

Interview, Diagnostic, and Legal Aspects in the Forensic Psychiatric Assessments of Deaf Persons

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Forensic psychiatric assessments rely on many underlying presumptions concerning the language development and abilities of their subjects. Although these assumptions may apply across a culturally diverse group of hearing subjects, they probably do not apply to those who are prelingually deaf because such deaf persons never developed verbal language. In this article, a review of the range of literature focusing upon the unique aspects of interviews, diagnosis, and legal understanding of the deaf is conducted. An attempt to illuminate those features believed to be most relevant to forensic assessments of this unique population is made. The demands of interviews conducted in manual language are discussed and particular attention is paid to the impact of the interpreter upon confidentiality, privilege, agency, and the dynamics of the interview. It is also suggested that many of the baseline behaviors of the deaf may, at least partly, result from differences in communication style between the deaf and hearing. This article reports that many major mental disorders occur with the same frequency among the deaf and hearing and include many of the same symptoms. However, organic mental disorders may occur at a somewhat greater rate among the deaf because of the organic basis of deafness. Finally, the ways in which deafness and the use of an interpreter may influence the deaf person's ability to understand and relate to legal concepts and process are discussed. It is noted that many of these problems may arise from a deaf persons inexperience or undereducation about legal matters rather than psychopathology.

In large measure, forensic psychiatric assessments rely upon verbal interchanges between the examiner and subject about some highly abstract concepts. Examiners may enter these evaluations with underlying presumptions that they share the use of mutually common language, communication pathways, and communication experiences with the subject. Subjects who diverge from these presumptions may substan-

tially challenge the reliability and validity of the evaluations.

The prelingually deaf* probably deviate most from these presumptions. They tend to use a manual rather than verbal language, a visual rather than auditory communication path, and may have never heard environmental sounds or spoken language. Therefore, the fo-

* The prelingually deaf are those who lost their hearing prior to the age at which they would have acquired verbal language. They include the congenitally deaf and those who became deaf sometime before ages 3 to 5. In this article, the terms prelingually deaf and deaf are used synonymously.

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rensic psychiatric evaluation of the prelingually deaf person is likely to hinge upon communication's impact on the interview, the diagnostic process, and the deaf person's ability to understand relevant legal issues.

Despite an exhaustive search of the literature, I have found no writing about forensic psychiatric evaluations of the prelingually deaf. This report attempts to somewhat fill this gap and serve as a starting point for future practice and research in this area by reviewing some relevant writings from diverse disciplines.

Interviews

The techniques used for interviewing hearing people fall short during the evaluation of the deaf because their communication processes are quite different. In this section, I review some works in which interview techniques involving prelingually deaf subjects are discussed. Interviews with the deaf were found to be more tiring, frustrating, lengthy, and to move more slowly than with the hearing.¹⁻¹⁰ Flexibility in using different communication methods was also commonly required. What follows is a summary of each author's other observations pertinent to the forensic psychiatrist.

Interviews in Other Than Mental Health Settings Schein¹ addressed some of the problems encountered by interviewers as he studied 1,132 members of the deaf community of Washington, DC. He encouraged interviewers to determine the subject's preferred communication method at the outset of the interview. He recommended using questions with predetermined response alter-

natives, rather than open-ended questions, to expedite the interview. Taking written notes tended to interrupt the flow of the interview, especially while using manual language.

Higgins² used interviews and observations to study more than 75 members of the deaf community in Chicago. He found that deaf people often mistrusted the hearing. He also observed that the hearing and the deaf tend to use different presumptions and coping strategies during informal conversation. For example, hearing people may overlook the hearing impairment of a deaf person who is among a group of hearing people. This may subsequently lead to the erroneous conclusion that the deaf person is uncooperative rather than hearing impaired. On the other hand, deaf people may manipulate the conversation by not disclosing their deafness or involving others, including interpreters, in the conversation.

Interviews in Mental Health Settings Altshuler and Rainer³ studied 230 deaf mental patients in New York. They found that sign language often only approximates spoken language, leaving much room for subjective interpretation. Their deaf subjects commonly used poor grammar, different idioms, and concreteness of expression and understanding. The writing of deaf persons was found to frequently reflect their poor language abilities. Facial expressions and body gestures were observed to be more important for communicating subtle emotions in sign language than in speech. They concluded that these numerous diagnostic obstacles could be overcome by specialized clinical

cal training, knowledge of the deaf and their language, and patience.

Rainer⁴ subsequently discussed ways in which the clinician could distinguish psychotic and nonpsychotic deaf patients. He noted that it was difficult to distinguish inappropriate or shallow emotional tone from the difficulties in appreciating and communicating the feelings between two people when one of them is deaf. One method by which he was able to discriminate between psychotic and nonpsychotic deaf patients was to observe the ability of the deaf patient to adjust his communication to the skills of the interviewer. He believed this conveyed the patient's feelings for, and awareness of, the listener. Thus, a deaf patient who was unable to adjust his communications accordingly was more likely to be psychotic.

Stokoe and Battison⁵ asserted that hearing and deaf people use different linguistic and nonverbal communications in the production and understanding of facial expressions and eye contact. The deaf and hearing also use sign language differently. They contended that such differences can result in misunderstandings and mutual judgments of "madness (craziness) or badness." They also commented that signers very carefully position themselves in rooms with regard to lighting and lines of sight between conversants. On the other hand, hearing people tend to position themselves away from distracting sounds. These tactics may work at odds between hearing and deaf people, thereby undermining communication between them.

Levine⁶ believed that examiners should have a solid knowledge of the

unique developmental and background features of the deaf. She noted that it was very important "to understand the concepts of the severely undereducated, for whom reality is often a jigsaw of unconnected pieces, and whose concepts simply represent their efforts to put the pieces together to make some sense." Perhaps most important, she recommended that the examiner should know how to "think deaf" and "talk deaf" when needed. She also believed that some useful information might be obtained through written exchanges with deaf clients.

Although Levine⁶ stressed the importance of obtaining collateral history concerning deaf clients, she suggested that the advantages of interviews with the deaf have not been sufficiently exploited. She subsequently discussed special considerations in a range of interview settings. For example, oral interviews can be conducted with lip readers, hearing aid wearers, and speaking deaf adults. Interviewers should arrange for appropriate visibility, speak in such a way as to minimize distortion of mouth and lip movements, and act to minimize fatigue. Misunderstood concepts should be rephrased into simpler more visible forms rather than repeated in the same way. The interviewer should prepare to shift into another form of communication such as writing, if necessary, to ensure understanding.

When interviewing hearing aid wearers, the interviewer should use a quiet room with special precautions against sudden loud noises. Not becoming fatigued is very important in these interviews and extra hearing aid batteries

should be kept nearby. Techniques used for lip readers may also be used for hearing aid wearers.

Finally, manual interviews of deaf persons often include elements of sign language, pantomime, facial expressions, gestures, and body movements. Levine⁶ particularly emphasized that interviewers should carefully observe the deaf subject's nonlanguage behavior.

Hoyt *et al.*⁷ reported that deaf patients may be slow to develop trust and may have overt or covert concerns about confidentiality of the interviews. The deaf are inclined to engage in concrete question and answer exchanges rather than expressive or open-ended dialogues. They may use their hearing impairment and dependence as resistance by signing too rapidly, looking away, or having selective understanding.

The Use of Interpreters Reisman *et al.*⁸ and Gerber⁹ discussed the use of interpreters for the deaf in medical and mental health settings, respectively. They advised that interviewers should maintain eye contact with and speak directly to the patient. The interviewer should not speak to the interpreter in the third person about the patient, nor should the interviewer and interpreter conduct parenthetical conversations. The interviewer should avoid instructing the interpreter to not interpret some statements. A comfortable, relaxed atmosphere should be created for the interview. A bright but not blinding light should illuminate the face and mouth of the hearing person and the hands and face of the interpreter, but should not shine in the eyes of the deaf patient because it could disrupt or distract the

patient's vision. The interviewer and interpreter should sit near each other and across from the deaf patient.

Levine⁶ made several recommendations concerning the practice of interpreted interviews. Professional interpreters should be used in virtually all circumstances, except for cases of uneducated deaf adults lacking conventional communication methods. Such people might necessarily rely on family members to interpret their homemade signs, pantomime, or other individualized communication methods. Unfortunately, this might inhibit disclosure by the deaf person because of fear that family members might talk about them or should not know this information. She recommended that the examiner ascertain whether the deaf client prefers someone known to him, who may be part of the deaf community, or a stranger.

The deaf are extremely observant of subtle behavior in the interviewer and Levine⁶ encouraged the interviewer to be aware that he is being closely watched. The interviewer should guard against conveying false impressions or revealing by act or facial expression that which should remain concealed.

Many issues germane to roles, authority and power, dependency, and confidentiality take on enhanced importance in interpreted interviews. Hoyt *et al.*⁷ found that the interpreter may dilute or distort the dyadic therapeutic relationship, becoming seen as the center of authority and the one who genuinely "understands" the patient.

Gerber¹⁰ subsequently discussed some additional ramifications of interpreter-

facilitated evaluations and therapy. The interviewer may yield power and authority to the interpreter because of fears of helplessness. It may be unclear for whom the interpreter is an agent: the patient, the therapist, or some other party. There may be exaggerated fears about confidentiality, despite the exceedingly high ethical standards of professional interpreters.

The deaf patient may be confused by the use of silence in the interview. Living in what may be absolute silence, this probably means something quite different to them than to the hearing: it might be perceived as a total communication breakdown of unknown meaning rather than a rhetorical pause.

There may be shifting alliances during interpreted interviews. The interviewer may perceive himself as an outsider, with the patient and interpreter united through a common language. The interviewer and interpreter may align against the patient, talking about him in the third person. The deaf patient may see the interpreter as a "window" to the hearing world, or as someone who can speak for him or explain things about him to the interviewer. Likewise, deaf patients tend to visualize hearing persons who sign fluently as wiser and more knowledgeable. The interpreter may be seen as the patient's friend or ally, or a surrogate or cotherapist. Or, the interpreter may function as a mediator who modifies and edits communication between the interviewer and patient.

The interpreter may also become the focus of transference or countertransference projection, identification, or ego modeling. Additionally, interpreters

may be used for resistance or may dilute or dampen the transference-countertransference.

Gerber¹⁰ concluded by noting that the greatest degree of interview-patient relatedness and empathic closeness should arise if the interpreter functioned as a neutral facilitator of accurate communication.

Comment Although it is difficult to generalize from these diverse sources, they suggest that forensic interviews with the deaf would be very different than those with the hearing. Such interviews would be tiring, demand greater attention and concentration, and require greater flexibility in using various communication modes. They would emphasize mutual observation between the interviewer and subject, possibly making each more self-conscious.

Forensic interviews with the deaf could be more easily disrupted by environmental distractions and preserving the interview for later analysis would be more difficult. Conducting the interview by only exchanging written notes would be inadequate because prelingually deaf people usually have very poor reading and writing skills. Note taking by the signing examiner involves looking away and using the hands and eyes to write rather than sign. This would disrupt the flow of the interview. Audiotape recording alone might usefully preserve the interpreter's voice but could not capture gestures, facial expressions, or the natural rate and rhythm of the manual language. Videotape recording seems to be the most effective way to preserve forensic interviews with the deaf. However, equipment may be unsuited to available

facilities, unavailable, or unaffordable. Additionally, the lighting and visual directional requirements necessary for indoor video camera use might interfere with visual communication between the deaf subject, interpreter, and interviewer.

Most forensic psychiatrists do not use manual language, so the use of an interpreter becomes an issue. The interpreter's presence may inhibit candid disclosure regarding sensitive medicolegal issues by the deaf subject or alter the dynamics of the interview. Out of frustration, the forensic psychiatrist might find himself/herself interviewing the interpreter rather than the deaf subject, or deferring to the interpreter on such issues as whether the deaf subject understands things or is attempting to practice deception.

As with the forensic psychiatrist, it is important to define for whom the interpreter is an agent. The client, the forensic psychiatrist, the court, or other source may be paying the interpreter and this may at least partly determine agency. However, the interpreter should be an impartial facilitator of accurate communication between the forensic psychiatrist and the deaf person, and should not align with anyone nor decide questions of fact or ultimate issues such as competency or criminal responsibility.

Psychiatric Diagnosis

Prelingually deaf mental patients often present with an array of complaints and behaviors confusing to the psychiatrist unfamiliar with the deaf. Unfortunately, communication differ-

ences may complicate the understanding of these findings. In this section, I review the literature on the phenomenology and rates of occurrence of mental disorders among the deaf and speculate on communication's role in how hearing mental health professionals process clinical findings about the deaf.

Phenomenology of Personality Altshuler¹¹ described some of what he believed to be the personality traits of the deaf. He observed that most deaf patients presented with complaints of impulsive and aggressive behavior, regardless of diagnosis. They tended to lack empathy and insight, were generally egocentric, had a low level of conscience, and adapted to adversity by "gross coercive dependence." Their reactions to tension and anxiety were characterized by "a kind of primitive riddance through action." He believed that such behavior might be manifest intrapsychically as simple projection and behaviorally as impulsivity and "the absence of much thoughtful introspection." Several other authors^{3,12-15} confirmed the common occurrence of impulsivity, aggression, and bizarre behavior among all deaf patients regardless of diagnosis.

Vernon¹⁶ observed that isolation, denial, underachievement, and suspiciousness were common features of one deaf population, independent of diagnosis.

Altschuler¹⁷ initially believed there were fewer obsessional symptoms among the deaf. However, he and his associates¹⁴ subsequently reported a high incidence of anxiety, phobias, and agitation among their deaf patients, regardless of diagnosis.

At least two authors attempted to de-

fine a personality structure for the prelingually deaf. On the basis of case reports and clinical experience, Basilier¹⁵ believed that such deafness may give rise to the personality of "surdophrenia." Unfortunately, he never gave an operational description of it. Rainer⁴ thought that the commonly occurring cluster of immaturity, temper tantrums alternating with friendly behavior, inexperience, a lack of empathy, and a lack of critical self-awareness should be named "primitive personality." While these terms may make some intuitive sense, they seem to have never been adopted outside their original sources.

Phenomenology of Certain Disorders

The disorders encountered are described below.

Psychosis Evans and Elliott¹⁸ attempted to develop screening criteria for the diagnosis of schizophrenia among the deaf. They excluded many of the "baseline" behaviors noted in the preceding section but ultimately included the loss of ego boundaries, delusions, illogicality, abnormal explanations, inappropriate affect, remoteness from reality, restricted affect, ambivalence, and hallucinations.

Auditory hallucinations among the prelingually deaf have been well documented since 1886 when Stearns¹⁹ reported the case history of a "deaf mute" (prelingually deaf) woman with *folie circulaire* accompanied by auditory hallucinations. In this century, Altshuler²⁰ discussed the case of a man, deaf since age 13 months, who heard the voice of God while psychotic. This patient drew a picture in which he showed God's voice as vibrations entering his body

through wires, some of which entered his ears. Remvig²¹ reviewed the Western literature on this phenomenon. The earliest reports of it he found were from 1867. He also reported the cases of four deaf-mute patients who had well-defined auditory hallucinations in which they also experienced vibrations as puffs of air. Altshuler¹⁷ subsequently reported that 22 of 57 deaf schizophrenics had hallucinations, 17 of whom "described some sort of auditory phenomena." He noted that "regardless of the ultimate terms of description, the question remains why these patients should insist they were hearing something." He discussed the phenomenon in detail and concluded that its occurrence among the prelingually deaf supports the hypothesis that auditory hallucinations are of organic, rather than functional, origin. When Evans and Elliott¹⁸ studied the phenomenology of schizophrenia among the deaf, their subjects tended to have visual, haptic, or somatic hallucinations. However, "(t)hey were auditory only in those patients who at some point in their lives had experienced sound to some degree."

Affective Disorders Altshuler¹¹ discussed the relationship between deafness and depressive illness, reporting that manic-depressive illness was extremely rare and that psychotic depressions were very infrequent among the deaf. He also observed that fewer than one-fourth of those patients with involuntional psychosis had depressive symptoms, rather presenting with either a paranoid form or an anxious agitated state without depression. He believed that these findings most likely reflected the sympto-

matic expression rather than prevalence of the disorders. He also speculated that "less uncomfortable self-limited manic episodes," possibly indistinguishable from other forms of excited behavior, might present among deaf persons as minor crimes like disturbing the peace rather than within a mental health setting.

Organic Mental Disorders Rainer⁴ described an impulsive disorder that tended to be associated with intellectual or organic defects. He believed it was similar to psychopathy, but without the suavity or complete disregard of right or wrong. He noted it was very important to differentiate between organic defect, brain damage, aphasia, and deafness among young deaf patients. Vernon and Rothstein²² reported that the most common causes of deafness are among the most common causes of mental retardation, brain damage, and epilepsy.

Psychogenic Deafness The diagnoses of feigned deafness and hysterical deafness may particularly interest the forensic psychiatrist. These diagnoses have been made by a combination of hydrotherapy and bromides,²³ sodium pentothal infusion,²⁴ and audiometric techniques.²⁵ Myers²⁶ gave a detailed description of several methods by which functional deafness can be diagnosed. Gibbons²⁷ discussed several aspects of these conditions based upon his experience with the Veterans Administration Audiology and Speech Pathology program in Los Angeles. He considered true psychogenic hearing loss to be extremely rare and recommended thorough and repeated examinations in suspected cases. Patients with organic total bilat-

eral deafness attempt to compensate for the loss: they seek visual cues, try to lip read, and demonstrate an eagerness to communicate. They also have an appreciable deterioration in speech quality with restricted melody, disappearance of final consonants, and changes in voice intensity. Those with nonorganic hearing losses have none of these features and attempt to undermine communication by avoiding eye contact with the examiner, reading with exaggerated concentration, and not responding to stimuli in their immediate vicinity. The examiner should remain objective and directly report inconsistent findings to the patient in a nonaccusatory manner, asking them to help account for the inconsistencies. Gibbons²⁷ recommended against using the term malingering.

Rates of Mental Disorders At least 10 investigations, some of which are cited in the preceding sections, included quantitative diagnostic studies of prelingually deaf patients from different clinical settings. Table 1 summarizes the findings of these studies. Among outpatients, situational reactions occurred at a rate between 22¹⁶ and 39 percent,²⁸ especially among younger populations. Schizophrenia was seen in 14¹⁶ to 21 percent^{28,29} of the outpatients. Personality disorders appeared at a rate of about 15 percent^{16,29,30} and mental retardation was seen in about 5 percent^{28,29} of the outpatients.

In hospitalized patients, schizophrenia seemed to be the most common diagnosis, occurring in 20¹³ to 84 percent¹⁶ of the patients, with several studies finding a rate of about 50 percent.^{3,12,14,31} Situational disorders oc-

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Table 1
Studies Involving Rates of Mental Disorders among the Prelingually Deaf

Authors	Study Population	Most Common Disorders (% of total)	
United States			
Altshuler <i>et al.</i> ³⁰	217 outpatients	46 (21.2)	schizophrenia
		34 (15.7)	passive-aggressive personality disorders
DeVos <i>et al.</i> ³¹	135 clinic patients	19 (8.8)	homosexual
		15 (6.9)	mental deficiency
		37 (27.4)	behavior disorders
		26 (19.3)	functional psychosis
		21 (15.6)	transient situational disturbance
Vernon ¹⁶	121 outpatients	20 (14.8)	personality disorders
		27 (22.3)	school situational reactions
		17 (14.0)	schizophrenia
	31 inpatients	9 (7.4)	inadequate personality
		9 (7.4)	antisocial reaction
Altshuler and Rainer ³	230 psychotic inpatients	26 (83.9)	schizophrenia
		3 (9.7)	inadequate personality
		3 (9.7)	depressive reaction
	92,409 hearing inpatients	120 (52.2)	schizophrenia
		42 (18.3)	psychosis with mental deficiency
		17 (7.4)	senile/arteriosclerotic psychosis
		16 (6.9)	other organic psychosis
		(56.5)	schizophrenia
		(16.2)	senile/arteriosclerotic psychosis
		(12.0)	other organic psychosis
(8.0)	cycloid and involuntal psychoses		
Altshuler <i>et al.</i> ¹⁴	171 inpatients	81 (47.4)	schizophrenia
		17 (9.9)	personality disorder
		17 (9.9)	adjustment reaction
Robinson ³³	150 inpatients	11 (6.4)	psychotic organic brain syndrome
		40 (26.7)	psychosis unassociated with brain syndrome
		35 (23.3)	transient situational disturbance
		23 (15.3)	neurosis
Europe			
Denmark and Eldridge ²⁹	170 outpatients and inpatients	66 (38.8)	behavioral problems/maladjustment
		36 (21.2)	schizophrenia
Denmark ¹²	28 inpatients	9 (5.3)	deafness with subnormality
			Author's diagnoses
		14 (50)	schizophrenia
		12 (42.9)	undiagnosed psychiatric disorder
			Others' diagnoses
		10 (35.7)	mental retardation
		7 (25.0)	schizophrenia
Denmark and Warren ³²	109 inpatients	4 (14.3)	manic-depressive illness
		3 (10.7)	undiagnosed psychiatric disorder
		47 (43.1)	schizophrenia

Table 1 (continued)

Authors	Study Population	Most Common Disorders (% of total)	
Remvig ¹³	30 inpatients	34 (31.2)	behavior problems/maladjustment
		6 (20.0)	schizophrenia
		6 (20.0)	unclassifiable psychosis
		5 (16.7)	behavioral disorders
		3 (10.0)	psychogenic psychosis
	3 (10.0)	organic brain syndrome with retinitis pigmentosa	
	10,390 hearing inpatients	(59.5)	schizophrenia
	(8.2)	manic-depressive psychosis	
	(7.4)	presenile psychosis	
	(5.4)	other organic psychosis	

curred at a rate between 10¹⁴ and 31 percent,³¹ while personality disorders were reported in about 10 percent^{14,16} of the inpatients. Organic mental disorders appeared in 6¹⁴ to 14 percent³ of the hospitalized prelingually deaf patients.

Although none of the studies were controlled, two of them involved comparison groups of hearing patients. Altshuler and Rainer³ reported the diagnoses of 230 psychotic deaf patients in New York State mental hospitals during 1958. They compared these data with official diagnostic information on 92,409 hearing inpatients similarly situated in the New York Department of Mental Hygiene during 1957. Although unruly behavior was apparently the most common reason for hospitalization of the deaf patients, 120 (52.2 percent) had schizophrenia, 42 (18.3 percent) had psychosis with mental deficiency, 17 (7.4 percent) had senile and arteriosclerotic psychosis, and 16 (6.9 percent) had other organic psychoses. The most common psychoses among the hearing inpatients were schizophrenia (56.5 percent), senile and arteriosclerotic psychosis (16.2 per-

cent), other organic psychoses (12 percent), and cycloid and involitional psychoses (8 percent). They noted the virtual absence of alcoholic psychosis among the deaf patients, despite its apparently common occurrence among the hearing. Unfortunately, there were different proportions of male and female patients in these two sample populations and no data were reported that compared other demographic or social dimensions of the deaf and hearing populations.

Remvig¹³ personally examined 30 deaf patients "partly with, and partly without, the assistance of an interpreter," in several Danish mental hospitals in 1966. Rather than using his diagnoses, he compared their hospital given diagnoses with those of 10,390 hearing inpatients from the same hospitals during 1966. Among the deaf patients, there were six (20 percent) with schizophrenia, six (20 percent) with unclassifiable psychosis, five (16.7 percent) with behavioral disorders, three (10 percent) with psychogenic psychosis, and three (10 percent) had organic brain syn-

drome with retinitis pigmentosa. The most common disorders among the hearing inpatients were schizophrenia in 59.9 percent, manic-depressive psychosis in 8.2 percent, presenile psychosis in 7.4 percent, and other organic psychoses in 5.4 percent. He also gave detailed case reports containing demographic and social data for each deaf patient. However, he presented no comparison data for the hearing population.

Another study compared diagnoses of deaf patients given by a signing psychiatrist against those given by nonsigning psychiatrists. Denmark¹² used manual language to interview all 28 profoundly deaf patients in two chronic mental hospitals in Northern England. He compared his diagnoses with those given by hospital psychiatrists who did not use manual language, but did not report whether the hospital psychiatrists used interpreters during their respective interviews. The hospital psychiatrists found 10 patients with mental retardation, 7 with schizophrenia, and 4 with manic-depressive illness. They found only three cases of undiagnosed psychiatric disorder. Denmark¹² diagnosed 14 cases of schizophrenia, but also found 12 patients with undiagnosed psychiatric disorders. He found no cases of mental retardation or manic-depressive illness. He acknowledged that the major problem encountered was arriving at a definite diagnosis. Unfortunately, Denmark¹² did not use a control population of hearing inpatients subject to similar diagnostic comparison at these same facilities.

Comment It is difficult to generalize findings from these studies of deaf pa-

tients to a forensic population of deaf subjects. Most of these studies lacked appropriate comparison groups and sufficient diagnostic rigor. They also had marked differences in methodology that preclude meaningful comparison between them. However, it seems likely that the forensic psychiatrist would see a deaf subject with a history of impulsivity, aggression, and bizarre-appearing behavior. Such deaf subjects also might have problems experiencing empathy and insight and might have a low level of conscience development. While these behaviors are apparently unrelated to mental illnesses *per se*, it remains unclear whether they constitute a prevailing interpersonal style such as a "deaf personality." Regardless, these behaviors seem to color the appearances of the personalities and mental disorders among the prelingually deaf and probably contribute to the diagnostic uncertainty noted by several investigators.

The forensic examiner should expect the common occurrences of schizophrenia, behavior problems, organic mental disorders, and personality disorders among deaf subjects. Schizophrenia probably has the same prevalence among the deaf and hearing,³³ and we can at least partly account for the behavior problems and personality disorders by the commonly observed behaviors described above. Given the organic bases of most hearing losses, it seems that at least some organic mental disorders probably appear with greater frequency among the deaf than among the hearing. The forensic examiner should carefully screen for organic and other neurologic disorders among the prelingually deaf.

The relative rates of other mental disorders among the deaf generally remain unknown.

It is unknown what role communication *per se* plays in defining or coloring the presentation of psychopathology among the prelingually deaf. Several studies have strongly suggested that interviews of hearing patients in their non-native language,³⁴⁻³⁸ or through a translator,³⁹⁻⁴¹ can lead to overlooking of, significant distortions in, or misperceptions about their psychopathology by the examiner. Brauer and Sussman⁴² believe that the communication, sociocultural, and attitudinal differences between the deaf and hearing contribute in large measure to the apparent psychopathology of the deaf. It seems likely that similar problems would occur during their forensic evaluations. Examiners should be aware of those possible complications during interviews of, deliberations on, and testimony by deaf subjects.

Legal Process

Prelingually deaf people have numerous problems communicating about and understanding the law, most of which are similar to those described earlier in this article. There is universal agreement that their language problems *per se* preclude any meaningful legal interaction without an interpreter competent to present legal material at an appropriate and flexible language level.^{27, 43-50} Additionally, adverse environmental circumstances in the courtroom and elsewhere severely limit the feasibility of speech reading, lip reading, or reading of transcribed material.⁴⁴⁻⁴⁶

As noted before, the use of interpreters

is not without complications. It has an important impact on issues of confidentiality, and authority and power to determine competency.⁴³ The interpreter may unwittingly edit, modify, or reject statements made by a deaf party because they believed the deaf person misunderstood a question or their answer was nonresponsive.^{26,47} The adequacy of interpretation may also affect the degree of voluntariness in statements made by the deaf.⁴⁷

This writer has found no quantitative studies of the knowledge deaf people have about the law despite an extensive search. However, Myers,²⁶ a postlingually deaf attorney, explained that prelingually deaf people, often grossly inexperienced and undereducated, have great psychologic difficulty handling abstract ideas. He emphasized that it is important to explain the opposing viewpoint and nature of the legal conflict. He also observed that deaf persons have a vague sense of past and future events. Deaf people tend to accept as fact things read in newspapers or magazines and tend to believe as true anything told to them in a bold or assertive manner. They also tend to disregard statements containing qualifications, exceptions, distinctions, or uncertainties. He suggested that they oversimplified problems, sometimes assigning great relevance to the irrelevant or relying on superficial similarities that are probably immaterial. They tend to require definite answers and have difficulty grasping relative solutions or the lack of an answer. They also may reject reasonable compromise that should be accepted. He noted that the deaf person's understand-

ing of the legal facts and proceedings can be ascertained by either expert opinion testimony or direct judicial inquiry of the deaf person through the interpreter.

Shepherd⁴⁸ commented that deaf clients frequently do not understand most of a contract and added that attorneys cannot be too careful in preparing a deaf client for trial. He observed that deaf clients frequently misunderstand the role of the lawyer.

Vernon and Coley⁴⁹ studied the reading level of the Miranda Warning and compared it with what they believed to be the reading level of most prelingually deaf adults in the United States. They found that the Miranda Warning was written at a reading level between grades seven and eight, while only 10 percent of prelingually deaf adults read at the sixth grade level or above. They pointed out that there are no signs in manual language that adequately convey some of the major terms and concepts in that warning. They also observed that signs for some of the terms in the Miranda Warning may be of an academic or esoteric nature and outside the knowledge of most deaf people. They concluded by noting that finger spelling would be a useless method by which to convey the warning to those deaf people who are illiterate or who read at a level below that of the seventh or eighth grade.

Richards and Rathbun⁵⁰ briefly mentioned obtaining informed consent from deaf persons by noting "a deaf patient should have an interpreter to help with questions and this interpreter should also sign the consent form." This is particularly relevant given that one study found the readability of surgical consent

forms to be at the level of scientific journals.⁵¹ Such problems may extend to contracts, installment loan agreements, divorce agreements, wills, and other legal documents by analogy.

Comment It is very difficult to generalize from the observations cited in this section because it is not known the conditions or techniques under which they were made. It seems that a substantial portion of the deaf clients reported by these observers were undereducated about and inexperienced in legal matters. However, we may infer little else about the subjects of these observations.

The combination of undereducation, inexperience, and low level of formal language functioning places prelingually deaf clients at a distinct disadvantage to hearing participants in the legal setting. Courtroom procedures seem to be more selectively based on hearing and acoustics rather than vision, likely leaving the deaf person in very unfavorable circumstances in the courtroom despite the use of interpreters.

Interpreters in the legal arena significantly alter the boundaries of confidentiality and the attorney-client privilege. Anyone within eyesight who knows manual language could penetrate the cloak of confidentiality that usually envelops softened voices, whether in the interview room or courtroom. These concerns may necessitate the use of visual barriers that may alter the evaluation process or the courtroom's functional nature.

It is highly important to use an impartial interpreter who is competent in the language of law and legal procedures. Unfortunately, such interpreters are

rare. Their scarcity might compromise the legal and ethical position of the only available such interpreter who might be called upon to function at several places and times, or for different purposes, during legal actions.

The difficulties encountered by the prelingually deaf in communicating about and understanding the law may also reflect psychopathology. However, with the exception of anecdotal comments by Myers,²⁶ I have been unable to find any studies addressing the interactions between psychopathology, inexperience, and undereducation as they affect the deaf person's relationship with the law. While some behaviors of the prelingually deaf suggest limited understanding or short-sighted appreciation of the law, the existence of a legally significant mental disorder should be conclusively demonstrated by behaviors and symptoms other than those supporting poor judgment alone.

Conclusion

This review has attempted to fill a gap in the literature concerning the forensic psychiatric evaluation of deaf subjects. Keeping in mind the problems of the forensic psychiatrist, I have attempted to describe what forensic examiners should expect in their dealings with deaf subjects and how these expectations might differ from those encountered in the forensic evaluation of the hearing subject. It is hoped that this work will help those who evaluate deaf subjects in the forensic setting to better appreciate the clinical and legal wrinkles in these assessments so that they may give a better informed opinion concerning the fo-

rensic psychiatric status of the deaf. It is also hoped that this report will stimulate future research in this area.

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