the development of advanced imaging techniques, the development of microsurgery, and the research on the connection between genetic factors and epileptic seizures. Introduction The history of epilepsy is intermingled with the history of human existence; the first reports on epilepsy can be traced back to the Assyrian texts, almost 2, B. Multiple references to epilepsy can be found in the ancient texts of all civilizations, most importantly in the ancient Greek medical texts of the Hippocratic collection. However, it was not until the 18th and 19th century, when medicine made important advances and research on epilepsy was emancipated from religious superstitions such as the fact that epilepsy was a divine punishment or possession [3 , 4]. At the beginning of the 18th century, the view that epilepsy was an idiopathic disease deriving from brain and other inner organs prevailed. One should mention the important work in this field by William Culen â€” and Samuel A. Tissot whose work set the base of modern epileptology describing accurately various types of epilepsies. Anatomy and Physiology of Epilepsy 2. Evolution of Thoughts around the Pathophysiology and Causes of Epilepsy At the beginning of the 19th century, physicians from the French medical school started to publish their research in the field of epileptology; famous French physicians published their works on epilepsy such as Maisonneuve â€” [5], Calmeil â€” [6], and Jean-Etienne Dominique Esquirol â€” Maisonneuve stressed the importance for hospitalization of epileptic patients, categorized epilepsy into idiopathic and sympathetic and described the so-called sensitive aura of sympathetic epilepsy. Esquirol distinguished between petit and grand mal and along with his pupils Bouchet and Cazauvieilh studied systematically insanity and epilepsy conducting clinical and postmortem studies [3]. During the second half of the 19th century, medicine focused on the delineation of pathophysiology of epilepsy and the topographic localization of epileptic seizures. The work, however, of John Hughling Jackson â€” Figure 1 , set the scientific base of epileptology [3]. Jackson studied epilepsy on pathological and anatomical basis. His Study of Convulsions was the culmination of his research stressing the existence of localised lesions on cortex involved in epileptic convulsions. In , Jackson gave the following definition for epilepsy: John Hughlings Jackson â€” adopted by public domain at http: Epileptology, based on the work of Jackson and other eminent doctors of the 19th century, such as John Simon â€” , John Russell Reynolds â€” , Samuel Wilks, William Richard Gowers â€” , Adolf Kussmaul â€” , and Adolf Tenner, expanded and made important steps towards the elucidation of the pathophysiology of the disease and in the field of therapeutics [3]. He was the first to describe the structure of neurons and synapses, a hallmark finding in the history of neurology. His findings were the culmination of efforts which began in , when he started employing the Golgi staining in the study of the nervous system. As a reward of his efforts, Cajal, in , received the Nobel Prize [8]. In , Gowers published his famous book The Borderlands of Epilepsy [9] focusing on faints, vagal and vasovagal attacks, migraine, vertigo, and some sleep symptoms, especially

narcolepsy. In , Dale â€" identified acetylcholine [10], the first neurotransmitter, a discovery confirmed later in by Loewi â€" who initially named it Vagusstoff, since it was released by the vagus nerve [11 â€" 13]. Lennox and Cobb focused on the effects of various stimuli to the generation of epileptic convulsions such as starvation, ketogenic diet, and lack of oxygen, most of them with negative results. During the s, important discoveries were made in the field of psychomotor epilepsy. In , Jasper â€" and Kershmann proved that the temporal lobe is the site of origin of psychomotor seizures [18]. At the same period, Moruzzi â€" and Magoun â€" discovered the reticular formation in the brain [19]. Magoun continued his research with Lindsley â€" and Starzl identifying various neural pathways within the brain and pointing out the important role in alert wakefulness as a background for sensory perception, higher intellectual activity, voluntary movements, and behaviors [20 , 21]. Dawson in recorded the responses from the human scalp in response to somatosensory stimuli somatosensory evoked potential [22], whereas in Roberts and Frankel discovered -aminobutyric acid GABA [23]. Important advances were made in the field of neuroscience and in the physiology of synapses by Eccles â€" , Kandel , Spencer â€" , Speckmann , Purpura, Meldrum, and others [24 â€" 38]. In the same year Gastaut managed to organize a meeting in Marseilles attended by members of ILAE and a preliminary classification of epilepsies was presented to a commission on terminology of epilepsy. The General Assembly of the ILAE accepted the first publication of clinical and electroencephalographic classification of epileptic seizures [39 , 40]. Dreifuss â€" worked on video-monitoring of absence seizures and helped in the classification of various epileptic conditions [41]. During the last two decades, various changes regarding the epileptic brain damage were also studied, such as the mossy fiber sprouting and synaptic reorganization [48 â€" 51]. Five years later, in , Caton â€" examined the electrical activity of nerve-muscle preparations and explored the possibility whether similar changes in electrical potential occurred in the brain [52]. A few years later, in , Beck from Cracau in the pages of Zentrallblatt for Physiologie argued the case for the priority of the electrical activity of the brain, after electrical stimulation in the brain of dogs and rabbits [53]. In , Kaufman â€" , a Russian physiologist, noticed the electric changes in the brain during experimentally induced seizures, associating epileptic attacks with abnormal electric discharges [54] EEG. In the same year, Pravdich-Neminsky â€" , a Ukrainian physiologist, published the first animal EEG and the evoked potential of the mammalian dog [55]. Two years later, Cybulski â€" , a Polish physiologist and pioneer in electroencephalography, in cooperation with Jelenska-Macieszyna [56], published the first photographs of electroencephalography recording action potentials at a dog with focal epilepsy. Important discoveries in the fields of electroencephalography were made during the s and s. In , Berger â€" , a German neurologist, reported his findings on human brain waves [57], five years after his initial recording of the first human electroencephalogram. His results brought controversy and scepticism within the scientific community, but he was neither rejected nor ignored; his results were confirmed later by Adrian â€" and Matthews [58]. In the next few years until , Berger made important observations on patients and on healthy subjects. In , he went to the Montreal Neurological Institute MNI with Wilder Penfield â€" , famous Canadian neurosurgeon, and Herbert Jasper Figure 3 â€" , a Canadian psychologist, physiologist, anatomist, chemist, and neurologist who established in an EEG laboratory and studied the role of thalamic reticular structures in the genesis of metrazol-induced generalized paroxysmal EEG discharges and developed the concept of centrencephalic seizures [65]. After his return to Marseilles, Gastaut founded the International EEG Federation and, in , became the Head of the Marseilles Hospital Neurobiological Laboratories establishing a school of neurology that dominated for the next decades. His contribution in the study of epileptology was monumental; with his wife, Yvette, he defined five major human EEG patterns lambda waves, pi rhythm, mu rhythm, rolandic spikes, and posterior theta rhythm [66 , 67]. He also described two syndromes under his name: Gastaut syndrome, a type of photosensitive epilepsy [68], and the Lennox-Gastaut syndrome severe childhood encephalopathy with onset in childhood with myoclonic seizures at night, head nodding, and drop attacks particularly prominent [69 , 70]. He also studied photic and other self-induced seizures, startle epilepsy, HHE syndrome, and benign partial epilepsy of childhood with occipital spike-waves [68 , 71 â€" 75]. Henri Jean

Pascal Gastaut â€" adopted by public domain at http: Wilder Penfield â€" on the right and Herbert Jasper â€" on the left adopted by public domain at http: During the s, important EEG studies were conducted in animals mainly by Prince and his research team demonstrating the spikes and waves associated with synchronous paroxysmal depolarizing bursts occurring in cortical neurons [76 â€" 79] and the spike-wave complex [80]. In , Falconer recognized the importance of hippocampal sclerosis in temporal lobe epilepsy [81]. The Patch-Clamp Technique An important development in the field of neuroscience was that of Neher , who invented the patch-clamp method to measure the flow of current through single-ion channels [82]. Neher and Sakmann developed the patch-clamp technique for which in they received the Nobel Prize [83]. Using the patch-clump technique, the various ion channels were able to be studied and, thus, the role of calcium channels was clarified in epilepsy [84]. Therapy of Epilepsy 3. The Evolution of Antiepileptic Surgery The first surgical procedures on epileptic patients were performed during the 19th century; Heyman in was the first one to perform a surgery to an epileptic patient due to a brain abscess. Surgical excision was performed on November 25, , by Dr. Godlee in the National Hospital of London. Both Theodor Kocher â€" , a Swiss surgeon from Bern, Nobelist, and pioneer in epileptic surgery, and Harvey Cushing â€" , father of modern neurological surgery, in Baltimore dealt with posttraumatic epileptic disorders especially with patients displaying high endocranial pressure [85 , 86]. In , Horsley â€" excised an epileptogenic posttraumatic cortical scar at the National Hospital of London in a year-old man under general anesthesia and discussed his choice of anesthesia: At the beginning of the 20th century, Dandy â€" introduced hemispherectomy as a neurosurgical procedure in [90]. However it was not until the s than important advances were made in epileptic surgery. The notion of operating the epileptogenic focus was introduced by Gibbs and Lennox in [91]. The introduction of EEG into epilepsy surgery was important in the development of surgical techniques. Penfield along with Jasper and Theodore Brown Rasmussen â€" in the Neurologic Center of University of Montreal also contributed importantly to the evolution of the surgery of epilepsy [92 , 93]. Penfield applied the Foerster method for removing epileptogenic lesions on an epilepsy patient. After founding the Montreal Neurological Institute MNI , in , in collaboration with Jasper, he invented the Montreal procedure for the surgical treatment of epilepsy. Then the surgeon proceeds in the removal of brain tissue in this location reducing the side effects of surgery [94]. Through his operations, Penfield was able to identify various brain centers and to create maps of the sensory and motor cortices of the brain. Research in MNI focused also on other areas of epileptology such as neurochemistry, oncology, and brain angiology. Penfield perfected and established his surgical procedures as a treatment of choice in intractable epilepsy, especially of neocortical regions [94 â€" 96]. In , Penfield published with Jasper one of the greatest classics in neurology, Epilepsy and the Functional Anatomy of the Human Brain [93]. Bailey â€" , an American neuropathologist, neurosurgeon, and psychiatrist, known for his work on brain oncology, was the first to attempt temporal lobectomies for psychomotor seizures and the first to use electrocorticography for intraoperative localization [98]. One should also mention the method of hemispherectomy introduced by McKenzie â€" [99] and Krynauw in [ ]. Bailey and Gibbs in employed the EEG as a guide to perform temporal lobe surgery [98], whereas, in , Falconer, a neurosurgeon from New Zealand, in London, introduced the en bloc anterior temporal lobe resection and the term mesial temporal sclerosis [ ]. The work of Margerison and Corsellis led to the term of hippocampal sclerosis [ ], a pathological entity which was initially described almost 80 years earlier by Sommer in [ ]. Niemeyer, in , suggested a more selective procedure of resection of the mesiobasal limbic structure [ ], a technique which was later on abandoned. The next important step in the field of antiepileptic surgery was done by Tailarach and his team. Within this operating room teleradiography would take place and the use of parallel X-ray beams would avoid distortions of skull, vessels, ventricles, and the frame and grids used for guiding the placement of intracranial electrodes. The first stereotactic surgery operating room was opened in Sainte-Anne in [ ]. Their method brought a revolution in the surgery of epilepsy, since it allowed investigative presurgical and therapeutic surgical phases to be completely dissociated. Tailarach and Bancaud employing their technique showed that lesional and irritative zones had a

variable topographic relationship within the epileptogenic zone [14]. During the s, Bogen and Vogel reintroduced the procedure of callosotomy [ ] as a procedure for certain cases of pharmacoresistant epilepsy with severe atonic akinetic seizures. In , White published a comprehensive review on the surgical procedure of hemispherectomy summarizing the results of published cases [ ] in the treatment of infantile-type hemiplegia and seizures. At the beginning of the s, in the field of antiepileptic surgery, MTLE suggested selective amygdalohippocampectomy AHE with the trans-Sylvian approach, replacing the anterior temporal lobe resection [ ]. Drug Therapy As far as therapies and the neurophysiology of epilepsy are concerned, much were already known during the second half of 19th century. Treatment of epilepsy till that time mostly consisted of herbal and chemical substances. In , Sir Locock â€" discovered the anticonvulsant and sedative traits of potassium bromide and began treating his patients. From that point, potassium bromide became a choice treatment for humans with epileptic seizures and nervous disorders until the discovery of phenobarbital [ ]. In , Hauptmann â€" , a German physician, introduced phenobarbital in the therapy of epilepsy, one of the first antiepileptic drugs [ ]. Phenobarbital was brought to market by the drug company Bayer using the brand Luminal.

Chapter 3 : Highights in the History of Epilepsy: The Last Years

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Page 26 Components of the Multifactorial Model The multifactorial model expands on the ecological model by incorporating the counter-control and routine activities models. The potential victim, the potential offender, inhibition and disinhibition within the offender, interactions between the potential victim and potential offender and the relationship that determines those interactionsâ€"social control agents, the environment in which interactions occur, and the culture of the society that influences every interaction within itâ€"these are the primary components of the multifactorial model and the primary factors that contribute to the increased risk of violence experienced by people with disabilities. Victim-Related Factors In attempting to understand why individuals with disabilities are victimized, some prefer not to examine the role of the victim, believing that such an examination shifts blame from the offender. Victimology, the study of the characteristics and behavior of people who are victimized, is relevant, however, for several reasons: Thus, exploring and understanding the reasons for differential risk may help to reduce risk for vulnerable members of society. Direct Effects of Disability A disability can directly affect the capacity of individuals to protect themselves, to avoid or escape from victimization, and to seek help. Some disabilities also increase dependency on caregivers. These effects of disability in increasing risk are minimal for very young children because all young children are extremely limited in these abilities , but they become increasingly important in older children and adults. In addition, some disabilities impair judgment. People with developmental or psychiatric disabilities often have difficulty identifying when to be compliant and when to assert themselves. As a result, they may be victimized both when they comply too easily and when their refusal to comply provokes retaliation. Page 27 Share Cite Suggested Citation: Crime Victims with Developmental Disabilities: Report of a Workshop. The National Academies Press. In addition, Sobsey and Calder maintain, they are rarely taught their human and civil rights; frequently taught to respond in the same way to a large number of caregivers rather than distinguishing family members and others from strangers; often denied appropriate sex education; often taught passive communication strategies but few social control functions; and often taught through physical prompting that does not allow for the development of an age-appropriate sense of personal space, which may be perceived as vulnerability by sexual offenders. These teachings or omissions in education put individuals with disabilities at risks that are not inherent to the individual or the disability. Victim Precipitation Victims sometimes exhibit behaviors that elicit violence on the part of the perpetrator. This does not mean, however, that the violence is justified by the behavior or that the violence was intended to be criminal. For instance, an individual with a developmental disability was beaten by police when he was mistaken for a robber who was resisting arrest because he did not communicate with the arresting officers St. Persons with developmental disabilities may have difficulty recognizing situations in which danger exists and therefore may be less likely to take precautions. These victim-precipitation factors are likely to interact with offender disinhibitions, particularly when the atypical behavior associated with some disabilities requires caregiver intervention. Attractive Victims Although perceived vulnerability is a factor in the selection of an individual with a developmental disability as a victim, vulnerability by itself is rarely, if ever, sufficient to motivate a crime. The potential victim must have something the offender wants or have the ability to produce an event the offender finds desirable. Control over the victim. Sexual offenses against people with disabilities appear to be common. In some cases, offenders have a special sexual attraction to people Page 28 Share Cite Suggested Citation: Others may have a need to direct sexual aggression toward individuals they consider to be vulnerable. In some cases, people with disabilities may stand between offenders and a large amount of money. Caregivers of individuals with disabilities have been known to kill their charges to gain control of money left by parents for the ongoing care of their offspring; medical negligence or other court awards; insurance

settlements; life insurance policies; social security benefits; and the like see, e. More commonly, however, such caregiver-offenders simply keep their victims alive in a state of fear and neglect, making money by collecting rent and other fees from them. Few alternatives to exploitation. Victims of violence who have disabilities sometimes allow themselves to remain in risky situations or to be victimized because life offers them few alternatives. For example, an abusive caretaker may be retained because no one else can be found. Offender-Related Factors In many instances, offenders target individuals with developmental disabilities because of their perceptions of them as vulnerable, their personality profile, or their lack of training in the care of individuals with disabilities. In addition, some offenders are themselves afflicted with a developmental disability. Specific offender-related factors in the victimization of people with developmental disabilities are discussed in the following sections. Perceived Vulnerability The perception that disability increases vulnerability may add to the risk of victimization. It may be based, in part, on actual vulnerability or on a misperception of vulnerability. In either case, an attractive victim is one who appears vulnerable to the offender. Media portrayals of people with disabilities may add to this perception of vulnerability see, e. Some movies portray persons with a vision, hearing, or other disability as helpless victims of predators. Profiles of Offenders Some authors suggest that at least some offenders against people with developmental disabilities fit specific profiles. These profiles apply mainly to paid and volunteer caregivers. One study found that 44 percent of the offenders in its sample against people with disabilities made initial contact with their victims through the web of special services provided to people with disabilities Sobsey and Doe, Predatory Caregivers Predatory caregivers seek or maintain employment as caregivers in order to have access to victims. These individuals typically commit offenses with greater elements of planning and organization, although they may also commit impulsive offenses if their authority is threatened. Their offenses may include extreme physical or sexual violence or may be limited to simple harassment and degradation of the victim. The profile of many of these offenders is an individual with overwhelming feelings of inadequacy, lack of control over others, and an overwhelming need to assert control over others seen as vulnerable. For these offenders, control can take the form of bondage, torture, sexual assault, or a variety of other actions. Corrupted Caregivers This type of caregiver typically does not plan to offend. Under some conditions, they may even be acceptable or very good caregivers. Lack of adequate training, supervision, or dear policy results in the development of abusive patterns of interaction by these individuals. At some point in their caregiving activities, most caregivers experience inappropriate feelingsâ€”anger or even sexual attraction toward a client. Most recognize that acting on those feelings is wrong, but some will cross the boundaries into offensive behavior. Often these offenders are corrupted gradually, in stages, but sometimes the deterioration is suddenâ€”for instance, a resident with a disability slaps or spits at the caregiver and the caregiver explodes into a violent rage. Offenders with Disabilities Sometimes crimes against people with disabilities are committed by others with disabilities. Much of this can be explained by a lifestyles exposure model, that is, the clustering of people with disabilities into group living situations increases the exposure of potential victims with disabilities to potential offenders with disabilities. Two mechanisms may increase offensive behavior on the part of some people with disabilities. First, residents who have been abused by staff may go on to abuse other residents. Relationship Factors Many individuals with developmental disabilities must depend on caregivers to a greater extent than other individuals of a similar age. This dependence on others may result in power inequities, and power inequities tend to increase the possibility of abuse Sobsey, In addition, people with disabilities may be exposed to a large number of caregivers because of the care requirements of the disability and the turnover in staff of service delivery systems. Exposure to large numbers of caregivers increases the risk that at least one may become abusive Sobsey, Healthy bonds with family members and other intimates provide a significant barrier to abuse and violence. Circumstances that commonly accompany disability may threaten or disrupt attachment and bonding. For instance, treatment of health problems may limit parent-child interactions. Moreover, parents are often implicitly and sometimes explicitly told that it is better not to get too attached to a child with a disability and that such a child will strain their marriage, career, happiness, and sanity. These

negative expectations may interfere with parent-child bonding. Environmental Factors Environmental factors can both lead to developmental disabilities and increase the risk of violence against those with disabilities. Sobsey and Calder noted as examples the following environmental factors: Many people have disabilities that result, in whole or in part, from violence or severe neglect that caused physical damage or permanent neurological changes. Children born to mothers with severe substance abuse problems or who have endured spousal abuse during pregnancy may be likely to be born with developmental disabilities. Children born into families in which violence was present before their birth are more likely to become abused children. Families of people with disabilities may become isolated from their Page 31 Share Cite Suggested Citation: Group homes and institutions can also be isolating. Alternative living situations may cluster vulnerable individuals with those who are likely to abuse them without providing safeguards against victimization. Foster care homes, group homes, and institutions have all been found to increase the risks of victimization compared with typical natural families. Adults, adolescents, and even some children without disabilities have often been able to escape from abusive living alternatives by making other life choices. People with disabilities are often prevented from making such choices. Disabilities affect routine activities and exposure to high-risk environments. Many people who have development disabilities do not drive and are therefore much more likely to rely on mass transportation, walking, or others to get where they need to go. One study analyzing patterns of the sexual abuse of children with disabilities and the sexual assault of adults with disabilities found that 5 percent of offenses were committed by specialized transportation providers and 10 percent of offenses took place in vehicles Sobsey and Doe, In addition, people are often committed to institutional care because they are unable to look after themselves or because they are dangerous to others. As a result, possible victims and prospective offenders are placed in close proximity with inadequate safeguards. They suggest a long list of potential mechanisms that may contribute to the increased risk of violence and abuse for people with disabilities. The list is not comprehensive and the research that supports it is limited, but the mechanisms described here do represent a starting point. In their paper, Sobsey and Calder conclude that research would be required to determine which of theseâ€”or which otherâ€”mechanisms play a significant role in the victimization of people with disabilities. Page 22 Share Cite Suggested Citation:

Chapter 4 : Epilepsy - Wikipedia

Special Services for People with Epilepsy in the s, HMSO, London () 18 D.L Patrick, E Scrivens, J.R Charlton Disability and patient satisfaction with medical care.

Disability History Timeline Ancient Times: The earliest physicians regard mental illness as a punishment inflicted for angering the gods, and believed that affected people must undergo an exorcism. If that failed, banishment followed. Hippocrates says mental illness should be understood in terms of disturbed physiology. Hippocrates also develops a diet for epileptics, possibly similar to the modern Ketogenic diet, which treats epilepsy. Epilepsy is believed to be contracted by touching and epileptic, or breathing in the same room the epileptic was in. Since epilepsy was considered contagious, epileptics were forced to live alone. Asylums first established in the Middle East. Witchcraft and demonic forces are the believed causes of disabilities, and religion was believed to be the solution. Epilepsy, known as "falling sickness," was cured by giving the patient a blessed ring. Mary of Bethlehem, was established in Britain. Patients were customarily chained to walls, and dunked in water or beaten if they misbehaved. A mental hospital was established in Granada. A mental hospital established in Valencia, Spain. First invalid chair made, predecessor to a modern wheelchair It states that disabled babies are left by fairies and demons as punishment for parents who had been evil, not worshiped God, or were seduced by the devil. The baby, likewise, was considered possessed by the devil. Physically and mentally-disabled people are used for amusement as court jesters. Paintings show infants and children with Downs Syndrome as cherubs. Epileptics are segregated from the rest of hospital populations, to prevent the spread of epilepsy to other patients. Public attitudes towards the mentally-ill improve with advances in European medicine. Bethlehem hospital in London welcomed the public to come each Sunday and observe the patients, chained and caged, as entertainment. Admissions fees helped pay for hospital upkeep. The Foundling Hospital in London was established because of the large number of disabled children being abandoned by parents, especially in the winter. Educated Europeans begin demanding a medical revolution, aimed at improving the lives of disabled people. York Asylum, also in England, continues cruel, punitive treatment of patients. Chiarugi begins humanitarian regimes in his Florence hospital. Philippe Pinel becomes head of the Bicetre, a Paris mental hospital. Pinel instigates a revolution in caring for disabled people, establishing these changes: Louis Braille completes the Braille system of embossed letters A school for mentally handicapped people is established in Paris. A school for mentally handicapped people is established in England. Generating respect for patients as individuals, and establishing the belief that cures are possible, were two goals of Dix. Braille introduced in the United States In England, The Idiots Act is passed to ensure the care, education, and training of disabled people, considered to be overwhelmed by the demands of an industrial society. American and European hospitals are over-crowded due to higher confinement numbers. In British asylums, "educable" patients received special training. Other patients were confined to workhouses. In Britain, The Elementary Education Act, or "defective and epileptic children act," stated that schools must be established for mentally and physically handicapped children, previously deprived of formal education. The United States prohibits immigration of disabled people. The Mental Deficiency Act mandates that British authorities accommodate the mentally handicapped. The act establishes four categories: Intelligence testing is used to determine which disabled children can, and therefore must, be educated. Many children with physical handicaps such as epilepsy, cerebral palsy, and muscular dystrophy were institutionalized because physical handicaps were considered indicative of mental deficiency. British law mandates the education of mentally handicapped children. Education of physically handicapped children is mandated in England. Physical therapy was used. In Nazi Germany, epileptics are sterilized and prohibited from marrying. Some effective anti-convulsive medicines are developed, but epileptics still face discrimination. First seeing eye dog, a German Shepherd, is trained and used s: Compulsory sterilization occurs in the USA, Germany, and Britain to prevent the mentally disabled or people with epilepsy from having children. In the United States, seventeen states prohibited

epileptics from marrying. Drugs, electroconvulsive therapy, and surgery increase in frequency as treatments for those classified as mentally-ill. Harry Jennings builds first modern wheelchair In Germany, compulsory sterilization is mandated for anyone with a hereditary disease. Roosevelt, using a wheelchair, begins his presidency German law mandates an abortion if either parent has a hereditary disease. Adolph Hitler encourages physicians to perform "mercy killings" on any mentally or physically handicapped adults. A program to perform "mercy killings" on disabled children soon followed. Riots in Bavaria cause Hitler to cease gas chamber "mercy killings. The Education Act introduces compulsory secondary education in Britain. Patients capable of caring for themselves are released, increasing capacity for people in need of care. As drugs are changed and improved, prescription rates rise. Behavior therapy and counseling become recognized as methods to diagnose and treat patients. The Disabled Persons Employment Act states that local authorities must provide employment training, and assistance in finding employment, for registered disabled people in Britain. As more prescriptions are written, more patients are released to live independently. Homeless rates rise as many patients receive insufficient outpatient care, or face housing and employment discrimination. Architectural Barriers Act First Special Olympics Four-hundred new school are opened to accommodate approximately 70, children. The Chronically Sick and Disabled Persons Act mandates British authorities to help disabled people in the home, with traveling, getting telephone service, and other needs. Wheelchair America, a pageant for women with disabilities According to Wolpe, "un-adaptive habits are weakened and eliminated; adaptive habits are initiated and strengthened. The Rehabilitation Act Education for all Handicapped Children Act makes it law that children with disabilities are educated. Civil Rights of Institutionalized Persons Act Air Carrier Access Act Fair Housing Act amended The Americans with Disabilities Act offers equality and opportunity in education, employment, and other areas. National Voter Registration Act makes voting easier for people with disabilities and the elderly.

DOWNLOAD PDF SPECIAL SERVICES FOR PEOPLE WITH EPILEPSY IN THE 1970S

Chapter 5 : Epilepsy and Seizure Center at MVH

Special services for people with epilepsy in the s: 1. Special services for people with epilepsy in the s Special services for people with epilepsy in the.

An instructional video about epileptic seizures A still image of a generalized seizure A bite to the tip of the tongue due to a seizure Epilepsy is characterized by a long-term risk of recurrent seizures. An example of this type is the absence seizure , which presents as a decreased level of consciousness and usually lasts about 10 seconds. A cry may be heard due to contraction of the chest muscles, followed by a shaking of the limbs in unison clonic phase. Tonic seizures produce constant contractions of the muscles. A person often turns blue as breathing is stopped. In clonic seizures there is shaking of the limbs in unison. When it occurs it typically lasts for seconds to minutes but may rarely last for a day or two. These include depression , anxiety , obsessiveâ€”compulsive disorder OCD , [40] and migraine. Causes of seizures Epilepsy can have both genetic and acquired causes, with interaction of these factors in many cases. There appears to be a specific syndrome which includes coeliac disease, epilepsy and calcifications in the brain. Factors within the neuron include the type, number and distribution of ion channels , changes to receptors and changes of gene expression. However, it is unknown under which circumstances the brain shifts into the activity of a seizure with its excessive synchronization. Seizures are often brought on by factors such as stress, alcohol abuse, flickering light, or a lack of sleep, among others. The term seizure threshold is used to indicate the amount of stimulus necessary to bring about a seizure. Seizure threshold is lowered in epilepsy. The diagnosis of epilepsy is typically made based on observation of the seizure onset and the underlying cause. The definition of epilepsy requires the occurrence of at least one epileptic seizure. In the definition, epilepsy is now called a disease, rather than a disorder. This was a decision of the executive committee of the ILAE, taken because the word "disorder," while perhaps having less stigma than does "disease," also does not express the degree of seriousness that epilepsy deserves. In particular, it aims to clarify when an "enduring predisposition" according to the conceptual definition is present. Researchers, statistically-minded epidemiologists, and other specialized groups may choose to use the older definition or a definition of their own devising. The ILAE considers doing so is perfectly allowable, so long as it is clear what definition is being used. When a person is admitted to hospital after an epileptic seizure the diagnostic workup results preferably in the seizure itself being classified e.

Chapter 6 : Developmental disability - Wikipedia

The need to improve services for people with epilepsy is gaining recognition. The present provision of services and shortfalls have been recently reviewed7, and an epilepsy needs document19 has been generated at the request of the Department of Health as a guide for pur- chasers and providers.

Each case is reviewed carefully to develop individual treatment plans. These spacious rooms are equipped with monitors that digitally track the electrical activity of the brain, heart rate and blood-oxygen saturation levels around the clock. Using infrared videocameras, EEG recordings and other equipment, we collect essential information to help understand what happens before, during and after seizures. Our team always uses the utmost caution to ensure patient privacy. Monitoring is performed with a privacy-protected, closed-loop video monitoring system viewed only by trained physicians and technicians. Monitoring sessions can last several days. In some cases, special imaging studies, called SPECT and PET scans, are done to provide information about the function of different brain areas during and between seizures. There are many medication choices available to treat epilepsy. It takes time to determine which medication or combination of medications works best to control seizures with the fewest side effects. In some cases, your doctor may try more than one medication to determine what works best for you. The length of time you must continue using your medication is hard to predict. It is not unusual for patients to stay on medications for two years or longer. Most people with epilepsy can achieve seizure control with medicines alone. When you and your doctor find a medication that works for you, you will need periodic follow-up. Even if you are seizure-free and feeling well on your medications, your doctor may recommend intermittent lab work or other exams, including: Specific blood tests to determine whether your medications are interfering with liver or bone marrow function. If they are, your doctor can recommend other treatment options. This affects a relatively small number of patients. Useful in determining whether you can or should change your medication dose. If you are not responding to anti-seizure medications, your epilepsy physician may suggest additional testing, such as inpatient video EEG monitoring in the Epilepsy Monitoring Unit. In these cases, surgery may be an option. Individuals who undergo successful epilepsy surgery may have a better quality of life than those who continue on medications alone with poor seizure control. Even after surgery, many patients have to continue some medication for the best seizure control. Miami Valley Hospital is experienced in performing a complete range of epilepsy surgical procedures. We offer temporal lobectomy and other surgeries that involve removing the area of the brain where seizures originate. Some people may benefit from an implantable device such as the vagus nerve stimulator. This is a pacemaker-like device that is implanted under the collarbone. The vagus nerve stimulator delivers regulated electrical signals to the brain, reducing the number, as well as the intensity, of seizures. Evaluation for Surgery Patients considering surgery generally go through a four-step evaluation process to plan the surgery and make sure it will provide the safest outcome. If you and your doctor decide you might benefit from surgery, you may have additional testing to help further characterize your seizures, including: An EEG takes about 40 minutes and involves pasting small wires on the head. These pictures may show structural abnormalities which can give rise to seizures and may help define treatment options. Special protocols are used to identify the often subtle changes in the brain that indicate where seizures may be arising. Here all of the members of the epilepsy team review the studies and determine if a patient is a good candidate for epilepsy surgery or vagus nerve stimulation. The epilepsy team comprises several epileptologists neurologists who specialize in epilepsy , an epilepsy surgeon, a psychologist specializing in epilepsy, an epilepsy social worker, epilepsy nurses and EEG technologists. If the team agrees that the benefits of epilepsy surgery outweigh the risks, we will arrange for you to consult with our epilepsy surgeon. Our surgeon will discuss the type of surgical options available, as well as any further testing that may be necessary prior to surgery. Intracranial Monitoring Sometimes video EEG monitoring with electrodes on the scalp does not provide enough information to show exactly where your seizures begin. In this situation, we may recommend additional video

EEG monitoring, this time using very thin, soft electrodes placed on the surface of the brain by the surgeon in the operating room, with the patient under anesthesia. This type of monitoring, called intracranial monitoring, gives much more precise information about where seizures begin. Functional testing may also be performed at this time to determine if seizures arise from critical brain areas. Wada Test This specialized form of testing uses anesthesia medications to help map the parts of the brain that must be protected during surgery, and helps your doctor decide whether epilepsy surgery is safe for you. Surgery Once your doctor understands precisely the brain region responsible for generating your seizures, a decision regarding treatment can be made. The risks of surgery will be discussed, and all other options will be weighed. You and your doctor will make a decision together about treatment strategy. This may involve removing brain areas responsible for seizures such as focal excision, lobectomy or hemispherectomy. Or treatment may be a disconnection therapy, such as corpus callosotomy or multiple subpial transactions. Alternatively, a vagus nerve stimulator may be recommended. Neurophysiology Laboratory The neurophysiology laboratory at Miami Valley Hospital is a critical component of the epilepsy program, offering a number of inpatient and outpatient services. They include video electroencephalography EEG monitoring in the Epilepsy Monitoring Unit, adult and neonatal outpatient EEG, as well as adult visual, auditory, and somatosensory evoked potentials. Miami Valley maintains its position as a leader in neurophysiology services by: For more information, ask your neurologist about studies you may be able to join. Our specially trained nurses and technologists collaborate with our physicians to ensure patients receive personalized, compassionate care. Learn about conditions, treatments, how to prepare for a surgery, and much more. Miami Valley Hospital does not have any control over the content of third-party websites and neither endorses nor accepts any responsibility for the content, products, and services on or sold on these websites. The symbol indicates a third-party website.

Chapter 7 : Social Services in Epilepsy | Neupsy Key

In , a task force for the International Professionals in Epilepsy Care conducted a worldwide survey of those providing social services in the field of epilepsy (R. Brown, Personal communication with Robin Brown, Co-Chair, International Epilepsy Professionals in Epilepsy Care. Melbourne, Australia,).

Your preliminary evaluation is performed by a board-certified neurologist with subspecialty training in epilepsy. A detailed history of your seizure activity and anticonvulsant drug regimens to help define the type of epilepsy you have and to determine whether it is resistant to medical treatment Outpatient testing to screen for abnormalities within the brain Inpatient EEG recordings to identify where, within the brain, the seizures begin Your doctor will also need to know about a family history of seizures or other similar conditions and medications prescribed. What questions is my doctor seeking to answer? If you are evaluated for suspected seizures or epilepsy, your doctor will work to answer these questions: Have you had an epileptic seizure or something else? What is the cause? If a cause is identified, can it be treated? What is the seizure type? What is the outlook? They will take your medical history, perform a physical examination and complete a series of neurological and blood tests. Although your tests will be performed as quickly as possible, you should expect some waiting; you may want to bring some reading material to help pass the time. This type of visit will typically take one to two hours. What do I need to bring to my first appointment? For Our Adult Patients Your past medical record is very helpful to us. Also, if you have recently been in the hospital other than Cleveland Clinic , please bring a copy of your hospital discharge summary sheet, as well as other relevant hospital information. Your local physician can help you obtain these items. This is essential in obtaining details of the seizures. It is best to bring these records physically with you to your first appointment; sending them via mail adds unnecessary delays to the procurement of the records. You may prepare ahead of time a list of all the previous and current antiepileptic medications, including information about the dose used and the duration for which they were given. You may also bring the bottles of the current medications that your child is prescribed. What questions should I be prepared to answer at my first appointment? Important questions that you should prepare for include: At what age did the seizures begin? What circumstances surrounded your first seizure? What factors seem to bring on the seizures? What do you feel before, during and after the seizures? How long do the seizures last? Have you been treated for epilepsy before? Which medications were prescribed and at what dosages? Was the treatment effective? If other individuals have seen you during a seizure, such as family members or close friends, they should be present to provide details because you may not have been aware of what was happening. What testing will occur? Most of the patients who come to Cleveland Clinic for a comprehensive epilepsy evaluation will be prescheduled for an outpatient EEG prior to their initial clinic visit. The EEG is an especially important part of the evaluation because seizures are defined by abnormal electrical activity in the brain. This test is useful not only to confirm a diagnosis of epilepsy, but also to determine the type of epilepsy. However, it is not uncommon for routine outpatient EEGs to show normal results in patients with epilepsy. Repeat EEGs after sleep deprivation can increase the chance of finding an abnormality. When routine outpatient EEG studies fail to provide the needed information, prolonged EEG monitoring may be necessary. Particularly, if the diagnosis is not clear, or the patient may be a potential candidate for epilepsy surgery, they will need to undergo an Epilepsy Monitoring Unit evaluation. The family is contacted by our epilepsy nursing staff for scheduling a return visit to the Epilepsy Monitoring Unit with the next available opening. Further tests as may be indicated are scheduled around this visit to coordinate a streamlined efficient visit for the convenience of the patient and their families. Such tests may include: As part of the evaluation, your doctor will need to perform additional tests, including: A complete physical and neurological examination of muscle strength, reflexes, eyesight, hearing and ability to detect various sensations. Imaging studies of the brain, such as those provided by magnetic resonance imaging MRI. Blood tests to measure red and white blood cell counts, blood sugar, and blood calcium and electrolyte levels, and to evaluate liver and

kidney function. Blood tests help rule out the presence of other illnesses. An electroencephalogram EEG , which measures electrical impulses in the brain. If video-EEG monitoring is needed, how long will the stay be? The expected length of stay is three to five days. The duration of stay largely depends upon the frequency and complexity of seizures and the necessity of doing additional testing e. In the case of a diagnostic evaluation where surgery is not being considered, the expected length of stay is three to five days. However, for a presurgical evaluation where additional testing e. SPECT and consultations e. Most of the time, you will stay in bed or in a reclining chair next to your bed. You will be disconnected from the equipment to get up and move about twice a day. You also will be disconnected to use the restroom and to shower. Having a family member or staff person accompany you on all walks is required for your safety as your medication will be reduced or discontinued. For your safety, we also limit your walking within the unit itself. Children are encouraged to bring along their favorite blankets, toys, books, pacifiers or other comfort items. Parents are encouraged to stay around-the-clock with their child, though only one person may stay overnight. After monitoring is completed, young patients are welcome to use the playroom and playdeck. At the end of the evaluation, the physician will provide you with a summary impression from the information gathered from the testing and provide further recommendations for a treatment plan. Within the following few days, your referring physician unless otherwise specified can expect to receive a copy of the complete evaluation and further recommendations. Epilepsy is a disorder that needs very close follow-up care on an ongoing basis. We like to work very closely with your referring physicians in providing them with feedback and future recommendations whenever needed. In many cases, medication levels and prescriptions are best handled by a follow-up closer to home with the regular physician. However, we would like to stay available for further consultation and follow-up visits at any time in the future. What is the study trying to find out and how long will it last? How much time do these take? What is involved in each test? How often does the study require me to go to the doctor or clinic? Will I be hospitalized? If so, how often and for how long? What are the costs to me? Will my health insurance pay for it? What follow-up will there be? What will happen at the end of the study? What are my other treatment choices? How do they compare with the treatment being studied? What side effects can I expect from the treatment being tested? How do they compare with side effects of standard treatment? Below, find clinical trials that are currently recruiting: The Spectrum of Familial Epilepsy This study is a data collection, non-treatment study to locate and study the genes that cause epilepsy. Eligible subjects will have a diagnosis of epilepsy and a positive family history of epilepsy. Identified subjects will have one single blood sample and questionnaires to complete. If you would like more information on this study please contact: Control subjects without a history of epilepsy will also be recruited. Identified subjects and family members will have one single blood sample and questionnaires to complete. A Double-Blind, Placebo-Controlled randomized trial to assess the effects of Lacosamide on sleep and wake in adults with Focal Epilepsy Sleepiness and fatigue are the most common complaints of people with epilepsy and can have a negative impact on quality of life. Though unproven, these problems are often blamed on anti-seizure medications. Focal epilepsy, also called partial epilepsy, is a disorder in which seizures are preceded by an isolated disturbance such as a twitching of a part of the body, a particular sensation or feeling, or some other disturbance in consciousness. The study is open to adults 18 and older with focal seizures. There are 5 study visits and participants will receive compensation for time spent in the study. The epilepsy research program has been continuously funded from national public and private institutions, including the National Institutes of Health and the Epilepsy Foundation of America, American Academy of Neurology, and the American Epilepsy Society since Instrumental epilepsy research that has helped neurosurgeons distinguish normal brain tissue from tissue that causes seizures. Because the difference is not apparent to the eye, they developed a brain mapping technique that allows them to identify and remove the desired tissue, thereby increasing the likelihood of eliminating seizures for adult epilepsy patients without damaging vital functions. Pioneering of a microsurgical technique used in anterior temporal lobe surgery that protects the lobe and adjacent tissue. Development method of sorting and analyzing electroencephalogram EEG imaging data on a computer to

make pertinent information more readily accessible.

DOWNLOAD PDF SPECIAL SERVICES FOR PEOPLE WITH EPILEPSY IN THE 1970S

Chapter 8 : Epilepsy Center | Cleveland Clinic

A district epilepsy service was inaugurated around specialist services based in a hospital clinic. Guidelines were produced to clarify respective roles and to assist non-specialist hospital doctors and general practitioners in epilepsy management.

Social Services in Epilepsy Patricia A. Gibson It has long been recognized that the social, psychological, and behavioral problems that frequently accompany epilepsy can be more handicapping than the actual seizures 1. The comprehensive care of those with epilepsy must include, in addition to medical evaluation and treatment, an assessment of the social needs and concerns of the patient. This personal history that is different from the history of the disorder becomes a crucial aspect of diagnosis 2. It is the role of the social worker to gather that history and to assure that the whole picture is considered in the treatment and management of epilepsy. The first national effort to promote comprehensive care of those with epilepsy originated in the s under the direction of Dr. Through the efforts of Dr. Penry and his colleague, Dr. Fritz Dreifuss, Director of one of the first comprehensive programs located at the University of Virginia, recognized, as did Dr. They insisted that a variety of disciplines were needed to assist in the comprehensive care of epilepsy. In these days of managed health care with pressure on physicians to see more patients in shorter time, the assistance of other health professionals is even more important in patient management. The infrastructure of these programs also provides an opportunity for research into the basic mechanisms of epilepsy and the social issues in an effort to develop better treatments for the epilepsies. Richard Cabot first introduced medical social services at Massachusetts General Hospital, Boston, in to contribute to the development of preventive medicine. Cabot recognized the importance of continuity of care and therefore included social workers as home visitors in his clinic. Ida Cannon was hired as the first medical social worker. Social work provided an enlarged understanding of psychosocial conditions that could have an impact on medical conditions 4. Social work is a diverse profession with fluid boundaries. There is much greater understanding of what physicians, nurses, lawyers, and psychologists do than is the case with social workers. According to Gibelman, this phenomenon results partly from the expansive and expanding boundaries of social work and the difficulty in providing succinct, encapsulated descriptions of a complex and multifaceted profession 5. Currently, the field of mental health is the fastest growing area of social work practice. As with other professions, managed care holds the potentials of limiting the role of social workers, as well as the quality and quantity of services available to the clients in need of social services. The Role of Social Work in Epilepsy In , a task force for the International Professionals in Epilepsy Care conducted a worldwide survey of those providing social services in the field of epilepsy R. In the United States it was found that social workers have widely varied roles in the treatment of epilepsy. Social workers were found providing patient education, individual, group, and family counseling, coordinating epilepsy monitoring units, monitoring drug studies, administering a variety of programs and services in epilepsy, advocating for patients and their families, and holding educational and research positions. Therefore, from setting to setting the role changes. Social workers are usually found in most hospital settings in the United States. They may or may not be specifically assigned to providing services to the epilepsy population. Except in special centers of excellence, most cover many population areas and do not have special expertise in epilepsy. Although the role of social workers in epilepsy varies greatly, the following are some of the most common areas in which social services are provided. Patient Education Patient education is crucial in the treatment of epilepsy. Many authors have pointed out the need for information for patients with epilepsy and their families 6 , 7 , 8 , 9. Psenka and Holden stressed the importance of patient education even in benign seizure syndromes in reducing the magnitude of psychosocial disruption In a review of 50, calls to the Epilepsy Information Service of Wake Forest University School of Medicine many patients and family members reported getting little information at the time of diagnosis Patients are often ill informed about epilepsy and may harbor a variety of fears and concerns 12 , 13 , and provision of a wide range of information

in a systematic format has been shown to benefit patients in a number of ways This education should start at the time of diagnosis and carried out on an ongoing basis, involving all members of the treatment team. Effective patient education involves the whole family and any others involved in the care of the patient. Information needs to be given on the educational level of the patient. For many patients, interacting with their physician can be an intimidating experience and some patients are hesitant to acknowledge that they do not understand what is being said. The social worker can be very helpful as an intermediary in this communication. In providing education, written materials are as important as verbal information. There are a number of sources for educational materials on epilepsy. The Epilepsy Foundation has a listing of materials available through their organization. A number of comprehensive epilepsy centers have designed their own educational materials, such as the Seizureman comic book on first aid for children developed by the social workers at the Wake Forest University Comprehensive Epilepsy Center in North Carolina. Many pharmaceutical companies that market antiepilepsy medications also offer free educational materials on epilepsy. Computer resources are being increasingly utilized by persons with epilepsy and their families as a source of information. Preventive Counseling Preventive counseling carries patient education a step further and is an important part of the social care of epilepsy. This counseling should begin shortly after diagnosis and involve the patient, family members, and any others involved in the care of the patient. Patients and family members need to ventilate their fears, worries, and concerns. Observing a seizure, especially a tonic-clonic seizure, in a loved one can be one of the most frightening moments a person may have. Ask a loved one about this experience and observe how deeply etched this moment is in his or her memory. Expressing these concerns is a first step in the process of dealing effectively with the psychosocial impact of epilepsy. Beckman and Frankel 17 in their study of the patientâ€”doctor relationship found that in interviews with their doctors, patients were most often redirected after the first expressed concern and after a mean time of only 18 seconds. Additionally, in only 1 in 52 visits did these redirected patients return to their agenda and complete their offering of concerns. Studies have shown that doing so actually takes less time than expected and can improve interview efficiency and yield increased data Yet listening of this very special kind is one of the most potent forces for change that I know. During this early stage, groundwork can be laid to help parents realize the important role their attitude toward epilepsy plays in influencing how the child will begin to feel about himself or herself. Parents need to understand how overprotection can lead to emotional crippling. The disabling potential of epilepsy depends heavily on the manner that the family adjusts to the disorder and is able to help the child cope with the issues that are a part of epilepsy. Many authors have stressed the need for a multidisciplinary approach to promote optimal care in epilepsy 10 , 19 , Early intervention with counseling by the social worker can help prevent many of the social problems that frequently accompany the diagnosis of epilepsy. Case Management Case management involves the coordination of services from different agencies on behalf of a client. Social workers are often involved as case managers for patients with epilepsy, especially patients who have other disabilities and are unable to function independently. Needs are assessed, and follow-up involves planning, locating resources, and monitoring services. A variety of interventions may be required and the social worker may take on an advocacy role when needed services are not available. An example of case management of a client follows: He was 16 and had moved to live with his grandparents a month ago. He had severe and intractable seizures, mental retardation, and cerebral palsy. His mother had left the family in his early years. The father eventually remarried but had recently died of a heart attack at the age of 38 and his wife did not want the responsibility of the child who was not hers. The grandparents were in total shock over these events and lacked any knowledge of resources. The social worker assisted in making an application for Medicaid and other services. Arrangements were made for him to be seen by the vocational rehabilitation specialist in an effort to develop future habilitation plans. Following this assessment an application was made to the Special Enrichment Center where he could learn social and daily living skills, as well as employment skills. This Center also functions as a sheltered workshop. Unfortunately, 2 years later, the grandfather died suddenly of a heart attack and the year-old grandmother had difficulty physically

managing J. The social worker began working with the client and grandmother to help locate an appropriate group home situation and to work with the family in their adjustment to this new living arrangement. A group home was located and the patient was able to continue attending the Special Enrichment Center. The patient adjusted well to the group home but after the first year, because of administrative changes in the group home management, the family was informed that the client would have to move to a home with lower functioning clients. The social worker became involved again, this time in an advocacy role, and petitioned the Division of Mental Health to intercede. Eventually the patient was allowed to stay in the more appropriate setting. Individual Counseling A chronic illness of any type has significant impact on the lives of people it touches and there are many social and psychological consequences when people do not cope well. For some, epilepsy may be looked upon as a minor inconvenience. They have a few seizures and are prescribed medicine; their seizures come under control and do not interfere with functioning. Others are not so lucky. For this group, epilepsy is a devastating diagnosis and looms large, coloring every aspect of their being. There are various emotional responses to any illness or disorder. Although not everyone with epilepsy needs counseling or special services, on occasion, the emotional responses may be maladaptive and require intervention. Patients with intractable epilepsy are particularly vulnerable to a number of secondary psychosocial problems including depression and anxiety 22 , In addition, low self-esteem and a feeling of loss of control over their lives are common features of children and adults with epilepsy When epilepsy is severe and persistent it is not surprising that it will be associated with behavioral and cognitive disorder, because social behaviors are every bit as dependent upon adequate cerebral functioning as cognition is. Only gold members can continue reading. Log In or Register to continue Share this:

Chapter 9 : Epilepsy SA | Organisational Information

We provide a range of educational opportunities, programs, and services for people living with epilepsy, families, friends, and caregivers. Many programs and services are available and implemented through our network of local Epilepsy Foundations and are often tailored to the communities they serve.

Please email our online counsellor with any epilepsy related questions to info epilepsy. Click here to play Organisational Information Epilepsy South Africa is the only national non-profit organisation in the country focussing exclusively on rendering specialised and comprehensive services to people living with epilepsy and other disabilities, including education and economic empowerment through job creation and entrepreneurship- and skills training suited to almost any level of development. We are dedicated to enhancing the quality of life of people living with and affected by epilepsy as well as other disabilities. The organisation renders vital services to numerous South Africans who, in addition to living with epilepsy, have multiple challenges ranging from mild to profound intellectual disability, Down Syndrome, hydrocephalus and speech impairments to physical and psychiatric disabilities such as schizophrenia. Establishment of Branches 17 June Western Cape Branch 13 August Natal Branch 29 January During this centre merged with the Geduld Centre to save costs. Dersley Centre became the regional office of the current Gauteng Branch. His position became that of Executive Director and the national office was transferred to Springs. The facility was sold to a private company. Duikweg centre in Springs, which accommodated 46 people, was opened. The centre merged with other centres in Springs to save costs during The facility was sold to a private buyer. The workshop in Wellington was opened. The branches were decentralised geographically and received autonomy with regard to services and finances. The following regional branches were formed: The National Office in Edenvale was closed. The Kwa Thema and Dersley workshops closed down and merged with the Geduld workshop, now known as the East Rand workshop. The name of the Gauteng Branch changed at the Annual General Meeting held on 11 June and all the other branches during During February the National Office relocated to Parow, Cape Town following the realisation of a long standing dream - owning premises. In the National Office followed international trends by creating a virtual office for improved service delivery and to enable improved funding of direct services.