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THE CAPACITY FOR INSIGHT AND UNDERSTANDING IN THE DEAF PATIENT

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A psychiatrist, like other workers in the field of deafness, is initially impressed by the concreteness of the deaf patient's communication. While his bafflement is gradually mitigated as he gets familiar with signs, manual alphabet and language patterns, he is often left with an erroneous understanding of the deaf patient's capacity to experience the more subtle and complicated nuances of human emotions and thoughts. One tends to regard the deaf as a stereotype incapable of delving into his inner world of feelings and conflicts. The establishment of such an attitude can prevent the therapist from helping the deaf to develop an insight into his problems, even when the patient is capable of that insight.

It is well known, of course, that the capacity for insight varies from individual to individual—hearing as well as deaf. An alert therapist, in the course of treatment, determines how much insight his patient is capable of and can use, and tailors his approach accordingly. Even in techniques of psychotherapy where behavior modification is the primary aim, the therapist cannot afford to overlook the possibility of helping the patient develop an improved understanding into his behavior. For the purpose of this paper the term 'insight' is not being used in the strict psychoanalytic sense, but in the broader meaning of self-awareness and understanding.

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The deaf patient, once he warms up to his therapist, can surprise the latter by his potentials if given the time and patience. This process of warming up is crucial in the psychotherapy of the deaf emotionally disturbed person. This warming up can come only if there is a readiness, on the part of the therapist, to empathize with the patient, and to have respect and sensitivity for his problems. The classical analytic attitude in the direction of cold objectivity is apt to be misconstrued by the deaf as callousness and disinterest. And that would block communication and impede the growth of the therapeutic relationship.

A patient in therapy is known to react fairly accurately to the expectations of his therapist. This is true for the deaf patient also. If his therapist anticipates a superficial level of understanding and limited insight from his deaf patient, that is what he is most likely to get. If he is interested enough to explore and discover, his efforts will not only be fruitful for the patient, but most rewarding and fulfilling to him, too. When a young deaf boy went to visit his mother for a few hours and returned to the hospital depressed and crest-fallen, the incident assumed more meaning when it was noted that he had gone there with a trunk load of clothes. His mother's indifference to his plea for acceptance back into the fold of the family, a plea made non-verbally but unmistakably, and its effects on his feelings of self-worth, were well brought out when the matter of the packed suitcase and its meaning to the patient were discussed in therapy.

It is granted that the awareness of relationship between behavior and feeling takes a longer time in the deaf and requires a greater understanding of the patient by the therapist. But that is where the challenge lies in the psychiatric management of the deaf. This is something beyond the simple learning of the sign language, which is just the beginning and not the end of the understanding of the deaf patient and his problems.

The deaf person, due to his particular handicap, tends to express his inner thoughts and feelings in concrete terms, but the concreteness is more in the *expression* of feelings than

in the feelings themselves. The poverty is not so much in the breadth, extent or intricacy of feelings as in the means of expressing them. How often do we hear the phrase, from those with normal hearing and speech, that words fail to express their feelings? To regard all deaf as concrete and limited in the scope and complexity of their emotions, because of their lack of verbal prowess, is, to say the least, anti-therapeutic.

A deaf girl goes home on convalescent care but returns soon thereafter following an attack on her brother-in-law for refusing to buy candy for her. It takes months before she comes out with the rest of the story which adds sense to her apparently bizarre behavior—her brother-in-law's attempts at having sexual intercourse with her. Even if this part of the story is only a product of her imagination, it adds a new dimension to her aggressive outburst and repressed sexual feelings. The candy that was refused was evidently more than just candy. In the light of this, her behavior becomes more comprehensible.

Understanding the behavior and feelings in terms of concrete expressions and acting out is only half of the therapeutic undertaking. The other half is the feed-back process. How best to make the deaf aware of his own complexes without becoming too high flown and incomprehensible? This problem is faced in dealing with the hearing patient too and a good therapist always takes his patient's capability to understand into consideration before rushing into interpretations. This is a very tricky job and requires much skill and experience on the part of the therapist. With the deaf patient the difficulty is greater but not insurmountable. Here again consideration has to be given to the individual's readiness and capacity to understand before the interpretation is made. As a matter of fact it has to be done at a level of concreteness at which the patient is most comfortable and receptive. For instance, a young deaf man always managed to create some severe behavior problem each time arrangements were made for him to leave the hospital, this time jeopardizing the rehabilitation program worked out for him; this in spite of his insistence that the only thing he wanted was to leave the hos-

pital. Very painstakingly he was confronted, in terms of the timings of his impulsive behavior, with the possibility that perhaps in fact he did not want to leave the security and structure of the ward's environment, perhaps he was too afraid of the world outside. Once he showed some awareness of his feelings of insecurity it became possible to explore them and give him reassurance and support, but above all, an improved understanding of his behavior.

In the management of the deaf patients at our in-patient as well as the out-patient services the emphasis, of necessity, is on behavior modification. The stresses evoked due to the adjustment difficulties in the hearing world are one of the most common factors in the emotional breakdown of the susceptible deaf individual. In the process of bringing about and encouraging more adaptive behavior, attempt is also made to improve the self-image of the individual. For this his active participation in the therapeutic process is sought and he is more and more aware of his own role and responsibility in the social milieu surrounding him. He is helped to see that he has to be more than just a passive recipient of social justice and community concern. When there is a breakdown in interpersonal relationship in the family or at work he has to understand his own contribution to it. In the course of this kind of total approach to his problems the patient starts to relate a great deal of material which opens little windows into his personality and problems—not only for the therapist but also for himself. The behavior changes achieved by this means are not only more lasting but also promote self-awareness and improve his chances of handling his conflicts more effectively with minimal outside help. When a young deaf boy was confused and angry at his 'loving' grandmother's rejection he was encouraged to go into the genesis of the situation. Perhaps he made too many demands on her, perhaps she thought he will never amount to anything and always be a burden on her. In spite of his extremely primitive communication skill, slowly and gradually, he started delving into his own angry and impulsive behavior in relationship to others and its effects on their reactions towards him. Although he still has a

long way to go, he has set into motion a chain of thinking which brings both the cause and effect into perspective. His feelings of helplessness, hopelessness and despair have receded as he has discovered his own influence on the happenings in life.

In summary it may be said that in the psychotherapy of the deaf emotionally disturbed person we must not underestimate the possibility of growth and understanding in the patient. We should also be prepared to accept and handle far greater complexity of feelings and thoughts, buried under the communication barriers, than we have been used to attributing to the deaf. Recognition and exploration of these will make the therapeutic process an enriching experience for the patient as well as the therapist.