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Article

The Limits of Forensic Psychiatric Expertise in Hearing Loss

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Abstract: Background: The forensic psychiatric evaluation of individuals with hearing impairment aims to determine the diagnosis, etiopathogenesis, and type of hearing loss, by assessing the effects of sensory alteration, correlating them with any possible concurrent speech disorder, as well as with the impact of these alterations on development, from both an evolutionary perspective and, on the other hand, from the standpoint of their effect on the individual’s ability to understand the criminal act committed and the legal implications thereof, particularly with respect to establishing criminal responsibility. **Methods:** We present a study on patients admitted to the Psychiatry and Safety Measures Hospital Pădureni-Grajduri of Iași County, Romania, and advocates for an understanding of the diagnostic, evaluative, therapeutic, and rehabilitative complexity of such cases, with the involvement of multidisciplinary teams. **Results:** For all 6 out of 450 patients with hearing loss diagnostic, we identified various characteristics and needs that should be covered in order to facilitate the communication with the forensic psychiatric experts. **Conclusions:** Forensic psychiatric evaluators (psychologists, psychiatrists, and forensic physicians) have hard time on accurately assessing patients with hearing loss. Qualified professionals-including psychiatrists, audiologists, psychologists, psycho-pedagogues, speech therapists, and interpreters fluent in sign language must be trained to participate in forensic psychiatric evaluations.

Keywords: hearing impairment; deaf-mutism; forensic psychiatric evaluation; jurisprudence

1. Introduction

Hearing impairment (deafness), whether total or partial, refers to the partial or complete inability to hear. It is characterized by a sudden, gradual, or progressive decrease-either unilateral or bilateral-in sound perception and may have a regressive, fluctuating, or stabilized course. Hearing impairment is often associated with significant speech disorders, potentially leading to deaf-mutism, especially when it occurs in children under the age of three.

Clinically, hearing impairment is considered a disease rather than a symptom, and it can be either present from birth (congenital) or acquired later in life.

The causes of hearing impairment are varied, and the predisposition to develop it depends on factors such as age, sex, environmental influences, and associated genetic disorders. Hearing impairment may be worsened over the course of life by factors such as prematurity (due to the persistence of amniotic fluid in the middle ear or underdevelopment of the auditory system), advanced age, accompanied by presbycusis (typically around ages 40-50, especially in men), exposure to a single high-intensity noise or prolonged exposure to lower-intensity noise, the

administration of ototoxic medications, as well as certain genetic and neurological conditions, chronic diseases, and autoimmune disorders.

The diagnosis of hearing impairment requires a multidisciplinary clinical examination (ENT, neonatology, pediatrics, genetics, neurology, cardiology, endocrinology), screening tests, and assessment of cranial nerves V, VII, and VIII. Audiological investigations include phonetic and instrumental tuning fork tests, pure tone and speech audiometry, audiogram with tympanogram, pure tone threshold audiometry (for children over 6 years), impedance audiometry (tympanometry and acoustic reflex testing for those over 6 years), otomicroscopy, vestibular tests, brainstem evoked potentials, instrumental tuning fork tests, and otoacoustic emissions. Paraclinical investigations may involve otic, nasal, and laryngeal endoscopy, high-resolution CT scan of the temporal bone and mastoid, contrast-enhanced cranial MRI, MR angiography and Doppler ultrasound of the cervical vessels. Laboratory tests may also be requested, including basic blood tests (complete blood count, lipid profile, bleeding and coagulation times, APTT, INR, blood glucose, TSH), as well as serological tests such as RBW, ANA, rheumatoid factor, ESR, and tests for syphilis, HIV, lupus, shingles, or herpes [1].

Individuals with hearing impairment make an additional effort to communicate with others and integrate into society, which can lead to social withdrawal, fatigue, stress, and even depression [2].

In forensic psychiatric evaluation, the aim is to determine the etiopathogenesis, diagnosis, and type of hearing impairment, to quantify the effects of the sensory deficit and its correlation with speech disorders, as well as to assess the consequences on psychocognitive development from an evolutionary perspective of the impairment on one hand, and on the other hand, the impact it has on the individual's capacity to understand the act committed, with implications in jurisprudence and its legal consequences [3,4].

2. Materials and Methods

We propose a retrospective, observational study conducted between 2015 and 2025 on a group of 450 patients evaluated by the forensic psychiatric commission within the Institute of Legal Medicine in Iași, Romania. The evaluations were staged according to the Romanian Penal Code and the New Penal Code (at 6 months and 12 months, respectively) at the Pădureni-Grajdui Psychiatry and Safety Measures Hospital in Iași County, Romania.

The study involves the analysis of medical, forensic, and legal information concerning institutionalized patients, from which subjects with hearing impairment and deaf-mutism were selected, using specific inclusion and exclusion criteria.

Inclusion criteria involved diagnoses of profound bilateral mixed hearing loss and deaf-mutism established through medical and forensic documentation (psychiatric forensic examination reports: initial, follow-up, and staged) available in the case file, and age over 18 years.

Exclusion criteria involved patients with hearing loss secondary to cranio-cerebral pathologies (clinically diagnosed and confirmed by paraclinical investigations-CT, dedicated audiometry), ENT pathologies (bilateral earwax impaction, chronic suppurative otitis media), and patients who died during the course of the study.

The selection of patients included in the study group was carried out in compliance with patient rights, current ethical principles and guidelines [6,7], and with the approval of the ethics committees of the affiliated institutions (Institute of Legal Medicine in Iași, Romania, and the Pădureni-Grajdui Psychiatry and Safety Measures Hospital in Iași County, Romania), as well as the GDPR (General Data Protection Regulation) applicable in Romania and the European Union. Given the specificity of these subjects, ethical and bioethical rules governing human subject research played an essential role in their involvement in the study. No personal information, such as names, birth dates, or other identifying data, was recorded in the research [5]. All processed data were handled with great care, particularly considering the special legal status of these institutionalized subjects in a hospital with a secure regime.

Following the evaluation of medical and forensic records, six cases were identified that met the defined inclusion and exclusion criteria. To minimize data variability, all selected patients underwent re-evaluation through ENT examination, audiometric testing, and cranio-cerebral computed tomography (CT).

3. Results

Analysis of the available data revealed that, in all six cases involving hearing impairment, both the initial and subsequent forensic psychiatric evaluations-conducted prior to institutionalization at the Pădureni-Grajdui Psychiatry and Safety Measures Hospital in Iași County, Romania-had been performed without the assistance of a certified interpreter and without complementary ENT, audiological, or cranio-cerebral imaging assessments.

Regarding psychiatric diagnoses established during these evaluations by the psychiatric forensic committees regarding the first and the new psychiatric forensic expertise, in the four cases involving congenital deaf-mutism, patients were diagnosed with moderate intellectual disability of a disharmonic type due to sensory deficits and moderate intellectual disability accompanied by antisocial behavioral disorders. The remaining two cases were diagnosed with delusional disorder and organic affective disorder, respectively. In the two cases involving profound bilateral mixed hearing loss, moderate intellectual disability with associated behavioral disturbances was reported.

None of the six patients had been fitted with hearing aids, despite partial or non-verbal communication methods being employed. Furthermore, none of the patients demonstrated knowledge of standardized sign language.

Subsequent staged forensic psychiatric evaluations, conducted in accordance with both the Romanian Penal Code and the New Romanian Penal Code at six-month and respectively at twelve-month intervals at the Pădureni-Grajdui Psychiatric and Safety Measures Hospital, were carried out with the legal involvement of an interpreter.

Despite this support, psychological (paper-and-pencil) and psychiatric assessments remained inconclusive. This was primarily due to a lack of formal education in four of the patients and only partial schooling (eight years) in the other two, combined with their inability to communicate in sign language. As a result, definitive psychiatric diagnoses could not be established with certainty.

During these follow-up evaluations, all patients were referred for complementary ENT examinations, audiometric evaluations, and cranio-cerebral CT scans.

Based on linear tonal audiometry, four cases were confirmed as congenital deaf-mutism, and two as profound bilateral mixed hearing loss. Cranio-cerebral CT imaging revealed no pathological findings of the neuraxial structures.

All patients were male, aged between 38 and 52 years, four originated from rural environments, and two from urban settings.

Personal medical and psychiatric histories, family medical histories, and behavioral background information were not available through direct patient interviews and were instead extracted from existing documentation in the case files.

Educational background analysis showed that most offenses leading to institutionalization had been committed by individuals with no formal schooling (four cases), compared to two cases with secondary school education. Employment history indicated that none of the six individuals had held formal jobs. Instead, they had engaged in sporadic manual labor within their communities of origin.

Socio-familial assessment revealed a complete lack of family support across all six subjects, each coming from disorganized family backgrounds.

The offenses committed included rape, theft, aggravated robbery, attempted rape, attempted assault against a public official, domestic violence, and violation of Article 109 of the Romanian Penal Code. Regarding recidivism, three subjects had prior criminal records, including theft, assault, robbery, rape, and sexual aggression toward minors. One of these had served multiple prison sentences for rape and sexual offenses against minors. The remaining three were first-time offenders.

From a forensic psychiatric standpoint, the most prevalent offenses were sexual assault and rape. In only one of the six cases was the act committed with preserved criminal responsibility; in the remaining five, discernment was absent.

According to the assessments conducted by the forensic psychiatric commissions during the initial and follow-up evaluations, the application of legal measures under Article 109 of the Romanian Penal Code was recommended in only one case, while in the remaining five cases, legal measures under Article 110 of the Romanian Penal Code were advised-despite the fact that, in one of these cases, the offenses were considered to have been committed with discernment.

From a criminal law perspective, legal measures under Article 110 of the Romanian Penal Code were applied in all cases, even though the forensic psychiatric commissions recommended the application of Article 109 in one case.

The duration of hospitalization for these patients in the same high-security psychiatric institution varied: 3 years, 4 years, 5 years (two patients), 7 years, and 21 years.

4. Discussion

The risks associated with erroneous evaluations in forensic psychiatric assessments include, among others, the potential failure to identify psychological distress or the misidentification of mental health conditions that are not actually present [8]. Given the significant power that mental health professionals may hold over their patients, such errors can result in unjustified and prolonged detention under mental health legislation, inappropriate placement of an individual in prison, a high-security psychiatric hospital, or in the community, and the failure to identify a high risk of self-harm or harm to others. Even when a deaf offender is appropriately placed in a high-security psychiatric hospital, the variety of methods used to assess psychological issues and criminal behavior remains unreliable, making it difficult to accurately formulate the problems and design interventions tailored to the individual's actual needs [9,10].

The dilemmas raised in the case of patients with hearing impairment and deaf-mutism, either fully or partially compensated through unstandardized non-verbal communication, were as follows:

1. The role of the interpreter and the justification for their presence during the forensic psychiatric evaluation

In judicial proceedings, it is essential for the hearing-impaired individual to understand the context in order to ensure effective communication. In this regard, the Romanian Criminal Procedure Code and Penal Code contain specific provisions. The court must ensure such procedures are in place to facilitate proper communication with all parties involved.

Article 105 of the Romanian Criminal Procedure Code [11]:

(3) If the person being heard is deaf, mute, or deaf-mute, the hearing shall be conducted with the participation of a person capable of communicating in the special language. In such cases, communication may also take place in writing.

(4) In exceptional cases, if no authorized person capable of communicating in the special language is present and communication cannot be carried out in writing, the hearing of the persons referred to in paragraph (3) shall be conducted with the assistance of any person who has communication skills.

Public and private institutions should have established protocols with various interpreters or with the Association of the Deaf to ensure interpreter services for individuals with hearing disabilities.

Article 5 of Romanian Law No. 27/2020 on Romanian Sign Language states [12]:

(1) Deaf and/or hearing-impaired persons have the right to use Romanian Sign Language in their interactions with central and local authorities and institutions, whether public or private, in order to exercise their civil rights.

(2) Central and local authorities and institutions, whether public or private, are obligated to provide, free of charge, authorized Romanian Sign Language interpreters for deaf and/or hearing-impaired persons, in accordance with current legislation.

(3) Access to an authorized Romanian Sign Language interpreter shall be granted upon request or ex officio.

Article 69 of Romanian Law No. 448/2006 on the protection and promotion of the rights of persons with disabilities states [13]:

(1) Central and local authorities and institutions, whether public or private, are required to provide, for direct communication with individuals with hearing disabilities or deafblindness, authorized interpreters in sign language or in the specific communication system used by persons with deafblindness.

The staged forensic psychiatric evaluations carried out by the forensic psychiatric commission in accordance with the Romanian Penal Code and the New Penal Code (at 6-month and 12-month intervals) at the Psychiatry and Safety Measures Hospital Pădureni-Grajdu, Iași County, Romania, were conducted with the legal support of an interpreter.

As a result of the aforementioned legal provisions, these evaluations were performed with the assistance of an interpreter, but proved inconclusive due to the patients' lack of sign language knowledge, stemming from either a complete lack of schooling or insufficient formal education.

2. Relevance and Validity of Psychological Tests in Forensic Psychiatric Evaluation

The assessment of patients with auditory sensory deficits (hearing impairment, deaf-mutism) from a forensic psychiatric perspective represents one of the most sensitive and complex challenges in forensic practice. These cases are particularly difficult to diagnose and evaluate due to the limited number of such cases and the lack of a standardized methodology for psychiatric and psychological assessment. As such, forensic psychiatric commissions often face diagnostic, therapeutic, etiopathological, and legal dilemmas, which are only partially addressed in the current specialized literature.

When conducting complementary evaluations to determine the mental health status of a person with hearing impairment or deaf-mutism, it is imperative that the medical team understands the individual's academic and linguistic abilities and identifies an optimal method for communication and message validation. Several factors justify this requirement, including the fact that much of the information concerning judicial procedures is presented in written format.

3. Recommended Treatment and the Role of High-Security Institutions in Supervision and Timely Implementation of Targeted Therapies

For clinical, paraclinical, and forensic psychiatric assessment, as well as for the application of appropriate treatment in cases of auditory sensory deficits (hearing impairment, deaf-mutism), it is essential that the members of the forensic psychiatric commission understand the often contradictory etiopathogenesis of such conditions. They must also consider the consequences on psychocognitive development, language acquisition, psychological development, Deaf culture, social behavior, and legal responsibility.

In cases of congenital hearing loss, if early diagnosis and appropriate intervention are lacking, both immediate and long-term negative consequences can arise in terms of speech and language development (due to maximum cortical plasticity during the first years of life), cognition, educational attainment, and cognitive-behavioral and social functioning during the day-to-day life of the individual. Hearing loss at an early age significantly impacts intellectual and psychological development, disrupts conceptual thinking, and fosters a sense of fear and isolation in the child. Experiences are perceived as incoherent and incomprehensible, and the surrounding environment may appear foreign or hostile. Clinically, such individuals often exhibit delayed language development, cognitive impairments, and reduced academic performance [14]. In adults, hearing loss can lead to social isolation and significant socio-professional difficulties [15].

Unfortunately, at present, in Romania, the culture of individuals with hearing impairments is poorly understood and insufficiently integrated. Although there are dedicated schools, organizations such as the National Association of the Deaf with branches in each county, various clubs for cultural and sports activities, and churches, individuals with special auditory needs represent a distinct world—a linguistic and cultural minority—for which modern society is largely unprepared.

For hearing-impaired individuals, nonverbal communication is of paramount importance and is interpreted differently depending on the educational level and expertise of the communicator. For example, touch is a common element during examinations and, when correlated with accurate interpretation of facial expressions, conveys the emotional tone of a message in a way analogous to vocal intonation in hearing individuals. Typically, facial expressions are exaggerated to reflect the signer's intent and to ensure that the tone and content of the message are clearly transmitted and received. Additionally, hearing-impaired individuals often perceive personal space differently, which may lead them to stand closer to one another during communication.

4. The Effects of Long-Term Institutionalization (Hospitalism) on Psychological Well-Being

The interruption of familial and community ties, particularly in such vulnerable patients and in the absence of targeted therapeutic interventions (e.g., speech therapy, psycho-pedagogy), leads to observable mental regression and gives rise to the clinical phenomena of hospitalism: indifference, irritability, apathy, increased susceptibility to illness, weight loss, loss of previously acquired skills and abilities, social alienation, and the development of maladaptive behaviors.

5. The Role of Psycho-Pedagogical Interventions in Education, Instruction, and Social and Familial Reintegration

The institutionalization of hearing-impaired individuals in high-security psychiatric hospitals does not enhance medical or social rehabilitation. Rather, it limits the implementation of specialized therapeutic interventions and recovery programs suited to such fragile and diagnostically complex individuals—who are often difficult to assess both medically and legally, and to reintegrate socially, within the family, or professionally. In the absence of a legislative framework that adequately acknowledges and addresses the legal complexities surrounding such cases, it becomes exceedingly difficult to appropriately interpret them from a forensic psychiatric perspective and to apply the legal provisions of Articles 109 or 110 of the Romanian Penal Code.

6. Determining Criminal Responsibility (Discernment)

From both historical and legal perspectives, in early common law, deaf-mute defendants were generally presumed to suffer from mental disorders and were considered legally irresponsible. In contemporary legal thought, however, deaf-mutism is recognized as potentially constituting *mens rea* and is understood to reflect limitations in critical discernment.

In individuals with hearing impairment, in the absence of other diagnosed mental illnesses of differing etiopathogenesis or significant cognitive disorders, cognitive and expressive limitations often stem from language deprivation. Indeed, the so-called “language deprivation syndrome” has been described as a possible neurodevelopmental disorder with well-established sociocultural origins [16,17].

In the context of hearing impairment, language deprivation is common and occurs in the absence of exposure to sign language necessary for acquiring such competencies, which severely impairs these individuals' ability to understand and participate in judicial proceedings [18].

Another legal challenge in the case of individuals with hearing impairment is their often low or absent educational level, and consequently, a lack of understanding of fundamental legal concepts and procedures [18]. These informational deficits are consistent consequences of language deprivation and frequently occur in the context of low literacy levels, limited intrafamilial communication, and poor educational attainment—even when linguistic competence remains otherwise intact.

In forensic psychiatric evaluation, it is crucial to distinguish the type of hearing impairment—whether unilateral or bilateral, prelingual or postlingual—since comprehension of native language

syntax, semantics, and grammar develops in children with normal hearing by the age of three, whereas in children with deafness, this level of comprehension may reach only around 30%. The presence of a hearing deficit presents lifelong challenges, placing such individuals at a significant disadvantage, particularly when attempting to understand or respond to judicial procedures [19,20].

Another important element in the forensic psychiatric evaluation of individuals with hearing impairment is the assessment of the etiology of the hearing loss-whether it is due to viral or infectious lesions affecting the brain, or traumatic injury. The genetic component, either as part of a syndrome or as a familial trait with hereditary patterns, influences both the assimilation and structuring of linguistic skills and the acquisition of language, including the specific communicative forms used by individuals with hearing impairments [11].

7. Competence of Forensic Psychiatric Evaluation Committees (Psychologists, Psychiatrists, and Forensic Physicians)

For hearing-impaired defendants, personality assessment and diagnosis of potential mental disorders should be based on a comprehensive history, a complete and accurate psychological and psychiatric examination (including validated, specific tests), and a targeted clinical interview. This interview should inquire about the individual's schooling, family history, the context and timing of the onset of hearing loss, and any use of assistive hearing devices. Family history should consider the auditory health of the biological family, as well as its general capacity for intrafamilial and interfamilial communication, and specifically communication with the hearing-impaired person. For instance, a deaf individual born into a hearing family with poor communication skills is likely to experience feelings of isolation and underdeveloped linguistic abilities.

The type of educational program is also a key consideration. Deaf students placed in educational settings that are inaccessible in terms of communication are often less capable of developing age-appropriate social and behavioral skills compared to peers immersed in environments where they can acquire sign language or even a second spoken language.

Reports of abuse are more frequently encountered among hearing-impaired children, as is the incidence of anxiety-depressive disorders and the impact of bullying. These anamnesis data can contribute to interpersonal misunderstandings or paranoid ideation that may be causally related to the alleged offense and are therefore significant in the diagnostic evaluation process. The interpretation of symptoms specific to mental disorders requires careful questioning during the clinical interview with hearing-impaired individuals. In some cases, a direct and explicit form of communication is necessary to highlight signs and symptoms that may serve as relevant indicators of psychiatric illness.

The evaluator must be capable of interpreting the behavior and self-reporting of the deaf defendant from a culturally informed perspective, with a clear and objective understanding of the psychological effects associated with hearing impairment.

A flawed clinical assessment may lead to an incorrect psychiatric diagnosis and, consequently, a misjudgment of the individual's criminal responsibility and an inappropriate legal classification of the offense. Hearing-impaired patients are at higher risk of such outcomes, particularly when the evaluator has no prior experience with deaf individuals.

Studies published in the specialized literature of the 1960s proposed several nosological entities to classify psychiatric pathology associated with deaf-mutism, including surdophrenia (Basilier) and primitive personality (Altschuler), characterized by extremely limited vocabulary, functional illiteracy, and minimal or nonexistent formal education. These studies compared the psychological profile of individuals with deaf-mutism to that of feral children.

The psychosocial outcome is reflected in impaired daily functioning and limitations in social, familial, and/or occupational capabilities, manifesting in significant difficulties performing even simple tasks. Deaf defendants may be considered unfit to stand trial and incapable of reintegration due to the cognitive deficits stemming from language deprivation, which prevents them from understanding basic legal concepts and terminology.

Since language is a cognitive skill, individuals who demonstrate developmental stagnation at a primitive personality level typically show mild cognitive impairment that can affect other areas of cognitive functioning as well, including general knowledge, reasoning, and behavior. Hearing-impaired individuals tend to respond well to concrete visual information but struggle to grasp abstract concepts such as good and evil, or personal responsibility-concepts that are essential to legal restoration and understanding the personal, social, and legal consequences of one's actions [17].

Recent studies published in the specialized literature identify a pathology consistent with language deprivation syndrome, characterized by deficits in adaptive behavior and behavioral skills akin to developmental stagnation at a primitive personality level. These deficits are attributed to the causal relationship between early language deprivation and increased vulnerability in social, behavioral, and cognitive domains. For deaf defendants, language deprivation syndrome may account for a lack of behavioral regulation skills associated with the alleged offenses, and for their perceived association with varying degrees of intellectual disability. In both diagnostic categories referenced above-discussed in current literature-language deprivation is the common underlying factor, seemingly causally linked to the skill deficits that can lead individuals into mental health assessment systems with potential legal consequences [17].

Unfortunately, neither primitive personality development nor language deprivation syndrome is currently quantified or recognized in the DSM-5 or ICD-10/11 classification systems [21], this concern being currently abandoned, underdiagnosed and undervalued.

According to findings published in the professional literature, individuals diagnosed with primitive personality disorder or language deprivation syndrome require the involvement of a specialized interpreter team to ensure that the accused fully understands the judicial procedures to which they are subjected. Such evaluation teams should include a certified deaf interpreter (a deaf individual whose first language is sign language) and a sign language interpreter, working together to guarantee that deaf or deaf-mute defendants comprehend what is being communicated and are able to express themselves adequately. In supporting the comprehension of a hearing-impaired or deaf-mute defendant, both interpreters collaborate to expand, clarify, and adapt the language being used. The consequence of language deprivation may lead to the determination that the hearing-impaired or deaf-mute defendant is unfit to stand trial.

On the other hand, recent research also suggests that deafness and associated language deficits may be contributing factors in the criminal behavior of hearing-impaired defendants. Some studies have indicated that deaf or deaf-mute individuals are more likely to commit violent or sexual offenses and less likely to engage in robbery [23]. This has been attributed to the fact that robbery typically requires verbal confrontation and the articulation of demands to a potential victim-forms of interaction that presuppose functional language use-whereas other types of offenses do not necessitate such interaction. While not directly related to behavioral restoration, this research underscores the impact of language deficits on the actions of deaf defendants.

5. Conclusions

The relevance of the topic addressed arises from the multitude of factors that influence the diagnosis, treatment, education, re-education, rehabilitation, and social, familial, and/or professional integration and reintegration of such individuals.

The challenges posed by individuals with congenital or acquired hearing impairment and deaf-mutism-a population segment in a disadvantaged position relative to other social groups-remain a complex and unresolved issue within forensic psychiatry.

The differentiation and assessment of individuals with hearing disabilities represent a complex interdisciplinary endeavor, involving fields such as medicine, psychology, pedagogy, and sociology, and focus on identifying and distinguishing the specific features of each individual's psychophysical development.

In the case of patients with profound bilateral mixed hearing loss or deaf-mutism, whose condition is compensated or partially compensated through non-verbal, non-standardized

communication and who lack knowledge of sign language, the role of the interpreter and the justification for their presence in forensic psychiatric evaluation become irrelevant.

Psychological tests applied in such cases are irrelevant, psychiatric examinations are virtually impossible to conduct, and consequently, treatment cannot be implemented [22]. Furthermore, the supervision of such patients does not fall within the competence of psychiatric or high-security institutions.

The inherent difficulties in conducting psychiatric assessments and psychological testing of these patients consistently lead to uncertain and arbitrary case resolutions, posing risks both for the patient and for the members of the forensic psychiatric commission.

The challenge of distinguishing the effects of neurodevelopmental deficits from the psychosocial personality profile suggests that standardized personality testing instruments (validated questionnaires) are currently inadequate and not suited for use in the evaluation of patients with hearing impairment or deaf-mutism.

The psychological impact of long-term institutionalization on such individuals is unfavorable, particularly due to the impossibility of implementing psycho-pedagogical interventions aimed at their instruction, education, and social and familial reintegration.

For high-security psychiatric institutions, the primary risks arise from the inability to provide appropriate treatment, due to the lack of interpreters, speech therapists, and psycho-pedagogues, as well as from the development of hospitalism.

For the patient institutionalized in such a setting, the risks include deprivation of liberty, misjudgment of criminal responsibility, lack of appropriate treatment, and prolonged hospitalization. In most cases, hospitalism is the result of the inability to discharge the patient in the absence of adequate post-discharge supervision.

Forensic psychiatric evaluators (psychologists, psychiatrists, and forensic physicians) currently lack the expertise required to accurately assess such cases. It is therefore imperative to train qualified professionals-including psychiatrists, audiologists, psychologists, psycho-pedagogues, speech therapists, and interpreters fluent in sign language-to participate in forensic psychiatric evaluations, ensuring the most accurate and objective assessment possible.

Cooperation among the systems involved in the care of hearing-impaired or deaf-mute patients is an essential condition for optimal management, particularly in the case of patients who are irreversibly affected and lack familial support [24].

Through the deinstitutionalization of such individuals, they may become a continuous source of subjects at risk for antisocial behavior, repeatedly passing through the legal procedures required for admission to psychiatric and safety measure institutions [25,26].

Creating conditions for education and schooling, socio-professional adaptation, and social integration of these patients should represent a collective community objective in all developing societies, of which Romania is inherently a part.

Among the measures that could lead to an improved trajectory for patients with auditory sensory impairments-and which are feasible for nationwide implementation-are:

- Mandatory and accurate implementation of universal newborn hearing screening protocols, in line with the Ministry of Health's recommendations for early intervention in identified cases, thereby preventing adverse developmental outcomes.
- Specific social work interventions aimed at identifying and optimally managing individuals with sensory disabilities, in order to halt educational deprivation, stigmatization, and social marginalization, while ensuring the protection of their legal rights and eliminating social, financial, institutional, and healthcare access inequities, as well as barriers to legal assistance.

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