Disease of any system of the body involves considerable strain in the person and in his family system, and in the wider sense his occupation and other areas of involvement and the importance of the effects of such stresses is slowly being understood. Increased incidence of death due to heart ailments in the spouses of the recently dead is significant study. Equally important is the study of the effect of the social factors on the diseased individual and on the course of the illness. These interactional patterns depend upon many factors, such as individual differences in personality, resourcefulness, economic situations, interpersonal attitudes, premorbidity, ability to face the stresses etc. Even the cultural variations contribute much to the interactions during the disease. Thus an ache in the leg is not considered as seriously as the headache. Among the various ailments, those of the head and hence of the brain are much more viewed with anxiety.

Diseases of the brain also bring about changes in higher intellectual functions and in the personality. Equally well, the ultimate results get decided by the way the families react to the illness, and the resultant anxiety or neglect and the varying degrees of hope with which they approach the illness.
In our study we have chosen patients who are understood by the relatives as those with 'problem involving the head'. Among them patients with epilepsy and those with head injury have been chosen for comparison. Though each differs within its own category in the aetiology, frequency, extent of concomitant complications etc., certain practically relevant criteria have been chosen, taking in view the clinical and socio-cultural considerations. Thus post-head injury unconsciousness gives both the clinical extent of the severity and the impact on the "seriousness" experienced by the relatives. The severity of the epilepsy is again arbitrarily measured by the frequency considering both the clinical issue and the recurrent impact upon the relatives and on the patient himself.

Both clinical entities can bring about psychological consequences which are attributable to the diseases.

The differentiation along with the severity enables us to study the intra-group variations and thus each clinical entity can be studied along with different areas of interaction. It is not only the areas where he is directly involved that are studied. Thus not only the interaction but
also the general human warmth of his surroundings are studied. Patients are asked to subjectively evaluate themselves in the Bell's Adjustment Inventory and any aberration due to a defect in the judgement discriminatory function of the individual is ruled out by the selection criterion that the neuro-surgeon/neurologist includes only those without any gross cognitive deficit.

Our study of the interactions in the mild epileptic group shows a general pattern improvement during the follow-up. In the severe epileptic group, though there is a general improvement in all the areas, the interaction of the spouses as parents seems to be very much deteriorated, even when parents-children, children-parents and child-child interactions begin to fare better. This probably indicates the extent to which the healthy partner has to adapt herself/himself to the changing needs and the extent of stress involved. Similar involvement appears to take place among the mildly head injured, though interactions involving children maintain status quo throughout. This implies that children are equally under stress and are open to the realities of the head injury on the parent. It is probable that the lack of adequate recovery (unlike the epileptic group) is because
the unhealthy parent inspite of the mildness of injury is not his original parenting figure, whereas among epileptics, even if it is severe, the patient regains the 'normal' composure in between the episodes. These findings assume further support from the extent of deterioration in the interactions in most of the spheres, among the severely head injured.

The severity of epilepsy did not show any significant impact on the overall family interactions both initially and during follow-up, whereas the severity of injury has no impact on family interactions initially, but over a period of time, the severely head injured group showed much strained interactions. On the whole the head injured group showed bad interactions compared to the epileptic group.

The one fact that emerges out of the estranged interactional patterns is the extent of adaptation that the family in general and the spouse in particular requires to undergo to maintain the normal equilibrium of the family. This also shows the amount of stress experienced by the children during the course of follow-up.
The ability of the patient to adjust in various endeavours of life and his assessment of his ability coupled with psychological consequences of the morbidity account for his evaluation of the changes during the follow-up measured in Bell's Adjustment Inventory. The mild epileptic group shows good improvement in the areas of 'home', 'health', 'emotional' and 'occupational' adjustments, like the mildly head injured group which indicates their ability to improve once the initial impact of the stress is over. The social adjustment does not show much change in both the groups and is found to be good in the initial stage itself. The severely head injured group, though less well adjusted than the mild group, shows good improvement in areas of home, health and social adjustments. Thus even when the head injury is severe, the victims are slowly able to improve in their relations. But the severe epileptics showed either a lack of improvement or deterioration in the various areas of adjustment. Though psychologically they are not more disturbed, the self rating in Bell's Adjustment Inventory indicates pessimism, which is probably a reaction to the environments 'looking down' upon their problem. The periodic occurrence of the problem, much against their will and prediction, makes them hesitate about their indulgence in social activities and even at times in their normal occupation,
Such a distress is experienced by the epileptics, in spite of the contradictory results in the family interaction. The severity of epilepsy did not show any impact on the overall adjustment initially but during follow-up. The severe category showed illadjustment compared to mild category. On the whole the head injured group showed significant maladjustment compared to the epileptics.

The significance and importance of any study rests with its utility. The study indicates the various areas of the problem and the extent to which each is involved. Thus it is not only the spouse but also the children who form the group necessarily involved in the total rehabilitation programme. The importance for choosing the vulnerable and important person in the programme is much evident. Thus among the families of the severe epileptics, the patients themselves require emotional support. Though other also need to be supported, the patients themselves require more detailed supportive measures. Equally well, among the severely head injured, it is the spouse and the children that need to get more attention in the rehabilitation measures. The study also
delineates the importance of the study of few more processes that normally happen, for example, the exemplary way in which the healthy parent is able to further his resources in the event of severe setbacks in the partner and the patterns of his adjustments and compensation for the loss of partner's health.

Inspite of all the natural resources at the maintenance of equilibrium, the extent of strain on these partners is much too evident. It is imperative that psychological measures for this population require to be carefully planned. Apart from individual measures of help, group interactions, imparting knowledge about the morbidity, about welfare measures drug management, possible consequences etc., will enable them to keep their anxiety at a lower level, where it is not disruptive of their endeavours. It is essential that they are told of possible eventualities and supported in their strive towards balancing the deficits as early as possible. It is evident from the above account that the task is a formidable one, and calls for long hours of close co-ordination with the 'significant others' and the expertise of the
social scientist who is well versed in human behaviour and its manipulation. Frequent references have been made on the need for a social worker Epilepsy Clinic (Lala and Samant, 1974) and Head Injury Clinic (Trimble 1981, Hook, 1959, Schmid, 1969) since designing and execution of an effective treatment programme for epilepsy and head injury require more knowledge than any one professional can command. The programme must be designed not only to meet the physical problems of the disabled but also his emotional, social, familial and vocational needs as well. The right person is a clinical social worker. N...S... (1976) defines him in the Register of Clinical Social Workers as one who is

"..... by education and experience, professionally qualified at the autonomous practice level to provide direct, diagnostic, preventive and treatment services to individuals, families and groups where functioning is threatened or affected by social and psychological stress or health impairment"

Meyer (1977) conceptualizes clinical social work as psychotherapy plus. The clinical social worker follows the client's interactions and transactions with his social orbit and seeks to modify those forces in the client's environment which hinder his personal and interpersonal functioning. His main concern is psychosocial dysfunctioning of the individual, family or group.
The modus operandi of clinical social worker starts with an initial assessment through interviews during which roles and role expectations of the client are defined and the needs understood, through 'good listening'. The basic policy is to 'begin where the client is'. In the diagnostic assessment, which is essentially psychosocial, the client and environment are studied in their dynamic interaction as they contribute to adaptation and maladaptation. The client's personality both premorbid and at present, client's situation, the clinical diagnosis, the deficits if any and his changed interactions in the newer context are taken into account. Compton and Galaway (1975) suggest that on the basis of social diagnosis the social worker will make decisions as to what aspect of client's situation he will deal with and how he will deal with them, in order to eventually formulate the client's goals and means for person-situation alteration.

The intervening social worker often takes up one or a combination of three roles: 1) The social broker role — serving as a linkage between the client and other community resources 2) The enabler role — directing toward assisting the client to find coping strengths and resources
within himself and 3) The advocate role - becoming a spokesman for the client. The various methods used in the intervention as evolved by Hollis (1964) are as follows:

1. Sustaining - demonstrations of interest and desire for help.
2. Direct influence - suggestions and advice
3. Catharsis or Ventilation
4. Reflective consideration of current person-situation
5. Encouragement of client to reflect on development of his response patterns. These methods are often used in the individual case work of the client, the particular difficulties in our cases being the possible cognitive sequelae when they are present. The case work at the individual level also involves the learning of his occupational problems, assessing them and help offered through facilitation brought about in the work situation. It is much more imperative that the patient continues to have regular follow-up with the specialists. The factors involved in the non-compliance, the dynamic reasons behind it and the corrective measures brought about through individual
work-up enable a better co-ordination in the clinical management of the individual. The difficulty in communication between the specialist who has little time to devote to the social problems of each patient and the individual who has difficulty in communicating his needs and expectations can be much narrowed by a skilled social worker.

As our work emphasizes, it is equally important to help the 'significant others' who are equally well involved. The group work with these families involve their utilization to help the client develop abilities, modify negative features of self-image, resolve interpersonal conflicts and find new and more constructive therapeutic change in individual through group achievement. It is essential that when the family is involved as a group, the problems of each has to be individually attended to. The focus of attention in this study has been that the illness (epilepsy or head injury) has an understandable impact not only on the sufferer but also the whole family system of which he is a part. It lays emphasis on the deeper repercussions of the
illness and the various ways it has been happening in neuro-psychiatrically ill patients—facts which have been happening amidst us almost daily but which we have been blind to, not of course intentionally but because of our sense of inadequacy in the face of impossibility. The beginning of explorations have often started with little, timid steps. Yet history recapitulates that little steps have been great leaps eventually.