

CHAPTER 3

PATHOLOGICAL CRIMINAL INCAPACITY AND THE CONCEPTUAL INTERFACE BETWEEN LAW AND MEDICINE

“Every isolated passion is, in isolation, insane; sanity may be defined as a synthesis of insanities. Every dominant passion generates a dominant fear, the fear of its non-fulfillment. Every dominant fear generates a nightmare, sometimes in the form of an explicit and conscious fanaticism, sometimes in a paralyzing timidity, sometimes in an unconscious or subconscious terror which finds expression only in dreams. The man who wishes to preserve sanity in a dangerous world should summon in his own mind a parliament of fears, in which each in turn is voted absurd by all the others.” (Bertrand Russel, 1955)

1 Introduction

He was born in Milwaukee and raised in Bath, Ohio which is an average middle class community. He grew up in a home where his parents were constantly fighting and detesting each other, paying little attention to him. Lonely and neglected, Dahmer retreated deeper and deeper into his own fantasy world. He developed a profound and unique hobby – killing small animals, skinning them and removing their meat with acid. He displayed his collection of squirrel and chipmunk skeletons in his backyard and also created a pet cemetery next to his house. One day several boys in the local neighbourhood, strolling by Dahmer’s house, made a shocking discovery – they found a decapitated dog’s head impaled on a stick. The skinned and gutted body of the animal was found not too far from this scene. His parents got divorced and eventually his mother abandoned him. One day he picked up a nineteen year old hitchhiker named Steven Hicks. After they enjoyed a pleasant evening together, Hicks told Dahmer that he was moving on. Dahmer smashed the back of Hicks’s skull and strangled him. He dragged the corpse into a space under the house, dismembered it and stored the pieces in plastic bags. Jeffrey Dahmer’s horrific and savage acts had begun. He was only eighteen years old. A year later Dahmer killed another gay man. He kept the skull as a souvenir after scraping it clean of flesh. Soon hereafter another victim

followed. Two years later, Dahmer was charged with sexual assault and enticement of a child for immoral purposes, after he lured a thirteen year old boy to his apartment, drugged him and fondled him. He was admitted to prison and released after ten months. Dahmer butchered three more men the following year. Eventually, neighbours started to complain about an obscure odor coming from Dahmer's apartment. Dahmer apologised and stated that the cause of the smell was his broken freezer which caused his meat to go rotten. Dahmer's victims increased with the passing of time until one evening in July 1991, two patrolmen saw a dazed man moving in their direction with a pair of handcuffs dangling from his one wrist. The police went to investigate Dahmer's apartment and discovered Jeffrey Dahmer's chamber of horrors. In his drawers the police discovered body parts and mutilated corpses. Inside a freezer the police found three human heads together with an assortment of organs which included intestines, lungs, livers, kidneys and a heart which Dahmer stated he was keeping to "eat later". Seven skulls and five complete skeletons were kept in various locations around the apartment. Other remains, including bone fragments, decomposed hands and sexual organs were kept in a lobster pot. These were the remains of eleven victims. At his trial in 1992, his legal representative argued that the very nature of Dahmer's deeds which included "skulls in a locker, cannibalism, necrophilia, lobotomies and defleshing" proclaimed the "madness" of the mental illness from which he was suffering. The jury, however, rejected the insanity defence and found Dahmer guilty¹ and sentenced him to fifteen consecutive life sentences. He was, however, murdered by another inmate in November 1994².

These terrible and horrific facts serve to set the stage for the defence of pathological criminal incapacity, often referred to as the "insanity" defence.

The interface between criminal law and the field of psychiatry and to a lesser extent, psychology, has manifested predominantly in pathological criminal

¹ Schechter, H "The Serial Killer Files – The who, what, where, how and why of the World's most terrifying murders" (2003) at 200– 204.

² Schmallegger, F "Criminology Today" (1996) at 198. Despite the fact that insanity was raised as a defence in Jeffrey Dahmer's case, one psychiatrist, Park Dietz, testified that although Dahmer suffered from various psychological disorders, he had the choice whether to kill or not. Another expert witness, however, provided a dissenting opinion by stating that Dahmer "had uncontrollable urges to kill and have sex with dead bodies ..."

incapacity or described differently criminal non-responsibility attributable to mental illness³.

³ Snyman, CR “Criminal Law” (2008) at 170 – 178; Snyman, CR “Strafreg” (2006) at 167 – 177; Snyman, CR “Criminal Law” (2002) at 167 – 176; Burchell, J and Milton, J “Principles of Criminal Law” (2005) at 370 – 402; Burchell, J and Milton, J “Cases and Materials on Criminal Law” (2007) at 348 – 360; Kaliski, SZ “Psycholegal Assessment in South Africa” (2006) at 93 – 110 and 237 – 249; Louw, R “Principles of Criminal Law: Pathological and Non-pathological criminal incapacity in Kaliski “Psycholegal Assessment in South Africa (2006) at 34 – 57; Africa, A “Psychological evaluations of mental state in criminal cases” in Tredoux *et al* “Psychology and Law” (2005) at 384 – 410; Strauss, SA “Doctor, Patient and the Law – A selection of practical issues” (1991) at 121 – 135; Report of the Commission of Inquiry Into the Responsibility of Mentally Deranged Persons and Related Matters R.P. 69/1967 (hereafter referred to as the “Rumpff report”); Kruger, A “Mental Health Law in South Africa” (1980) at 146 – 220; Du Toit *et al* “Commentary on the Criminal Procedure Act” (2007) at 13-1 - 13-30; Joubert, WA and Faris, JA “The Law of South Africa” vol. 6 (2004) at 65 – 70 hereafter “LAWSA”; De Wet, JC and Swanepoel, HL “Die Suid-Afrikaanse Strafreg” (1974) at 108 – 114; Krieger, J and Kruger, A “Hiemstra – Suid-Afrikaanse Strafproses” (2008); Burchell, EM and Hunt, PMA “South African Criminal Law and Procedure – General Principles of Criminal Law” (1997) at 162 – 182; Visser, PJ and Maré, MC “Visser and Vorster’s General Principles of Criminal Law through the cases” 3rd ed. (1990) at 316 – 359; Smith, JC “Smith and Hogan – Criminal Law” (2002) 10th ed. at 213 – 231 hereafter “Smith and Hogan”; Card, R “Card, Cross and Jones – Criminal Law” (21004) 16th ed. at 724 – 741; Greig, DN “Neither Bad Nor Mad – The competing Discourses of Psychiatry, Law and Politics” (2002) at 107 – 122; Fradella, HF “From Insanity to Diminished Capacity – mental illness and Criminal Excuse in Contemporary American Law” at 15 – 58; Whitlock, FA “Criminal Responsibility and Mental illness” (1963) at 1 – 93; Slovenko, R “Psychiatry and Criminal Culpability” (1995) at 1 – 66; Slovenko, R “Psychiatry in Law – Law in Psychiatry” (2002) at 187 – 290; Slovenko, R “Psychiatry and Law” (1973) at 77 – 91; Slovenko, R “Crime, Law and Corrections” (1966) at 82 – 101, 367 – 373; Jones, DW “Understanding Criminal Behaviour – Psychosocial approaches to criminality” (2008) at 37 – 71; Bean, P “Madness and Crime” (2008) at 1 – 60; Bartol, CR “Criminal Behavior – A Psychosocial Approach” (1991) at 143 – 171; Carson *et al* “Applying Psychology to Criminal Justice” (2007) at 1 – 20; Dennison, S “Criminal Responsibility” in Carson *et al* (2007) at 131 – 146; Winstone, J and Pakes, F “The Mentally Disordered Offender Disenablers for the Delivery of Justice” in Carson *et al* (2007) at 167 – 182; Roche, PQ “The Criminal Mind ... A study of Communication Between the Criminal Law and Psychiatry” (1958) at 1 – 30; Bartol, CR and Bartol, A: Criminal Behavior – A Psychosocial Approach” (2005) at 187 – 235; Schopp, RF “Automatism, insanity, and the psychology of criminal responsibility” (1991) at 27 – 69; Melton, GB, Petrila, J, Poythress, NG and Slobogin, C “Psychological Evaluations for the Courts” (2007) at 201 – 266; Kermani, E “Handbook of Psychiatry and the Law” (1989) at 152 – 193; Meyer, RG, Landis, ER and Hays, JR “Law for the Psychotherapist” (1988) at 57 – 86; Macdonald, JM “Psychiatry and the Criminal – A Guide to Psychiatric Examinations for Criminal Courts” (1976) 3rd ed. at 62 – 84; Fesch, EA “Psychology and Psychiatry in Courts and Corrections – Controversy and Change” (1980) at 1 – 37; Brody, BA and Engelhardt, HT “Mental illness: Law and Public Policy” (1980) at 3 – 25; Rubin, S “Psychiatry and Criminal Law – Illusions, Fictions and Myths” (1965) at 1 – 18; Mcauley, F “Insanity, Psychiatry and Criminal Responsibility” (1993) at 1 – 90; Arrigo, CEA “Punishing the Mentally ill – a critical analysis of law and psychiatry” (2002) at 127 – 144; Power, DJ, Curran, P and Hughes, JM “Criminal Law and Forensic Psychiatry” (1996) at 332 – 355; Wright, F, Bahn, C and Rieber, RW “Forensic Psychology and Psychiatry” (1980) at 3 – 26; “The Mental Health Professional and the Legal System” Report no. 131 formulated by the Committee on Psychiatry and Law (Group for the Advancement of Psychiatry) (1991) at 26 – 29; Carstens, PA “Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid” (unpublished LLD thesis University of Pretoria) at 522 – 523; Carstens, PA and Pearmain, D “Foundational Principles of South African Medical Law” (2007) at 745 – 747; Schiffer, ME “Mental Disorder and the Criminal Trial Process” (1978) at 121 – 151; Brakel, SJ and Brooks, AD “Law and Psychiatry in the Criminal Justice System” (2001) at 5 – 60; Shapiro DL “Forensic Psychological Assessment – An integrative Approach” (1991) at 59 – 91; Gutmacher, MS “The Role of Psychiatry in Law” (1968) at 3 – 108; Finkel, NJ “Insanity

The defence of criminal incapacity is primarily and exclusively concerned with the human mind and the human psyche. Few things are so complex and difficult to comprehend as the human mind, controlling human behaviour. In the previous chapter, the author addressed the essential need for expert evidence in support of the defence of non-pathological criminal incapacity. A discussion was also provided of the current sections in the Criminal Procedure Act which do not oblige a court to require expert evidence in cases of non-pathological criminal incapacity. The prejudicial effect this has on an accused's right to a fair trial was highlighted. In short, in the previous chapter, the argument was advanced for the proper

on Trial" (1988) at 23 – 48, 73 – 100; Blau, T "The Psychologist as Expert Witness" (1998) at 104 – 130; Halleck, SL "Law in the Practice of Psychiatry – A Handbook for Clinicians" (1980) at 207 – 246; O'Brien, K "Forensic Psychiatry: Criminal Issues in Freckelton, I and Selby, H "Expert Evidence in Criminal Law" (1999) at 606 – 633; Viljoen, G "Toerekeningsvatbaarheid. Wrywingspunte en Raakvlakke tussen die Reg en die Psigiatrie" (1983) *TRW* at 121 – 131; Van Rensburg, PHJ, Verschoor, T and Snyman, JL "Psigiatriese en Juridiese Aspekte van die Begrip Geestesongesteldheid" (1983) *TRW* at 162 – 171; Kruger, A "Tekortkominge in Wetgewing oor Geestesongesteldheid" (1983) *TRW* at 182 – 192; McKay, IM "Scientific Reliability of Psychiatric Expert Witness Testimony Involving the Use of Classifications from the Diagnostic and Statistical Manual of Mental Disorders" (1992) *Criminal Justice Journal* at 345 – 384; Ryan, C and Smith, ME "When insanity is convenient" (2005) *Without Prejudice* at 7 – 9; Zabow, T "Psychiatric Evidence in Extenuation: Assessment and Testimony in Homicide Defendants" (1989) *Medicine and Law* at 631 – 639; Goldstein, RL and Stone, M "When Doctors Disagree: Differing Views on Competency." (1977) *Bull Am Acad Psychiatry* at 90 – 97; Slovenko, R "The Meaning of Mental illness in Criminal Responsibility" (1984) *The Journal of Legal Medicine* at 1 – 61; Dolin, G "A Healer or an Executioner? The Proper Role of a Psychiatrist in a Criminal Justice System" (2002/2003) *Journal of Law and Health* at 169 – 216; Dix, GE "Criminal Law: Psychological Abnormality as a factor in Grading Criminal Liability: Diminished capacity, Diminished Responsibility, and the like" (1971) *The Journal of Criminal Law, Criminology and Police Science* at 313 – 334; Mihalik, J "Legal Aspects of Forensic Psychiatry in South Africa" (1992) *Medicine and Law* at 239 – 248; Stone, A "The Insanity Defense on Trial" (1982) *Hospital and Community Psychiatry* at 636 – 640; Stone, MH "Healing the Mind" (1998) at 394 – 414; Samuels, A "Mental Condition as a Defence in Criminal Law: A Lawyer Addresses Medical Men" (1988) *Medicine, Science and the Law* at 21 – 25; Mackay, RD "Fact and Fiction about the Insanity Defence" (1990) *The Criminal Law Review* at 247 – 255; Tadros, V "Insanity and the Capacity for Criminal Responsibility" (2001) *The Edinburgh Law Review* at 325 – 354; Bromberg, W "Psychiatrists in Court: The Psychiatrist's View" (1969) *American Journal of Psychiatry* at 1342 – 1347; Reid, W "Law and Psychiatry – The Insanity Defense: Bad, or Mad or Both" (2000) *Journal of Psychiatric Practice* at 169 – 172; Strauss, SA "Regsaspekte van geestesversteurdheid – Legal aspect of mental disorder" (1971) *THRHR* at 1 – 15; Gerard, JB "The Medical Model of Mental illness – Its application to the Insanity Defense" (1999) *International Journal of Law and Psychiatry* at 65 – 78; Carstens, PA "Paraphilia in South African Criminal Case Law" (2002) *SALJ* at 603; Van Oosten, FFW "The insanity defence: its place and role in the criminal law" (1990) *SACJ* at 1 – 9; Hayson, N, Strous, M and Vogelmann, L "The Mad Mrs Rochester Revisited: The involuntary confinement of the mentally ill in South Africa" (1990) *SAJHR* at 341; Kaliski, SZ "My brain made me do it – how neuroscience may change the insanity defence" (2009) *SAJP* at 4; Zabow T "Forensic Psychiatry" in Dada, M and McQuoid-Mason, DJ (eds) "Introduction to Medico-Legal Practice (2001) at 103; Mason, JK "Forensic Medicine for Lawyers" (2001) at 391; Bekker, PM, Geldenhuys, T, "Criminal Procedure Handbook" (2009) 9th ed at 217-218 (hereafter "Bekker et al").

recognition and establishment of expert evidence in cases of non-pathological criminal incapacity. In cases of pathological criminal incapacity expert evidence is statutorily provided for and embodied in the Criminal Procedure Act⁴. This does, however, not mean that the defence of pathological criminal incapacity is less problematic.

The interplay between law and medicine with specific reference to the fields of psychiatry and psychology is fundamentally rooted in the defence of pathological criminal incapacity. In cases where the defence of pathological criminal incapacity is raised, the Criminal Procedure Act provides for a panel of three psychiatrists and a clinical psychologist to evaluate, observe and report on the mental status of the accused. On face value it would seem that the interaction between law and medicine is less controversial in cases of pathological criminal incapacity. A post-mortem of the interface between law and medicine in cases of pathological criminal incapacity, however, reveals a different picture.

Hiemstra describes the interface between law and psychiatry as follows⁵:

⁴ See sections 77–79 of the Criminal Procedure Act 51 of 1977 as discussed below. See also Lansdown, AV and Campbell, J “South African Criminal Law and Procedure” (Formerly Gardiner and Lansdown) (1982) at 347 – 359.

⁵ Hiemstra (2008) *supra* note at 3. See also Greenspan (1978) at 138 – 139 *supra* note 3 where he quotes the words of Honorable Judge Bazelon:

“Psychiatry, I suppose, is the ultimate wizardry. My experience has shown that in no case is it more difficult to elicit productive and reliable expert testimony than in cases that call on the knowledge and practice of psychiatry ... The discipline of psychiatry has direct relevance to cases involving human behaviour. One might hope that the psychiatrists would open up their reservoirs of knowledge in the courtroom. Unfortunately in my experience, they try to limit their testimony to conclusory statements couched in psychiatric terminology. Thereafter, they take shelter in a defensive resistance to questions about the facts that are or ought to be in their possession, they thus refuse to submit their opinions to the scrutiny that the adversary process demands.”

See also Arrigo (2002) *supra* note 3 at 128 where he states the importance of the interface between law and psychiatry:

“The intersecting categories of crime and behavior provide many relevant examples that demonstrate just how important law and psychiatry are for setting social policy or for shaping forensic practice.”

See also Stone, A “The Insanity Defense on Trial” (1982) *Hospital and Community Psychiatry* at 636 where he describes the relationship between Law and Psychiatry as follows (at 636): “It is sometimes said after a marriage ends in divorce ‘Anyone who really knew them both could have told you it would never last’. That is what is now being said about the marriage between law and psychiatry. ‘What could they have possibly seen in each other; they are so different. He, the law, is so formal, rigid and traditional. She, psychiatry, is so flighty, expansive, and unconventional. His style is objective and judgmental; her style is subjective and understanding.’”

“Die psigiatrie sien die mens as ‘n geheel en dinamies; die psigiatrie wil behandel, nie veroordeel nie. Die Strafbereg wil weet of dit regverdigbaar is om ‘n persoon strafbaar te hou vir sy of haar daad.”

The Rumpff-report also acknowledges the tension between the law and psychiatry⁶:

“Psychiatry is essentially therapeutic and is not oriented towards morality of the law. ... It is the difference between the essential purpose of the law

⁶ Rumpff report *supra* note 3 paragraph 9.39. See also paragraph 1.12 where the words of Sheldon Glueck are quoted stating the following in respect of the interaction between law and psychiatry:

“As is so often true of partners in joint enterprise where each has a different job to perform for the success of the whole, disagreements are likely to arise. Lawyers tend to look upon psychiatrists as fuzzy apologists for criminals, while psychiatrists tend to regard Lawyers as devious and cunning phrase-mongers.”

From a legal perspective, scepticism towards the psychiatric profession is also evident in the words of Van den Heever JA in *R v Von Zell* 1953 (3) SA 303 (AD) at 311 A-B where it is stated:

“In the circumstances the learned Judge was clearly right to warn the jury of the tenuous premises from which they were invited to infer that the deed was done as the result of irresistible impulse. If they rejected the story of complete amnesia and appellant’s unsupported allegations of the grounds upon which he had reason to hope for a reconciliation, nothing remained upon which to base their finding save the deductions of – as appears from the evidence – on empirical and speculative science with rather elastic notation and terminology, which is usually wise after the event.”

The words of Innes CJ in *S v Smit* 1906 TS. 783 at 784 – 785 as quoted in Viljoen (1983) *TRW supra* note 3 at 130, also encapsulates the fundamental differences in outlook between law and mental health experts:

“The two classes approach the matter from different standpoints, and are perhaps unwittingly influenced by different predilections, and by varying importance of different considerations. Doctors and mental experts have to deal with obscure forms of disease, and they realise more than other men how bodily disease may affect the mind. It is brought home to them every day what different degrees of strength of will exist in different people, what varying ideas of moral responsibility various men present, and how the strength of will and the idea of moral responsibility are undoubtedly affected by nervous disease or physical lesion. They are apt, perhaps, to refine overmuch, and to take the sentimental view of such cases. The lawyer, on the other hand, may be liable to go the other extreme. He is not concerned so much with the disease as with its consequences. The lawyer, the judge and the jury have to investigate crime, in the interests not only of the injured person and of the accused, but also in the interests of society. And they may feel compelled to take, perhaps, a coarser, certainly a more practical, view than a mental expert – to look to the consequences of the deed rather than to the mental condition of the man who did it. Perhaps both classes are apt, unless they are careful, to go a little wrong.”

See also Whitlock (1963) *supra* note 3 at 1 where he states:

“The long, uneasy flirtation between law and medicine is unlikely ever to end in harmonious matrimony with understanding and acceptance of the points of view of each side. At the very best one might foresee some marriage *de convenance* but, more likely, there will be a shotgun wedding forced on the parties concerned by a public impatient both with legal argument and psychiatric differences in open court.”

These are some of the expressions explaining the conflict that often exists between law and psychiatry.

and that of psychiatry, especially in its present state of development, which is responsible not only for lack of mutual appreciation but also, what is even more important, for the adoption of different stands on principle, moral arguments sometimes even being resorted to.”

According to Strauss the essential difference between the approach followed by the criminal law as opposed to the psychiatric profession is predicated on the fact that the criminal law is primarily concerned with the assessment of individual responsibility⁷. Traditionally the field of criminal law is founded on the principle of free will or indeterminism. Conversely, psychiatrists follow a more deterministic approach⁸.

Whenever the defence of “insanity”, or in South African criminal law terms, the defence of pathological criminal incapacity is raised, this inherent conflict between law and medicine becomes clear⁹. The questions which fall to be considered are primarily the following:

- What are the fundamental sources of conflict between law and medicine whenever the defence of pathological criminal incapacity is raised?
- How can this conflict be resolved?

One of the primary sources of conflict between psychiatry and criminal law in cases where pathological criminal incapacity is raised, relates to the definition of “mental illness” or “mental defect”. In order to successfully establish the defence of pathological criminal incapacity, it has to be proved that the accused at the time of committing the offence suffered from a “mental illness” or “mental defect” which rendered him or her incapable of appreciating the nature and/or wrongfulness of his or her act or omission and/or acting in accordance with such appreciation of

⁷ Strauss (1971) *TRW supra* note 3 at 3-4. See also Gilmer, BT, Louw, DA and Verschoor, T “Law and Psychology: An exploration of the conceptual interface” (1997) SACJ at 19; Monohan, J and Loftus, EF “The Psychology of Law” (1982) *Annual Review of Psychology* at 441 – 475.

⁸ *Ibid.*

⁹ During the course of this chapter the term “pathological criminal incapacity” will be used. For a discussion on the concept of pathological criminal incapacity, see chapter 1 paragraph 2.6.

wrongfulness. The threshold requirement for pathological criminal incapacity is thus “mental illness or defect”.

The following questions therefore arise:

- What constitutes a mental illness or mental defect?
- Should the law rely on psychiatry for a circumscribed list of mental disorders constituting such illness or defect?
- If an accused did in fact suffer from a “mental illness” or “mental defect”, does such mental illness or mental defect satisfy the legal criteria required for the defence of pathological criminal incapacity?

The inherent anomaly in respect of the terms “mental illness” or “mental defect” could be traced to the fact that the presence of either of the two holds the key to answering the following questions:

- Is an accused competent to stand trial?
- Did the accused lack criminal capacity at the time of the commission of the offence in question?
- Was the accused’s criminal capacity diminished at the time of the commission of the offence?

The problem with the current defence of pathological criminal incapacity is that it does not specifically identify the mental disorders which could constitute a “mental illness” or “mental defect”. The defence only provides for the specific effects that must result from a particular “mental illness” or “mental defect”. This problem is exacerbated by the fact that the term “criminal incapacity” is a legal term and not a medical one¹⁰. The question which falls to be considered is whether the criminal

¹⁰ Strauss (1991) *supra* note 3 at 127-128; Viljoen (1983) *TRW supra* note 3 at 123. See also De Wet, JC and Swanepoel, HJ “Die Suid-Afrikaanse Strafreg 2nd ed (1960) at 101 where it is stated: “Kranksinigheid of geesteskrankheid is, as sodanig nie regsbegrippe nie, maar begrippe van die mediese wetenskap. Die regsbegrip is toerekeningsvatbaarheid en hierdie begrip is weer nie ‘n begrip van die mediese wetenskap nie. En hier lê die kernprobleem van die toepassing van die toerekeningsvatbaarheidsbegrip in die regspleging. Alhoewel die uiteindelijke beslissing of die persoon skuldig of onskuldig is, by die regter berus, moet die regter op die getuienis van vakkundiges steun, en hier ontstaan die probleem of regsgeleerde

law and psychiatry should not work together rather than against one another where the defence of pathological criminal capacity is raised? The human mind and psyche remains complex and difficult to analyse. Should the assessment and definition of “mental illness” not be left to the medical profession?

Stone correctly states that extreme forms of mental illness, for example schizophrenia, poses less challenges to the legal system than the so-called “gray zone”, where milder disorders and personality disorders can be traced. These milder disorders present enormous challenges to the legal profession¹¹. During the assessment of psychological disorders, use is made of the *DSM-IV*¹², which is a compendium of mental disorders. The DSM-IV in its current format as well as its predecessors include a cautioning statement warning against its usage in legal contexts pertaining to the diagnoses set forth in the manual. The DSM-IV accordingly includes the following *caveat*¹³:

“The purpose of the DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Paedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.”¹⁴

en geneeskundige met mekaar gedagtes kan wissel op grondslag van begrippe wat vir albei dieselfde betekenis het.”

¹¹ Stone (1998) *supra* note 3 at 404.

¹² American Psychiatric Association “*Diagnostic and Statistical Manual of Mental Disorders*” 4th ed. (1994) (hereafter “DSM-IV”). See also Sadock, BJ and Sadock, VA “Kaplan and Sadock’s Synopsis of Psychiatry – Behavioral Sciences/Clinical Psychiatry” (2003) (hereafter “Kaplan and Sadock”).

¹³ DSM-IV *supra* note 12 at xxvii; Slovenko (2002) *supra* note 3 at 259; McKay (1992) *Criminal Justice Journal supra* note 3 at 352.

¹⁴ Emphasis added.

Assessment of
competency to
stand trial
(Present role)

Assessment of
Pathological criminal
incapacity (“mental illness”
and “mental defect”)
(Past role)

Forensic Psychiatry
and Psychology
(Past and Present roles)

This model represents reflections on the past and present roles of the mental health expert within the context of the defence of pathological criminal incapacity which will be addressed in this chapter.

2 Constitutional foundation

The Constitutional relevance and importance of the current study has already extensively been covered in chapter 2 and will not be repeated in this section¹⁷. It is, however, important to discuss the specific rights contained in the Bill of Rights of the Constitution¹⁸ that could play a role and accordingly impact on the distinct issues addressed in this chapter.

2.1 Equality

One of the prohibited grounds for unfair discrimination in terms of section 9(3) of the Bill of Rights of the Constitution, is the ground of “disability”¹⁹.

¹⁷ For a discussion on the Constitutional relevance of the current study see paragraph 2.3 of chapter 2 above.

¹⁸ The Constitution of the Republic of South Africa, 1996.

¹⁹ Currie, I and De Waal, J “The Bill of Rights Handbook” 5th ed (2005) at 256; Cheadle, MH, Davis, DM and Haysom, ARL “South African Constitutional Law” (2002) at 92 – 93; Devenish, GE “The South African Constitution” (2005) at 47. Section 9 of the Bill of Rights reads as follows:

Equality

9. (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

A question which falls to be considered is whether mental disorder qualifies as “disability” for purposes of section 9(3). Currently an accused person relying on the defence of pathological criminal incapacity has to prove on a balance of probabilities that he or she suffered from a mental illness or mental defect at the time of the commission of the offence²⁰. The question that accordingly arises is whether this burden of proof discriminates unfairly against mentally disordered offenders or whether it constitutes a justifiable limitation of a right, contained in the Bill of Rights.²¹

2.2 Privacy

In this chapter, similar to chapter 2, the question arises as to the extent to which communications between the accused and the mental health expert are protected from disclosure²². The question which has to be answered is whether statements made by an accused during the enquiry into his or her mental status should be privileged or whether the basic premise of the forensic context does not provide that confidentiality to a certain extent becomes de-emphasized for the greater need of fully assessing the accused’s mental status for determining criminal

(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

See also *Master of the High Court v Deedat and Others* 1999 (1) BCLR 1285 (W) for a general discussion of unfair discrimination on grounds of “disability”.

²⁰ See section 78 (1A) and 78 (1B) of the Criminal Procedure Act. This section will be discussed below. See also Burchell and Milton (2005) *supra* note 3 at 390 – 395; section 5(b) of the Criminal Matters Amendment Act 68 of 1998; *R v Zulch* 1937 TPD 400 at 403; Snyman (2008) *supra* note 3 at 174 – 175; Du Toit *et al* (2008) *supra* note 3 at 13 – 19; *S v Steyn* 1963 (1) SA 797 (W) at 799 C-H; Hiemstra (2008) *supra* note 3 at 13 – 23; LAWSA (2004) *supra* note 3 at 65; Strauss (1971) *THRHR supra* note 3 at 1; Strauss (1974) *THRHR supra* note 3 at 219; Burchell and Hunt (1997) *supra* note 3 at 178 – 179; Strauss (1991) *supra* note 3 at 132; *S v Van Zyl* 1964 (2) SA 113 (A) and *S v Bezuidenhout* 1964 (2) SA 651 (A).

²¹ This issue will be addressed below.

²² See section 79(7) of the Criminal Procedure Act which provides that statements by an accused during an enquiry shall be inadmissible against the accused except to the extent that it is relevant for determining the mental condition of the accused.

responsibility. Is there an essential distinction between therapeutic privilege as opposed to forensic privilege and is this distinction warranted? The specific section of the Bill of Rights which is applicable to is section 14 (d) which states:²³

- “14. Everyone has the right to privacy, which includes the right not to have –
- (a) ...
 - (b) ...
 - (c) ...
 - (d) the privacy of their communications infringed.”

The issues relating to privacy of communications within the forensic context will accordingly be assessed in this chapter²⁴.

2.3 Access to information

The principles enunciated in chapter 2 paragraph 2.3 also apply to this chapter and will accordingly not be repeated here.

²³ For a discussion on the right to privacy see Currie and De Waal (2005) *supra* note 19 at 315 – 335; Cheadle, Davis and Haysom (2002) *supra* note 19 at 183 – 201. See also *Bernstein and Others v Bester and Others* 1996 (4) BCLR 449 (CC) at paragraph 77 where Ackermann J stated the following in respect of privacy: “A very high level of protection is given to the individual’s intimate personal sphere of life and the maintenance of its basic preconditions and there is a final untouchable sphere of human freedom that is beyond interference from any public authority. So much so that, in regard to this most intimate core of privacy, no justifiable limitation thereof can take place. But this most intimate core is narrowly construed. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere, the individual’s activities then acquire a social dimension and the right of privacy in this context becomes subject to limitation.” See also Devenish (2005) *supra* note 19 at 79 – 87; *Minister of Safety and Security, Curtis v Minister of Safety and Security* 1996 (5) BCLR 609 (CC), 1996 (3) SA 617 (CC), 1996 (1) SACR 587 (CC); *Deutchmann NO and Another; Shelton v Commissioner for the South African Revenue Service* 2000 (6) BCLR 571 (E); Carstens and Pearmain (2007) *supra* note 3 at 32 – 33.

²⁴ See Du Toit *et al* (2008) *supra* note 3 at 13 – 29; as well as the conflicting approaches in *S v Forbes and Another* 1970 (2) SA 594 (C) and *S v Webb* (1) 1971 (2) SA 340 (T); Hiemstra (2008) *supra* note 3 at 13 – 27.

2.4 Arrested, detained and accused persons

The principles discussed in chapter 2 paragraph 2.3 apply *mutatis mutandis* apply to this chapter.

“The Constitution envisages that the ‘compendium of values’ contained in it, will be all persuasive in all spheres of life, regulated by the law and administrative agencies, and will be the measure against which all law and conduct is tested.” (Devenish, 2005)

3 Historical development of the defence of pathological criminal incapacity

3.1 Position before 1977

According to De Wet and Swanepoel, even though the Roman law was not always clear on the concept of criminal capacity, it nevertheless recognized that a person who commits a crime whilst having defective mental capacity, should not be held accountable for such act²⁵. According to the Roman and Roman-Dutch law insane persons, as well as infants, were not held criminally responsible²⁶. Burchell and Hunt state that as a result of the fact that the older authorities lived in times where a scientific approach to criminal law was largely absent and medical knowledge very little, our courts began to rely very heavily on English law in this regard²⁷.

²⁵ De Wet, JC and Swanepoel, HL “Die Suid-Afrikaanse Strafreg” (1975) at 105.

²⁶ Burchell, EM and Hunt, PMA “South African Criminal Law and Procedure – General Principles of Criminal Law” (1983) at 258; De Wet and Swanepoel (1975) *supra* note 10 at 108 – 109; Burchell and Milton (2005) *supra* note 3 at 370. See also Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 3 where he states that the Roman law classically divided the insane (*dementes*) into the categories of weak understanding (*mental capti*) and the restless and furious (*furiosi*). The French and Prussian codes used the terminology of *démence*, *furor* and *imbecillite* without providing a clear definition of these terms. The English common law distinguished two kinds of insanity, *idiocy* and *lunacy* and these concepts fell under the umbrella term of *non-compos mentis*. See also Ray, I “A Treatise on The Medical Jurisprudence of Insanity” (1962) at 15.

²⁷ *Ibid.*

As a result, South African courts began to follow the rules that were laid down in the well-known case of Daniel M’Naghten²⁸.

The facts of the *M’Naghten*-decision were briefly the following:

Daniel M’Naghten was the son of a Glaswegian woodturner. According to Jones and Slovenko M’Naghten would most likely today have been diagnosed with “paranoid schizophrenia”²⁹. Five to six years prior to his trial, M’Naghten started behaving eccentrically. He developed feelings and ideas that he was being persecuted by the Tories who were then in power³⁰. He consequently decided to kill the Prime Minister, Sir Robert Peel. During that era, photographs of politicians were not made available in newspapers and accordingly, M’Naghten was under the impression that Peel’s private secretary, Edward Drummond, was in fact Sir Robert Peel³¹. On 20 January 1843 he followed Edward Drummond and consequently shot him in the back. M’Naghten was arrested. Edward Drummond died five days later as a result of the shooting. During his trial medical evidence was sufficient to convince the jury that he was not guilty by reason of insanity.

²⁸ Snyman (2008) *supra* note 3 at 170; The Rumpff-report paragraph 3.18; Burchell and Milton (2005) *supra* note 3 at 370 – 371; Viljoen (1983) *TRW supra* note 3 at 123 – 127; Strauss (1971) *THRHR supra* note 3 at 5 – 7; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 2-4; Whitlock (1963) *supra* note 3 at 20 – 34; Slovenko (2002) *supra* note 3 at 218 – 219; Slovenko (1995) *supra* note 3; Brakel and Brooks (2001) *supra* note 3 at 18 – 22; Mcauley (1993) *supra* note 3 at 21 – 25. Mcauley notes that interestingly there are several different spellings of M’Naghten’s name in legal literature which include: “M’Naughten, Mac-naughten, Macnaughten, Macnaghten.” The case citation is *R v M’Naghten* (1843) 4 St. Tr. (n.s) 817; 10 Cl & F. 200; 8 Eng. Rep. 718. See also Van Oosten (1990) SACJ *supra* note 3 at 1 – 2; Strauss (1991) *supra* note 3 at 123 – 124; Slovenko, R “The Continuing Saga of the Insanity Defense” in *Essays in Honor of Deon Paul le Ryu* (1988) at 46; Jones (2008) *supra* note 3.

²⁹ Jones (2008) *supra* note 3 at 44; Slovenko (2002) *supra* note 3 at 218. See also Macdonald, JM “Psychiatry and the Criminal – A Guide to Psychiatric Examinations for the Criminal Courts” (1976) 3rd ed. at 63 where it is noted that M’Naghten provided the court with the following explanation for his actions: “The Tories in my native city have compelled me to do this. They follow and persecute me wherever I go, and have entirely destroyed my peace of mind. They followed me to France, into Scotland and all over England, in fact, they follow me wherever I go. I can get no rest from them night or day. I cannot sleep at night in consequence of the course they pursue towards me. I believe they have driven me into consumption. I am sure I shall never be the man I formerly was. I used to have good health and strength but I have not now. They have accused me of crimes of which I am not guilty, they do everything in their power to harass and persecute me, in fact they wish to murder me. It can be proved by evidence. That’s all I have to say.”

³⁰ *Ibid.*

³¹ *Ibid.*

M’Naghten was accordingly first transferred to Bethlem lunatic asylum and later to Broadmoor where he passed away in 1865 as a result of tuberculosis³².

Due to public uproar and disquiet about the decision of the court in the *M’Naghten* case, various questions were addressed to the judges by the House of Lords. The answers provided to these questions became known as the so-called “M’Naghten-rules”³³.

These rules can be summarized as follows³⁴:

- (1) Every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary is proved.
- (2) To establish the defence of insanity, it must be proved that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of his act, or if he did know it, that he did not know he was doing what was wrong.
- (3) A person who labours under a partial delusion only, and is not in other respects insane, must be considered in the same situation as to responsibility as if the facts with respect to which the delusion existed were real.

The test which was established in this case essentially denotes the “right” or “wrong” test.

According to Strauss, the rules in the *M’Naghten*-case were later expanded by adding a further test which entailed that where it is proved that the accused realised the nature and quality of his act as well as the wrongfulness thereof, he is not criminally responsible where he was unable to control his conduct as a result

³² *Ibid.*

³³ Burchell and Hunt (1983) *supra* note 26 at 258; De Wet and Swanepoel (1975) *supra* note 10 109 – 110; Strauss (1971) *THRHR supra* note 3 at 6 – 7; Slovenko (2002) *supra* note 3 at 218 – 219; Slovenko (1995) *supra* note 3 at 21 – 22.

³⁴ *R v M’Naghten* (1843) 10 Cl & Fin 200, 8 ER 718 at 722 – 723. See also Burchell and Hunt (1983) *supra* note 3 at 288; De Wet and Swanepoel (1975) *supra* note 10 at 109 – 110; Slovenko (2002) *supra* note 3 at 218 – 219; Smith and Hogan (2002) *supra* note 3 at 217 – 218; Card, R “Card, Cross and Jones – Criminal Law” (2004) 16th ed. at 725 – 726.

of the mental disease³⁵. The latter test later became known as the “irresistible impulse” test and was later firmly established as part of South African law³⁶.

The M’Naghten rules have, however, been criticised especially by psychiatrists and psychologists on the following basis³⁷:

- The rules are founded on the premise that the existence or absence of knowledge of the nature and quality of the act, or the right or wrong in respect of an act, can be determined by psychiatry. Strauss indicates that such assumption is incorrect as there is no scientific method of evaluating the existence of such knowledge.
- Modern psychiatry acknowledges the fact that man is an integrated personality and that reason, which constitutes only one facet of such personality, is not the sole determining factor of his conduct. Accordingly, the M’Naghten rules only recognizes the cognitive (perceptive) function of the mind whilst disregarding the conative (volitional) and affective (emotional) functions.
- The rules fail to provide for complete and adequate testimony.

³⁵ Strauss (1971) *THRHR supra* note 3 at 6.

³⁶ Burchell and Hunt (1983) *supra* note 18 259. Burchell and Hunt indicates that in the majority of cases the aspect of “irresistible impulse” relating to the defence of insanity was the deciding factor. See also *R v Smit* 1906 TS 783; *R v Van der Veen* 1909 TS 853; *R v Ivory* 1916 WLD 17; *R v Holiday* 1924 AD 250; *R v Westrich* 1927 CPD 466; *R v Anderson* 1928 CPD 195; *R v Orsmond* 1936 EDL 142; *R v Zulch* 1937 TPD 400; *R v Theunissen* 1946 (2) PH H 242 (N); *R v Smit* 1950 (4) SA 165 (O); *R v Koortz* 1953 (1) SA 371 (A); *R v Von Zell* (1) 1953 (3) SA 303 (A); *R v Harris* 1965 (2) SA 340 (A). See also Snyman, CR “Criminal Law” (1995) 3rd ed. at 157. See also *R v Hay* (1899) 16 SC 290 at 301 where De Villiers CJ held the following: “Where the defence of insanity is interposed in a criminal trial the capacity to distinguish between right and wrong is not the sole test of responsibility in all cases; in the absence of legislation to the contrary, Courts of law are bound to recognise the existence of a form of mental disease which prevents the sufferer from controlling his conduct, and choosing between right and wrong; the defence of insanity is established if it be proved that the accused had, by reason of such mental disease, lost the power of will to control his conduct in reference to the particular act charged as an offence.” See also the Rumpff-report paragraph 3.22.

³⁷ Strauss (1971) *THRHR supra* note 3 at 6; Slovenko (1995) *supra* note 3 at 22; Slovenko (2002) *supra* note 3 at 219 – 220. According to Slovenko psychiatric evidence has been admitted in establishing “disease of the mind” and in assisting to interpret the word “know” contained in the phrase “know he was doing what was wrong”. To know denotes something more than mere knowledge that something is wrong and implies an adequate understanding of the implications of the act. See also Yeo, S “The Insanity Defence in the Criminal laws of the Commonwealth of Nations” (2008) *Singapore Journal of Legal Studies* at 241 where it is stated that the M’Naghten rules continue to form part of the English law as well as other Commonwealth jurisdictions such as Sierra Leone and the Australian state of New South Wales.

- The psychiatric expert testifying in terms of the rules does not render a scientific contribution but rather portrays the role of ethical judge.

Strauss similarly notes that the irresistible impulse doctrine was also subjected to criticism due to the fact that it creates the misleading assumption that mental disease conditions result only in sudden, momentary or spontaneous inclinations to commit unlawful acts³⁸.

The effect of the *M’Naghten*-decision on expert evidence was, according to Viljoen, a positive one³⁹. The importance of the decision relates to the fifth question offered to the judges by the House of Lords and the answer provided thereto which were the following⁴⁰:

“Q.V. Can a medical man, conversant with the disease of insanity, who never saw the prisoner previously to the trial, but who was present during the whole trial, and the examination of the witnesses, be asked his opinion as to the state of the prisoner’s mind at the time of the commission of the alleged crime, or his opinion whether the prisoner was conscious at the time of doing the act that he was acting contrary to law, or whether he was labouring under any, and what, delusion at the time?”

“A.V. We think the medical man, under the circumstances supposed, cannot, in strictness, be asked his opinion in the terms above stated, because each of those questions involves the determination of the truth of the facts deposed to, which is for the jury to decide, and the questions are not questions upon a mere matter of science, in which case such evidence is admissible. But where the facts are admitted, or not disputed, and the question becomes substantially one of science only, it may be convenient to allow the question to be put in that general form, though the same cannot be insisted on as a matter of right.”

³⁸ Strauss (1971) T *supra* note 3 at 7; Viljoen (1983) TRW *supra* note 3 at 128.

³⁹ Viljoen (1983) TRW *supra* note 3 at 124 – 125.

⁴⁰ *Ibid.*

After the establishment of the M’Naghten rules it became practice to admit expert evidence whenever the alleged insanity of the accused was raised or placed in dispute. Viljoen submits that the importance of the answer to the question quoted above lies in the judicial acceptance that the question regarding the criminal capacity of the accused should be answered by the medical science, provided that the facts are not in dispute⁴¹.

The courts accordingly began to rely more heavily on medical evidence.

South African law pertaining to insanity prior to the Criminal Procedure Act of 1977 thus entailed that an accused person was not criminally responsible if, at the time of the offence, as a result of mental disease:

- (i) he or she did not know the nature and quality of his or her act; or
- (ii) did not know it was wrong; or
- (iii) he or she acted under an irresistible impulse⁴².

3.2 Reflections on the recommendations of the Rumpff-Commission

On 6 September 1966, Demetrios Tsafendas stabbed the Prime Minister, Dr. HF Verwoerd, to death during a Parliamentary sitting. On 17 October 1966, he appeared before the Judge President and two assessors in Cape Town on a

⁴¹ *Ibid.* Viljoen also notes that gradually the practice was established to allow the expert to sit in during the trial and listen to the evidence led during the course of the proceedings. The expert was then allowed to state an opinion and if he or she was not present during the trial or did not listen to all the evidence, the practice emerged to put the facts to the expert as undisputed facts or where either the State or the defence calls such expert, would ask the expert to express his or her opinion based on hypotheses. See also Bromberg, W “Crime and the Mind – An outline of Psychiatric Criminology” (1948) at 44 where he states: “As psychiatry developed stature during the nineteenth century, such conditions as homicidal mania, insanity of imbecility, and paranoia were being recognised clinically and lawyers used this defense more and more to relieve criminals suffering from mental conditions of responsibility.” and further:

“In a sense the McNaghten decision stimulated the alienist to study medical jurisprudence and enrich medical experience in the world of crime. Analysis of the criminal mind, occasioned by the wish to solve the tortuous problems raised by the McNaghten ruling passed through many vicissitudes before it arrived at its present level of use in our courts.”

⁴² Burchell and Hunt (1983) *supra* note 26 at 260; Snyman (1995) *supra* note 3 at 159.

charge of murder⁴³. An application was lodged for an inquiry to be conducted to assess the mental condition of Tsafendas.

Various experts were called upon to provide expert testimony as to the mental state of Tsafendas. Dr Cooper, a psychiatrist, testified that during his four interviews with Tsafendas, he (Tsafendas) mentioned a tapeworm he was supposed to have in him. Dr Cooper stated this tapeworm Tsafendas believed to have inside of him and the attribute to it were highly significant⁴⁴.

Dr Cooper stated the following⁴⁵:

“This is a tapeworm much larger than life. It is a grossly exaggerated description of a tapeworm. He insists that he has the tapeworm in spite of all medical evidence against the fact that he has it. He says that he can feel the tapeworm crawling around in him and that if he passes delicious foods the tapeworm smells the foods and he can feel the tapeworm wriggling towards his neck.

...

He has referred to this tapeworm at different interviews variously as a devil, a dragon, as a snake. Demon was another one. He feels that this tapeworm has changed his entire life. ... He believes that the tapeworm

⁴³ Rumpff report *supra* note 3 at paragraph 4.14. The Tsafendas decision is discussed in this chapter as it was a key motivation for reassessing the M’Naghten rules which prevailed as the foundation of the insanity defence at that stage. Demetrios Tsafendas was an illegitimate child of a Greek father and a Swazi mother who was born in Mozambique in 1918. Tsafendas was always an outsider who spent most of his life swifiting between jobs and being incarcerated in mental asylums on three continents. The *New Internationalist Magazine* describes him as follows: “His dabbling in both Communism and Christianity suggests a heartfelt need to belong and repeated rejection eroded his fragile mental stability. Verwoerd’s killing was a last mad, desperate act in a country that was itself mad” in “Mouthful of glass” (2000). *New Internationalist Magazine* <http://findarticles.com/p/articles/mi-mOJQP/is-330/ai-30443224/> [accessed on 2009/05/09]. Tsafendas was found unfit to stand trial by reason of insanity. The Judge President of the Cape, Mr Justice Beyers, observed: “I can expect a certain amount of shock and dissatisfaction among certain people ... but I am sure they will realize it could not be otherwise, and that it is not humane or Christian to condemn mentally ill people. I can as little try a man who has not at least the makings of a rational mind as I could try a dog or an inert implement. He is a meaningless creature.” See “The Tapeworm murder” (1966) *Time Magazine*, “Tsafendas: The Tapeworm Assassin” Diatribe (2009) <http://diatribe-column.blogspot.com/2009/02/tsafendas-tapeworm-assassin.html>. [accessed on 2009-05-09] *S v Tsafendas* 1966 (CPD) unreported. See also Steyl, GC “Regters aan die Woord” (1971) at 7.

⁴⁴ Rumpff report *supra* note 3 at paragraph 4.15

⁴⁵ *Ibid.*

influences his thoughts. He insists that on many occasions he has said things which he would not otherwise have said if it had not been for the tapeworm. He insists that the tapeworm influences his behaviour. He said at one stage: ‘If I did not have the tapeworm I would not have killed Dr Verwoerd, I would not have wandered round the world, I would not have become involved in a fight with Nicholas Vergos and I would not have been taken in by certain thoughts’.”

Dr Cooper diagnosed Tsafendas with schizophrenia with paranoid features⁴⁶. Dr Cooper further testified that Tsafendas had probably suffered from this condition for twenty years and that this mental illness rendered him certifiably mentally disordered. Dr Cooper stated that the prognosis in Tsafendas’s case was extremely poor⁴⁷. Dr Cooper also indicated that Tsafendas, in his opinion, was unable to understand the proceedings so as to be able to construct a proper defence and accordingly to properly instruct his legal representative in the matter⁴⁸. Dr Cooper testified that it is not inconsistent for someone suffering from schizophrenia to act deliberately as Tsafendas did by purchasing daggers and entering Parliament with the sole purpose of assassinating Dr Verwoerd⁴⁹.

Two further psychiatrists, Dr Safinofsky as well as Dr Zabow, diagnosed Tsafendas as schizophrenic and psychotic. Both of these experts also testified that despite the presence of schizophrenia, Tsafendas could still, under the influence of a “diseased” brain, kill someone⁵⁰.

Dr Safinofsky stated⁵¹:

⁴⁶ Rumpff report *supra* note 3 at paragraph 4.16.

⁴⁷ Rumpff report *supra* note 3 at paragraph 4.19. Dr Cooper stated: “I say that first of all by virtue of his mental condition as I see it now, in that in my opinion the mental picture now is indicative of a chronic long -standing type of schizophrenia which tends not to respond favourably to treatment.”

⁴⁸ Rumpff report *supra* note 3 at paragraph 4.20.

⁴⁹ Rumpff report *supra* note 3 at paragraph 4.21. See also paragraph 4.22 where Dr Cooper testifies as to Tsafendas’s delusion about the tapeworm and states: “ ... Once an individual is deluded it means that he is suffering from a profound mental disturbance. One cannot assess a delusion as an isolated thing. Once a person is deluded then one is justified in assuming that he is a very mentally disturbed person.”

⁵⁰ Rumpff report *supra* note 3 at paragraphs 4.26 – 4.30.

⁵¹ *Ibid.*

“... because every psychiatrist knows that chronic schizophrenia of the paranoid kind into which this man fits, while apparently amenable and moving about society could be subject to sudden eruption.”

Dr Zabow similarly testified⁵²:

“It is not uncommon for paranoid schizophrenics to be able to plan very ably, but in keeping with their autistic view of the world ... One could even credit a paranoid (schizophrenic) with planning something more complex. So that I don’t see any contradiction between what has been described to the Court in this man’s actions and his mental condition.”

Various other medical witnesses provided expert evidence. All the expert witnesses considered Tsafendas certifiable. It was consequently ordered that Tsafendas be detained in an institution pending the signification of the State President’s decision⁵³.

The *Tsafendas* decision is important as it had played a very significant role in the appointment of the Commission of Inquiry into the responsibility of mentally disordered persons. The Commission produced the well-known Rumpff-report which had a profound effect on our current legal framework for the defence of pathological criminal incapacity in its current form. The Rumpff-report further provides an excellent exposition of the interface between law and psychiatry⁵⁴.

As the interface between law and medicine is a central theme of this study, it is necessary to discuss the Rumpff-report and to explain the manner in which the report contributed to the development of this interface.

The Rumpff Commission received recommendations from various psychiatrists and psychologists in preparing its report on aspects relating to the insanity defence and the M’Naghten rules.

⁵² *Ibid.*

⁵³ Rumpff report *supra* note 3 at paragraph 4.37.

⁵⁴ A synopsis of the most important views of psychiatrists will be discussed in this section.

One expert, Dr C C Elliot, provided his opinion and it is interesting to take note of this in order to comprehend the development of the defence of pathological criminal incapacity. He offered the following suggestions⁵⁵:

- There is a need for a skilled psychiatrist being available to the court either in an advisory capacity or in a consultative capacity.
- Instead of both prosecution and defence calling their own medical witnesses, there should be an impartial board of experts to examine a particular case and report to the court.
- Lawyers should become more acquainted with the subject of mental deficiency.
- Punishments should be graded according to the degree of responsibility.

Another expert, Dr E Swift, stated that in terms of the English law, in other words in terms of the M’Naghten formula, emphasis is placed only on cognitive and intellectual impairment, while conduct and responsibility are largely influenced by other aspects of the mind such as emotions, instinct and will. He accordingly submitted that normal restraining influences can be impaired in ways not necessarily related to the intellect or will. With reference to the M’Naghten rules, he stated the following:

“I submit that the universal application of a rigid formula as a test for responsibility should be abandoned, and that degrees of responsibility should be recognised. Each individual case should be considered on its merits, and the facts should be submitted without being hampered by a formula. The first question which should be decided is whether the accused is or was mentally disordered or defective and the second is whether the act with which he is charged was influenced by or related to the mental disorder, and if so, to what extent.”⁵⁶

⁵⁵ Rumpff report *supra* note 3 at paragraph 5.1.

⁵⁶ Rumpff report *supra* note 3 at paragraph 5.3.

Dr RA Forster stated the following in respect of the M'Naghten-rules⁵⁷:

“It would seem that the question of criminal responsibility, especially as governed by the McNaughten Rules or even by the broader view taken of those rules in South Africa, is quite impossible to the majority of psychiatrists. The rules endeavour to apply to the herd what can only be applied to a few individuals.”

Professor Hoernlé similarly reflects the criticisms of psychiatrists and psychologists pertaining to the legal principles applicable to the insanity defence:

- The legal definition of insanity, as well as the tests which is used to establish insanity according to the law, is thoroughly unscientific⁵⁸.
- The methods employed by the law for ascertaining insanity are scientifically valueless and accordingly the question as to whether an accused was in fact insane when he committed the criminal act, is answered in an unscientific way⁵⁹.

Professor Hoernlé also expressed criticism against the presumption of sanity by stating:

“Unless I completely misinterpret the attitude of psychologists and doctors, they say that, if presumptions were in order at all, it would be more reasonable to presume insanity than sanity in a person who has committed a crime. But, actually, presumptions are completely out of place.”

Hoernlé stated that from the psychologist's perspective, the question is not about presumptions but rather about scientific investigation and examination. A psychologist therefore cannot state an opinion as to the sanity of a person until he or she has examined the particular person⁶⁰.

⁵⁷ Rumpff report *supra* note 3 at paragraph 5.4.

⁵⁸ Rumpff report *supra* note 3 at paragraph 5.15

⁵⁹ Rumpff report *supra* note 3 at paragraph 5.18.

⁶⁰ Rumpff report *supra* note 3 at paragraph 5.19.

- With the tests used to assess insanity and the methods of applying these tests, the result is that many persons in whom psychiatrists would diagnose mental disorder, are legally treated as sane and punished as such for their criminal deeds⁶¹.

Dr B Crowhurst Archer stated the following in respect of the M’Naghten rules⁶²:

“I find myself in agreement with those who believe that if a medical formula of criminal responsibility were introduced we might be called upon to adhere rigidly to its specifications, with resulting hardship to offenders and embarrassment to psychiatrists. The immediate need is not a reform in the law regarding criminal responsibility but an improvement in the evidence we give as forensic psychiatrists.”

In respect of expert evidence, he stated the following⁶³:

“Expert evidence in these cases should be given by trained psychiatrists and they should take care under examination not to overstate their case and advance theories and hypotheses that have not been generally accepted by the profession. Above all they should never forget when they testify that they themselves and the profession they represent are on trial.”

From these views it becomes apparent that there was a general scepticism amongst members from the medical profession pertaining to the M’Naghten rules which regulated the defence of insanity. It is also evident that even at that stage the “uneasy flirtation” between law and medicine was clearly apparent judging by the views of the psychiatrists and psychologists. The views from the psychiatrists also indicated that the M’Naghten rules were not in conformity with the state of psychiatric knowledge.

⁶¹ Rumpff report *supra* note 3 at paragraph 5.21.

⁶² Rumpff report *supra* note 3 at paragraph 5.28.

⁶³ Rumpff report *supra* note 3 at paragraph 5.30.

The Rumpff Commission also advanced the following recommendations which are important within the context of the defence of pathological criminal incapacity:

- Whenever the question of insanity or any pathological disturbance of the mental faculties arises, the court has to be assisted by a psychiatrist and a psychologist⁶⁴.
- The question of non-responsibility is assessed in terms of an inquiry into pathological mental abnormalities, but even where these are absent, the psychologist's evidence may nevertheless be of great importance with reference to diminished responsibility⁶⁵.
- The human personality is defined as a dynamic integration of psychophysical functions in terms of which purposeful and directed behaviour is induced. Accordingly the mind and the body constitutes a whole and the mental functions are very closely interrelated with the physiological and biochemical reactions of the body⁶⁶.
- There are generally three categories of mental functions present in human beings, namely the cognitive, affective and the conative functions. These functions consist of the following attributes⁶⁷:
 - (i) Cognitive – a person's understanding of, conception of or insight into an act is mainly dependent on his or her cognitive mental function. These functions include perceiving, thinking, reasoning, remembering and insight or intelligence.
 - (ii) Affective – the affective mental function relates to an individual's feelings or emotions which could range from the pleasurable to the unpleasant and also include very intense emotional feelings such as jealousy or hatred⁶⁸.

⁶⁴ Rumpff report *supra* note 3 at paragraph 9.4.

⁶⁵ Rumpff report *supra* paragraph note 3 at paragraph 9.5. It is submitted that within the current context of the defence of pathological criminal capacity, this paragraph could be construed to refer to the psychiatrist as well.

⁶⁶ Rumpff report *supra* note 3 at paragraph 9.7.

⁶⁷ Rumpff report *supra* note 3 at paragraph 9.9.

⁶⁸ *Ibid.* The Rumpff Commission also states that intense emotions may sometimes induce strong tensions in the internal muscular organs, as well as in the external skeletal muscles, that a person involuntarily contracts his muscles and may accordingly even result in uncontrolled action. The Commission also notes that some psychiatrists emphasise this type of impulse activity and advance that a person cannot be held responsible for his actions during such an emotional storm.

- (iii) The conative or volitional function – this function relates to a person’s ability of controlling his or her behaviour by means of the voluntary exercise of his or her will. A human being, unlike an animal, is capable of controlling his or her behaviour by voluntarily exercising his or her free will.
- The cognitive, affective and conative mental functions invariably form an integrated unit⁶⁹.
 - Two psychological factors render a person responsible for his voluntary actions, namely insight and self-control⁷⁰.
 - Criticism against the M’Naghten-rules as well as the additional “irresistible impulse” test, was well founded as this formula which entails that a particular condition can deprive a person of his or her capacity to distinguish between right and wrong and in addition a condition in which an irresistible impulse has arisen despite the existence of the capacity to distinguish between right and wrong is in conflict with the psychological perception of the integrated unity of the cognitive functions, the affective as well as the conative mental functions⁷¹.

The role of the psychiatrist is portrayed as follows⁷²:

“The concepts of right and wrong are ethical ones, and the psychiatrist is reluctant to state, even in a roundabout way, as usually happens, what the attitude was concerning these concepts at the time when the accused committed the act. Nor is there any test by which a psychiatrist can determine this, and even in a case of a serious psychosis, such as schizophrenia, it may prove difficult to establish the complete absence of the capacity to appreciate because it is impossible to draw any clear dividing line.”

The Rumpff Commission accordingly recommended that the defence of criminal incapacity or non-responsibility be amended as follows:

⁶⁹ Rumpff report *supra* note 3 at paragraph 9.10.

⁷⁰ Rumpff report *supra* note 3 at paragraph 9.32.

⁷¹ Rumpff report *supra* note 3 at paragraph 9.89.

⁷² *Ibid.*

“The existing formulation of the criteria of non-responsibility should be altered by a provision in the Criminal Procedure Act to the effect that an accused who in respect of an alleged crime was not capable on account of mental disease or mental defect of appreciating the wrongfulness of his act, or of acting in accordance with such appreciation, shall be held not to be responsible.”⁷³

The latter formulation inadvertently resulted in the current formulation of the defence of pathological criminal incapacity in terms of section 78(1) of the Criminal Procedure Act which reads as follows:

“78 Mental illness or mental defect and criminal responsibility

(1) A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable –

- (a) of appreciating the wrongfulness of his or her act or omission; or
- (b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

shall not be criminally responsible for such act or omission.”⁷⁴

In the following section the role of psychiatry and psychology will be discussed with reference to competency of an accused to stand trial. In practice, whenever a person’s competency to stand trial or criminal responsibility is in issue, such person is referred to a psychiatrist or a panel of psychiatrists and also a clinical psychologist in order to be examined and reported on in terms of section 77(1) and 78(1) of the Criminal Procedure Act. The court then consequently considers the psychiatric reports and the conclusions formulated therein and renders a decision

⁷³ Rumpff report *supra* note 3 at paragraph 9.97.

⁷⁴ Du Toit *et al* (2008) *supra* note 3 at 13-8; Hiemstra (2008) *supra* note 3 at 13-12; LAWSA (2004) *supra* note 3 at 66; Burchell and Hunt (1997) *supra* note 3 at 163; Snyman (2008) *supra* note 3 at 170; Kaliski (2006) *supra* note 3 at 102; Strauss (1991) *supra* note 3 at 126 – 127; Burchell and Milton (2005) *supra* note 3 at 360 – 361; Africa “:Psychological evaluations of mental state in criminal cases” in Tredoux *et al* (eds) (2005) *supra* note 3 at 394.

as to the person's fitness to stand trial and/or his or her criminal responsibility⁷⁵. Accordingly, in terms of the criminal procedure, the Criminal Procedure Act deals with two questions, namely the "now" question and the "then" question⁷⁶.

The "now" question relates to an accused person's competency to stand trial and does not address the accused's mental state at the time of the offence in question. The "then" question relates to the mental condition of the accused at the time of the offence.

With regards to the role of the psychiatrist in assessing these two aforementioned questions, Hiemstra states the following⁷⁷:

"The psychiatrist must bear in mind that these quotations are put from a legal point of view – it may, perhaps, be difficult from a psychiatric point of view to draw the distinction between the 'now' and the 'then' questions. Often the 'now' question will also answer the 'then' question."

4 Defining and assessing competency to stand trial

"... if a man in his sound memory commits a capital offense and before arraignment for it, he becomes mad, he ought not to be arraigned; because he is not able to plead to it with that advice and caution that he ought ..."
(Blackstone, 1984)

4.1 General

Competency to stand trial is a concept of jurisprudence, which provides for the postponement of criminal proceedings for those accused persons who are considered to be unable to take part in their defense as a result of a particular mental illness or mental defect.⁷⁸ Competency to stand trial is generally a very

⁷⁵ Hiemstra (2008) *supra* note 3 at 13-3.

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ Hess and Weiner (1999) *supra* note 3 at 327; Du Toit *et al* (2008) *supra* note 3 at 13-1 – 13-8; Hiemstra (2008) *supra* note 3 at 13-1 – 13-12; Burchell and Hunt (1997) *supra* note 3 at 163; Menzies, RJ, Webster, CD and Jackson, MAJ "Legal and Medical Issues in Forensic Psychiatric Assessments" (1981) *Queens Law Journal* 3 at 7; Snyman, J "The Declaration of

common field where psychiatric assessment by forensic mental health experts is requested by the courts⁷⁹.

It is a basic tenet of our law of criminal procedure that an accused person must be triable⁸⁰. The latter principle is closely related to another fundamental principle of our criminal procedure which entails that the trial of an accused person must take place in the presence of the accused⁸¹. An accused's presence during the trial thus comprises of a physical as well as a psychic or psychological element which provides that the accused must have the required mental capacity to understand and follow his or her trial. According to Snyman, the following reasons are advanced as justification for the requirement of triability⁸²:

- Triability is regarded as essential for upholding the dignity and integrity of the legal process;
- Triability forms the foundation of punishment as the accused must be able to understand for what and why he is being punished;
- Triability is required for reasons of humanity and for ensuring the fairness of the trial.

a person as a State President's Patient" (1988) *Acta Juridica* at 128; Oosthuizen, H and Verschoor, T "Faktore wat 'n invloed op die verhoorbaarheid van 'n beskuldigde kan hê" (1991) *TRW* at 138; Oosthuizen, H and Verschoor, T "Herstel van Verhoorbaarheid deur psigotropiese middels" (1990) *TRW* at 74; Kermani (1989) *supra* note 3 at 133; "The Mental Health Professional and the Legal System" (1991) by the Group for the Advancement of Psychiatry at 35; Schiffer (1978) *supra* note 3 at 51; Gutmacher (1968) *supra* note 3 at 97; Blau (1998) *supra* note 3 at 76; Snyman (2008) *supra* note 3 at 178; Kaliski (2006) *supra* note 3 at 98; Burchell and Milton (2005) *supra* note 3 at 372; Strauss (1991) *supra* note 3 at 124.

⁷⁹ Menzies, Webster and Jackson (1981) *Queens Law Journal supra* note 3 at 7,

⁸⁰ Snyman (1988) *Acta Juridica supra* note 78 at 128. See section 77 of the Criminal Procedure Act discussed below which acknowledged this principle negatively by stating grounds upon which fitness to stand trial are excluded.

⁸¹ See section 158 of the Criminal Procedure Act; Hiemstra (2008) *supra* note 3 at 13-6. See also Snyman (1988) *Acta Juridica supra* note 78 at 128-129. See also Calitz, FJW, Verschoor, T and Van Rensburg, PHJJ "Die ontwikkeling en problematiek van die Verhoorbaarheidsbegrip" (1992) *TRW* 29 at 33 where it is stated that within the context of South African law, the concept of triability was first formally introduced by the "Wet op Geestesgebrekken" 38 of 1916. This Act addressed issues pertaining to the detention and treatment of mentally ill and mentally defective persons as well as contained provisions dealing with the institutions in which these persons should have been treated. Section 28 specifically dealt with the enquiry into an accused's mental state where it appeared during the trial that the accused could perhaps be mentally ill or mentally defective. See also Slovenko, R "The Developing Law on Competency to stand Trial" (1977) *Journal of Psychiatry and Law* at 165. See also section 35(3)(e) which provides that every accused person has a right to a fair trial which includes the right to be present when being tried.

⁸² Snyman (1988) *Acta Juridica supra* note 78 at 129. See also Stone, A "Mental Health Law: A system in Transition" (1976) at 203 – 204.

It is accordingly a basic necessity that an accused should be mentally capable of participating during his or her trial and within the true spirit of our adversarial system, as the adversaries of the prosecutor.⁸³ Triability should therefore provide for the following:

- The ability of the accused to comprehend the nature and consequences of the proceedings.
- The ability of the accused to communicate with his or her legal counsel in a meaningful manner.
- The ability of the accused to testify coherently and also to assess all the evidence which has already been presented at the trial⁸⁴.

Essentially, an accused person is unfit to stand trial if he or she is incapable of:

- (i) understanding the proceedings in court during his or her trial, and
- (ii) conducting a proper defence⁸⁵.

The factors which can influence the triability of an accused can be summarised as follows⁸⁶:

Psychical or Psychological	Physical causes
-----------------------------------	------------------------

⁸³ Snyman (1988) *Acta Juridica supra* note 78 at 130. See also Slovenko (2002) *supra* note 3 at 191. See also *Dusky v United States* 362 U.S. 402 (1960) where the U.S. Supreme Court established the classic test for triability as the test as to whether a person: "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him."

⁸⁴ *Ibid.* See also Du Toit *et al* (2008) *supra* note 3 at 13-3. See also *Dusky v United States*, 362 U.S. 402 (1960) where the United States Supreme Court laid down a basic definition of competency to stand trial by stating that the test should be whether he (the accused) has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of proceedings against him. According to Melton *et al* the test comprises of two elements:
 (i) the accused's capacity to understand the criminal process as it applies to him or her,
 (ii) the accused's capacity to function in the criminal process by consulting with his/her counsel in the preparation of a defense. See Melton *et al* (2008) *supra* note 3 at 127.

⁸⁵ *Ibid.*

⁸⁶ See Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 139 – 153; Snyman (1988) *Acta Juridica supra* note 78 at 135 – 139; Slovenko (2002) *supra* note 3 at 189 – 198.

causes⁸⁷	
<ul style="list-style-type: none"> • Mental illness • Mental defect 	<ul style="list-style-type: none"> • Arteriosclerosis⁸⁸ • Hypoglycaemia⁸⁹ • Epilepsy⁹⁰ • Deaf and dumbness⁹¹ • Stress⁹² • Amnesia⁹³

⁸⁷ *Ibid.* Mental illness and/or mental defect are the major causes of non-triability. As will be indicated below section 77(1) of the Criminal Procedure Act only mentions “mental illness” or “mental defect” as factors which could include unfitness to stand trial. According to Oosthuizen and Verschoor not all mental illnesses necessarily lead to non-triability but examples of some which could lead to non-triability are:

- Mental retardation
- Organic mental illnesses
- Mental illnesses induced by the use of psycho-active medication
- Delusional disorders
- Psychotic disorders
- Affective disorders
- Anxiety disorders

⁸⁸ See *R v Kemp* (1956) 3 ALL ER 249, 253 B-E where Devlin J stated:

“ ... this is a physical disease and not a mental disease, that arteriosclerosis is primarily a physical not a mental condition, ...”

⁸⁹ See Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 143 where they note that if a person suffers from hypoglycaemia, the trial of the accused must be postponed until a later stage when the accused’s blood sugar levels are restored. Courts should, however, be cautious and guard against manipulation by the accused who could for example intentionally not eat correctly or take an overdose of insulin in order not to be triable.

⁹⁰ Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 143 note that epilepsy can be defined as the disturbance of the central nervous system manifesting mainly in convulsions or loss of consciousness. Despite being an epileptic, psychiatric evidence can nevertheless still indicate that such person is triable. See also *Youtsey v United States* 97 F 937 (6th Cir 1899).

⁹¹ Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 144; Snyman (1988) *TRW supra* note 78 at 136. Deafness, muteness or dumbness is a physical cause and not a form of mental illness. If it is impossible to communicate with such accused person, the accused is not capable to follow the proceedings in order to conduct a defense. See also Hiemstra (2008) *supra* note 3 at 13-1-13-12 where it is noted that if it appears impossible to communicate with a mentally healthy deaf mute person, it will be impossible to put such person on trial. Guilt cannot be established and the accused should be set free. Where communication with the deaf mute is possible the trial should continue in the normal fashion. The problem in this regard is that there are no statutory or administrative guidelines on how courts should treat cases where the accused is deaf mute. Oosthuizen and Verschoor (1991) *supra* note 78 at 144 state: “Wanneer hierdie persone vir verhoor gebring word, kan dit oneindige probleme vir die aanklaer en voorsittende beampte meebring, vanweë die nie-beskikbaarheid van genoegsame bepalings, omskrewende terminologie en prosedures wat hierdie gekompliseerde aangeleentheid moet reël. Indien die regte prosedures gevolg word en daar van die hulp van deskundiges soos psigiaters, sielkundiges, spraak- en gehoorreksioniste en terapeute, sowel as vingertaaldeskundiges gebruik gemaak word om die hof te adviseer of gedurende die verhoor by te staan, kan die probleem opgelos of vergemaklik word.”

⁹² Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 145-149.

⁹³ Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 147. For a comprehensive discussion on amnesia see chapter 2 above. Amnesia is generally approached with caution and will generally not render an accused unfit to stand trial.

	<ul style="list-style-type: none"> • Speech defect⁹⁴ • Dysphasia⁹⁵ • Organic diseases⁹⁶
--	---

Competency to stand trial and the psychiatric enquiry into fitness to stand trial is regulated in terms of section 77 of the Criminal Procedure Act. It is important to note that section 77 deals with the “now” question discussed earlier. From the forensic mental health expert’s view, the expert will have to evaluate whether the accused’s current mental state impairs his or her ability to stand trial⁹⁷.

According to Melton *et al*, competency to stand trial may involve the ability of an accused⁹⁸:

- To understand his or her current legal disposition.
- To understand the charges against him or her.
- To understand the facts relevant to his or her case.
- To comprehend the issues of law in his or her case.
- To have knowledge of possible defenses on his or her behalf.
- To appraise the likely outcomes.
- To comprehend the roles of the defense counsel, the prosecutor and the judicial authority.
- To identify and locate witnesses.

⁹⁴ Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 151.

⁹⁵ Snyman (1988) *Acta Juridica supra* note 78 at 138; Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 150. Dysphasia entails the partial inability to communicate by means of speech. Oosthuizen and Verschoor *supra* note 78 at 151 note that where it is established that an accused suffers from dysphasia it should be noted in the psychiatric report and accordingly that the accused’s inability to communicate is not attributable to a mental illness or mental defect as this will prevent unnecessary detention in psychiatric institutions. See also *R v Hughes 1987 (3) SA 97 (A)*.

⁹⁶ Oosthuizen and Verschoor (1991) *TRW supra* note 78 at 152. The following organic diseases could play a role in triability assessments:

- metabolic disturbances
- genetic abnormalities
- alcohol and drugs
- infections
- cancer
- brain damage

⁹⁷ Kaliski (2006) *supra* note 3 at 98; Africa “Psychological evaluations of mental state in criminal cases” in Tredoux *et al* (eds) (2005) *supra* note 3 at 387.

⁹⁸ Melton *et al* (2008) *supra* note 3 at 130.

- To trust and communicate with counsel.
- To comprehend instructions and advice.
- To make informed decisions after receiving advice.
- To maintain a collaborative relationship with his or her legal representative and to help plan a legal strategy.
- To follow testimony for errors.
- To challenge prosecution witnesses.
- To refrain from irrational and unmanageable behaviour at trial.

For purposes of clarity, section 77 will be quoted below. Section 77 provides as follows:

“77 Capacity of accused to understand proceedings

(1) If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.

(1A) At proceedings in terms of ss 77(1) and 78(2) the court may, if it is of the opinion that substantial injustice would otherwise result, order that the accused be provided with the services of a legal practitioner in terms of s 3 of the Legal Aid Amendment Act, 1996 (Act 20 of 1996).

(2) If the finding contained in the relevant report is the unanimous finding of the persons who under s 79 enquired into the mental condition of the accused and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence.

(3) If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused.

(4) Where the said finding is disputed, the party disputing the finding may subpoena and cross-examine any person who under s 79 has enquired into the mental condition of the accused.

(5) If the court finds that the accused is capable of understanding the proceedings so as to make a proper defence, the proceedings shall be continued in the ordinary way.

(6) (a) If the court which has jurisdiction in terms of section 75 to try the case, finds that the accused is not capable of understanding the proceedings so as to make a proper defence, the court may, if it is of the opinion that it is in the interests of the accused, taking into account the nature of the accused's incapacity contemplated in subsection (1), and unless it can be proved on a balance of probabilities that, on the limited evidence available the accused committed the act in question, order that such information or evidence be placed before the court as it deems fit so as to determine whether the accused has committed the act in question and the court shall direct that the accused –

(i) in the case of a charge of murder or culpable homicide or rape or compelled rape as contemplated in sections 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or a charge involving serious violence or if the court considers it to be necessary in the public interest, where the court finds that the accused has committed the act in question, or any other offence involving serious violence, be detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act, 2002; or

(ii) where the court finds that the accused has committed an offence other than one contemplated in subparagraph (i) or that he or she has not committed any offence –

(aa) be admitted to and detained in an institution stated in the order as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002,

(bb) ...

and if the court so directs after the accused has pleaded to the charge, the accused shall not be entitled under section 106(4) to be acquitted or to be convicted in respect of the charge in question.

(b) If the court makes a finding in terms of paragraph (a) after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside, and if the accused has pleaded guilty it shall be deemed that he has pleaded not guilty.

(7) Where a direction is issued in terms of subsection (6) or (9), the accused may at any time thereafter, when he or she is capable of understanding the proceedings so as to make a proper defence, be prosecuted and tried for the offence in question.

(8) (a) An accused against whom a finding is made -

(i) under subsection (5) and who is convicted;

(ii) under subsection (6) and against whom the finding is not made in consequence of an allegation by the accused under subsection (1), may appeal against such finding.

(b) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.

(9) Where an appeal against a finding in terms of subsection (5) is allowed, the court of appeal shall set aside the conviction and sentence and direct that the person concerned be detained in accordance with the provisions of subsection (6).

(10) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the direction issued under that subsection and remit the case to the court which made the finding, whereupon the relevant proceedings shall be continued in the ordinary way.”))

It is clear from the abovementioned section that whenever it appears to the court that an accused person cannot follow the proceedings in order to construct a

proper defence, the court will order in terms of section 77(1) that the accused's mental capacity be enquired into⁹⁹. The two main factors are:

- (i) The ability of the accused to follow the proceedings;
- (ii) The ability of the accused to communicate with his or her legal representative in order to conduct a defence¹⁰⁰.

The question relating to the competency of an accused to stand trial can be raised at any time during the course of the proceedings and accordingly an order that an accused be referred for observation can be rendered at any stage during the trial, even after conviction¹⁰¹.

The warrant for removal of an accused person from detention to the relevant institution where the enquiry into fitness to stand trial and/or criminal responsibility is to be conducted, is executed in terms of the so-called form "J138E"¹⁰².

Central to the assessment and determination of fitness to stand trial, stands the forensic mental health expert who will be called upon by the court to indicate whether the accused is fit to stand trial or whether his or her mental status renders a finding of unfitness to stand trial. Before a court can render a finding as to whether an accused is fit to stand trial or not, it has to receive a report in terms of section 79 of the Criminal Procedure Act from the relevant mental health experts. When assessing fitness to stand trial, the following procedural aspects should be taken into consideration¹⁰³:

- Before a referral for observation is ordered the court should be satisfied that a factual or medical foundation for the lack of competency to stand

⁹⁹ Hiemstra (2008) *supra* note 3 at 13-6; Du Toit *et al* (2008) *supra* note 3 at 13-3.

¹⁰⁰ *Ibid.*

¹⁰¹ Hiemstra (2008) *supra* note 3 at 13-6; Du Toit *et al* (2008) *supra* note 3 at 13-4; Strauss (1991) *supra* note 3 at 125; *S v Leeuw* 1980 (3) SA 815 (A). See also *S v April* 1985 (1) SA 639 (NC) where it was established after conviction but before sentence that an accused was unfit to stand trial. The conviction was consequently set aside. See also generally *S v Van As* 1989 (3) SA 881 (W); *S v M* 1989 (3) SA 887 (W). See also *S v V* 1984 (1) SA 33 (T).

¹⁰² For an example of this form see the example included in this chapter.

¹⁰³ Hiemstra (2008) *supra* note 3 at 13-7; Du Toit *et al* (2008) *supra* note 3 at 13-4. See also generally *S v Mogorosi* 1979 (2) SA 938 (A). See also *S v Mabena and another* 2007 (1) SACR 482 (SCA) at paragraph 16.

trial or criminal capacity, has been established. The inherent cause of the incompetency to stand trial should constitute either a mental illness or mental defect¹⁰⁴.

- The order can be granted by the court *suo motu* or at request of one or both parties. In each case the implications of a referral must be carefully evaluated as it could impact severely on an accused and the cost implications associated with a referral should also be carefully considered¹⁰⁵.
- The following directions should be made:
 - (i) Whether the enquiry should be conducted in terms of section 77 or 78 or both.
 - (ii) The place where the enquiry should be conducted which should inevitably be an institution for the mentally ill unless such an institution is not available¹⁰⁶.
 - (iii) The duration of such enquiry which should not exceed thirty days at a time. Extensions to this period are permissible if the psychiatric team cannot reach a finding during the initial period of thirty days¹⁰⁷.
 - (iv) With the exception of the first extension, the accused should each time be brought before the court. In *S v Eyden*¹⁰⁸ it was held that proceedings relating to the extension of the period of enquiry, constitutes “criminal proceedings” and as such should comply with the provisions of section 158 of the Criminal Procedure Act stating that proceedings had to take place in the presence of the accused¹⁰⁹.
 - (v) The court has to render a finding as to the “then” and “now” questions. If the finding on either of the two or both is positive, the court should make an order

¹⁰⁴ The meaning of “mental illness” or “mental defect” will be discussed below. These two concepts are not defined in the Criminal Procedure Act and this is one area where law and medicine are not *ad idem*.

¹⁰⁵ See Hiemstra (2008) *supra* note 3 at 13-7 where it is noted that in a survey conducted in 2005 the cost associated with a single referral amounted to R80 000.

¹⁰⁶ Hiemstra (2008) *supra* note 3 at 13-7; Oosthuizen, H and Verschoor, T “Verwysing van Onverhoorbare beskuldigdes en die daarstelling van ‘n verhoorbaarheid-vasstellingseenheid” (1993) *SACJ* at 155-156.

¹⁰⁷ Oosthuizen and Verschoor (1993) *SACJ supra* note 106 at 157, and also 155 where it is noted that a period of thirty days is in most cases unnecessary long for purposes of psychiatric observation.

¹⁰⁸ *S v Eyden* 1982 (4) SA 141 (T).

¹⁰⁹ See 144 H of the judgment. See also Hiemstra (2008) *supra* note 3 at 13-8.

in terms of subsection 6 of section 77 or in terms of subsection 6 of section 78.

When an accused is referred for observation, the court has to specify the specific condition which has to be investigated specifically with reference to the “now” or “then” question. If the court is uncertain where the defect lies, the accused can be sent for observation or enquiry on both of these aspects¹¹⁰. The abovementioned principle was clearly formulated in the decision of *S v V*¹¹¹. The facts of this decision were that the accused, who had been charged with two offences in terms of the Immorality Act¹¹², pleaded guilty to both charges. After questioning him, the magistrate altered his plea to one of not guilty in terms of section 113 of the Criminal Procedure Act¹¹³. He was accordingly found guilty on both charges at the end of the full hearing. At that stage the magistrate, having doubts as to the accused’s mental condition, referred him to a psychiatric hospital for observation. The investigating psychiatrist reported as follows¹¹⁴:

“Sy begrip van die betrokke hofverrigtinge is beperk en hy is nie in staat om sy verdediging na behore te voer nie. Beskuldigde is in staat om die ongeoorlooftheid van sy handeling te besef maar kan nie ten volle die gevolge daarvan voorsien nie. Dus ten gevolge is sy moontlikheid om volgens ‘n dergelike besef op te tree, beperk.”

Accordingly, the magistrate again, in terms of section 113, noted a plea of not guilty and ordered that the accused be detained in terms of section 77 (6) pending the decision of the State President.

¹¹⁰ Hiemstra (2008) *supra* note 3 at 13-8.

¹¹¹ *S v V* 1984 (1) SA 33 (T).

¹¹² Act 23 of 1957.

¹¹³ Section 113 provides for the correction of a plea of guilty which can be effected at any stage of the criminal proceedings in terms of section 112 of the Criminal Procedure Act before sentence has been passed. Section 113 can apply in the following four instances:

(i) when the court doubts whether the accused is really guilty of the offence to which he or she pleads guilty;

(ii) if the court is convinced that the accused does not admit to an averment in the charge;

(iii) if the court is of the opinion that the accused wrongfully admitted an averment in the charge;

(iv) if the court is of the opinion that the accused has a valid defence to the charge in question.

¹¹⁴ At 35 E.

On review, one of the questions which had to be determined related to the question as to how a referral for observation should be done. The court per Van Reenen J distinguished between the two instances where a referral for observation can be conducted, namely:

- (i) where it appears that the accused lacks the ability to understand the proceedings;
- (ii) where the accused lacked the capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation¹¹⁵.

Van Reenen J held the following¹¹⁶:

“Verder is dit duidelik dat die Wetgewer hier met twee heeltemal verskillende aangeleenthede te doen het, en waar ‘n verwysing onder een van die twee bepalings gedoen word, is die ondersoekspan streng gesproke gebonde aan die voorskrif van die ondersoek wat gedoen moet word. Maar die praktyk het al dikwels getoon, soos trouens in hierdie saak, dat die persoon inderdaad onder die verkeerde subartikel verwys is. Die praktyk het dus ontstaan dat die ondersoekspan in gepaste gevalle die ondersoek na òf albei subartikels òf die ander subartikel doen. Die gebruik, alhoewel nie stiptelik volgens die bepalings nie, is aanvaar. Dit wil egter voorkom dat, vir die doel van regsekerheid, ‘n hof die verwysing onder albei subartikels moet doen. Dit sal die ondersoekspan meer beweegruimte gee om op alle aspekte van die aangewese persoon se geestestoestand in te gaan.”

This decision serves as authority that an inquiry into the mental status of an accused could relate to both an inquiry into his or her competency to stand trial as well as an assessment of criminal capacity or a lack thereof at the time of the

¹¹⁵ At 37 E-F.

¹¹⁶ At 37 H – 38A. See also *S v Morake* 1979 (1) SA 121 (B) at 122 E-F where Hiemstra CJ states: “It can of course happen, especially where the court acts *suo motu* as in this case, that the court does not know what the most appropriate field of enquiry would be. There is no reason why the court could not specify two or even all three of the fields, the one under 577(1) and the other two under s 78(1). This might be desirable where the accused is unrepresented and there is little guidance for the court on the mental condition of the accused.”

offence. The latter necessitates a proper understanding of the precise role of the mental health professional during the assessment phase relating to both aforementioned inquiries.

4.2.1 The role of the mental health expert in the observation and report on the accused's mental status

The panel for purposes of the enquiry into an accused's fitness to stand trial is determined in terms of section 79 of the Criminal Procedure Act. Section 79 provides the following¹¹⁷:

“79. Panel for purposes of enquiry and report under sections 77 and 78

(1) Where a court issues a direction under section 77(1) or 78(2), the relevant enquiry shall be conducted and be reported on –

(a) where the accused is charged with an offence other than one referred to in paragraph (b), by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; or

(b) where the accused is charged with murder or culpable homicide or rape or compelled rape as contemplated in sections 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or another charge involving serious violence, or if the court considers it to be necessary in the public interest, or where the court in any particular case so directs –

(i) by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court;

(ii) by a psychiatrist appointed by the court and who is not in the full-time service of the State;

(iii) by a psychiatrist appointed for the accused by the court; and

¹¹⁷ For purposes of clarity section 79 is quoted in full within the context of fitness to stand trial. This particular section will also be referred to within the discussion of section 78 below. See also Snyman (1988) *Acta Juridica supra* note 78 at 142; Africa “Psychological evaluations of mental state in criminal cases” in Tredoux *et al* (eds) (2006) *supra* note 3 at 388.

(iv) by a clinical psychologist where the court so directs.

(1A) The prosecutor undertaking the prosecution of the accused or any other prosecutor attached to the same court shall provide the persons who, in terms of subsection (1), have to conduct the enquiry and report on the accused's mental capacity with a report in which the following are stated, namely –

- (a) whether the referral is taking place in terms of section 77 or 78;
- (b) at whose request or on whose initiative the referral is taking place;
- (c) the nature of the charge against the accused;
- (d) the stage of the proceedings at which the referral took place;
- (e) the purport of any statement made by the accused before or during the court proceedings that is relevant with regard to his or her mental condition or mental capacity;
- (f) the purport of evidence that has been given that is relevant to the accused's mental condition or mental capacity;
- (g) insofar as it is within the knowledge of the prosecutor, the accused's social background and family composition and the names and addresses of his or her near relatives; and
- (h) any other fact that may in the opinion of the prosecutor be relevant in the evaluation of the accused's mental condition or mental capacity.

(2) (a) The court may for the purposes of the relevant enquiry commit the accused to a psychiatric hospital or to any other place designated by the court, for such periods, not exceeding thirty days at a time, as the court may from time to time determine, and where an accused is in custody when he is so committed, he shall, while he is so committed, be deemed to be in the lawful custody of the person or the authority in whose custody he was at the time of such committal.

(b) When the period of committal is for the first time extended under paragraph (a), such extension may be granted in the absence of the accused unless the accused or his legal representative requests otherwise.

(c) The court may make the following orders after the enquiry referred to in subsection (1) has been conducted –

- (i) postpone the case for such periods referred to in paragraph (a), as the court may from time to time determine;

- (ii) refer the accused at the request of the prosecutor to the court referred to in section 77(6) which has jurisdiction to try the case;
 - (iii) make any other order it deems fit regarding the custody of the accused; or
 - (iv) any other order.
- (3) The relevant report shall be in writing and shall be submitted in triplicate to the registrar or, as the case may be, the clerk of the court in question, who shall make a copy thereof available to the prosecutor and the accused.
- (4) The report shall –
- (a) include a description of the nature of the enquiry; and
 - (b) include a diagnosis of the mental condition of the accused; and
 - (c) if the enquiry is under section 77(1), include a finding as to whether the accused is capable of understanding the proceedings in question so as to make a proper defence; or
 - (d) if the enquiry is in terms of section 78(2), include a finding as to the extent to which the capacity of the accused to appreciate the wrongfulness of the act in question or to act in accordance with an appreciation of the wrongfulness of that act was, at the time of the commission thereof, affected by mental illness or mental defect or by any other cause.
- (5) If the persons conducting the relevant enquiry are not unanimous in their finding under paragraph (c) or (d) of subsection (4), such fact shall be mentioned in the report and each of such persons shall give his finding on the matter in question.
- (6) Subject to the provisions of subsection (7), the contents of the report shall be admissible in evidence at criminal proceedings.
- (7) A statement made by an accused at the relevant enquiry shall not be admissible in evidence against the accused at criminal proceedings, except to the extent to which it may be relevant to the determination of the mental condition of the accused, in which event such statement shall be admissible notwithstanding that it may otherwise be inadmissible
- (8) A psychiatrist and a clinical psychologist appointed under subsection (1), other than a psychiatrist and a clinical psychologist appointed for the accused, shall, subject to the provisions of subsection (10), be appointed

from the list of psychiatrists and clinical psychologists referred to in subsection (9)(a).

(9) The Director-General: Health shall compile and keep a list of -

(a) psychiatrists and clinical psychologists who are prepared to conduct any enquiry under this section; and

(b) psychiatrists who are prepared to conduct any enquiry under section 286A (3), and shall provide the registrars of the High Courts and all clerks of magistrates' courts with a copy thereof.

(10) Where the list compiled and kept under subsection (9)(a) does not include a sufficient number of psychiatrists and clinical psychologists who may conveniently be appointed for any enquiry under this section, a psychiatrist and clinical psychologist may be appointed for the purposes of such enquiry notwithstanding that his or her name does not appear on such list.

(11) (a) A psychiatrist or clinical psychologist designated or appointed under subsection (1) by or at the request of the court to enquire into the mental condition of an accused and who is not in the full-time service of the State, shall be compensated for his or her services in connection with the enquiry from public funds in accordance with a tariff determined by the Minister in consultation with the Minister of Finance.

(b) A psychiatrist appointed under subsection (1)(b)(iii) for the accused to enquire into the mental condition of the accused and who is not in the full-time service of the State, shall be compensated for his or her services from public funds in the circumstances and in accordance with a tariff determined by the Minister in consultation with the Minister of Finance.

(12) For the purposes of this section a psychiatrist or a clinical psychologist means a person registered as a psychiatrist or a clinical psychologist under the Health Professions Act, 1974 (Act 56 of 1974)."

Before a report can be done in terms of section 79, an accused has to be sent for observation in terms of section 79. The minimum number of mental health experts who should conduct the observation is determined with reference to section

79(1)¹¹⁸. In *S v Ramokoka*¹¹⁹ Willis J expressed the view that in terms of section 79, at least two reports from the medical practitioners referred to in section 79 have to be obtained. As soon as there is a reasonable possibility that an accused might lack the ability to follow the proceedings or the issue of criminal responsibility ensues, the court is obliged to direct an enquiry in terms of section 77, 78 and 79¹²⁰. For purposes of the enquiry, it is the function of the mental health experts to determine whether or not the accused's mental condition satisfies the criterion determined for his or her triability¹²¹.

In *S v Motshekgwa*¹²² it was held that when determining the mental status of an accused all previous and relevant psychiatric reports should be provided to the trial court. The sole purpose of the enquiry in terms of section 79, whenever the triability of an accused person is at issue, is to provide the trial court with clarity on the accused's mental status. The determination of an accused's mental condition in order to stand trial, requires expert specialized knowledge.

Du Toit *et al* also state¹²³:

“The purpose of the provisions of the Act is to place this issue on a proper footing, so that the court does not have to make an uninformed judgment on a specialized issue where expert evidence is of vital importance.”

A court is not at any stage empowered to act in the absence of a report from mental health professionals and as such the provisions of section 77(1) are obligatory¹²⁴. After an accused person has been referred for observation, the mental health professionals will compile a report. The report must contain a

¹¹⁸ Du Toit *et al supra* note 3 at 13-4; Hiemstra (2008) *supra* note 3 at 13-8.

¹¹⁹ *S v Ramokoka* 2006 (2) SACR 57 (WLD) at 62 paragraph (27); Du Toit *et al supra* note 3 at 13-4, Hiemstra (2008) *supra* note 3 13-8.

¹²⁰ *S v Tom and others* 1991 (2) SACR 249 (B) at 250 H – 251 C; Du Toit *et al* (2008) *supra* note 3 at 13-4.

¹²¹ Snyman (1988) *Acta Juridica supra* note 78 at 744. See also Monahan, J and Steadman, HJ “Mentally Disordered Offenders” (1983) at 3.

¹²² *S v Motshekgwa* 1993 (2) SACR 247 (A); Du Toit *et al* (2008) *supra* note 3 at 13-4. This finding is supported as previous psychiatric evaluations can provide clarity to a trial court in assessing an accused's mental status.

¹²³ Du Toit *et al* (2008) *supra* note 3 at 13-5.

¹²⁴ *Ibid.*

finding as to whether or not an accused is able to understand the procedure in order to make a proper defence¹²⁵. If the report by the mental health professionals is unanimous, the court can assess the matter on the report without hearing further evidence¹²⁶.

If, however, the report by the mental health experts is:

- not unanimous
- disputed by the prosecution
- disputed by the accused,

the court can order the hearing of further evidence¹²⁷.

The party who disputes a particular finding may cross-examine any of the mental health experts who enquired into the mental status of the accused. The latter constitutes a so-called “point *in limine*” and does not bear upon the merits of the case¹²⁸.

It is also important to note that the burden of proof to show beyond reasonable doubt that the accused is able to follow the proceedings to make a proper defence, rests on the State¹²⁹.

The report by the mental health expert should contain the following information¹³⁰:

- a description of the nature of the inquiry;
- a diagnosis of the accused’s mental condition;
- a review of the medical and psychiatric history of the accused;

¹²⁵ Du Toit *et al* (2008) *supra* note 3 at 13-6; Hiemstra (2008) *supra* note 3 at 13-10; *S v Sithole* 2005 (1) SACR 311 (W) at 313 e-f.

¹²⁶ *Ibid.* See section 77(2) *supra*.

¹²⁷ *Ibid.* See section 77(3) *supra*. See also Bekker, *et al* (2009) *supra* note 3 at 217–218 (hereafter “Bekker *et al*”). See also *S v Kahita* 19873 (4) SA 618 (C). See also Strauss (1991) *supra* note 3 at 124.

¹²⁸ Snyman (1988) *Acta Juridica supra* note 78 at 147.

¹²⁹ Du Toit *et al* (2008) *supra* note 3 at 16–6; Hiemstra (2008) *supra* note 3 at 13-7. See also *S v Ebrahim* 1973 (1) SA 868 (A) at 871F; *S v Mashimbi* 1958 (1) SA 390 (T) at 392 D-H.

¹³⁰ Section 79(4). Snyman (1988) *Acta Juridica supra* note 78 at 144.

- the psychiatrist's clinical findings during the time of observation;
- the intelligence level of the accused;
- the type of treatment or other disposition which will be the fairest to the accused as well as in the best interest of the community;
- prognosis of the accused's possible treatment;
- a finding as to whether the accused is capable of understanding the proceedings so as to make a proper defence.

If the mental health experts are not unanimous in their finding, it must be stated in the report and accordingly each of the experts will provide their opinion on the accused's mental status¹³¹.

If the court finds that an accused is capable of understanding the proceedings so as to make a proper defence, the trial will continue as usual¹³². It is important to emphasise that it is the court, and not the medical team, who at the end of the day renders a finding of triability or not¹³³.

It is also important to note that during the process of compiling a report by a psychiatrist pursuant to an enquiry in terms of section 77, 78 or 79, the *audi alteram partem* rule is not applicable¹³⁴. The latter principle was established in *S v Dobson*¹³⁵. In this case the accused was charged with murder. The accused had on two occasions been sent for observation to Valkenberg Mental Institution for an enquiry and a report on his mental condition in order to determine whether he was capable of understanding the proceedings in order to conduct a proper defence. During the first observation, the two psychiatrists appointed in terms of section 79(1)(b) to conduct the enquiry were Dr Kaliski and Dr Quail. They provided a unanimous report that the accused was fit to stand trial and consequently the accused informed the magistrate that he agreed with the findings of the psychiatrists and he accordingly pleaded guilty to the charge. When the matter was heard in the Supreme Court, counsel for the accused submitted that an

¹³¹ Section 79(5).

¹³² Bekker *et al supra* note 3 at 217; Strauss (1991) *supra* note 3 at 124.

¹³³ Snyman (1988) *Acta Juridica supra* note 78 at 147; Du Toit *et al* (2008) *supra* note 3 at 13-6.

¹³⁴ Du Toit *et al* (2008) *supra* note 3 at 13-4.

¹³⁵ *S v Dobson* 1993 (4) SA 55 (E). See also *S v Dobson* 1993 (2) SACR 86 (E).

irregularity had occurred in that the magistrate had failed to inform the accused that he is entitled to have a psychiatrist of his own choice added to the psychiatrists appointed by the Court to enquire into his mental condition. The accused was consequently again sent for observation and the accused elected Dr Royds as the psychiatrist of his choice. Again all the psychiatrists rendered a finding that the accused was indeed fit to stand trial. Counsel for the accused, however, again submitted that in terms of the second enquiry an irregularity occurred due to the fact that the accused should have been assessed by an entirely new panel of psychiatrists. Dr Kaliski expressed the view that it would have been impossible to put together an entirely new panel of psychiatrists as all the other psychiatrists had some knowledge of the accused as a result of his first thirty day observation period. Dr Kaliski also stated that a further observation would be a waste of time and money¹³⁶.

Counsel for the accused further submitted that the State or the psychiatrists failed to observe the *audi alteram partem* rule due to the fact that the psychiatrists conducting the enquiry were supplied with a copy of the record of proceedings drawn up by the prosecutor in the magistrate's court and the accused or his legal representative were not supplied with such report.

Zietsman JP held the following¹³⁷:

“For this purpose an enquiry by a panel of psychiatrists is ordered and they then furnish the result of their findings and their opinion to the court. For the purpose of their enquiry they obtain information from various sources. They want to know what the State's allegations are against the accused and they obtain background information from various sources concerning his past behaviour and any past incident which may throw light upon his present mental condition and what his mental condition might have been at

¹³⁶ See 58 A-B. Counsel for accused also claimed that it was irregular that Dr Kaliski did not conduct a personal interview with the accused during the second assessment. Zietsman JP, however, held: “It is clear from Dr Kaliski's evidence that the opinions of the psychiatrists are not based purely upon their own interviews with the patient. The patient is observed continuously by various people during the 30-day period and reports on his behaviour are submitted to the psychiatrists who also obtain relevant background information from outside sources such as family members of the patient.”

¹³⁷ At 59 A-D.

the time when the offence was allegedly committed. ... Their purpose is not to try to determine whether the information they have received is correct or not, but to determine the accused's mental state, and in particular whether he can understand and appreciate the concept of wrongfulness.”

Counsel for the accused accordingly contended that the principle of *audi alteram partem* required that material information acquired and subsequently relied upon should be disclosed to the party entitled to a hearing.

Zietsman JP held in respect of the *audi alteram partem* rule¹³⁸ that in this case the psychiatrists in question were not performing an administrative, a judicial or a quasi-judicial function but that they were conducting their own independent enquiry in their own way in order to enable them to furnish an opinion concerning the mental capacity of the accused. They were also not furnishing advice based on information received to an administrative body planning to take an administrative decision. In order to enable them to perform their functions it was necessary that they obtain information from numerous sources and the information they could obtain from the prosecutor was important to them. As such they did not accept the information as being correct, and acted upon it. It was information they put to the accused to assess his reactions thereto, and they then had to form their own opinion regarding his mental condition. In such a case what the psychiatrists are required to do is to form an opinion and to advise the court of their opinion and findings and, if their findings are disputed, the Act gives the accused the right to have the psychiatrists subpoenaed and submitted to cross-examination and as such the *audi alteram partem* principle did not apply.

The court held that the unanimous finding of the psychiatrists should prevail and therefore that the accused was fit to stand trial.

If a court finds that the accused is not capable of understanding the proceedings so as to make a proper defence, the court may, if it is of the opinion that it is in the interest of the accused having regard to the nature of the accused's incapacity,

¹³⁸ At 61 B-D.

and unless it can be proved on a balance of probabilities that, on the limited evidence available, the accused committed the act in question, order that such information or evidence be placed before the court as it deems necessary to assess whether the accused has in fact committed the act in question¹³⁹.

The court must also order that the accused:

- In the case of murder, culpable homicide, rape or compelled rape as contemplated in subsection 3 or 4 of the Sexual offences and Related Matters Amendment Act¹⁴⁰, respectively or in cases where the charge is one involving serious violence and the court is of the opinion that the accused has committed the act in question, be detained in a psychiatric hospital or prison pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act¹⁴¹.
- In cases where the court finds that the accused has committed an offence *other* than the abovementioned offences or that he or she has not committed any offence, be admitted to, or detained and treated in an institution mentioned in the order as if the accused were an involuntary mental health care user as contemplated in Section 37 of the Mental Health Care Act¹⁴².
- If a court makes the finding in terms of section 77 (6) (a) after an accused has been convicted of the offence charged but before sentence is passed, the relevant court will set the conviction aside, and if the accused has pleaded guilty, it shall be deemed that he or she has pleaded not guilty. It is also important to note that where the court issues a directive in terms of section 77 (6) (a), the accused shall not be entitled to be acquitted or

¹³⁹ Du Toit *et al* (2008) *supra* note 3 at 13-7; *S v Ramokoka* 2006 (2) SACR 57 (W) at paragraph (20).

¹⁴⁰ Act 32 of 2007. This Act came into operation on 16 December 2007 and amended the Criminal Procedure Act in certain respects and also contains various provisions pertaining to mentally disordered criminals. These provisions will be addressed during the course of the chapter. See also Du Toit *et al* (2008) *supra* note 3 at 13-7.

¹⁴¹ Act 17 of 2002. (hereafter the "Mental Health Care Act") See section 77(6)(a)(i).

¹⁴² Du Toit *et al* (2008) *supra* note 3 at 13-7; Hiemstra (2008) *supra* note 3 at 13-11; Bekker *et al* (2009) *supra* note 3 at 217 and also 234 where it is stated that in terms of section 106(4) of the Criminal Procedure Act an accused who has pleaded to a charge is entitled to demand that he or she either be acquitted or convicted.

convicted in respect of the charge in question in terms of section 106 (4) of the Criminal Procedure Act¹⁴³.

It is important to note that before the Criminal Law Amendment Act¹⁴⁴ came into operation the only option a court retained was to declare an accused a State patient. This is still the case if the charge is murder, culpable homicide, rape, compelled rape or a charge of serious violence but with other charges an order can also be made that the accused be treated as a patient in terms of section 37 of the Mental Health Care Act¹⁴⁵.

If, after the direction as mentioned above has been made, an accused becomes capable of understanding the proceedings in order to make a proper defence, he or she can be prosecuted and tried for the offence in question¹⁴⁶.

*S v Leeuw*¹⁴⁷ was one of the first reported decisions in which the provisions of section 77 (7) of the Criminal Procedure Act were applied. The facts were briefly that the accused was convicted on four counts including murder and sentenced to death. During his trial the accused was sent for observation after it was alleged that he was unfit to stand trial. The report from the two psychiatrists who examined the accused stated that as a result of mental abnormality, the accused was not sufficiently capable of comprehending the court proceedings in order to properly conduct his defence and also that due to his mental abnormality he was not criminally responsible at the time of commission of the offences. It was accordingly ordered that the accused be detained as a State President's patient. The Attorney General later applied for the discharge of the accused as a State President's patient. The order was refused and the accused was charged with the same offences again. At his trial he pleaded not guilty and contended that the State was not in a position to prosecute him. The court rejected these contentions and the accused was sentenced and convicted. On appeal the Appellate Division held that in terms of section 77 (7) of the Criminal Procedure Act a person

¹⁴³ See section 77(6)(a)(ii); Du Toit *et al* (2008) *supra* note 3 at 13-7.

¹⁴⁴ Hiemstra (2008) *supra* note 3 at 13-11.

¹⁴⁵ Mental Health Care Act 17 of 2002.

¹⁴⁶ See section 77(7); Snyman (1988) *Acta Juridica supra* note 78 at 150; Du Toit *et al supra* note 3 at 13-7.

¹⁴⁷ *S v Leeuw* 1987 (3) SA 97 (A); Snyman (1988) *Acta Juridica supra* note 78 at 150–151.

detained under section 77 (6) of the Criminal Procedure Act was not absolved from prosecution if after the order which authorised his detention he became capable of being tried.

It is evident from the discussion above that the expert evidence of psychiatrists in particular, and also psychologists if desirable, plays a crucial and essential role in the determination of competency to stand trial. In the absence of this evidence a court will be unable to make an informed decision as to an accused's ability to understand the proceedings in order to conduct a proper defence.

4.3 Appeal and review

Whenever an accused is found competent to stand trial, he or she has a right of appeal after conviction. The accused who is found incompetent to stand trial also has a right of appeal if he or she did not allege that he or she was unfit to stand trial¹⁴⁸.

In respect of review, proceedings in terms of section 77 (6) are not subject to automatic review in terms of section 302 (1) (a)¹⁴⁹.

In *S v Ramokoka*, Willis J, however, expressed the opinion that in view of the potential for serious prejudice to an accused person where an order is made in terms of section 77 (6), some kind of review mechanism is needed¹⁵⁰. Willis J

¹⁴⁸ Du Toit *et al* (2008) *supra* note 3 at 13-7; Hiemstra (2008) *supra* note 3 at 13-11; Bekker *et al* (2009) *supra* note 3 at 213.

¹⁴⁹ Hiemstra (2008) *supra* note 3 at 13-11; *S v Blaauw* 1980 (1) SA 536 (C); Du Toit *et al* (2008) *supra* note 3 at 13-7; *S v Gxako* 1965 (4) SA 12 (E); *S v April* 1985 (1) SA 639 (NC).

¹⁵⁰ *S v Ramokoka* 2006 (2) SACR 57 (WLD) at paragraph 12 Willis J also stated:
"Section 47 of the Mental Health Care Act 17 of 2002 relates to the application to a judge in Chambers for the discharge of the State patient. Section 47(1) of that Act reads 'Any of the following persons may apply to a judge in Chambers for the discharge of a State patient and then enumerates the various persons, including the State patient, who may do so. It therefore seems clear to me that in the absence of some review mechanism, a person detained in terms of s 77(6) of the Criminal Procedure Act remains so detained unless (a) an application is made to a Judge in Chambers for his or her release and (b) the Judge in Chambers orders the release. In other words, an order made in terms of s 77(6) of the Criminal Procedure Act does not have the automatic consequence that it is put before a Judge in Chambers for confirmation.'" (paragraph 11).

accordingly noted that the court does have the power at common law to exercise powers of review and accordingly held as follows¹⁵¹:

“It seems to me that, as a matter of good practice, magistrates should refer their orders made in terms of s 77 (6) to the High Court for review.”

4.4 Re-establishing triability by means of psychotropic medication

A question that frequently arises is whether a mentally ill or mentally defective person’s triability can be re-established by means of psychotropic medication. Psychotropic medication can be defined as substances which influence the psychiatric functioning, behaviour and experience of a person¹⁵².

According to Oosthuizen and Verschoor, psychotropic medication can re-establish an accused’s competency to stand trial¹⁵³. The criticisms levelled against the use of psychotropic medication are the following¹⁵⁴:

- It could be argued that the medication could possibly affect the mind of the accused in such a manner that he or she will be unable to respond properly to the events at the trial;
- The medication could also portray an inaccurate picture of the accused.

Psychotropic medication by means of which triability can be re-established can be divided into the following categories:

¹⁵¹ Paragraphs (14) and (16). The facts of this case were that the accused was charged with one count of assault with the intent to commit grievous bodily harm. During his trial the accused and his brother informed the court that he was “mentally unsound”. He was accordingly referred for observation in terms of section 77 of the Criminal Procedure Act and the consequent report stated that he was unable to appreciate the wrongfulness of his actions or to follow the proceedings against him. The magistrate accordingly directed that the accused be detained at Sterkfontein Hospital pending the decision of a Judge in Chambers in terms of section 77(6) of the Criminal Procedure Act, and thereafter referred the matter to the High Court on Special review. It was accordingly held by Willis, J that only one psychiatric report had been obtained and that the magistrate’s decision had been based solely on that report. According to section 79 at least two reports were required. The magistrate’s order for detention in terms of section 77(6) was set aside and the matter was remitted to the court *a quo* to be dealt with in terms of section 77(1), 78(2) and 79(1)(b) of the Criminal Procedure Act.

¹⁵² Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 76.

¹⁵³ Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 74.

¹⁵⁴ *Ibid.* See also Bennett, G “A guided tour through selected ABA standards relating to incompetency to stand trial” (1985) *George Washington Law Review* at 375.

(i) Anti-psychotic medication

Anti-psychotic medication is frequently used in the treatment of schizophrenia. This medication assists in re-establishing the cognitive functioning of a person with a resultant decrease in psychotic thoughts, suspicion and agitation. There is furthermore a reduction in hallucinations, paranoia and hostility. This form of medication is accordingly very important in the re-establishment of triability of the schizophrenic. According to Oosthuizen and Verschoor the accused should only appear before a court after a few weeks of use of this medication due to the sedative effect that this medication could have on an accused¹⁵⁵.

(ii) Anti-depressive medication

Anti-depressants have the effect that persons suffering from major depression can be treated within the community rather than in a hospital¹⁵⁶. Accused persons found to be unfit to stand trial, can regain triability by means of the use of anti-depressants.

(iii) Anti-manic substances

Mania can be described as a mood disorder which could result in non-triability. General characteristics of this disorder include elation, hyperactivity, hypersensitivity and talkativeness. The most popular substance used to control mania is Lythium. According to Oosthuizen and Verschoor accused persons who use lythium will be competent to stand trial¹⁵⁷.

(iv) Anxiety medication

Medication for the control of anxiety is generally known as tranquilisers. The most important substance used is Valium. Anxiety neurosis is caused by insecurity

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.* Depression will be discussed at a later stage in this chapter.

¹⁵⁷ Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 78.

characterised by a feeling of tension, irritability and insomnia. By means of medication an accused's triability can be improved if the accused suffers from anxiety neurosis¹⁵⁸.

Triability can accordingly be re-established through the use of psychotropic medication. Pivotal to the administration of such medication is the role of the mental health professional who will most probably be the psychiatrist who will have to monitor the use of this medication as well as the side effects of it on the accused.

Oosthuizen and Verschoor caution that courts should be aware of the side effects of these medications on the accused as some of these medications could influence an accused's emotions and functioning in court¹⁵⁹.

Oosthuizen and Verschoor also acknowledge the crucial role of expert evidence by stating¹⁶⁰:

“n Bevel wat die verpligte behandeling om verhoorbaarheid te bewerkstellig impliseer, behoort ook nie ligtelik gemaak te word in gevalle waar die newe-effekte grotesk en onomkeerbaar dreig te wees nie. Die aanhoor van deskundige getuies oor die aard van enige newe-effekte op die beskuldigde moet as voorvereiste beskou word.”

Melton *et al* also note that even though psychotropic medication do have side effects, they often enable an individual to attain at least the minimum threshold of understanding required in terms of the standard for competency to stand trial¹⁶¹. Reid notes that often defense attorneys have the idea that if an accused with

¹⁵⁸ *Ibid.*

¹⁵⁹ Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 81.

¹⁶⁰ Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 82.

¹⁶¹ Melton *et al* (2007) *supra* note 3 at 131. See also Oosthuizen and Verschoor (1990) *TRW supra* note 78 at 78–79 where they note that the two most important side effects of psychotropic medication are:

- “Tordiktiewe diskinesie” which is a syndrome characterised by involuntary movements by lips, tongue and jawbone;
- “Akinesie” which is characterised by behaviour with reduced spontaneity, apathy, indifference towards general and usual activities and a feeling of despondence.

severe mental illness is allowed to remain psychotic, he or she will stand a better chance of convincing the court that he or she suffers from a mental illness and accordingly his or her true condition at the time of the offence¹⁶². The problems associated with such a plan are the following:

- Avoiding treatment would deprive the accused of his or her right to be competent during trial.
- Many accused persons with psychotic illnesses have symptoms that fluctuate from week to week, day to day or even hour to hour. Some develop psychosis only after the specific incident by for example becoming depressed about what they have done. Other accused persons improve after a crime. Accordingly any psychosis that results from withholding anti-psychotic medication will almost never be exactly the same as that allegedly present when the crime was committed.
- There is a substantial ethical issue associated with a mental health expert being a party to stopping clinically needed care.

In *Sell v United States*¹⁶³ the Supreme Court of the United States established four principles applicable to the use of psychotropic medication which could also be useful within the South African context. The Supreme Court stated that psychotropic medication can be administered if:

- it is substantially likely to render the accused competent to stand trial;
- it is substantially unlikely to have any side effects which will affect the accused negatively in assisting his or her legal representative in conducting a defense;
- it is necessary to further interests;
- it is medically appropriate.

¹⁶² Reid, WH "The Insanity Defense: Bad or Mad or Both" (2000) *Journal of Psychiatric Practice* 169 at 171.

¹⁶³ *Sell v United States*, 539 U.S. 166 (2003) as discussed in Melton *et al* (2008) *supra* note 3 at 131.

Kaliski notes that the best approach would be to commence treatment as soon as a definitive assessment has been concluded and if consequently the accused becomes competent to stand trial, the resulting report should mention this¹⁶⁴.

4.5 Guidelines in assessing competency to stand trial

“Nowhere is the power and influence of psychiatry more evident in the psycholegal arena than when the psychiatrist is called upon to advise the Court as to who is competent to stand trial and who shall be deprived of personal liberty until such time as he becomes competent.”¹⁶⁵

A competency assessment should generally address the issues of whether an accused is capable of understanding the nature of the judicial proceedings. The accused should understand how and why he or she is being charged, the pre-trial and trial procedures that will occur as well as the consequences of conviction¹⁶⁶. The psychiatrist and, if requested, the psychologist play an essential role in assessing whether an accused is indeed fit to stand trial or not. It is, however, true that the determination of competency to stand trial is complex and sometimes difficult to assess. The essence of a competency evaluation is rooted in the accused’s current mental state and whether his or her mental status presently enables an accused to stand trial. The latter stands in contrast to the assessment of pathological criminal incapacity which is a retrospective enquiry of the accused’s mental state at the time of the commission of the offence¹⁶⁷.

According to Kaliski it is important to determine both whether a mental disorder is present in an accused as well as its onset and accordingly the following questions should be put to an accused by the mental health expert¹⁶⁸:

- Do you know with what offence you have been charged?
- Do you know what the police say you did?

¹⁶⁴ Kaliski (2006) *supra* note 3 at 102.

¹⁶⁵ Goldstein, RL and Stone, M “When Doctors Disagree: Differing views on competency” (1977) *Bull Am Acad Psychiatry* at 90.

¹⁶⁶ Blau, T “The Psychologist as expert witness” (1998) at 80.

¹⁶⁷ Kaliski (2006) *supra* note 3 at 98.

¹⁶⁸ Kaliski (2006) *supra* note 3 at 99.

- Can you explain why this charge is regarded as a crime?
- Do you know why you were referred for an assessment?
- Are you familiar with the court procedure?
- What do you intend to plead?
- It should also be ascertained whether the accused can consult with his or her legal representative.

Kaliski also states that it is often difficult to distinguish between ignorance and incompetence due to the fact that South African courts and the legislature have not yet determined clearly defined criteria for the assessment of incompetency and accordingly declaring an accused unfit to stand trial. These decisions often reside within the mental health expert's subjective opinion¹⁶⁹.

Kaliski states that frequently an indirect assessment is necessary if the abovementioned questions and the answers provided to it do not provide a clear enough analysis. Indirect assessment entails the following¹⁷⁰:

- The difference between a "guilty" and a "not guilty" plea could be explained to the accused to ascertain which he or she elects.
- The accused's general use of language could be assessed as well as the ability to discuss concepts unrelated to the charge.
- Information pertaining to the accused's activities of daily living could also be assessed as the adequate ability to engage in independent living could indirectly be indicative of adequate mental capacity.

According to Melton *et al*, a standardised competency assessment should comprise of the following components¹⁷¹:

- Pre-evaluation preparation and consultation

¹⁶⁹ Kaliski (2006) *supra* note 3 at 100.

¹⁷⁰ *Ibid.*

¹⁷¹ Melton *et al* (2007) *supra* note 3 at 157–161. See also Bonnie, R "The Competence of Criminal Defendants: A theoretical Reformulation" (1992) *Behavioral Sciences and the Law* at 291; Scott, CL "Commentary: A road Map for Research in Restoration of Competency to Stand Trial (2003) *Journal of the American Academy of Psychiatry* at 95.

During this phase the mental health expert needs to obtain information from the referral source in order to better understand the purpose of the evaluation. This information will include court documents as well as information from the accused's legal representative with specific reference to contextual obstacles that impact on the anticipated defence.

- Notification to the accused

The mental health expert should disclose information to the accused pertaining to the purpose and the nature of the assessment as well as possible limitations with regard to confidentiality.

- Psychosocial history

According to Melton *et al*, the social history of the accused serves the following functions¹⁷²:

- (i) It serves as a way of "building rapport between the defendant and examiner."
- (ii) It can provide verbal examples of general mental status from which inferences can be extracted pertaining to the accused's capacity for expressing thoughts.
- (iii) The history can assess the general incapacity to establish or sustain relationships as a means of determining how the accused relate to the legal representative.
- (iv) The content of the history may become important if substantial impairment in competency-related abilities is discovered during other sections of the evaluation.

- Mental status evaluation

¹⁷² Melton *et al* (2007) *supra* note 3 at 158.

The various methods employed to evaluate cognitive, emotional and behavioural functioning can vary from unstructured and simple questions to highly structured interviews¹⁷³.

- Administration of a competency assessment measure
- Interviewing for case-specific information

During this phase, two components should be included:

- (i) The first component will relate to the offence and will entail a determination of the accused's awareness of the charges as well as the ability to elaborate on the specific allegations and their consequences.
 - (ii) The second component will encompass the accused's ability to relate with the legal process and will deal with issues pertaining to the accused's understanding of the nature and purpose of the trial, the respective roles of the various participants in the trial as well as the consequences of pleading guilty.
- Psychological testing

In limited circumstances psychological testing will be useful. These instances are for example:

- (i) where malingering is suspected;
- (ii) for corroboration of the degree of mental impairment;
- (iii) for the evaluation of the ability to consider alternatives and process information in an organised situation.

Hess and Weiner in addition state that mental health professionals should, even before meeting with the accused for the first time, meet with both the defense as well as the prosecuting authority to determine the reason why the fitness issue

¹⁷³ Melton *et al* (2007) *supra* note 3 at 159.

was raised, the evidence that was offered as well as the trial and dispositional alternatives which will be borne in mind by both sides¹⁷⁴.

Hess and Weiner summarise the following guidelines for assessing competency to stand trial¹⁷⁵:

- Information of prior mental health contacts should be pursued before an interview is conducted in order for the mental health expert to have a complete set of mental health records.
- Complete police reports as well as a record of past criminal activities should be made available.
- The mental health expert should keep accurate records of when, where and how information about an accused was made available as well as a date and time record of all contacts with the accused and other mental health professionals.
- The conduct of a competency evaluation and the consequent reports prepared for the court should be in line with both the “spirit and letter of contemporary legal standards”.¹⁷⁶

Africa correctly notes that a mere diagnosis of mental illness does not necessarily imply that an accused is unfit to stand trial¹⁷⁷. It has to be indicated that the symptoms of these disorders impact on the accused in such a way that the accused is unable to comprehend the criminal process and accordingly unable to contribute to the process by means of consulting with his or her legal representative¹⁷⁸. Africa states¹⁷⁹:

“The central question that the psychologist is therefore faced with is how these symptoms impact on fitness to stand trial.”

¹⁷⁴ Hess, AK and Weiner, IB “The Handbook of Forensic Psychology” 2nd ed. (1999) at 342. See also Blau (1998) *supra* note 166 at 80–81.

¹⁷⁵ *Ibid.*

¹⁷⁶ Hess and Weiner (1999) *supra* note 174 at 343.

¹⁷⁷ Africa “Psychological evaluations of mental state in criminal trials” in Tredoux *et al* (eds) (2005) *supra* note at 389–391.

¹⁷⁸ *Ibid.*

¹⁷⁹ *Ibid.*

In assessing competency to stand trial, the clinical interview is a crucial tool in the evaluation process as it provides the mental health professional an opportunity to assess the extent to which the symptoms are impairing the accused's mental functioning¹⁸⁰. Throughout the clinical interview, the accused's mental state is evaluated with three main areas that have to be addressed, namely¹⁸¹:

- The accused's psychosocial history;
- The accused's understanding of the offence;
- The accused's understanding of the legal process.

Melton *et al* in addition conclusively state¹⁸²:

"... clinicians should attempt to avoid offering legal conclusions about competency, or, if the court orders otherwise, should couch their conclusions in cautious terms. Moreover, they should include in their reports and testimony descriptive details about defendants' functioning that will enable the court to reach its own opinions on the issue."

4.6 Cost implications of a referral for observation and the establishment of a fitness assessment unit

It remains an undeniable fact that when an accused is referred for observation there will inevitably be cost and time implications associated with such referral. Despite the fact that there could be various motivating factors in support of a referral for observation, one should not lose sight of the cost implications inherent in such referral as well as possible ulterior motives behind a request for referral. Hiemstra notes that a referral for observation has considerable cost implications for the community and according to research the cost for referrals was estimated at R80 000 in 2005¹⁸³. According to Kruger, the criterium applied whenever an

¹⁸⁰ *Ibid.*

¹⁸¹ *Ibid.* See also Melton *et al* (2007) *supra* note 3 at 157.

¹⁸² Melton *et al* (2007) *supra* note 3 at 136.

¹⁸³ Hiemstra (2008) *supra* note 3 at 13-7.

application is lodged to have an accused referred for observation is problematic¹⁸⁴. Kruger submits that presiding officers and prosecutors often feel that applications for referrals are done merely to delay the proceedings or as a tactic to place evidence before the court which would later serve in mitigation of sentence¹⁸⁵.

Kruger further states that psychiatrists and psychologists should already be present during a trial proceeding before a referral for observation is made¹⁸⁶. The Criminal Procedure Act should then accordingly be amended to provide for a specific criterion or test which should be applied during a determination of whether an accused should be referred for observation or not¹⁸⁷. The latter should entail that before an accused person is referred for observation, evidence or some factual medical foundation should be placed before the court as a motivation for such referral¹⁸⁸. This procedure will curtail the provisions pertaining to referrals for observation to the extent that courts will not lightly refer an accused for observation where a medical foundation is lacking.

The latter approach is supported by the author. Psychiatrists and psychologists should already be present in a trial before a referral for observation is ordered. This approach could also be welcomed in respect of the defence of non-pathological criminal incapacity. The opinion evidence of the psychiatrists and psychologists will then assist the trial court in determining whether an accused should in fact be referred for observation whether or not the reason for requesting a referral is for determining competency to stand trial or lack of criminal capacity or both. The cost and time constraints associated with a referral as well as unsupported claims of non-triability or criminal incapacity will accordingly be limited. In addition to the abovementioned procedure, Oosthuizen and Verschoor also support the establishment of a so-called "Fitness Assessment Unit" to assist a court whenever it is alleged that an accused is unfit to stand trial¹⁸⁹.

¹⁸⁴ Kruger, A "Tekortkominge in Wetgewing oor Geestesongesteldes" (1983) *TRW* 182 at 185.

¹⁸⁵ Kruger (1983) *TRW supra* note 184 at 185.

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ Oosthuizen and Verschoor (1993) *SACJ supra* note 106 at 163. See also Oosthuizen, H "n Regsvergelykende Ondersoek na Verhoorbaarheid" (1990) Unpublished LLD thesis (University of the Free State) at 252–303.

Oosthuizen and Verschoor note that in the majority of referrals, the period of thirty days which is currently the set period for purposes of referrals, is generally too long¹⁹⁰. In order to curtail the cost implications of referrals, the establishment of a Fitness Assessment Unit could be of much assistance to courts¹⁹¹. This unit will comprise of a psychiatrist, a psychologist as well as a legal practitioner with experience in the field of triability. The unit will be summoned to enquire into the triability of an accused whenever there is doubt during criminal proceedings as to whether an accused is fit to stand trial or not¹⁹². As soon as the triability of an accused is raised during the trial, the accused will be referred to the unit for assessment by a multi-disciplinary team of experts. This assessment will entail a once-off assessment and interview with the accused¹⁹³. Once it is established that an accused is triable, he or she will be remitted to the trial court where the trial will take its ordinary course. If, however, it becomes clear that the accused is unfit to stand trial or there is doubt in that regard, the accused will be referred to a mental institution for further investigation¹⁹⁴. According to Oosthuizen and Verschoor psychiatrists, psychologists, neurologists, social workers and even nursing personnel could all play a role in the multi-disciplinary assessment of an accused¹⁹⁵. Emphasis should be placed on the proper training of persons assisting in such a unit. The names of the persons providing their services to the Fitness Assessment Unit could also be placed on a list in order to make contact with them more efficiently and speedily¹⁹⁶. This process will accordingly be time efficient as it only lasts for a few hours as opposed to thirty days. It is also cost effective with the further benefit of not depriving the accused unnecessarily of his or her freedom¹⁹⁷.

5 Analysis and assessment of pathological criminal incapacity

“Foul whisperings are abroad. Unnatural deeds
Do breed unnatural troubles, infected minds

¹⁹⁰ Oosthuizen and Verschoor (1993) *SACJ supra* note 106 at 162–163.

¹⁹¹ *Ibid.*

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ Oosthuizen and Verschoor (1993) *SACJ supra* note 106 at 164.

To their deaf pillows will discharge their secrets
More deeds she the divine than the physician.
God, God forgive us all! Look after her;
Remove from her the means of all annoyance.
And still keep eyes upon her. So, goodnight.
My mind she has mated, and amazed my sight.
I think, but dare not speak.”¹⁹⁸

The mentally ill have for a long time been held not legally responsible for their actions.

There are few areas in law where the interplay between law and medicine with specific reference to the field of psychiatry becomes more evident than in the case of assessing pathological criminal incapacity, or put differently, in cases of insanity. On face value it seems as though the interface between these disciplines is more structured in cases of pathological criminal incapacity as opposed to non-pathological criminal incapacity. Closer scrutiny of this defence, however, reveals that law and medicine do not always see eye to eye in respect of various issues related to this defence. The mere fact that the Criminal Procedure Act provides for expert evidence within a statutory framework in cases of pathological criminal incapacity does unfortunately not eliminate issues of conflict between the fields of law and medicine. Probably the most difficult question that the psychiatrist is called upon to answer, is the mental status of the accused retrospectively at the time of the commission of the crime.

This question stands in contrast to the question of the present mental state of the accused for purposes of competency evaluations addressed in paragraph four above. With the increasing development of the science of psychiatry, the criminal

¹⁹⁸ Act v Scene, extracted from “Macbeth” by William Shakespeare in Peskin, SG (ed) “Macbeth-William Shakespeare” (1978) 86. In this specific scene the setting is at Macbeth’s castle in Dunsinane. Lady Macbeth’s Gentlewoman tells a doctor that Lady Macbeth sleepwalks. Lady Macbeth tries to wash imaginary blood from her hands. The doctor states that he can do nothing to relieve her malady as it is a sickness of the mind rather than the body. Within the context of the quote the words “*amazed my sight*” means it placed him (the doctor) in a state of confusion. This quote encapsulates one of the core themes of this chapter dealing with what constitutes a “sickness of the mind” and the role of the mental health expert.

justice system has attempted to utilize the increased scientific knowledge in answering questions of criminal incapacity¹⁹⁹.

According to Norrie, one of the fundamental problems associated with the insanity defence, lies in the differing ways in which law and psychiatry describe human conduct. He accordingly notes the following²⁰⁰:

“Within the scientific discourse of the psychiatrist, mental conditions can be studied to reveal the relationship between abnormality of the mind and the propensity to crime as a matter of cause and effect, but the question of the mental responsibility of the accused raises a metaphysical question of the freedom of the will which scientific discourse does not recognise and cannot answer ... The defence of insanity intermingles scientific and metaphysical discourses in a way that produces an amelioration of the law’s narrowness but on the basis of an intellectual muddle and compromise.”

According to Strauss, neither law nor psychiatry should have the sole prerogative of defining and assessing criminal responsibility²⁰¹. Meyer, Landis and Hays in addition submit that legal practitioners are often uncomfortable with the idea that accused persons will escape liability for their actions, whereas clinicians on the other hand find it disquieting to view the actions of some individuals as blameworthy when those actions are the product of “ingrained processes largely shaped by experience or genetics.”²⁰²

Derschowitz also noted the following²⁰³:

¹⁹⁹ Dolin, G “A Healer or an Executioner? The Proper Role of A Psychiatrist in a Criminal Justice System” (2002/2003) *Journal of Law and Health* 169 at 170. See also Perlin, ML “Unpacking the Myths: The Symbolism Mythology of Insanity Defence Jurisprudence” (1989/1990) *W. Res. L. Rev.* 599 at 674.

²⁰⁰ Norrie, A “Crime, Reason and History” (1993) 182 as discussed in Tadros, V “Insanity and the Capacity for Criminal Responsibility” (2001) *Edinburgh Law Review* 325 at 326.

²⁰¹ Strauss (1971) *THRHR supra* note 3 at 10–11. See also Visser and Vorster (1991) *supra* note 3 at 323.

²⁰² Meyer, RG, Landis, ER and Hays, JR “Law for the Psychotherapist” (1988) at 59.

²⁰³ Derschowitz, A “Abolishing the Insanity Defense” (1975) *Crim. L. Bull* at 434. See also Slovenko (2002) *supra* note 3 at 218 as well as Slovenko (1995) *supra* note 3 at 33 where he quotes the words of Professor George Fletcher who stated: “The issue of insanity requires us to probe our premises for blaming and punishing. In posing the question whether a person is responsible for a criminal act, we are forced to resolve our doubts about whether anyone is

”No matter how the law reads, it is a deeply entrenched human feeling that those who are grossly disturbed – whether they are called ‘madmen’, ‘lunatics’, ‘insane’, or ‘mentally ill’ – should not be punished like ordinary criminals. This feeling, which is as old as recorded history, is unlikely to be rooted out by new legislation.”

Within the South African context the defence of pathological criminal incapacity is embodied in section 78 of the Criminal Procedure Act and has already been quoted in full under paragraph three above. Section 78 (1) of the Criminal Procedure Act provides that an accused is not criminally responsible for an act or omission which constitutes an offence if at the time of the commission of the alleged offence the accused suffered from a mental illness or mental defect which rendered him or her incapable

- of appreciating the wrongfulness of his or her act, or
- of acting in accordance with an appreciation of the wrongfulness of his or her act²⁰⁴.

According to Snyman, the test for pathological criminal incapacity comprises of a²⁰⁵:

- Pathological or biological leg which entails that the accused should have suffered from a mental illness or mental defect at the time of commission of the offence, and a

ever responsible for criminal conduct. And if some are responsible and some are not, how do we distinguish between them. Is it a matter for the experts or is it a question of common sense? If it is for experts, why do they persistently disagree; if it is a matter of common sense, why is the issue so difficult to resolve?”

²⁰⁴ LAWSA (2004) *supra* note 3 at 66; Snyman (2008) *supra* note 3 at 170; Burchell and Milton (2005) *supra* note 3 at 373; Strauss (1991) *supra* note 3 at 130; Du Toit *et al* (2008) *supra* note 3 at 13-8; Hiemstra (2008) *supra* note 3 at 13-13; Kaliski (2006) *supra* note 3 at 102; Louw, R “Principles of Criminal Law: Pathological and non-pathological criminal incapacity” in Kaliski (ed.)(2006) *supra* note 3 at 40; Burchell and Hunt (1997) *supra* note 3 at 164 – 165; Africa, A “Psychological evaluations of mental state in criminal case” in Tredoux (ed)(2005) *supra* note 3 at 394; *S v Mahlinza* 1967 (1) SA 408 (A) at 414H; Van Oosten, FFW “The insanity defence: its place and role in the Criminal Law” (1990) SACJ at 1-2.

²⁰⁵ Snyman (2008) *supra* note 3 at 171.

- Psychological leg – this leg entails that the accused should have, as a result of a mental illness or mental defect, lacked the capacity of appreciating the wrongfulness of the act or of acting in accordance with such appreciation.

The test applied is accordingly a so-called “mixed” test in that both the pathological as well as the psychological factors are taken into account in determining whether an accused lacked criminal capacity²⁰⁶.

Earlier in this chapter, it was stated that the Rumpff Commission distinguished cognitive, conative and affective mental functioning²⁰⁷. The Rumpff Commission further held that these mental functions of an individual can break down, or stated differently, there may be a disintegration of the personality of an accused²⁰⁸. Whenever a total disintegration of personality occurs, the individual cannot be held criminally responsible. The disintegration of the personality can result in either the disintegration of the cognitive or the conative functions of the human personality²⁰⁹. In cases where there is a disintegration of the cognitive functioning, the accused lacks insight²¹⁰. The disintegration of the conative functions will result in an accused lacking the capacity to control his or her action²¹¹.

The Rumpff report also noted the following²¹²:

²⁰⁶ *Ibid.*

²⁰⁷ See paragraph 2.2 above.

²⁰⁸ Louw, R “Principles of Criminal Law: Pathological and non-pathological criminal incapacity” in Kaliski (ed.) 2006 *supra* note 3 at 40 – 41.

²⁰⁹ *Ibid.*

²¹⁰ *Ibid.*

²¹¹ *Ibid.* The Rumpff report *supra* note 3 at paragraph 9.25 also stated: “Through insight, reasoning and abstract thinking, man is capable of setting himself a goal which he can pursue voluntarily and deliberately. Such a goal may well constitute a far stronger motivating force in his behaviour than any physiological or social drive.” See also paragraph 9.26 where it is stated: “When a man kills his friend in a fit of rage, his behaviour does not spring from any blind, impulsive drive or uncontrollable emotion. He is performing a goal-directed act. In his (momentary) rage he has not controlled himself, but his action was by no means uncontrollable, as in a case of automatism for example. No matter how enraged he is, he nevertheless knows that it is wrong and unlawful to commit murder or assault, and even though his fists may be clenched (an involuntary physiological reaction) he is still capable of deciding to refrain from action (of exercising volitional control)”.

²¹² Rumpff report *supra* paragraph 9.27.

“Every decision, along with the goal resulting from it, has a psychophysical after-effect, which is called a determining tendency. Such determining tendency not only regulates and directs the individual’s resultant conscious activity, but also persists, even unconsciously, until the ultimate goal has been attained. Such a determining tendency is no blind impulse. It usually consists of an imagined result, or anticipation of the object the person has in view, plus a physiological state of tension in the neuro-muscular systems of the body.”

Before embarking on a discussion pertaining to the pathological leg of the test for pathological criminal incapacity, it is necessary to discuss the two psychological components for criminal non-responsibility. The threshold requirement for the defence of pathological criminal incapacity is the existence of a mental illness or mental defect at the time of the commission of the act. This is also referred to as the pathological leg of the test for criminal responsibility. This requirement will be discussed below. The fact, however, remains that the mere fact that a person suffers from a mental illness or mental defect does not necessarily warrant a finding of criminal non-responsibility. The particular mental illness or mental defect must in addition render the accused incapable of appreciating the wrongfulness of his or her act, or acting in accordance with an appreciation of the wrongfulness of the act²¹³. The latter two defences apply in the alternative²¹⁴.

5.1 Capacity to appreciate the wrongfulness of the act (insight or cognitive capacity)

The issue in respect of the defence of pathological criminal incapacity, is not whether an accused is able to differentiate between right and wrong, but rather whether he or she was able to *appreciate* the *wrongfulness* of the particular act²¹⁵.

²¹³ Snyman (2008) *supra* note 3 at 172; Burchell and Milton (2005) *supra* note 3 at 377; Van Oosten (1990) SACJ *supra* note 3 at 2; Burchell and Hunt (1997) *supra* note 3 at 169–175.

²¹⁴ *Ibid.* An accused person can be capable of appreciating the wrongfulness of his or her act, but nevertheless lack the capacity to act in accordance with such an appreciation. See also chapter 1 above for a discussion of the conceptual aspects of the defence of pathological criminal incapacity.

²¹⁵ Burchell and Milton (2005) *supra* note 3 at 378; Burchell and Hunt (1997) *supra* note 3 at 169; Smith, JC “Smith and Hogan – Criminal Law” (2002) 10th ed at 223.

Snyman as well as Burchell and Milton note that it is unclear whether the term “wrongfulness” refers to legal wrongfulness or moral wrongfulness²¹⁶. The distinction between the latter two formulations lies specifically in the fact that if the term “wrongfulness” refers exclusively to insight into the criminality or unlawfulness of the act, the insanity defence will not be available to an accused who appreciated that his or her act was contrary to the law. Conversely, if an accused appreciated the moral wrongfulness of his or her act, but as a result of a mental illness fails to appreciate that it is also legally wrong, he or she would still be able to rely on the insanity defence²¹⁷.

In the case of *R v Chaulk*²¹⁸, the Canadian Supreme Court per Lamer CJC stated the following²¹⁹:

“... the insanity defence should not be made unavailable simply on the basis that an accused knows that a particular act is contrary to law and that he knows, generally, that he should not commit an act that is a crime. It is possible that a person may be aware that it is ordinarily wrong to commit a crime but, by reason of a disease of the mind, believes that it would be ‘right’ according to the ordinary morals of his society to commit the crime in a particular context. In this situation, the accused would be entitled to be acquitted by reason of insanity.”

Snyman as well as Burchell and Milton opine, and it is submitted here that this view is correct, that the term “wrongfulness” should denote either legal wrongfulness or moral wrongfulness²²⁰.

²¹⁶ Burchell and Milton (2005) *supra* note 3 at 378; Snyman (2008) *supra* note 3 at 173.

²¹⁷ *Ibid.*

²¹⁸ *R v Chaulk* (1991) CRR 1 (SCC).

²¹⁹ At 38. See also Burchell and Milton (2005) *supra* note 3 at 380.

²²⁰ Snyman (2008) *supra* note 3 at 173; Burchell and Milton (2005) *supra* note 3 at 380–381; Burchell and Hunt (1997) *supra* note 3 at 173; Du Toit *et al* (2008) *supra* note 3 at 13–14. See also Strauss (1974) *THRHR supra* note 3 at 234 where he states: “By die bepaling van toerekeningsvatbaarheid gaan dit ... eerder om die dader se algemeen etiese verantwoordelikeheidsbesef betreffende sy daad en nie soseer om die projeksie van sy gesindheid op spesifiek die wederregtelikheid van sy daad nie, wat as vereiste vir ‘n bevinding van opset gestel word.” See also Kruger, A “Mental Health Law in South Africa” (1980) 198 – 199; Hiemstra (2008) *supra* note 3 at 13-19.

A particular mental illness or mental defect can profoundly affect an accused's judgment in respect of the wrongfulness of an act. An accused suffering from a mental illness, for example schizophrenia, may very well know that killing another human being is legally wrong, but may believe that some higher power is instructing him or her to commit the specific act which renders the act in his or her eyes morally correct and accordingly he or she does not appreciate the moral wrongfulness of the act. Wrongfulness should therefore include both moral as well as legal wrongfulness²²¹.

The mental health expert will also have to ascertain whether an accused was in fact able to appreciate the wrongfulness of the particular act.

Kaliski notes that appreciation of wrongfulness entails that the accused had an awareness that his or her act was wrong and does not entail that the accused should possess a comprehension of the moral or ethical dimensions of wrongfulness²²². Kaliski takes the view that even some of the most disturbed individuals to a certain extent have an idea of wrongfulness and more often than not the failure to know that an act is wrong could be attributed to ignorance and not impairment.²²³ Mildly handicapped persons are unaware that it is wrong to have sexual intercourse with children due to a lack of education as such, but are able to learn such rule and accordingly only those whose cognitive capacities are extremely compromised such as severely demented or mentally retarded individual, would fail this test completely.

5.1.1 The meaning of “appreciation”

In terms of section 78 (1) (a) an accused should have lacked the capacity to appreciate the wrongfulness of the act.

²²¹ Kaliski (2006) *supra* note 3 at 103 also states:

“A psychotic person almost invariably knows that murder is wrong, but because of hallucinations or delusions may have acted in the mistaken belief that he was acting in self-defence.”

²²² Kaliski (2006) *supra* note 3 at 103. See also Africa, A “Psychological evaluations of mental state in criminal cases” in Tredoux (ed.) (2005) *supra* note 3 at 394.

²²³ *Ibid.*

Burchell and Milton encapsulate the concept of appreciation as follows²²⁴:

“The notion of appreciation postulates not only a knowledge of the nature of an act, but also the capacity to evaluate the act, its implications, and its effects upon the accused himself and others who may be involved. ‘Appreciation’ implies something in the nature of ‘deliberate judgment’ or ‘perception’. Where a person is deprived of the capacity, it would follow that he lacks the insight into the true moral nature of his act, or the implications of the act or its consequences for himself or others.”

5.2 The capacity to act in accordance with an appreciation of the wrongfulness of an act (self-control or conative capacity)

Certain mental illnesses may not necessarily affect an accused’s capacity to appreciate the wrongfulness of his or her actions, but may nevertheless deprive the accused of the ability to control conduct or, put differently, to act in accordance with the appreciation of wrongfulness²²⁵. Section 78(1)(b) of the Criminal Procedure Act accordingly provides that even though an accused was capable of appreciating the wrongfulness of his or her act, he or she will still not be criminally responsible if at the time of the commission of the act, he or she suffered from a mental illness which rendered him or her incapable of acting in accordance with such appreciation. Section 78(1)(b) completely substituted the previous doctrine of “irresistible impulse.”²²⁶

Burchell and Milton note the following in respect of the previous “irresistible impulse” doctrine:²²⁷

²²⁴ Burchell and Milton (2005) *supra* note 3 at 381.

²²⁵ Burchell and Milton (2005) *supra* note 3 at 381; Snyman (2008) *supra* note 3 at 173; Burchell and Hunt (1997) *supra* note 3 at 174; Hiemstra (2008) *supra* note 3 at 13–19.

²²⁶ Hiemstra (2008) *supra* note 3 at 13–19; Burchell and Milton (2005) *supra* note 3 at 382; Burchell and Hunt (1997) *supra* note 3 at 174; Du Toit *et al* (2008) *supra* note 3 at 13–15. The irresistible impulse doctrine was approved in various decisions including *R v Hay* (1899) 16 SC 290; *R v Smit* 1906 TS 783; *R v Van der Veen* 1909 TS 853; *R v Ivory* 1916 WLD 17; *R v Holiday* 1924 AD 250.

²²⁷ Burchell and Milton (2005) *supra* note 3 at 382. See also Hiemstra (2008) *supra* note 3 at 13–19 where it is stated: “To succeed with the alternative defence in paragraph (b), the accused does not have to show that his or her act or omission was the result of a sudden bubbling or flushing impulsive desire.”

“... the description was misleading since the illnesses concerned did not necessarily manifest themselves in impulsive actions. Further, the notion of ‘irresistible’ suggested that the victim had to have been subjected to an overpowering force, while the true issue is whether his normal capacity for self-control has been substantially impaired.”

It is important to note that the crucial issue is the accused’s incapacity to act in accordance with an appreciation of the wrongfulness of the act and accordingly it does not have to be indicated that the accused’s conduct was involuntary in the sense that it was automatic or reflexive as this would relate to a different element of criminal liability, namely the act, in which case the question of criminal capacity does not arise²²⁸. The test applied in respect of section 78 (1) (b) of the Criminal Procedure Act is subjective and the question is not asked what the reasonable person in similar circumstances would have done²²⁹.

Africa notes that²³⁰ this legal test for responsibility requires that either cognitive functioning or self-control be impaired and that a diagnosis of mental illness or retardation alone was not sufficient. In order for a successful reliance on the defence to be raised, it has to be proven that the symptoms of the disorder resulted in a significant impairment of psychological functioning.²³¹

Expert evidence of mental health professionals, with specific reference to psychiatrists, is pivotal in assessing whether an accused in fact had the ability of acting in accordance with an appreciation of the wrongfulness of an act.

Burchell and Hunt correctly state²³²:

²²⁸ Burchell and Milton (2005) *supra* note 3 at 382; Burchell and Hunt (1997) *supra* note 3 at 174–175.

²²⁹ Hiemstra (2008) *supra* note 3 at 13–19.

²³⁰ Africa, A “Psychological evaluations of Mental State in criminal cases” in Tredoux (ed.)(2005) *supra* note 3 at 395.

²³¹ *Ibid.*

²³² Burchell and Hunt (1997) *supra* note 3 at 174–175.

“Expert medical evidence will, therefore, be accorded great weight ... Inevitably therefore, ..., in reaching a decision on this issue the court will rely largely on psychiatric opinion.”

A case where the accused specifically relied on the inability to act in accordance with the appreciation of the wrongfulness of the act, was the case of *S v Kavin*²³³. The facts of this decision were the following: The accused stood trial on four charges, three of murder and one charge of attempted murder. According to the evidence the accused had shot his wife, Denise Kavin, his daughter, Adele Dawn Kavin and his son, Lance Kavin and attempted to murder his other daughter, Debbie Kavin. At the time of the shooting the accused experienced financial difficulties and suffered from severe reactive depression. The evidence revealed that the accused’s motive behind the shooting was to shoot his wife and all his children and thereafter himself in the belief that they would all be reunited in heaven²³⁴. Before the trial commenced, the accused was examined by three psychiatrists namely Prof Bodemer, Dr Garb as well as Dr Shubitz.

The psychiatric report that was submitted in terms of section 79 (4) of the Criminal Procedure Act stated the following²³⁵:

“Section 79 clause 4A

A. Description of the nature of the enquiry

Answer: The three psychiatrists:

1. Prof W Bodemer
2. Dr R Garb

²³³ *S v Kavin* 1978 (2) SA 731 (W). See also Burchell and Milton (2007) *supra* note 3 at 353–356; Visser and Vorster (1990) *supra* note 3 at 336–339; Snyman, CR “Criminal Law – case book” 3rd ed (2003) at 112.

²³⁴ At 736 D–F Irving Steyn J states the following in respect of the alleged motive behind the killings: “What, in my view, distinguishes the instant case from other cases involving murder and accordingly makes it somewhat singular and unique is that, whereas in the main, if not always, other murders involve, for example, motives such as hatred, revenge, jealousy or anger, the instant case did not, on the evidence, involve any of these motives. It was common cause that the accused murdered three people he dearly loved and attempted to murder the sole remaining member of his family whom he also loved dearly. It was also common cause that all four of his victims dearly loved him. His apparent motive for the shooting of his whole family was that, after he himself had committed suicide, they should all be reunited in heaven. To put it in another way, he shot his family by reason of his love for them, albeit misguided love.”

²³⁵ At 732 H–733 D as quoted from the judgment.

3. Dr C Shubitz

Separately and independently examined and reported on the accused. The nature of the enquiry covered chronologically the following periods:

- (a) From 9.6.77 – 4.8.77 at Weskoppies Hospital by Prof Bodemer.
- (b) For a period of six hours at the Fort Prison, Johannesburg, on 17.9.77 and 1.10.77 by Dr R Garb.
- (c) By Dr C Shubitz at the Brixton Police Station on the evening of Wednesday 9 June 1977 for two hours. At the Weskoppies Mental Hospital on 18 June 1977 for three hours. At a medico-legal conference held at Weskoppies Mental Hospital. At a routine conference conducted by Prof Bodemer for about one and a half hours on 1 July 1977.

A psychiatric assessment was the purpose of the interviews.

B. Severe reactive depression superimposed on a type of personality disorder displaying immature and unreflective behaviour. In the opinion of Dr Shubitz and Dr Garb it produced a state of dissociation.

C. Yes he can make a proper defence and understand the proceedings.

D. 3(a) In the opinion of Dr Shubitz and Prof Bodemer the answer is – the accused could appreciate the wrongfulness of his act. In the opinion of Dr Garb there is uncertainty.

(b) All three psychiatrists agree that he could not act in accordance with an appreciation of the wrongfulness of his act.

We base this opinion on the basis of his progressive depression. We regard him therefore as not being criminally responsible for the acts in question (as laid down in s 78 (1)).”

It is accordingly clear that the three psychiatrists, who evaluated the accused, unanimously came to the conclusion that the accused lacked the capacity to act in accordance with an appreciation of the wrongfulness of the act as a result of severe reactive depression.²³⁶

The State disputed the findings of the experts on the following grounds²³⁷:

²³⁶ See also 738 F–H.

²³⁷ At 738 H–739 F.

- The accused was fully aware during the acts and there was only a post-repressive amnesia.
- The accused showed planning, foresight and rational thinking.
- The accused's obsessive desire to protect his family might be a deviation but did not constitute a psychosis.
- The psychiatrists purported to interpret section 78 (1) (b) which is not their function but which is the function of the court.
- The psychiatrists sought for a cause with a preconception that there had to be something wrong to explain the killing. The latter inadvertently entails that due to the fact that the killing itself was of such an atrocious nature, it immediately raised in their minds the thought that "*the man must have been mad*".
- The psychiatrists were obliged to project their minds retrospectively which created a difficulty due to the fact that the accused became increasingly depressed after the event.
- The psychiatric diagnoses were conflicting.
- The acts of the accused were rational.

The court per Irving Steyn J made important findings in respect of the role and necessity of expert evidence in support of his defence.

Irving Steyn J held the following²³⁸:

"It was common cause that the onus is on the defence to prove that the accused falls within the ambit of s 78 (1) (b) of the Act and that we are not compelled to accept any psychiatric opinion as sufficient proof that he did so fall within the ambit of this section. If ... we find that the evidence concerning facts upon which any psychiatric opinion is based is not credible evidence, we are entitled to refuse to accept such psychiatric diagnosis. In addition, psychiatric evidence is valueless unless it is coupled to the particular facts of the case. On the other hand, it seems to us that where, as in the instant case, there is a unanimous finding by three eminent

²³⁸ At 736 G–737 A.

psychiatrists which is disputed by one of the parties, there should be acceptable grounds upon which such dispute is based and that we are not entitled, in the absence of such acceptable grounds, to reject the unanimous finding simply because it has been disputed. This would, in our view, be requiring us to substitute our lay opinion for the expert opinion of three experts in a particular field in which we have no qualifications and profess no expert knowledge. We are called upon to examine the expert evidence in all the surrounding circumstances of the case, together with all the other evidence tendered, and then to decide whether in the light of all the circumstances and all the evidence there is any good or sufficient reason for not accepting or for rejecting the unanimous finding of the expert witnesses.”

The court proceeded to find that section 78 (1) (b) is wider than the common law concept of “irresistible impulse”. The latter is, however, included within the context and ambit of section 78 (1) (b)²³⁹. Irving Steyn J also held that in conjunction with “irresistible impulse” section 78 (1) (b) also includes behaviour caused by a gradual personality disintegration by reason of which a person may suffer from a mental illness which makes him incapable of acting in accordance with an appreciation of the wrongfulness of his act²⁴⁰.

Irving Steyn J further stated that where the psychiatric evidence adduced amounts to a gradual disintegration of the personality of the accused, as opposed to an irresistible impulse, courts are more dependent on the psychiatric evidence regarding such gradual disintegration than in the case where the psychiatric evidence related to the effect that the accused acted by reason of an ‘irresistible impulse’.²⁴¹

²³⁹ At 737 A–B.

²⁴⁰ *Ibid.*

²⁴¹ At 737 C–D.

The court held that in this case there was no “irresistible impulse” or impulsive act.²⁴² The court accordingly attached a lot of weight to the expert evidence specifically since it was a unanimous finding.

Irving Steyn in addition stated²⁴³:

“In a defence such as the one raised by the accused in this case the court must of necessity rely heavily upon the evidence of expert psychiatrists.”

The court per Irving Steyn J held that the State had not advanced sufficient reasons as to why the unanimous finding of the three psychiatrists should be rejected and found that the accused, by reason of mental illness, was incapable of acting in accordance with an appreciation of the wrongfulness of his acts at the time of the commission of the offences. The accused was accordingly not criminally responsible for his acts in terms of section 78 (1) (b) of the Criminal Procedure Act²⁴⁴.

This decision provides an excellent example of the crucial role of expert evidence in support of the defence of pathological criminal incapacity. The court accepted the unanimous finding of the experts and held the opinion provided by the psychiatrists in high regard. In the majority of cases where the defence of pathological criminal incapacity is raised, emphasis falls on the second leg of the test for criminal capacity similar to the *Kavin* decision. In the majority of these cases the facts do not necessarily reveal an irresistible impulse, but rather as was stated in the *Kavin* decision, a gradual disintegration of the personality caused by a mental illness rendering the accused incapable of acting in accordance with an appreciation of the wrongfulness of the act. The court reaffirmed the pivotal role of psychiatrists where the latter situation arises. A question which could be asked is whether a battered woman who kills her abusive husband, should not rather rely on the absence of this second leg of the capacity enquiry within the context of pathological criminal incapacity in support of possible justification of her actions as

²⁴² At 737 H. Irving Steyn J describes it as: “It was a slow and deliberate course of conduct.”

²⁴³ At 738 A–B.

²⁴⁴ At 741 E–G.

severe depression is present in many cases where battered women kill their abusers and this is also very often not an example of an “irresistible impulse” but rather a gradual personality disintegration of the battered women resulting in the final fatal blow. Although this decision is not very recent, it could be used as a good example of the clinical dissemination of psychiatric evidence in support of this defence of pathological criminal incapacity and the crucial role that such evidence portrays in these cases.

Another case where reliance was placed on the absence of the ability to act in accordance with the appreciation of the wrongfulness of the act was the case of *S v McBride*²⁴⁵. The facts of this decision were the following: The accused was charged with murder in that he killed his wife, Josephine Ethel McBride. The accused was referred for observation in terms of section 78 (2) of the Criminal Procedure Act and was committed to Sterkfontein Hospital for observation. The panel for purposes of observation consisted of:

- Dr Luiz, who was the psychiatrist appointed by the medical superintendent of the hospital in terms of sub-paragraph (i) of section 79 (1) (b).
- Dr Shubitz, the psychiatrist appointed by the court under paragraph (ii).
- Dr Levinson, the psychiatrist appointed on behalf of the accused under paragraph (iii).

The three psychiatrists prepared a joint report and reached a unanimous finding²⁴⁶:

- The accused was suffering from an endogenous depression which manifested in a depressed effect which resulted in impaired judgment.
- The accused was able to appreciate the wrongfulness of his act.
- All three psychiatrists agreed that he could not act in accordance with an appreciation of the wrongfulness of his act due to the fact that he suffered

²⁴⁵ *S v McBride* 1979 (4) SA 313 (W). See also Burchell and Milton (2007) *supra* note 3 at 356–357; Visser and Vorster (1990) *supra* note 3 at 339–342.

²⁴⁶ At 316 A–C.

from endogenous depression and that he was not criminally responsible for the act in question.

Subsequent to the murder of his wife, the accused had recovered from his mental disease but there was a possibility of it recurring. It was contended on behalf of the accused that a finding in terms of section 78 (7) of the Criminal Procedure Act should be made instead of a finding in terms of section 78(6) which provided that the accused be committed to a mental hospital or prison pending the signification of the State President's decision²⁴⁷. The reasoning behind the latter argument was that the accused had recovered from his depression since the commission of the act and it was argued that it would be more likely to be harmful than beneficial to the accused to be detained in a mental hospital. It was also contended that section 78(6) did not provide any alternative to sending a person who falls under that subsection to a mental institution even though he or she had recovered from his or her illness²⁴⁸.

It was therefore argued on behalf of the accused that the court should rather render a finding that the accused's capacity to appreciate the wrongfulness of his act or to act in accordance with such appreciation was diminished by reason of mental illness. The court would then be at large to impose a sentence as the court deems appropriate²⁴⁹.

The court per Mcewan J, rejected this argument and held that the correct verdict is one of not guilty by reason of mental illness and that the accused be detained in a

²⁴⁷ In terms of section 78(6) of the Criminal Procedure Act. This decision was, however, rendered before the amendment to section 78(6) came into operation in terms of the Criminal Matters Amendment Act 68 of 1998 which commenced on 28 February 2002. In terms of the latter amendment a court is granted various options when an accused is found not guilty resulting from a lack of criminal capacity. This section will be discussed below.

²⁴⁸ At 323 F–H.

²⁴⁹ At 317 F. See also 322 G–H where Mcewan J emphasises the unanimous opinion of the experts despite the argument in favour of a finding of diminished responsibility where he states: "They were firmly of the view that at the time of the shooting the accused was incapable by reason of mental illness of exercising any rational control over his actions."

mental hospital or prison pending the signification of the decision of the State President²⁵⁰.

This case reaffirms the importance of expert psychiatric evidence as well as the effect of a unanimous decision by a panel of experts on the outcome of a case. The decision, it is submitted, was correct as the court was called upon to assess the accused's mental state retrospectively at the time of the commission of the act. This decision was supported by well-established expert evidence. Consideration cannot be given solely to which finding would be the most favourable for an accused's current status without due regard to the accused's mental state at the time of the commission of the act. As will be indicated below, the current section 78(6) of the Criminal Procedure Act provides for alternative options to deal with an accused who was found not guilty in terms of section 78(1) due to a lack of criminal capacity.

6 Defining and assessing “mental illness” and “mental defect” as threshold requirements in support of the defence of pathological criminal incapacity

“A clear and complete insight into the nature of madness, or correct and distinct conception of what constitutes the difference between the sane and the insane has as far as I know, not yet been found”.²⁵¹

The threshold requirement for establishing the defence of pathological criminal incapacity entails that the accused at the time of the commission of the crime, should have suffered from a “disease of the mind” or as defined in section 78(1) of the Criminal Procedure Act, a “mental illness” or a “mental defect”.²⁵² Once it is established that an accused indeed suffered from a mental illness or mental defect at the time of the commission of the offence an assessment is conducted in order

²⁵⁰ At 324 H. See also 324 D–E where Mcewan J stated: “The fact that the result in this case may be unfortunate does not in my view indicate that the Legislature must have intended otherwise.”

²⁵¹ Schopenhauer “*The world as Will and Idea*” as quoted in Barlow, DH and Durand VM “*Abnormal Psychology*” (1995) at 1.

²⁵² See section 78(1) of the Criminal Procedure Act as discussed above. The assessment of mental illness or mental defect denotes the pathological leg of the test for criminal incapacity as stated above.

to determine the impact of this illness on the cognitive or conative capacity of the accused at the time of the commission of the offence. If the cognitive or conative capacity of the accused was sufficiently impaired as a result of a mental illness or mental defect, the accused is said to have lacked criminal capacity.²⁵³

The concept of mental illness is not a static one, but an evolving and changing concept amenable to the changing conditions of life.²⁵⁴ This part of the capacity enquiry is probably one of the most difficult tasks facing the forensic mental health expert. Not all disorders will excuse accused persons from criminal liability. It therefore has to be determined which mental illnesses will be regarded as mental illnesses for purposes of the test for pathological criminal incapacity. According to Burchell and Milton, the question as to which mental illnesses give rise to insanity is addressed by the application of the test for insanity.²⁵⁵ Historically various tests for insanity were applied, including the “Wild beast” test, the “right or wrong” test and the M’Naghten test.²⁵⁶ These tests focused strongly on mental illnesses

²⁵³ Snyman (2008) *supra* note 3 at 171; Burchell and Milton (2005) *supra* note 3 at 3; LAWSA (2004) *supra* note 3 at 67; Du Toit *et al* (2008) *supra* note 3 at 13-11; Hiemstra (2008) *supra* note 3 at 13-16; Strauss (1991) *supra* note 3 at 127-128; Slovenko, R “The meaning of Mental illness in Criminal Responsibility” (1984) *The Journal of Legal Medicine* at 1; Gerard, JB “The Medical Model of Mental illness” (1999) *International Journal of Law and Psychiatry* at 65-78; Fingarette, H “The concept of Mental Disease in Criminal Law Insanity tests” (1965-1966) *U. Chi. L. Rev.* at 229; Slovenko, R “The Mental Disability Requirement in the Insanity Defense (1999) *Behavioral Sciences and the Law* at 165; Melton *et al* (2007) *supra* note 3 at 210; Schiffer, ME “Mental Disorder and the Criminal Trial Process” (1978) at 127-128; Africa, “Psychological Evaluations of Mental State in Criminal cases” in Tredoux *et al* (eds)(2005) *supra* note 3 at 388; Louw, R “Principles of Criminal Law: Pathological and non-pathological criminal incapacity” in Kaliski (ed)(2006) *supra* note 3 at 46; Brakel, SJ and Brooks, AD “Law and Psychiatry in the Criminal Justice System” (2001) at 61; Slovenko (2002) *supra* note 3 at 247; Slovenko (1995) *supra* note 3 at 54; Visser and Vorster (1990) *supra* note 3 at 324.

²⁵⁴ Slovenko (1995) *supra* note 3 at 54 notes: “Notions expand, or contract, with increased knowledge of mental disorders (or what are accepted as mental disorders) and of different conditions causing different disorders.”

²⁵⁵ Burchell and Milton (2005) *supra* note 3 at 374; Burchell and Hunt (1997) *supra* note 3 at 164-166.

²⁵⁶ Burchell and Milton (2005) *supra* note 3 at 374; Platt, A and Diamond, BL “The origins of the ‘Right and Wrong’ test of criminal Responsibility” (1966) 54 *California Law Review* at 1227. See also *R v Arnold* (1724) 16 Howell’s State Trials 695 at 764 (as quoted in Burchell and Milton (2005) *supra* note 3 at 374): “... It is not every frantic and idle humour of a man that will exempt him from justice and the punishment of the law ... (I)t must be a man that is totally deprived of understanding and memory and doth not know what he is doing, no more than an infant, than a brute, than a wild beast”. See also Slovenko (1995) *supra* note 3 at 54 where he states that in Biblical times mental disease was strong based on the theory of demonic possession. It is interesting to note that historically Benjamin Rush was the first American physician to state that mental illness was a disease of the mind and not a possession of demons. He also later earned the title of “Father of American Psychiatry.” Rush’s work on mental illness has received support due to his precise diagnosis and treatment of psychiatric disorders. See <http://www.psychiatry.us/>.

leading to an impairment of the cognitive capacity (“insight”) to the exclusion of illnesses impairing the conative capacity (“self control”).²⁵⁷

Currently the test for pathological criminal incapacity or insanity provides that a mental illness which affects the cognitive or conative capacity in such a manner that the accused is deprived of the appreciation of the wrongfulness of his or her conduct or of the capacity to act in accordance with such an appreciation, constitutes insanity.²⁵⁸

The test for pathological criminal incapacity or insanity does not define the terms “mental illness” or “mental defect” nor does it specify the particular mental disorders that constitute “mental illness” or “mental defect”. What becomes evident is that the test only identifies the effects which should result from a particular “mental illness” or “mental defect”.

The first question which falls to be answered is whether there is an acceptable definition of the concept of mental illness. Should the definition of mental illness be a legal or a medical prerogative or both, in the sense that the primary diagnosis of mental illness is a medical prerogative whilst the acceptance of such diagnosis as sufficient for the establishment of legal insanity remains essentially within the legal domain? It is often difficult to assess where the borderline between medical and legal prerogatives lies when the assessment of insanity is evaluated.

Slovenko encapsulates this dilemma in the following manner:²⁵⁹

“During the past two centuries the courts have often said that the term “disease of the mind’ or ‘mental disease or defect’ in the test of criminal responsibility is not a medical but a legal term. At the same time, however, since medical or psychiatric opinion is necessary to give meaning to the

²⁵⁷ Burchell and Milton (2005) *supra* note 3 at 374. See also the Rumpff report *supra* paragraph 9.84 where it was argued that the test should be broadened to also accommodate impairment of the conative capacity. It was stated: “In terms of the law in force in South Africa insight and self control must be regarded as criteria of responsibility.”

²⁵⁸ Burchell and Milton (2005) *supra* note 3 at 374; Snyman (2008) *supra* note 3 at 172; Du Toit *et al* (2008) *supra* note 3 at 13-10–13-11; Hiemstra (2008) *supra* note 3 at 13-16; LAWSA (2004) *supra* note 3 at 66-67.

²⁵⁹ Slovenko (1984) *The Journal of Legal Medicine supra* note 253 at 4.

term, it becomes a fusion of legal and medical components. To be sure, no rule of law can be reliable when absolutely dependent on another discipline, but without input from other areas, the law would just be arid verbal agonizing.”

The role of mental health experts in the assessment of insanity with specific reference to psychiatry can never be overstated. The fact remains – the law needs medicine to provide meaning to the defence of insanity and accordingly medical input in the assessment of insanity is pivotal if not essential.

It is accordingly pivotal to disseminate the issues relating to the conceptual framework of the terms “mental illness” and “mental defect”, as one of the core issues pertaining to the defence of pathological criminal incapacity relates to a lack of an adequate definition or conceptual context for these two terms. It is also one of the fundamental areas of conflict between law and medicine.

6.1 A conceptual analysis of mental illness and mental defect

In terms of section 78(1) of the Criminal Procedure Act, the terms “mental illness” and “mental defect” are used interchangeably. These two terms are not defined within the legislative framework of the Criminal Procedure Act and it is accordingly often unclear what the precise distinction between these two concepts entails.²⁶⁰

²⁶⁰ Hiemstra (2008) *supra* note 3 at 13-76. See also Strauss, SA “Geestesongesteldheid en die Strafreë: Die Voorgestelde nuwe reëling in die Strafproseduurewetsontwerp” (1974) *THRHR (Journal of Contemporary Roman Dutch Law)* 219 at 229; Van Rensburg, PHJ, Verschoor, T and Snyman, JL “Psigiatriese en Juridiese Aspekte van die Begrip Geestesongesteld” (1983) *TRW* at 163; Snyman, JL “Die siviele opneming van Geestesongesteldes: Regte en Regsbeskerming van die Betrokkene” (1981) (Unpublished LLD thesis Unisa); Strauss (1974) *THRHR supra* note 3 at 229 notes that it is unclear where the borderline between these two concepts can be found. In the Rumpff-report *supra* at paragraph 9.97 reference is made to the words “geesteskrankheid of geestesgebrek” without a clear demarcation of these terms. At paragraph 8.13 – 8.16 of the Report, however, reference is specifically made to “geestesgebrekigheid” as a distinct concept. In paragraph 9.13 the Commission refers to “gebreklike verstandelike vermoë which according to the Rumpff Commission, denotes the disintegration of the cognitive functioning. In terms of the former “Wet op Geestesgebrekken” Act 38 of 1916 Section 3 provided that mentally ill persons were those who suffered from a form of mental illness and mentally defective persons included “stompsinniges”, “swaksinniges” and “swakhoofdiges”. This provision was, however, not incorporated again in the current Mental Health Care Act 17 of 2002 (hereafter Mental Health Care Act”).

The dynamics of life and the conditions associated therewith change and evolve with the passing of time. Notions and concepts of mental illness centuries ago will most probably not be in accordance with current perceptions of mental illness. The latter is due to the increased research and development in assessment technique used when evaluating the human mind. To a certain extent law and medicine have one main characteristic in common – they both develop and change consistently and frequently. The challenge that the current criminal justice system is faced with is how to improve cooperation between these two complex sciences in assuring more just and equitable decisions when the defence of criminal incapacity is raised. One of the key areas where the latter becomes evident is when the definition of mental illness is concerned.²⁶¹

The current Mental Health Care Act defines mental illness as follows:²⁶²

“... a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis.”

Despite the fact that this definition provides guidance as to the concept of mental illness, the definition is not binding on a criminal trial and not a determinant of criminal capacity.²⁶³

²⁶¹ See for example Hogget, B “Mental Health” (1976) at 89 where it is stated: “ ... defining mental disorder is not a simple matter, either for doctors or for lawyers. With a physical disease or disability, the doctor can presuppose a state of perfect or ‘normal’ bodily health and point to the ways in which the patient’s condition falls short of that. A state of perfect mental health is probably unattainable and certainly cannot be defined. The doctor has, instead, to presuppose some average standard for normal intellectual, social or emotional functions, and it’s not enough that the patient deviates from this, for some deviations will be in the better than average direction. Even if it is clear that the patient’s capacities are below the supposed average the problem still arises of how far below is sufficiently abnormal, among the vast range of possible variations, to be labelled a ‘disorder’. See also Kruger (1980) *supra* note 220 at 49; Haysom, N, Strous, M and Vogelmann, L “The Mad Mrs Rochester Revisited: The Involuntary Confinement of the Mentally Ill in South Africa” (1990) *SAJHR* 341 at 348.

²⁶² Mental Health Care Act 17 of 2002.

²⁶³ Snyman (2008) *supra* note 3 at 172; Burchell and Hunt (1997) *supra* note 3 at 164; Louw in Kaliski (ed)(2006) *supra* note 3 at 46; Strauss (1974) *THRHR supra* note 260 at 230 at footnote 35 states: “... dit is ‘n dwaalleer dat iemand nie as ontorekeningsvatbaar geestesongesteld beskou kan word nie tensy hy ingevolge die Wet op Geestesongesteldheid as geestesongesteld gesertifiseer kan word. Sertifisering as geestesongesteld ingevolge laasgenoemde Wet en toerekeningsvatbaarheid in die Strafbereg is afsonderlike kwessies ... Die feit dat iemand ingevolge die Wet op Geestesgesondheid as geestesongesteld gesertifiseer kan word, is hoogstens ‘n faktor vir die bewys dat hy moontlik ook ontorekeningsvatbaar is.

Accordingly, the fact that a person has been, or may be, declared mentally ill in terms of the Mental Health Care Act, does not result in such a person also being mentally ill in terms of section 78(1) of the Criminal Procedure Act.²⁶⁴ The declaration of a person as mentally ill in terms of the Mental Health Care Act is different from criminal non-responsibility attributable to mental illness or mental defect. Such declaration will at most be taken into account in the assessment of criminal incapacity.²⁶⁵ Burchell and Milton submit that the essential distinction between mental illness and mental defect is that mental defect constitutes a mental state identifiable by an intellect so exceptionally low as to deprive the accused of the normal cognitive or conative capacities.²⁶⁶

Burchell and Milton state the following:²⁶⁷

“Mental defect is distinguishable from mental illness in that mental defects are usually evident at an early age and prevent the child from developing or acquiring elementary social and behavioural patterns. The condition is usually permanent. Mental illness, by contrast, usually manifests itself later

Dit is egter geen afdoende bewys nie.” See also De Wet and Swanepoel (1974) *supra* note 3 at 114; *R v Kruger* 1958 (2) SA 320 (T) at 320; *S v Harman* 1978 (3) SA 767 (A) at 770 H; *S v Mnyanda* 1976 (2) SA 751 A at 764; *S v Mahlinza* 1967 (1) SA 408 (A) at 416 B. See also *R v Von Zell* (1) 1953 (3) SA 303 (A) at 309 where Van den Heever JA stated: “The fact that a person charged with a crime of violence is or is not certifiable under the Mental Disorders Act is relevant, it narrows the issue, for evidence that the person concerned is certifiable may in certain circumstances assist to rebut the presumption that he is sane for the purposes of determining his criminal responsibility.”

²⁶⁴ *Ibid.*

²⁶⁵ *Ibid.*

²⁶⁶ Burchell and Milton (2005) *supra* note 3 at 377; Kruger (1980) *supra* note 220 at 184.

²⁶⁷ Burchell and Milton (2005) *supra* note 3 at 377. See also Tredoux *et al* (eds)(2005) *supra* note at 420 – 421 where the term “mental retardation” is defined as follows: “Synonyms include mental defect, mental handicap or intellectual disability. A person with an intellectual disability is one whose cognitive/intellectual ability is markedly below the average level and whose ability to adapt to his/her environment is decreased.” See also *Durham v United States* 214 F2d 862 (D.C. Cir. 1954) at 875 where the Court distinguished between “disease” and “defect” in that the former phrase was used “in the sense of a condition which is considered capable of either improving or deteriorating” whilst the latter condition denoted a nonchanging state “which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease.” See also Fingarette, H “The concept of Mental Disease in Criminal Law Insanity Tests” (1965 – 1966) *U. Chi. L. Rev* 229 at 239; Snyman (2008) *supra* 171. See also Louw in Kaliski (ed) (2006) *supra* note 3 at 48 where he states that mentally retarded individuals have dysfunctional emotional lives and volitional activities. They have little power of abstract thinking and are incapable to act purposefully. Accordingly these individuals may lack cognitive or conative functions.

in life, after the individual has developed normal intellectual, social and behavioural patterns. Mental illness is usually episodic in its onset.”

An important decision where the interpretation of “mental illness” was considered was the case of *S v Mahlinza*.²⁶⁸ The facts were briefly the following: The accused, Julia Mahlinza, stood trial on charges of murder of her son who was six months of age, and two charges of attempted murder of her two other children. One evening the accused, together with her three children, left the hut in which they were staying and went to another hut. During the course of the evening the accused poured paraffin over firewood in a basin and then set fire to the wood. The accused then took off the petticoat she was wearing and placed it on the fire. She then placed the baby and her daughter who was six years old, on the fire. The daughter managed to escape. The accused then took her other child and placed him on the fire but he, too, managed to escape. The baby was burnt to death but the other children escaped. The accused pleaded not guilty to the charges. The trial court found her not guilty. On appeal the following two questions of law were reserved for consideration:²⁶⁹

- (i) Whether the trial court, having found that the accused was not criminally responsible for the acts charged against her because at the time she committed them she was suffering from a temporary defect of reason or mind induced by an episode of hysterical dissociation, it should not by reason of the provisions of section 182 of Act 56 of 1955 have returned the special verdict provided for by section 29 (1) of Act 38 of 1916;
- (ii) Whether, on the facts found by the trial court to have been proved, the mental condition of the accused at the time she committed the acts charged against her was such as to render her mentally disordered or defective within the meaning of section 29 (1) of Act 38 of 1916.

The district medical practitioner, Dr Fismer, stated the following in respect of the accused’s mental state:²⁷⁰

²⁶⁸ *S v Mahlinza* 1967 (1) SA 408 (A). See also Burchell and Milton, (2007) *supra* note 3 at 349.

²⁶⁹ At 411 D-E.

²⁷⁰ At 412 B-C.

“She was laughing and generally was very rowdy. Her mood and behaviour was out of line with the injuries sustained by her children. She could not give an account of herself or of her behaviour; she was disorientated and she had no insight into her condition ...

Friedman J: Doctor would you say that at the time of your examination ... she was mentally disordered or defective in terms of the Mental Disorders Act? (Answer by Dr Fisser) – Yes, yes she was.”

A psychiatrist, Dr Boyd, testified that the accused was mentally disordered at the time of the crime.²⁷¹ Dr Boyd further testified that the accused’s mental state was one of hysterical dissociation caused by unbearable emotional stress but that she did not act in a state of automatism. Dr Boyd also stated that the accused suffered from a temporary mental disorder but not a permanent mental illness which would render her certifiable.²⁷²

Rumpff JA encapsulated the conceptual interface between law and medicine as follows:²⁷³

“Die begrippe ‘toerekeningsvatbaarheid’ en ‘elemente van ‘n misdaad’ is suiwer juridiese begrippe. Wanneer ‘n ondersoek in die geestesvermoëns

²⁷¹ At 412 E-F.

²⁷² At 414 A. See also at 413 D-F where the conversation between the trial judge and Dr Boyd is quoted. This conversation illustrates the difficulties between law and medicine where mental illness is questioned. The conversation provided as follows: “Doctor could one say in this case that we are dealing with a case here of a person who is suffering from a defect of reason or a total absence of reason? ... (Answer) Well as we usually interpret the phrases, both terms would imply some form of mental disorder within the meaning of the Act, but the accused is not quite in that category. ... Not quite in the category of a? (Answer) Mentally disordered person within the meaning of the Act. She is not permanently mentally disordered. ... Was mental disorder due to any – it was not due to any disease of the mind? (Answer) Well there again, hysteria is a difficult thing to define, and its manifestations are protean. It can resemble mental disorder certainly. Do I understand from you Doctor, I suppose this is really a matter for the Court to decide, although you see that medical evidence has been led and referred to in certain of these cases to which I have referred, that she was not a mentally disordered person in terms of the Act? (Answer) Well, we usually regard it as someone who is permanently disordered due to some defect of reason or other cause, but we could find nothing in the woman’s history to suggest that before this act she had ever been mentally disordered, nor, I think, is she at the moment.”

²⁷³ At 416 B-C.

van 'n beskuldigde gedoen word met die doel om sy toerekeningsvatbaarheid te beoordeel, is die getuienis van medici en mediese deskundiges vanselfsprekend in baie gevalle van groot belang, maar nie konklusief nie. Die begrippe geesteskrankheid en geestesgebreke waar Wet 38 van 1916 oor handel, is egter psigiatriese begrippe en nie juridiese begrippe nie, en by 'n behandeling van daardie begrippe is die getuienis van mediese deskundiges in alle gevalle van die grootste belang.”

Rumpff JA in addition held the following:

- Mental illness does not have to be permanent in order to cause criminal incapacity and accordingly temporary mental illness is included within the concept of criminal incapacity.²⁷⁴
- A court will have to determine on the facts deposed before it whether a mental disorder is of a temporary or permanent nature.²⁷⁵
- Due to a lack of definition of the concept of mental illness, medical psychiatric evidence becomes indispensable.²⁷⁶
- In the light of the fact that a court has to assess each case according to the facts and the medical psychiatric evidence before it, it would be impossible and also dangerous to attempt to identify a general symptom whereby it may be diagnosed as a pathological mental disorder as this could amount to speculation by the courts in a field which they do not have expertise in and accordingly such approach could result in approach which is medically scientifically unjust.²⁷⁷
- When assessing the issue whether mental illness was present, the cause of the mental illness is not important provided that the disorder is pathological.²⁷⁸

²⁷⁴ At 417 D-E. See also LAWSA (2004) *supra* note 3 at 66-67; *R v Senekal* 1969 (4) SA 478 (RA) at 487 H, *S v Edward* 1992 (2) SACR 429 (ZH) at 433 D-E.

²⁷⁵ At 417 E-F.

²⁷⁶ At 417 F-G.

²⁷⁷ At 417 F-H.

²⁷⁸ At 418 D-E.

Rumpff JA held that there was no evidence of a mental state of unconsciousness without mental illness. Due to the fact that the evidence regarding the act committed by the accused as well as the psychiatric evidence can only be reconciled with a pathological mental disorder, the two questions of law had to be answered in the affirmative.²⁷⁹

The decision in *Mahlinza* reaffirms the important role of psychiatry especially in the assessment of mental disorders for purposes of criminal incapacity. It further emphasized the danger from a legal point of view of laying down general criteria in terms of which a disorder may be classified as pathological, which reaffirms the medical prerogative of establishing such diagnostic criteria.

In *S v Mabena*²⁸⁰ Nugent JA emphasized the importance of expert evidence in the following way:

“Mental illness’ and ‘Mental defect’ are morbid disorders that are not capable of being diagnosed by a lay court without the guidance of expert psychiatric evidence. An inquiry into the mental state of an accused person that is embarked upon without such guidance is bound to be directionless and futile.”

In *S v Stellmacher*²⁸¹, Mouton J conceptualized the term “mental illness” as follows:²⁸²

“... dit dui op ‘n patologiese versteuring van die beskuldigde se geestesvermoëns en nie ‘n bloot tydelike verstandelike beneweling wat nie

²⁷⁹ At 419 D-F.

²⁸⁰ *S v Mabena & another* 2007 (1) SACR 482 (SCA). See also Du Toit *et al* (2008) *supra* note 3 at 13-11.

²⁸¹ *S v Stellmacher* 1983 (2) SA 181 (SWA).

²⁸² At 187 H. See also Burchell and Milton (2005) *supra* at 375 where this quote by Mouton J as to what constitutes a mental illness or mental defect is translated as follows: “a pathological disturbance of the accused’s mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation.” See also Louw in Kaliski (ed) (2006) *supra* note 3 at 47; Snyman (2008) *supra* note 3 at 172; Du Toit *et al* (2008) *supra* note 3 at 13-11; Jonck, JW and Verschoor, T “Noodsaaklikheid van toestemming deur ‘n beskuldigde by ‘n ondersoek kragtens artikel 79, van die Strafproseswet” (1997) *TRW* 196 at 198; LAWSA (2004) *supra* note 3 at 67 Hiemstra (2008) *supra* note 3 at 13-16; Strauss (1991) *supra* note 3 at 127.

aan 'n geestesabnormaliteit toe te skryf is nie, maar te wyte is aan uitwendige prikkels soos alkohol, verdowingsmiddels of provokasie. Daar moet derhalwe aangetoon word dat die beskuldigde se toestand 'n erkende patologiese afwyking openbaar. Die feit dat die beskuldigde se geestestoestand moontlik in 'n mate kon afgewyk het van die normale is nog nie bewys van 'n siektetoestand nie.”

Smith and Hogan define mental illness in broader terms by stating:²⁸³

“It seems that any disease which produces a malfunctioning of the mind is a disease of the mind. It need not be a disease of the brain. Arteriosclerosis, a tumour on the brain, epilepsy, diabetes, sleepwalking, pre-menstrual syndrome and all physical diseases, may amount in law to a disease of the mind if they produce the relevant malfunction.”

Tredoux *et al* state that a mental illness comprises a number of conditions in which a person's emotional, behavioural or cognitive functioning is severely impaired which typically results in increased levels of distress to that person or other persons.²⁸⁴

In *R v Byrne*²⁸⁵, Lord Parker defined “abnormality of the mind” in the following way:²⁸⁶

“... a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide

²⁸³ Smith, JC “Smith and Hogan – Criminal Law” (2005) *supra* note 3 at 258.

²⁸⁴ Tredoux *et al* (eds) (2005) *supra* note 3 420.

²⁸⁵ *R v Byrne* (1960) 3 AER 1.

²⁸⁶ At 1 as discussed in Van Rensburg, PHJ, Verschoor, T, and Snyman, JL “Psigiatriese en Juridiese Aspekte van die Begrip Geestesongesteldheid” (1983) *TRW* 162 at 168. The authors also quote a definition of the concept of a mentally healthy person by Soddy who states: “n Gesonde persoonlikheid beantwoord aan die lewe sonder te veel inspanning. Sy ambisies lê binne die speelruimte van praktiese verwerkliking, en insig in eie krag en swakhede. Hy kan behulpsaam wees, maar ook hulp aanneem, hy is veerkragtig by mislukking en nugter by sukses. Hy is in staat tot vriendskap en aggressiwiteit. Die patroon van sy gedrag het vastheid sodat hy getrou is aan homself. Niemand sal ten opsigte van hom die gevoel hê dat hy te groot eise stel aan sy omgewing nie. Sy persoonlike geloof en sy denke asook sy aanvaarde waardesisteem is vir hom 'n bron van krag.”

enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment as to whether the act was right or wrong, but also the ability to exercise willpower to control physical acts in accordance with that rational judgment.”

This definition by Lord Parker to an extent resembles the current test for criminal incapacity embodied in section 78(1) of the Criminal Procedure Act. Despite the numerous advancements that have been made as to the precise definition of mental illness, the question relating to the conceptualisation of this term remains an open one. This could perhaps be traced to the realisation that any definition of this concept for purposes of legal insanity will be the subject of major scrutiny. A too wide definition will give rise to unsubstantiated claims of criminal incapacity, whilst an overly critical and rigid definition will exclude persons who may be suffering from a mental illness within the eyes of the medicine but not for purposes of the legal framework for the defence of insanity. Various alternative definitions have been ascribed to the term mental illness without a specific definition being universally singled out as the benchmark classification of mental illness.²⁸⁷ The question which arises is whether the circumstances of each case coupled with expert psychiatric evidence are not the sole determinants of the existence or not of mental illness.

It is submitted that the *dictum* in the *Mahlinza* decision should also apply to the current application of the insanity defence. The law should not lay down general

²⁸⁷ The National Alliance for the mentally ill defines mental illness as “... disorders of the brain that disrupt a person's thinking, feelings, moods, and ability to relate to others. Mental illnesses are brain disorders resulting in a diminished capacity for coping with the demands of life” as stated on <http://karisable.com/crmh.htm> [accessed on 2009/04/17]. Wikipedia encyclopedia defines mental disorder or mental illness as “... a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture. The recognition and understanding of mental disorders has changed over time and across cultures” as defined on http://en.Wikipedia.org/wiki/Mental_illness [accessed on 2009/06/11]. The Thesaurus defines mental illness as “Serious mental illness or disorder impairing a person's capacity to function normally and safely”. The Dental Dictionary defines mental illness in similar terms as: “Any disturbance of emotional equilibrium as manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biologic, psychologic, or social and cultural factors”. See <http://www.answers.com/topic/mental-illness> [accessed on 2009/06/11].

criteria for the existence of mental illness or mental defect as this is an area where the law lacks adequate expertise.

Despite the lack of a set definition of the concept of mental illness, there are certain guidelines according to which mental disorders should be measured in the assessment of the existence of a mental illness in order to establish the defence of pathological criminal incapacity. These guidelines are the following:

- Only mental disorders that are the product of a disease will be sufficient for purposes of section 78(1). The condition the accused suffers from must therefore be the consequence of a pathological disturbance or disease of the mind.²⁸⁸
- There exists an implicit analogy between physical disease and mental disease. Fingarette encapsulates this analogy²⁸⁹ by stating that ‘Disease’ provides a serviceable analogy for use in the context of criminal responsibility because it is possible to view some “criminal-like” conduct as morally identical to the symptom of a disease. The ordinary physical disease symptom is an abnormality which is enumerated from within the individual himself and it is the result of something within the individual, or of something about the individual’s personality makeup which is at least for the time a part of him. Fingarette states:²⁹⁰ “Yet, although it exists within the person and may be said to be produced by him, it is produced involuntarily. Not only is the symptom produced involuntarily, but the condition which produces it, the disease, is itself present independently of the person’s will at the time.”
- The fact that the accused’s mental state deviated from what is accepted as normal behaviour, is not indicative of mental illness.²⁹¹

²⁸⁸ Burchell and Milton (2005) *supra* note 3 at 375; Strauss (1974) *THRHR supra* note 3 at 230; Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 162-163 where it is stated: “Daar moet derhalwe aangetoon word dat die beskuldigde se toestand ‘n erkende patologiese afwyking openbaar.” See also Strauss (1991) *supra* note 3 at 127; Louw in Kaliski (ed) (2006) *supra* note 3 at 47.

²⁸⁹ Fingarette (1965–1966) *U. Chi, L. Rev supra* 245; Burchell and Milton (2005) *supra* note 3 375.

²⁹⁰ *Ibid.*

²⁹¹ Strauss (1974) *THRHR supra* note 260 at 230; Visser and Vorster (1990) *supra* note 3 at 326; Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163.

In *R v Harris*,²⁹² the appellant was convicted of murder and two counts of sabotage. The charges related to the explosion of a time bomb in the main concourse of the Johannesburg railway station on 24 July 1964. In respect of the charge of murder the appellant conceded that he was not responsible for his actions as a result of mental disease. The expert psychiatrist who testified in support of the defence, Prof Hurst, stated that the accused suffered from manic ecstasy which precluded criminal responsibility. The appellant on appeal conceded that during the trial in the court *a quo*, an irregularity occurred due to the fact that certain portions of a journal article was put to Prof Hurst in evaluating his assessment of the appellant, but not the whole of the article and accordingly the whole of the article was not in evidence. It was submitted that it was an irregularity to rely on passages therein not approved or assented to by any witness in arriving at a conclusion unfavourable to Prof Hurst's views without affording him an opportunity to deal with them. The Court per Steyn CJ conceded that the contention in respect of the abovementioned procedural irregularity was correct. The issue then turned to the mental state of the accused.

Prof Hurst stated the following in respect of the definitions of manic ecstasy:²⁹³

“A peculiar, entrancing, peaceful rapture, a tranquil sense of power, a sense of merging with the cosmos and the Universe, or of consciousness of the cosmos, i.e. of the life and order of the Universe, a feeling of detachment or intellectual enlightenment which places the patient in a new plane of existence. A religious feeling is an essential part of it, but not necessarily in the sense of any Sectarian religion. It could also be a mystical sense or a transcendent feeling of being one with the cosmos and of being identified with an immense cosmic power.”

Due to various inconsistencies in the appellant's evidence, also when compared to the evidence of Prof Hurst with reference to the characteristics of manic ecstasy, Steyn CJ dismissed the appeal and held:²⁹⁴

²⁹² *R v Harris* 1965 (2) SA 340 (A).

²⁹³ At 351 F-H.

“On such a view of the amnesic and other alleged symptoms, the Court would, I think, on a consideration of all the relevant features, find itself bound to conclude that, although the appellant’s mental condition may possibly have deviated to some extent from the normal, neither the ecstatic experience on the bench at the station, nor a psychotic condition excluding criminal responsibility had been proved and that the appellant had accordingly failed to establish this extraordinary defence.”

- The origin of mental illness can be psychological or organic, as in the case of arteriosclerosis²⁹⁵ and either permanent or temporary in nature. In *R v Kemp*²⁹⁶, an elderly man who suffered from arteriosclerosis, struck his wife with a hammer and inflicted a grievous wound to her. He was charged with causing grievous bodily harm to her. At the subsequent trial medical evidence was called by both the prosecution and the defence which indicated that at the time when he committed the act he did not know what he was doing. It was common cause that all the requirements of the rule laid down in the M’Naghten case were satisfied. The crucial issue was whether there was a disease of the mind. One doctor stated in his opinion that the physical disease of arteriosclerosis induced a mental condition of melancholia as a result of which the accused committed the act and that melancholia was a disease of the mind. Two other doctors, however, stated that the disease had led to a congestion of blood in the accused’s

²⁹⁴ At 360 D-E.

²⁹⁵ *R v Kemp* 1957 (1) QB 339, 1956 (3) A11 ER 249.

²⁹⁶ *R v Kemp* 1957 (1) QB 339, 1956 (3) A11 ER 249. See also Strauss (1974) *THRHR supra* note 260 AT 230-231; Burnell and Milton (2005) *supra* note 3 at 376; Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163; Visser and Vorster (1990) *supra* note 3 at 326; Strauss (1991) *supra* note 3 at 128; Burchell and Hunt (1997) *supra* note 3 at 166-167; Smith and Hogan (2005) *supra* note 3 at 219-220; Card, R “Card, Cross and Jones – Criminal Law” 16th ed (2004) at 727. See also *R v Sullivan* (1984) AC 156, (1983) 2 ALL ER 673 at 677 where Lord Diplock states: “The nomenclature adopted by the medical profession may change from time to time ... But the meaning of the expression ‘disease of the mind’ ... remains unchanged for the purposes of the application of the M’Naghten Rules ... ‘Mind’ in the M’Naghten Rules is used in the ordinary sense of the mental faculties of reason, memory and understanding. If the effect of a disease is to impair these faculties ... it matters not whether the aetiology (i.e. assignment of the cause) or the impairment is organic as in epilepsy (or arteriosclerosis or brain tumours), or functional (as in the case of schizophrenia, paranoia or manic depression) or whether the impairment itself is permanent or is transient and intermittent, provided it subsisted at the time of the commission of the act”. See also Snyman (2008) *supra* note 3 at 171; *S v Mahlinza supra* note 268 at 417.

brain as a result of which he had suffered from a temporary loss of consciousness which made him act irrationally and irresponsibly, but that the degeneration of the accused's brain cells were not such as to amount to a disease of the mind. If the latter was the case, the accused would have been entitled to be tried on the assumption of sanity and if responsibility for the said act was not proved by the prosecution, the accused would be acquitted.

- This argument was, however, rejected and it was held that whichever medical opinion the jury accepted they would be bound to return the special verdict provided for in section 2 (1) of the Trial of Lunatics Act, 1883 since on either medical view it was established that the accused was labouring under a defect of reason within the rule laid down in M'Naghten and that the defect was caused by a disease, arteriosclerosis, which was capable of affecting the mind and thus was a disease of the mind within the rule and accordingly it was immaterial whether the disease had a mental or physical origin or whether it was permanent or temporary.
- In delivering judgment, Lord Devlin stated that²⁹⁷ it would probably be conceived by medical practitioners that there are mental diseases which have an organic cause and other disturbances of the brain which can be traced to some hardening of the arteries or to some degeneration of the brain cells or to some physical condition which account for mental derangement. Accordingly there are diseases functional in origin about which it is not possible to point to any physical cause but simply to state that there has been a mental derangement of the functioning of the mind, such as melancholia, schizophrenia and many other disturbances which are primarily encountered by psychiatrists. Lord Devlin in addition held:²⁹⁸ "The distinction between the two categories is irrelevant for the purposes of the law, which is not concerned with the origin of the disease or the cause of it but simply with the mental condition which has brought about

²⁹⁷ At 253 B-I of the Judgment. At 253 H-I Devlin J also stated: "If one read for 'disease of the mind', 'disease of the brain' it would follow that in many cases pleas of insanity would not be established because it would not be established that the brain had been affected either by degeneration of the cells or in any other way. In my judgment the condition of the brain is irrelevant and so is the question whether the disease is curable or incurable, or whether it is temporary or permanent."

²⁹⁸ *Ibid.*

the act. It does not matter, for the purposes of the law, whether the defect of reasoning is due to a degeneration of the brain or to some other form of mental derangement. That may be a matter of importance medically, but it is of no importance to the law, which merely has to consider the state of mind in which the accused is, not how he got there. ... It is the effect which is produced on the mind and not the precise cause of producing it which is relevant.”

- Once it is established that the accused indeed suffered from a disease of the mind, it has to be ascertained whether the specific disease originated spontaneously within the mind of the accused, or whether it is the consequence of external stimuli or the intake of substances which caused the mental disorder. In the latter instance the “illness” will not constitute a mental illness for purposes of the insanity defence.²⁹⁹ Accordingly the illness must be endogenous and not exogenous.³⁰⁰ A malfunction of the mind which is the result of a concussion or the intake of alcohol or drugs will not constitute a mental illness or disease of the mind for purposes of the insanity defence.³⁰¹

According to Fingarette the question whether a disease has its source in mental disease or defect, can be resolved by asking three questions:³⁰²

- (i) Whether the mental illness originated as a result of a condition or feature of the accused’s own makeup or a condition suffered involuntarily.

²⁹⁹ Burchell and Milton (2005) *supra* note 3 at 37; Smith and Hogan (2005) *supra* note 3 at 221-222; Card (2004) *supra* note 3 at 727-728; Strauss (1974) *THRHR supra* note 260 at 231 where it is stated: “Blote breinskudding daarenteen, waardeur die bloedtoevoer na die brein tydelik onderbreek en ‘n verstandelike beneweling veroorsaak word, kom egter nie op geestesongesteldheid neer nie”. *R v Kemp supra* note 296 at 253; Burchell and Hunt (1997) *supra* note 3 at 165; Visser and Vorster (1990) *supra* note 3 at 326; Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163; Strauss (1991) *supra* note 3 at 128. See also *R v Quick* (1973) QB 910 at 922 where Lawton LJ states: “A malfunctioning of the mind of transitory effect caused by the application of the body of some external factor such as violence, drugs, including anaesthetics, alcohol and hypnotic influences cannot fairly be said to be due to disease.” See also LAWSA (2004) *supra* note 3 at 67; *S v Swart* 1978 (1) SA 503 (C); Hiemstra (2008) *supra* note 3 at 13-16.

³⁰⁰ *Ibid.*

³⁰¹ *Ibid.*

³⁰² Fingarette (1965–1966) *U. Chi. L. Rev supra* note 3 at 246.

- (ii) Whether the mental illness originated independent of external causes, of foreign substances induced into the body or of intentional or negligent conduct by the accused himself/herself.
- (iii) Whether the mental debility ... was relatively limited in time, of some particular external circumstance, or external occurrence, or foreign substance incorporated into his body.

If the answers to (i) or (ii) are negative or (iii) is answered affirmatively, the defence of insanity will fail. If the contrary prevails, the insanity defence will succeed.

- The particular mental illness the accused suffered from must have existed at the time of the commission of the offence. If the accused suffers from a mental illness and commits an offence during a *lucidum intervallum*, the accused could in fact be held criminally responsible for the act. The latter could prevail even where a court had previously found that the accused was mentally ill.³⁰³
- The chronic and long-term abuse of drugs and alcohol can result in a condition that can be diagnosed as a recognised mental illness such as *delirium tremens*.³⁰⁴
- The mere tendency to violent behaviour is not *per se* indicative of mental illness.³⁰⁵
- The question as to whether a mental illness or mental defect existed or exists in an accused, is a matter to be determined by expert psychiatric evidence.³⁰⁶

³⁰³ Strauss (1991) *supra* note 3 at 128; Strauss (1974) *THRHR supra* note 260 at 231; *S v Steyn* 1963 (1) SA 797 (W); Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163.

³⁰⁴ Strauss (1991) *supra* note 3 at 128; Visser and Vorster (1990) *supra* note 3 at 326; Strauss (1974) *THRHR supra* note 260 at 231; *R v Bourke* 1916 (TPD) 303 at 307; *R v Holiday* 1924 (AD) 250; LAWSA (2004) *supra* note 3 at 67.

³⁰⁵ Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163. See also Dughard, CJR "Whither Insane Automatism?" (1967) 131 at 134; Strauss (1974) *THRHR supra* note 260 at 230; Strauss (1991) *supra* note 3 at 128; Hiemstra (2008) *supra* note 3 at 13-16.

³⁰⁶ Snyman (2008) *supra* note 3 at 172; De Wet and Swanepoel (1974) *supra* note 3 at 108; Van Rensburg, Verschoor and Snyman (1983) *TRW supra* note 286 at 163-164; Strauss (1991) *supra* note 3 at 127; Strauss (1971) *THRHR supra* note 3 at 8; Van Oosten (1990) *SACJ*

In *R v Harris*³⁰⁷, Williamson JA held the following in respect of expert psychiatric evidence:

“... in the ultimate analysis, the crucial issue of appellant’s criminal responsibility for his actions at the relevant time is a matter to be determined, not by the psychiatrists but by the Court itself. In determining that issue the Court – initially, the trial Court, and, on appeal, this Court – must of necessity have regard not only to the expert medical evidence but also to all the other facts of the case, including the reliability of appellant as a witness and the nature of his proved actions throughout the relevant period.”

The discussion above focused on the fundamental guidelines that have thus far evolved in assessing mental illness and mental defect in respect of the defence of insanity or pathological criminal incapacity. It became clear that law and medicine do not always see eye to eye when the concept of mental illness is addressed. The *cul de sac* question arises: Should the definition of mental illness be a medical or legal prerogative? Medical evidence is crucial in ascertaining whether a mental illness was present at the time the accused committed the offence. But to what extent will the law open the gates to welcome such evidence and where do the parameters of such evidence lie? The author will accordingly proceed with a discussion of the various arguments in support of a medical *versus* a legal model of mental illness respectively.

6.2 The medical model of mental illness

It has been held that whilst the term “insanity” is a legal concept, “mental disease” remains essentially a medical concept.³⁰⁸

supra note 3 at 6; Strauss (1974) *THRHR supra* note 260 at 229; Snyman (1988) *Acta Juridica supra* note 78 at 154.

³⁰⁷ *S v Harris supra* note 292 at 365 B-C. This classical quote will also be addressed in Chapter 4 pertaining to the ultimate issue doctrine.

³⁰⁸ Finkel, NJ “Insanity on Trial – Perspectives in Law and Psychology” (1988) at 73; Menzies, RJ, Webster, CD and Jackson, MA “Legal and Medical issues in Forensic Psychiatric Assessments” (1981 – 1982) *Queens Law Journal* 3 at 14-15; Slovenko (1995) *supra* note 3

Weihofen argues in favour of the medical model of mental illness by stating:³⁰⁹

“The existence of mental illness, like physical illness, is a medical question. This implies that just as in cases where the issue is the existence or non-existence of tuberculosis or a bone fracture, the law should look to factual evidence, and especially, where the fact is not easily apparent, to expert evidence. On its face, it would seem as absurd for the law to attempt its own definitions of mental illness as it would to define for itself what constitutes a physical ailment.”

Similarly, Diamond states that it would be unjust to concede to any threshold definition of mental illness which differs from those accepted in terms of scientific and clinical knowledge.³¹⁰ According to Diamond, the diagnosis and assessment of mental illness should be governed by clinical criteria and definitions.³¹¹ Diamond notes:³¹²

“... it is not up to the law to establish the threshold for the existence of mental illness in a criminal defendant. But it is up to the law to determine the particular forms and degree of psychopathology it will recognize as exculpatory.”

The American Psychiatric Association supports the view that psychiatrists should be allowed to testify as elaborately as needed with respect to the accused’s

at 54-57; Slovenko (2002) *supra* note 3 at 249; Schiffer, ME “Mental disorder and Criminal Trial process” (1978) at 127; Fingarette (1965–1966) *supra* note 3 *U. Chi. L. Rev* at 232; Gerard, GB “The Medical Model of Mental Illness – Its application to the Insanity Defense” (1999) *International Journal of Law and Psychiatry* 65 at 67; Slovenko, R “The Mental Disability Requirement in the Insanity Defense (1999) *Behavioral Sciences and the Law* 165 at 167.

³⁰⁹ Weihofen, H “The Definition of Mental illness” (1960) *Ohio State Law Journal* 1 at 4; Slovenko (2002) *supra* note 3 at 249; Slovenko (1999) *Behavioral Sciences and the Law supra* note 3 at 167; Slovenko (1984) *The Journal of Legal Medicine supra* note 253 at 1-12.

³¹⁰ Diamond, B “Reasonable Medical Certainty, Diagnostic Thresholds, and Definitions of Mental illness in the Legal Context (1985) *Bull. Am. Aca. Psychiatry and the Law* at 121; Slovenko (2002) *supra* note 3 at 249; Slovenko (1999) *Behavioral Sciences and the Law supra* note 3 at 168.

³¹¹ *Ibid.*

³¹² *Ibid.*

diagnosis, mental state and motivation at the time of the alleged offence in order to assist the judge in reaching the ultimate conclusion.³¹³

Gerard submits that the question whether a specific disorder classified in terms of the DSM-IV³¹⁴ qualifies as a disorder for purposes of the insanity defence, remains a legal and not a medical question.³¹⁵ According to Gerard whether or not a particular condition constitutes a psychiatric condition, remains a medical question subject to the fact that the law selects those disorders that justify the insanity defence.³¹⁶

Gerard confirms the medical prerogative of the term “mental disease or defect” but notes the following:³¹⁷

“The law is not in the business of creating illnesses and diseases. So the insanity defense inevitably looks to medicine for the conditions that justify a finding of non-responsibility. But it does not follow that the law is required to accept for its purposes everything medicine calls a disorder for its quite different purposes. The issue in law is the moral blameworthiness. The issue in medicine is the physical problem of treatment. Because the issues are so different there is no logical reason why the law’s categories of illnesses should be identical to medicine’s.”

Gerard notes that supporters of the medical model demand that the study and assessment of psychiatric disorders is a medical problem and accordingly that mental illnesses are the consequence of physical malfunctions.³¹⁸ The hypothesis of physical “malfunction” thus correlates with the concept of “disease” as

³¹³ American Psychiatric Association “Statement on the Insanity defence” 1982 as quoted in Finkel (1988) *supra* note 3 at 79.

³¹⁴ The DSM-IV as well as those disorders that are of significance to the defence of pathological criminal incapacity or the insanity defence will be discussed below.

³¹⁵ Gerard (1999) *International Journal of Law and Psychiatry supra* note 308 at 67. See also Gerard JB “The Usefulness of the Medical Model to the Legal System” (1987) *Rutgers L. Rev* 377 at 391-394.

³¹⁶ *Ibid.*

³¹⁷ *Ibid.*

³¹⁸ Gerard (1999) *International Journal of Law and Psychiatry supra* note 281 70.

understood in medicine.³¹⁹ Gerard further states that the natural history of a disease consists of five elements, namely:³²⁰

- clinical description
- etiology
- epidemiology
- physiology
- pathology

The most important element is a valid clinical description.³²¹ According to the medical model, a clinical description must consist of three requirements in order for a particular phenomenon to constitute a disease, namely:³²²

- A comprehensive description of the disease's signs and symptoms, its origin and progression;
- The description must distinguish the particular disease from other diseases and therefore constitute a "differential diagnosis";
- The description must elaborate on the consequences if the particular disease is left untreated.

If the abovementioned criteria is applied to the disorders listed in the DSM-IV, the purview of disorders that will qualify for purposes of insanity, is narrowed down to thirteen disorders and the medical model thus establishes a scientific foundation for distinguishing disorders that are legally significant from those that are not.³²³

³¹⁹ *Ibid.*

³²⁰ *Ibid.*

³²¹ Gerard (1999) *International Journal of Psychiatry and Law supra* note 308 at 71. See also generally Guze, S "Criminality and Psychiatric Disorders" (1976) at chapter 2 and also Taylor, F "Psychopathology: Its causes and symptoms (1979) at 6 (as quoted in Gerard (1999) *supra*). "A typical disease entity ... is conceived as composed of typical constellations of concurrent clinical symptoms and an equally typical sequence of consecutive and clinical symptoms. A constellation of concurrent clinical symptoms is also called a 'symptom complex' or 'syndrome'. A sequence of consecutive clinical symptoms that is believed to be typical of a disease entity is also referred to as the 'natural history' of the disease ... The difference between a symptom and a disease is often blurred by the habit of labeling a clinical disease entity by its most conspicuous clinical symptom."

³²² Gerard (1999) *International Journal of Psychiatry and Law supra* note 308 at 73.

³²³ *Ibid.* Gerard notes that these disorders are: (1 and 2) affective disorders (mania and depression); (3) schizophrenia; (4) panic disorder (anxiety neurosis); (5) obsessive

The list of disorders that will qualify for the insanity defence is, however, not a *numerus clausus*. Variance to this list can be effected with the development of scientific knowledge. One of the major criticisms leveled towards the medical profession relates to unreliable diagnoses. Gerard notes that the medical model can assist in resolving this issue.³²⁴ Gerrard correctly asserts that the law cannot formulate criteria for the diagnosis of any mental or physical disease, but it can very well accept the medical criteria for reliable diagnoses and require that expert witnesses adhere to them when presenting expert evidence.³²⁵ According to Gerard there are two major obstacles to reliable diagnoses:³²⁶

- (i) The descriptions of the signs and symptoms of many illnesses are vague and ambiguous. The current DSM-IV and its predecessors contain lists of the symptoms of the various disorders. According to Gerard expert witnesses should not be permitted to testify as to disorders not stated in the DSM-IV.³²⁷
- (ii) There is often disagreement between mental health practitioners as to the specific symptoms that have to be present to substantiate a specific diagnosis. This is also referred to as “criterion variance”. The DSM-IV does, however, contain extensive diagnostic criteria of the particular clinical descriptions and accordingly expert witnesses should not be allowed to present diagnoses that fall short of the DSM-IV criteria for that illness.³²⁸

compulsive disorder; (6) phobic disorders; (7) somatization disorder (hysteria); (8) alcoholism; (9) drug dependence; (10) antisocial personality (sociopathy); (11) delirium and dementia (brain syndrome); (12) eating disorders (anorexia nervosa) and (13) mental retardation. These clinical disorders of legal significance will be discussed below.

³²⁴ Gerard (1999) *International Journal of Law and Psychiatry supra* note 308 at 77. See also Ennis, B and Litwack, T “Psychiatry and the Presumption of Expertise: Flipping coins in the Courtroom” (1974) *Calif. L. Rev.* at 693.

³²⁵ Gerard (1999) *International Journal of Law and Psychiatry supra* note 308 at 77.

³²⁶ *Ibid.*

³²⁷ *Ibid.*

³²⁸ *Ibid.* See also Slovenko (1984) *Journal of Legal Medicine supra* note 253 at 10 who takes a different stance by stating that there will always be disagreement between psychiatrists as to diagnosis in the courtroom. He further states: “Classifications and definitions of mental diseases and disorders are in a state of constant flux. So, in the adversarial arena of the courtroom, differences are not only to be expected but exacerbates. ... Indeed, no two therapists will ever do the same thing in a similar therapeutic situation – nor should they, since the most important experience in therapy is the relationship itself between two people.”

The medical model proposes that the insanity defence should only succeed if the following questions are answered positively:³²⁹

- Is the mental illness that the accused suffers from one that accords with the medical model's criteria of true mental disease?
- If so, does the mental illness impair the accused's capacity to render decisions about legally relevant behaviour as required in terms of the specific insanity standards?
- If so, does the diagnosis of the accused measure up to the diagnostic criteria for that disorder as required in the DSM-IV?

The description of the medical model of mental illness to some extent resembles the definition of mental illness as contained in the Mental Health Care Act of South Africa, as quoted above.

The *dicta* in *Mahlinza* and *Mabena* stated above could be construed as supporting the medical model of mental illness.³³⁰

The medical model accordingly asserts that the definition, diagnosis and assessment of mental illness should remain within the domain of the medical profession. A mental health professional which in almost all cases where the defence of insanity is raised, will be the psychiatrist, will have to assess the accused in order to ascertain whether he or she suffered from a mental illness at the time of the commission of the offence. Such assessment is conducted in terms of classified diagnostic criteria as set forth in the DSM-IV for example. The DSM-IV provides the diagnostic criteria for numerous mental illnesses. It is, however, true that the criminal law cannot accept for purposes of the insanity defence, each and every mental illness as sufficient for establishing the defence of insanity. Placing all emphasis on the medical profession, it is submitted, for providing answers to the insanity defence will be problematic.

³²⁹ Gerard (1999) *International Journal of Law and Psychiatry* supra note 308 at 78.

³³⁰ *S v Mahlinza* supra note 268 at 416 B-C; *S v Mabena* supra note 280 at paragraph 16.

In the decision of *Carter v United States*³³¹ the dichotomy of the medical model was personified as follows:

“Mental ‘disease’ means mental illness. Mental illnesses are of many sorts and have many characteristics. They, like physical illnesses, are the subject matter of medical science ... The problems of the law in these cases are whether a person who has committed a specific act – murder, assault, arson, or what not – was suffering from a mental disease, that is, from a medically recognized illness of the mind”.

The assessment of mental illness and the evaluation of whether an accused meets the specific diagnostic framework determined for a disorder, remains a medical prerogative as this is a task the law lacks adequate expertise in. The determination of the specific mental disorders sufficient for the insanity defence, however, remains a legal prerogative.

6.3 The legal model of mental illness

Proponents of the legal model of mental illness assert that the exact meaning of this term is a legal rather than a psychiatric question.³³² According to this model the definition of mental illness and mental defect should be a legal definition.

A typical example of the legal model is illustrated in the decision of *Mcdonald v United States*³³³ where the court stated:³³⁴

“Our purpose now is to make it very clear that neither the court nor the jury is bound by *ad hoc* definitions or conclusions as to what experts state is a disease or defect. What psychiatrists may consider a ‘mental disease or defect’ for clinical purposes, where their concern is treatment, may or may

³³¹ *Carter v United States* 252 F. 2d 608 (D.C. Cir. 1957).

³³² McAuley, F “Insanity, Psychiatry and Criminal Responsibility” (1993) at 63; Slovenko (2002) *supra* note 3 at 251; Slovenko (1999) *Behavioral Sciences and the Law supra* note 3 at 169.

³³³ *Mcdonald v United States* 312 F. 2d 847 (D.C. Cir. 1962).

³³⁴ At 851.

not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility.”

The legal model is also not a satisfactory model for determining mental illness. To grant the law the sole prerogative of deciding whether a mental disorder does indeed constitute a mental illness for purposes of the defence of insanity would result in the disregard for modern psychiatric science which is essential for determining criminal capacity. Melton *et al* in addition submit that legal definitions of the mental illness threshold are generally vague and it would be detrimental to equate a particular diagnosis with insanity.³³⁵

6.4 A cross dimensional concept of mental illness

Law and medicine have one common characteristic – they are both inexact sciences in a constant state of flux. The question that falls to be answered is whether mental illness should not be construed as a cross dimensional concept providing for legal and medical principles. Within the paradigm of criminal incapacity, law needs the mental health professional to tell the tale of the unknown – the mind of the criminal and more specifically, the criminal mind at the time of the commission of the offence. Mental illness is a concept comprising both medical as well as legal components. Neither law nor medicine should have the sole prerogative of defining mental illness for purposes of criminal incapacity.

Finkel describes the cross dimensional concept of mental illness by stating:³³⁶

“... if the answer to the question is that ‘mental illness is a cross-dimensional concept’ – where medical, legal, occupational, social, political, economic, actuarial and moral factors play a part – then it follows that the medical perspective is but one view on this complex matter, rather than the solely authoritative view.”

³³⁵ Melton *et al* (2007) *supra* note 3 at 212.

³³⁶ Finkel (1988) *supra* note 3 at 78.

Fingarette correctly asserts that due to the fact that the concept of mental disease is defined and formulated in medical terms, medical criteria should be adopted and the authority for adopting this criteria should be a medical prerogative.³³⁷

Fingarette notes the following in respect of the cross dimensional nature of the concept of mental illness:³³⁸

“Nevertheless, it is crucial for our purposes to realize that the whole affair is initiated for legal purposes, that the definition is authoritatively formulated by lawmakers, and that the fundamental grounds justifying the enterprise are largely nonmedical.”

Accordingly, mental illness becomes a cross dimensional concept with medical as well as legal components. It is submitted that mental illness should be viewed as a cross dimensional concept where law and medicine play equally important roles. A cross dimensional concept of mental illness will provide a more balanced and just approach to the assessment of criminal incapacity as opposed to viewing mental illness as a sole medical or legal prerogative.

Strauss submits that any formulation in terms of which either law or psychiatry is granted the sole prerogative of defining and determining criminal capacity would be unjust.³³⁹

Strauss with reference to the interface between law and psychiatry³⁴⁰ is of the opinion that although the law is a normative science and, being ‘soewerein in eie kring’ might theoretically establish its own norms for defining and assessing any legally relevant fact, it would be unjustifiable to disregard modern scientific knowledge as full recognition should be accorded to modern sciences in all spheres of law. In the absence of the latter, the law would run the risk of “degenerating into some kind of intellectual game unrelated to the realities of

³³⁷ Fingarette (1965 – 1966) *U. Ch. L. Rev. supra* note 3 at 238.

³³⁸ *Ibid.*

³³⁹ Strauss (1971) *THRHR supra* note 3 at 10-11. See also Visser and Vorster (1990) *supra* note 3 at 323; Melton *et al* (2007) *supra* note 3 at 212.

³⁴⁰ *Ibid.*

life”.³⁴¹ Strauss in addition state that the psychiatrist should not be entitled to demand that the definition and assessment of criminal responsibility should be an exclusively psychiatric prerogative as criminal responsibility and mental disease are not identical concepts and in addition it is important to bear in mind that psychiatry is in essence a therapeutic science, whereas the law defines minimum standards acceptable for human social conduct.³⁴² Strauss notes:³⁴³ “Obviously not any degree of mental abnormality can lead to complete exoneration from criminal liability. ... But the minimum standards of conduct set by society in the form of legal rules should not be so high that we are in effect meting out punishment to persons who are in dire need of psychiatric treatment, or at least of detention under continuous psychiatric care. Therefore some kind of balance must be struck. It need not be stressed how difficult it is to strike this balance ...”.

Strauss’s statement is supported by the author. It is pivotal that scientific psychiatric knowledge is provided when the defence of criminal incapacity is raised. The legal profession should accordingly welcome such evidence to the extent needed to explain the behaviour of the accused, at the time of the offence. The medical profession, with specific reference to psychiatry, should, however, also adhere to the boundaries of psychiatric evidence and remain within the ambit of assessment as opposed to providing conclusive opinions as to criminal responsibility which is essentially a legal phenomenon.

7 The role and application of the DSM-IV and the ICD-10 in assessing pathological criminal incapacity

The definition and assessment of mental disorder is one of the core functions of the mental health professional, with specific reference to the psychiatrist, when competency to stand trial and pathological criminal incapacity stand to be evaluated. It is interesting to note that a great majority of international clinical texts use the term “mental disorder” rather than “mental illness”.

³⁴¹ *Ibid.*

³⁴² *Ibid.*

³⁴³ *Ibid.*

There are currently two widely established and recognized diagnostic systems that classify mental disorders. These are the International Classification of Diseases (ICD-10) which is provided by the World Health Organisation and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association.³⁴⁴

The motivation for incorporating a discussion of the systems of classification into the framework of the current study is to provide an analysis of the most important diagnostic contexts from which mental health professionals deduce their diagnosis

³⁴⁴ Burchell and Milton (2005) *supra* note 3 at 383; Faulk, M “Basic Forensic Psychiatry” 2nd ed. 1994; Bartol, CR “Criminal Behavior – A Psychosocial Approach” 3rd ed. (1991) at 143-147; Woo, SM and Keatinge, C “Diagnosis and treatment of Mental Disorders across the lifespan” (2008) at 111-117; Sadock, BJ and Sadock, VA “Kaplan and Sadock’s Synopsis of Psychiatry – Behavioral Sciences/Clinical Psychiatry” 9th ed. (2003) at vii-ix; Schulte-Markwort, M, Marutt, K and Riedesser, P “Cross-walks ICD-10 - DSM-IV-TR – A synopsis of Classifications of Mental Disorders” (2003) at 1-2; Howitt, D “Introduction to Forensic and Criminal Psychology” 2nd ed. (2005) at 309-313; Chiswick, D “Forensic Psychiatry” in Mason, JK (ed.) “Forensic Medicine for lawyers” 4th ed. (2001) at 391-400; Barlow, DH and Durand VM “Abnormal Psychology – An integrative Approach” (1995) at xix – xxiii; Bartol, CR and Bartol, AM “Criminal Behavior – A psychosocial Approach” 7th ed. (2005) at 188-192; Dziegielewski, SF “DSM-IV-RR in Action” (2002) at 4-10; Brakel, SJ and Brooks, AD “Law and Psychiatry in the Criminal Justice System” (2001) at 60-65; Widiger, TA, Simonsen, E, Sirovatka, PJ and Regier, DA “Dimensional Models of Personality Disorders – Refining Research Agenda for DSM-V” (2006) at xvii-xxxiii; Gunn, J and Taylor, PJ “Forensic Psychiatry – Clinical, Legal and Ethical issues” (1995) at 374-380; LaBruzza, AL and Mendez-Villarubia, JM “Using DSM-IV: A Clinician’s Guide to Psychiatric Diagnosis” (1994) at 7-15, 31-49; Slovenko (1995) *supra* note 3 at 55, Slovenko (2002) *supra* note 3 at 250-260; Slovenko (1999) *Behavioral Sciences and the law supra* note 3 at 169-179; McKay, IM “Scientific Reliability of Psychiatric Expert Witness Testimony involving the Use of the classifications from the Diagnostic and Statistical Manual of Mental Disorders” (1992) *Criminal Justice Journal* at 345-384; “International Statistical Classification of Diseases and Related Health Problems” Wikipedia encyclopedia <http://en.wikipedia.org/wiki/ICD> [accessed on 2009/06/11]; American Psychiatric Association “Diagnostic and Statistical Manual of Mental Disorders – DSM-IV” (1994) (official reference); American Psychiatric Association “Diagnostic and Statistical Manual of Mental Disorders – DSM-IV-TR (Text Revision) (2000). See also Spitzer, RL, Gibbon, M, Skodol, AE, Williams, JBW and First, MB “DSM-IV-TR – Case Book – A Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision” (2002); First, MB, Frances, A and Dincus, HA “DSM-IV-TR – Handbook of Differential Diagnosis” (2002). It is also interesting to note that the DSM-V is planned and scheduled for publication in 2012. See <http://en.wikipedia.org/wiki/Diagnostic-and-Statistical-Manual-of-Mental-Disorders> [accessed 2009/07/27]. During 1999, a DSM-V Research Planning Conference, sponsored jointly by the American Psychiatric Association and the National Institute of Mental Health was held to set the specific research priorities. There were six workgroups focusing on specific topics namely: Nomenclature, Neuroscience and Genetics, Developmental Issues and Diagnosis, Personality and Relational Disorders, Mental disorders and Disability. See also Kleinplatz, PJ and Moser, C “Politics versus science: An addendum and response to Drs Spitzer and Fink” (2005) *Journal of Psychology and Human Sexuality* at 135-139; Spitzer, RL and Wakefield, JC “DSM-IV diagnostic criterion for clinical significance: does it help solve the false positives problem?” (1999) *American Journal of Psychiatry* at 1856-1864. It should be noted that the publication of the DSM-V is planned to be effected in May 2013. The DSM-V Task Force and Work Group Members are working to develop criteria for diagnoses that reflect new advances in the science and conceptualization of mental disorders.

and assessments. It is also pivotal to understand the diagnosis and assessment of mental disorders from the point of view of the mental health professional in order to illustrate the interdisciplinary context of pathological criminal incapacity as a defence in criminal law.

The DSM-IV and the ICD-10 are considered reflective of the official nomenclature on mental health and are generally used by psychiatrists, physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists and other mental health professionals.³⁴⁵ The DSM-IV-TR is the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.³⁴⁶

The categories, diagnostic codes and criteria as set forth in the DSM-IV were not changed by the text revision of the DSM-IV-TR, save for additional information provided for some of the categories.³⁴⁷ With the revised text diagnostic codes

³⁴⁵ DSM-IV *supra* note 344 at XV; Dziegielewski (2002) *supra* note 344 at 4; Kaplan and Sadock (2002) *supra* note 344 at vii; Woo and Keatinge (2008) *supra* note 344 at 113-114.

³⁴⁶ Woo and Keatinge (2008) *supra* note 344 at 115; Kaplan and Sadock (2002) *supra* note 344 at vii; Dziegielewski (2002) *supra* note 344 at 4. The historical development of the DSM-IV can be summarised as follows: The American Psychiatric Association published its first version of the DSM in 1952. The main aim of this action was to create an interface between the psychological and biological phenomena in order to provide the mental health professional with a psychobiological framework. The DSM-I provided for a glossary of descriptions of the diagnostic categories and was also the first official manual of mental disorders with an emphasis on clinical use. In 1968, the DSM-II was published with the main goal of framing the various diagnostic categories in a more scientific manner. The DSM-I as well as the DSM-II was criticized as being unscientific and for promoting negative diagnostic labelling. In 1980 the DSM-III was published. It was contended that this edition of the DSM was less biased and more scientifically reliable. The DSM-III was becoming a very popular tool for diagnoses requested for clients for reimbursement from insurance companies. The question, however, still remained as to the practicality of this edition and the information contained therein. In 1987 the DSM-III-R was published which was a revised version of the DSM-III that made use of field trials which the developers asserted provided scientific reliability. Concern was, however, still raised as to the diagnostic reliability, misuse, danger of misdiagnosing and ethical implications. In 1994, the DSM-IV was published with the goal dispelling the earlier criticisms of the DSM. The DSM-IV includes literature reviews as well as reported data and reports from field trials. In 2000 the DSM-IV-TR was published which retained the criteria enunciated in the DSM-IV with additional information of the various diagnostic categories. Dziegielewski notes that the intended aims of the DSM-IV-TR were the following:

- To eliminate any factual errors identified in the publication of the DSM-IV;
- To ensure that information contained in the DSM is recent and updated;
- To enhance the educational value of the DSM;
- To ensure the ICD-9 codes were reflected in the text as many of these codes only became available a year after publication of the DSM-IV. (Dziegielewski (2002) *supra* note 344 at 9 and also at 5-8 pertaining to the historical overview of the DSM). See also Brakel and Brooks (2001) *supra* note 344 at 62-64; LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 47.

³¹⁰ Dziegielewski (2002) *supra* note 344 at 8; Woo and Keatinge (2008) *supra* note 344 at 115-116. See also First, MB and Pincus, HA "Classification in Psychiatry: ICD-10 vs DSM-IV"

were corroborated with the ICD-10 system of classification in order to maintain consistency between these two classification systems.³⁴⁸ In current practice the DSM is similar to the ICD-10 in terms of diagnostic codes.³⁴⁹ Most mental health professionals are familiar with both systems of classification but the DSM has, however, gained the greatest support from psychiatrists, psychologists and other mental health professionals.³⁵⁰ For purposes of the current study the emphasis will be on the diagnostic framework provided in the DSM-IV for the classification of the various disorders relevant for purposes of the insanity defence. In the event of any distinction between the DSM-IV and the ICD-10 in terms of diagnostic classification or related aspects, such distinction will be mentioned.³⁵¹

(1999) *British Journal of Psychiatry* 175 at 205-209; First, MB and Pincus, HA "The DSM-I text revision: Rationale and potential impact on clinical practice" (2002) *Psychiatric Services* at 288-292.

³⁴⁸ *Ibid.*

³⁴⁹ Dziegielewski (2002) *supra* note 344 at 4. See also Kutchins, H and Kirk, SA "The business of diagnosis" (1988) *Social Work* 2 –220; Woo and Keatinge (2008) *supra* note 344 at 117.

³⁵⁰ *Ibid.*

³⁵¹ See <http://www.icd10.ch/ebook/FRetENetGe-Omset> DMDI-FR/vzpzzi [accessed on 2009/07/07]. The ICD-10 specifically provides for a section classifying mental and behavioral disorders. Specific reference is made to clinical descriptions and diagnostic guidelines. This volume which was published in 1992 provides for each category in chapter V (Mental and Behavioural Disorders) a general description and guidelines pertaining to the diagnosis as well as recommendations as to a differential diagnosis. See also <http://en.wikipedia.org/wiki/ICD> where it is stated that the ICD-10's classification of mental and behavioural disorders has developed alongside the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and these two manuals generally seek to use the same or similar codes. There are, however, also differences between these two systems with specific reference to the fact that the ICD includes personality disorders on the same axis as other mental disorders unlike the DSM. Since the 1990's the American Psychiatric Association and the World Health Organisation have worked together with the main goal of bringing the DSM and the relevant sections of the ICD into concordance. The ICD further provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, social circumstances and external causes of illnesses. The ICD is published by the World Health Organisation and used worldwide for morbidity and mortality statistics. The ICD is revised on a regular and periodical basis and is currently in its tenth version. The first draft of the ICD-II system is expected in 2010. The expected publication will take place in 2014 and the consequential implementation will be effected in 2015. See also Mezzich, JE "International Surveys on the Use of ICD-10 and Related Diagnostic Systems" (2002) *Psychopathology* 72-75. See also "ICD-10 Implementation Review – January 2004 – October 2006" (2006) by the National Task Team on ICD-10 Implementation where the purpose of the ICD-10 is described as follows: (at 6) "The purpose of ICD-10 is to translate diagnoses of diseases and other health problems from descriptions into an alphanumeric code, which permits easy storage, retrieval and analysis of the data. It also allows for the establishment of a systematic recording, analysis, interpretation and comparison of morbidity and mortality data collected within the country but also with other countries." See also generally Sartorius, N "Understanding the ICD-10 classification of mental disorders: a pocket reference" (2002); Meads, S "ICD-10 coding fundamentals: a comprehensive coding guide for healthcare professionals" (1999).

The DSM-IV also states the following:³⁵²

“Those preparing ICD-10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence. ICD-10 consists of an official coding system and other related clinical and research documents and instruments. The codes and terms provided in DSM-IV are fully compatible with both ICD-9 and ICD-10.”

The DSM-IV is one of the most frequently used publications of mental disorders used by mental health professionals.³⁵³ Dziegielewski, however, correctly submits that there is no single diagnostic system of classification that will be completely acceptable by all mental health experts.³⁵⁴ It is pivotal that mental health professionals have adequate knowledge of precisely how the manual should be utilised as well as knowledge and debate as to the utility of particular diagnostic criteria in order to reduce abuse.³⁵⁵

The DSM-IV-TR in addition states:³⁵⁶

“No classification of mental disorders can have a sufficient number of specific categories to encompass every conceivable clinical presentation.”

The DSM-IV-TR remains an evolving and developing system of diagnostic classification and accordingly has both strengths and weaknesses.³⁵⁷ Woo and

³⁵² DSM-IV (1994) *supra* note 344 at xxi; DSM-IV-TR (2000) *supra* note 344 at xxix.

³⁵³ Dziegielewski (2002) *supra* note 344 at 5.

³⁵⁴ *Ibid.*

³⁵⁵ *Ibid.*

³⁵⁶ DSM-IV-TR (2000) *supra* note 344 at xxviii.

³⁵⁷ Woo and Keatinge (2008) *supra* note 344 at 116; Dziegielewski (2002) *supra* note 344 at 5 summarises the following pro's and con's of the DSM-IV-TR:

Pro's (Strengths)

- *Results in uniform and improved diagnosis.
- *Promotes informed professional communication by means of uniformity.
- *Provides the framework for educational purposes.

Con's (Weaknesses)

- *Can result in diagnostic labelling.
- *Provides limited information on the relationship between environmental factors and aspects of the mental health condition.
- *Lacks a description of intervention strategies.

Keatinge encapsulate the advantages and disadvantages of the DSM-IV-TR as follows:³⁵⁸

<u>Advantages</u>	<u>Disadvantages</u>
* Communication system	* Cumbersome and inconsistent format
* Atheoretical	* Atheroretical and medical model
* Categorical mode	* Heterogenity and comorbidity
* Descriptive and objective criteria	* Relies on consensus and clinical judgment
* Nonetiological diagnostic criteria	* Exclusion criteria
* Scientific basis and terms defined*	* An appearance of clarity and scientific basis
* Increased diagnostic reliability	* Reliability at the expense of validity
* Multiaxial assessment	* Focus on impairment and distress
* Cultural and diversity considerations	* Limited applications to diverse groups
* Correlates with treatment	* Self-fulfilling and a focus on labelling
* Relationship with ICD-10 and revisions	* Reification of classification and instability

It is thus important to bear in mind that despite the pivotal role of the DSM-IV-TR, a scientific document of this nature will always be open to debate. Despite the various criticisms leveled towards the DSM-IV-TR and its predecessors and the alleged disadvantages associated with the application thereof, it remains the most advanced, scientifically founded system of nosology in current psychiatric practice and related fields of mental health. A classification system such as the DSM-IV-TR as an assessment tool is generally evaluated in terms of its:

³⁵⁸ Woo and Keatinge (2008) *supra* note 344 at 117. See also Barlow and Durand (1995) *supra* note 344 at 111-112 where the concern is expressed that our science faces huge challenges in establishing reasonably valid and meaningful categories of psychopathology. Barlow and Durand further notes that knowledge about etiology should be expanded. Barlow and Durand in addition criticize the atheroretical nature of the DSM and state that a theoretical stance towards classification is not always incorrect.

- reliability³⁵⁹ and
- validity³⁶⁰.

The DSM-IV-TR appears to be both reliable and valid as it is a huge improvement on previous editions and is founded on:³⁶¹

- literature reviews
- data analysis and reanalysis and
- field trials.

The DSM-IV-TR also contains the following statement:³⁶²

“It is our belief that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, the DSM-IV is grounded in empirical evidence.”

Mental illness or mental defect remains threshold requirements for establishing incompetence to stand trial as well as pathological criminal incapacity. Whether the forensic mental health expert’s testimony is provided for the prosecution or defense, the expert’s opinion will most likely contain reference to the diagnostic criteria set forth in the DSM-IV-TR.³⁶³ Within the context of pathological criminal

³⁵⁹ Comer, RJ “Fundamentals of Abnormal Psychology” 5th ed. (2008) at 68 and 83. Reliability refers to the consistency of assessment measures. A proper assessment will produce the same results in the same situation. An assessment tool will be regarded as reliable if different assessors reach the same conclusion pertaining to the set of facts. Scientific reliability and validity of psychiatric expert testimony are discussed in chapter 5 below.

³⁶⁰ *Ibid.* Validity entails that the assessment tool should accurately measure precisely that which it is supposed to measure.

³⁶¹ Dziegielewski (2002) *supra* note 344 at 34-35; McKay (1992) *Criminal Justice Journal supra* note 344 at 346.

³⁶² Dziegielewski (2002) *supra* note 344 at 34; Comer (2008) *supra* note 359 at 83; Woo and Keatinge (2008) *supra* note 344 at 115-116; DSM-IV-TR (2000) *supra* note 344 at xxvi-xxx.

³⁶³ DSM-IV-TR (2000) *supra* note 344 at xxiv. See also Woo and Keatinge (2008) *supra* note 344 at 117 where they note that the DSM-IV-TR has become standard in the United States for ascertaining psychiatric diagnosis and has been translated into 13 other languages. International Surveys further indicate that 95% of clinicians use the DSM-system for teaching, 97% for research and 81% for clinical practice.

incapacity the defense will typically present psychiatric expert evidence to the effect that the accused was mentally ill at the time of the act whereas the prosecution will seek to prove that the accused's mental state was not severe enough to be exculpatory.

It is crucial to bear in mind that the mere existence of a mental illness or mental defect is not sufficient in itself to establish non-triability or non-responsibility. The particular mental illness or mental defect has to render the accused unfit to stand trial or has to have caused the accused to lack the capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation. A diagnosis in terms of the DSM-IV-TR will accordingly only satisfy one of the requirements.

Dziegielewski in addition mentions the following:³⁶⁴

“... in forensic settings the use of a diagnostic label, regardless of the supporting criteria, cannot be utilized as a legal definition of a mental disorder or mental disability. Nor can a diagnosis of a mental disorder alone be used to determine competence, criminal responsibility or disability. Information needs to clearly describe a person's behavioral problems and other functional impairments.”

It is accordingly necessary to disseminate specific aspects contained in the DSM-IV-TR and its impact on the defence of pathological criminal incapacity.

7.1 The DSM definition of mental disorder

It has already been emphasized that defining mental disorders has been conceptually difficult and extremely controversial.³⁶⁵

The DSM-IV-TR in addition states:³⁶⁶

³⁶⁴ Dziegielewski (2002) *supra* note 344 at 34.

³⁶⁵ Slovenko (2002) *supra* note 3 at 251; Slovenko (1999) *Behavioral Sciences and the Law supra* note 3 at 169; Brakel and Brooks (2001) *supra* note 344 at 61-64.

³⁶⁶ DSM-IV-TR (2000) *supra* note 344 at xxx; DSM-IV (1994) *supra* note 344 at xxi.

“... although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder’. The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent and operational definition that covers all situations.”

It was only after the DSM-III that a definition of mental disorder was provided.³⁶⁷

The DSM-IV-TR provides the following definition of mental disorder:³⁶⁸

“In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.”

A major obstacle associated with the application of the DSM-IV relates to the fact that none of the psychiatric diseases necessarily entail the impairment of either the cognitive or conative capacity as required for establishing pathological criminal incapacity.³⁶⁹ The forensic psychiatrist is faced with the task of diagnosing a

³⁶⁷ Slovenko (2002) *supra* note 3 at 251.

³⁶⁸ DSM-IV-TR (2000) *supra* note 344 at xxxi; DSM-IV (1994) *supra* note 344 at xxi-xxii; Woo and Keatinge (2008) *supra* note 344 at 123; Slovenko (2002) *supra* note 3 at 251; Brakel and Brooks (2001) *supra* note 344 at 63-64; Slovenko (1999) *Behavioral Science and the Law supra* note 3 at 169-170; Dziegielewski (2002) *supra* note 344 at 33. See also LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 47.

³⁶⁹ See also Slovenko (2002) *supra* note 3 at 252.

particular mental disorder and if the said psychiatrist is appointed for the defense, he or she will also have to argue that the particular mental disorder affected the cognitive or conative capacity of the accused in such a manner that the accused lacked criminal capacity.

The definition of mental disorder provides for the recognition of a “psychological syndrome or pattern” that occurs in an individual. The question that accordingly arises is whether the “battered woman syndrome” or, if termed alternatively, “abusive partner syndrome” could possibly classify as a psychological syndrome in terms of this definition. A battered woman will then rely on the defense of pathological criminal incapacity as an alternative to non-pathological criminal incapacity.³⁷⁰

7.2 The DSM cautionary statement and the use of the DSM in forensic settings

The current DSM-IV-TR as well as its predecessors contain a statement cautioning against the legal application of the various diagnoses contained in the manual.³⁷¹ McKay in addition notes that the initial version of the DSM did not provide a discussion as to the use of the DSM within the legal setting, but as a result of the increased use and criticism of DSM testimony subsequent manuals began to include cautionary statements.³⁷²

The current DSM-IV-TR provides the following *caveat* or cautionary statement:³⁷³

“The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose,

³⁷⁰ Possible mental disorders that a battered woman could suffer from as provided for within the diagnostic framework of the DSM-IV-TR will be discussed below. A question which falls to be considered is whether a battered woman over a period of abuse, could develop a mental disorder which could lead to the particular woman lacking criminal capacity due to pathological causes when she eventually, for example, kills her abusive husband or partner.

³⁷¹ DSM-IV-TR (2000) *supra* note 344 at xxxvii; DSM-IV (1994) *supra* note 344 at xxvii; Slovenko (2002) *supra* note 3 at 258; Slovenko (1999) *Behavioral Sciences and the Law supra* note 3 at 178; Brakel and Brooks (2001) *supra* note 344 at 64-65.

³⁷² McKay (1992) *Criminal Justice Journal supra* note 344 at 352.

³⁷³ DSM-IV-TR (2000) *supra* note 344 at xxxvii.

communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.”

What becomes striking from this cautionary statement is the use of the word “may not be wholly relevant”. The terminology does not mean “irrelevant”³⁷⁴. Whenever the diagnostic criteria and textual explanations are applied within the forensic context, the danger of misuse and misunderstanding of diagnostic information exists.³⁷⁵ This danger is the result of the essential difference between ultimate questions of law as opposed to information contained in a clinical diagnosis.³⁷⁶ In many cases, the clinical diagnosis of a DSM-IV mental disorder will not satisfy the requirements for legal purposes of a “mental illness” or “mental disability” or

³⁷⁴ See Slovenko (2002) *supra* note 3 at 258 where the words of Stanley Brodsky, a renowned expert witness, is quoted, who stated the following: “When the phrase ‘such as Pathological Gambling or Pedophilia’ is used, the reader is unclear how broad the reach of such diagnoses may be. In the same sense, the phrase ‘may not be wholly relevant’ does not mean the same as irrelevant. Rather, the phrase describes an extensive range from almost wholly relevant to legal judgments down to partially relevant all the way to irrelevant. The term ‘may be’ is equally mushy. The more important part of the caution is the warning against wholesale application of diagnostic concepts to legal conclusions.”

³⁷⁵ DSM-IV-TR (2000) *supra* note 344 at xxxii-xxxiii; DSM-IV (1994) *supra* note 344 at xxiii-xxiv; Slovenko (2002) *supra* note 3 at 259; Brakel and Brooks (2001) *supra* note 3 at 65-66; Slovenko (1999) *Behavioral Science and the law supra* note 3 at 178.

³⁷⁶ *Ibid.* See also DSM-IV-TR (2000) *supra* note 344 at 2 where it is stated that a specific DSM-IV diagnosis is applied to a person’s current presentation and is not used to denote previous diagnoses from which the individual has recovered. Specific specifiers or indicators are used to determine the severity and onset of the particular disorder. The specific indicators are the following: Mild: Few, if any symptoms more than those required to render the diagnosis are present and the particular symptoms result in mind impairment in functioning. Moderate: Functional impairment between “mild” and “severe” are present. Severe: Symptoms more than the amount required to render the diagnosis or various symptoms that are serious or the symptoms cause marked impairment in functioning. In full remission: There are no longer any significant signs or symptoms of the disorder, but the disorder should be noted. Prior history: It may often be useful to note the history of a criteria having been satisfied for a specific disorder even if the individual has already recovered from it. See also LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 63 where it is stated that the mental health expert should apply the mild, moderate and severe criteria to all of the official DSM-IV categories.

“mental disease”, and accordingly, as stated above, additional information is essential.³⁷⁷

The DSM-IV-TR in addition clearly states³⁷⁸ that the fact that an individual’s presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual’s degree of control over the behaviors that may be associated with the disorder.

The DSM-IV-TR further notes that further research in future and clinical experience will result in a better understanding of the various disorders contained in the DSM and also to the possible identification of new disorders in future classifications.³⁷⁹ Diagnostic information contained in the DSM-IV can, however, provide much assistance to decisionmakers in their ultimate assessments.³⁸⁰ The DSM-IV-TR improves the reliability of a determination where it is used for determining the existence of a mental disorder and it may facilitate the legal decisionmaker’s understanding of the distinctive requirements of mental disorders.³⁸¹ The DSM-IV-TR in addition encapsulates its value for the criminal law and for forensic purposes by stating:³⁸²

“The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decisionmaking when the legal issue concerns an individual’s mental functioning at a past or future point in time.”

7.3 Multiaxial assessment

An understanding of the use of the DSM within the forensic context and in the courtroom, requires a brief discussion of the mode of assessment followed by a mental health professional employing the DSM in reaching an expert opinion as to

³⁷⁷ *Ibid.*
³⁷⁸ *Ibid.*
³⁷⁹ *Ibid.*
³⁸⁰ *Ibid.*
³⁸¹ *Ibid.*
³⁸² *Ibid.*

the accused's mental status. A multi-axial system of classification entails an assessment on several axes, each of which refers to a distinct level of information that may aid the clinician in assessment of treatment and outcome.³⁸³ Woo and Keatinge note that the implementation of a multi-axial system by the DSM enables mental health professionals to assess not only the current acute problems, but also the underlying personality characteristics, appropriate medical conditions or physical factors, psychosocial stressors as well as the individual's highest level of functioning.³⁸⁴ The use of the multi-axial system enhances comprehensive and systematic assessment.

With the emphasis on the various mental disorders and general medical conditions, various psychosocial and environmental problems might be overlooked if the emphasis were on assessing a single problem.³⁸⁵

LaBruzza and Mendez-Villarubia state that the motivation of the multi-axial system was to provide a useful, comprehensive and systematic analysis of clinical situations.³⁸⁶

There are five axes provided for in the DSM-IV multi-axial classification.³⁸⁷

Axis I - Clinical Disorders
Other conditions that may be a focus of Clinical attention.

Axis II - Personality Disorders
Mental Retardation

Axis III - General Medical conditions

Axis IV - Psychosocial and Environmental Problems

³⁸³ DSM-IV-TR (2000) *supra* note 344 at 27; DSM-IV (1994) *supra* note 344 at 25.

³⁸⁴ Woo and Keatinge (2008) *supra* note 344 at 131; Dziegielewski (2002) *supra* note 344 at 56-58; LaBruzza and Mendez-Villarubia (1994) *supra* note 324 at 69-70.

³⁸⁵ DSM-IV-TR (2000) *supra* note 344 at 27; DSM-IV (1994) *supra* note 344 at 25.

³⁸⁶ LaBruzza and Mendez-Villarubia (1994) *supra* note 324 at 69.

³⁸⁷ *Ibid.* See also Dziegielewski (2002) *supra* note 344 at 57; Woo and Keatinge (2008) *supra* note 344 at 131-135; LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 70-80; Brakel and Brooks (2001) *supra* note 344 at 69-75.

Axis V - Global Assessment Functioning

The clinical disorders enlisted in terms of Axis I are the following:³⁸⁸

- Disorders usually first diagnosed in infancy, childhood or adolescence (excluding mental retardation which is diagnosed in terms of axis II).
- Delirium, Dementia and Amnestic and other cognitive disorders.
- Mental disorder due to a general medical condition.
- Substance-related Disorders.
- Schizophrenia and Other psychotic Disorders.
- Mood Disorders.
- Anxiety Disorders.
- Somatoform Disorders.
- Factitious Disorders.
- Dissociative Disorders.
- Sexual and Gender Identity Disorders.
- Eating Disorders.
- Sleep Disorders.
- Impulse-Control Disorders not elsewhere classified.
- Adjustment Disorders.
- Other conditions that may be the focus of Clinical Attention..

The personality disorders provided for in terms of axis II are the following:³⁸⁹

- Paranoid Personality Disorder.
- Schizoid Personality Disorder.
- Schizotypal Personality Disorder.
- Antisocial Personality Disorder.
- Borderline Personality Disorder.

³⁸⁸ DSM-IV-TR (2000) *supra* note 344 at 28; DSM-IV (1994) *supra* note 344 at 26; Dziegielewski (2002) *supra* note 344 at 62-64; Brakel and Brooks (2001) *supra* note 344 at 70-75.

³⁸⁹ *Ibid.*

- Histrionic Personality Disorder.
- Narcissistic Personality Disorder.
- Avoid Personality Disorder.
- Dependent Personality Disorder.
- Personality Disorder Not Otherwise Specified.
- Mental Retardation.

Axis III is generally important for reporting present general medical conditions that are potentially relevant to the comprehension or management of the individual's mental disorder, but are classified outside the "Mental Disorders" chapter of ICD-10 and outside Chapter V at ICD-10.³⁹⁰ Axis IV is used for reporting psychosocial and environmental issues that may affect the diagnosis, treatment, and prognosis of mental disorders.³⁹¹ Axis V enables the clinician to evaluate the individual's

³⁹⁰ *Ibid.* Axis III contains general medical conditions which correlate with ICD-9-CM codes and are the following:

- Infectious and Parasitic Diseases
- Neoplasms
- Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders
- Diseases of blood and blood-forming Organs
- Diseases of Nervous Systems and sense Organs
- Diseases of the Circulatory System
- Diseases of the Respiratory System
- Diseases of the Digestive System
- Diseases of the Genitourinary System
- Complications of Pregnancy, Childbirth and the Puerperium
- Diseases of the Skin and Subcutaneous Tissue
- Diseases of the Musculoskeletal System and Connective Tissue
- Congenital Anomalies
- Certain Conditions Originating in the Perinatal Period
- Symptoms, Signs and ill defined conditions
- Injury and Poisoning

These conditions are not relevant to the present study and will not be addressed.

³⁹¹ DSM-IV-TR (2000) *supra* note 344 at 31; DSM-IV (1994) *supra* note 344 at 29; Brakel and Brooks (2001) *supra* note 344 at 73 where it is stated that a psychosocial or environmental problem may entail a negative life event, an environmental difficulty or problem, a familial or interpersonal stress. The DSM-IV-TR (2000) *supra* note 344 at 32 lists the following Psychosocial and Environmental problems:

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system
- Other psychosocial and environmental problems

level of functioning by means of a rating scale known as the Global Assessment of Functioning Scale which should be rated with respect to psychological, social and occupational functioning.³⁹² Administration of the Global Assessment of Functioning Scale requires special expertise.³⁹³

The multi-axial assessment discussion is provided to enhance an understanding of the role of the mental health professional from a purely diagnostic perspective. The use of the multi-axial assessment has been subjected to criticism for being cumbersome but the recognition of the role of medical factors, psychosocial elements and level of impairment of functioning provides for a more intensive and detailed assessment of an individual and will provide more insight in respect of an accused's mental state at the time of the offence.³⁹⁴

8 Clinical disorders of legal significance

“But I must go and meet with danger there,
Or it will seek me in another place,
And find me worse provided” (Scene II Henry IV II.3.48)³⁹⁵

The DSM-IV-TR generally classifies disorders into seventeen major diagnostic categories.³⁹⁶

These factors are also not relevant for the present study but are stated here to provide the broad context of the multi-axial system. See also Woo and Keatinge (2008) *supra* note 344 at 134-135; LaBruzza and Mendez-Villarubia (1994) *supra* note 324 at 76-78.

³⁹² DSM-IV-TR (2000) *supra* note 344 at 32-33; Woo and Keatinge (2008) *supra* note 344 at 135; Dziegielewski (2002) *supra* note 344 at 91-92.

³⁹³ Woo and Keatinge (2008) *supra* note 344 at 135; Dziegielewski (2002) *supra* note 344 at 91 notes that professionals are not expected to memorise the GAF but should retain a copy for purposes of reference.

³⁹⁴ Woo and Keatinge (2008) *supra* note 344 at 135. See also Dziegielewski (2002) *supra* note 344 at 103-104 where it is stated: “Equipped with a basic knowledge of the use and misuse of the DSM-IV as a tool in the creation of a diagnostic impression, the mental health practitioner can more constructively participate in the consultation process. Knowledge of diagnostic impressions and criteria can assist the practitioner in impacting and enhancing the client's overall functioning level. ... With an updated knowledge of mental health diagnosis and subsequent intervention, mental health practitioners can help prepare, as well as educate, clients and family members about the responsible use and expectations for psychiatric care. Professional Schools that train mental health practitioners need to strongly encourage course work on use of the multi-axial assessment system since practitioners are held accountable for their own practice actions, they must strive to achieve the highest standards of their profession.”

³⁹⁵ As quoted in Cox, M and Theilgaard, A “Shakespeare as Prompter – The Amending Imagination and the Therapeutic Process” (1994) at 12.

Slovenko correctly states that it would in fact be unwise to link the test for criminal responsibility to specific diagnostic categories as it would take insufficient notice of the continuing redefining and imprecision of diagnostic information as well as the distinctive character of each individual's mental disorder.³⁹⁷ Within the forensic arena the mental health professional will be called upon to provide a diagnosis of the accused as to his or her mental state. Rendering a diagnosis often creates the illusion that disorders of a common name indicate absolute similarity or that the specific disorders have a distinct symptomatology.³⁹⁸ It is important to always bear in mind that there will always be a difference between the conceptual generality of nosology and the clinical specifications of a particular accused's case.³⁹⁹ The forensic mental health expert will have to indicate how the accused fits the specific diagnostic category. This is not always an easy task and the expert will inadvertently face severe cross-examination as to the precise means employed in arriving at a specific diagnosis.⁴⁰⁰ Diagnostic criteria do, however,

³⁹⁶ These categories are the following:

- Disorders usually first diagnosed in infancy, childhood, or adolescence.
- Delirium, Demential, and Amnestic and other Cognitive Disorders.
- Mental Disorders due to a General medical condition.
- Substance-related Disorders.
- Schizophrenia and other psychotic disorders.
- Mood Disorders.
- Anxiety Disorders.
- Somatoform Disorders.
- Factitious Disorders.
- Dissociative Disorders.
- Sexual and Gender Identity Disorders.
- Eating Disorders.
- Sleep Disorders.
- Impulse-Control Disorders not elsewhere classified.
- Adjustment Disorders.
- Personality Disorders.
- Other conditions that may be a focus of Clinical Attention.

See DSM-IV-TR (2000) *supra* note 344 at xii-xiii; First, MB, Frances, A and Pincus, HA "DSM-IV-TR – Handbook of Differential Diagnoses" (2002); Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 15-52; Slovenko (1995) *supra* note 3 at 67; Burchell and Milton (2005) *supra* note 3 383-389. See also Bartol and Bartol (2005) *supra* note 3 at 190-201.

³⁹⁷ Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 15. See also Freckleton, I and Selby, H "Expert evidence in Criminal Law" (1999) at 580 where they state: "The continuing development of, and refinements to, classificatory systems such as DSM-IV attest to an awareness within the psychiatric profession that 'old ways' will have to change if the status and reputation of psychiatry is to be maintained in relation to other disciplines."

³⁹⁸ Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 15.

³⁹⁹ *Ibid.*

⁴⁰⁰ *Ibid.* Slovenko also notes the following: "In an attempt to discredit the expert, the cross-examiner will question the expert on just how the accused fits the given category. The focus

provide more detailed information than a mere generic statement and a proper diagnosis will inform the court as to the mental illness of the accused, the seriousness of the mental illness, how the accused became mentally ill and how the particular mental illness affected the accused at the time of the commission of the offence.⁴⁰¹

In the following section a *capita selecta* of clinical disorders of legal significance will be discussed with emphasis on the main categories of mental disorders which could lead to pathological criminal incapacity. In the ultimate analysis it should be borne in mind that the accused's mental illness will not be exculpatory unless the particular mental illness affected the accused's cognitive or conative capacities to the extent required in the test for pathological criminal incapacity. As the central theme of this study relates to the role of the mental health expert in assessing alleged criminal incapacity, a closer analysis of the essential mental disorders that could influence criminal capacity is pivotal in order to comprehend the factual scenario from the mental health professional's point of view.

8.1 Delirium and dementia as manifestations of cognitive disorders⁴⁰²

then is on the category and the expert may be embarrassed by the imprecision of the fit. Many disorders have overlapping symptoms and like the colors of a rainbow, have no sharp dividing line. The salient issues in the case can be deflected by bickering over how the defendant's condition should be characterized. As a consequence, the controversy over diagnosis may overshadow all other issues when it should be only a minor factor. There is an inherent danger that the jury may lose the forest for the trees."

⁴⁰¹ Slovenko (1984) *Journal of Legal Medicine supra* note 253 at 16; Slovenko (1995) *supra* note 3 at 67. See also Woo and Keatinge (2008) *supra* note 344 at 136 where the value of a diagnostic interview is encapsulated in the following way: "The diagnostic interview can be used to identify the anatomy of clinical disorders, namely the presence and severity of essential (core) symptoms and associated features. Essential or key symptoms are necessary but not sufficient for a diagnosis of a disorder, and associated features are specific signs and symptoms that occur only if specific essential symptoms are present. In most cases, classification is based on a cross-sectional assessment of the diagnostic clues, which the clinician then matches to the key or essential features of a specific DSM-IV-TR diagnostic category."

⁴⁰² It is important to take note that the term "organic mental disorders" has been removed from the DSM-IV terminology as it assumes that other disorders in the manual do not consist of an organic component. See "DSM-IV Update" (1994) by the American Psychiatric Association at 6 as quoted in LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 221. See also Kaplan and Sadock (2003) *supra* note 344 at 319 where it is stated: "This century old distinction between organic and functional disorders is outdated and has been deleted from the nomenclature. They only unbiased conclusion to be made from evaluation of the available data is that every psychiatric disorder has an organic (that is, biological or chemical) component. Because of this reassessment of the data, the concept of functional disorders has been determined to be misleading, and the term 'functional' and its historical opposite 'organic', are not used in that context in DSM-IV-TR." See also Kaplan and Sadock (2003)

Delirium and Dementia are both cognitive disorders which entails that their primary feature relates to the impairment of cognitive abilities such as memory, attention, perceptions and chains of thought.⁴⁰³ It is necessary to take a closer look at these two manifestations of cognitive disorders as they could possibly have an impact on the cognitive functioning of an accused or a particular individual.

8.1.1 Delirium

The term “delirium” denotes an acute confusional mental state characterized by changes in cognitive functioning, mood, thinking, perception and sleep patterns that occur over a relatively short period of time.⁴⁰⁴ According to the DSM-IV, the essential diagnostic feature of a delirium is a disturbance in consciousness with a reduced ability to maintain attention.⁴⁰⁵ Other cognitive changes as a result of delirium include symptoms such as disorientation, inadequate memory, language difficulties and perceptual abnormalities such as hallucinations or illusions and delusions.⁴⁰⁶

supra note 344 at 323 where it is stated that the ICD-10 does still retain the term “organic mental disorder” and the term “organic” implies only that “the syndrome ... can be attributed to an independently diagnosable cerebral or systematic disease or disorder”. The categories included as organic mental disorders are dementias in Alzheimer’s disease, vascular dementia, unspecified dementias, organic amnesia syndrome, not induced or caused by alcohol or other psychoactive substances, delirium, not caused by alcohol or other psychoactive substances, other mental disorders due to brain damage and also unspecified organic or symptomatic mental disorder. See also Barlow and Durand (1995) *supra* note 344 at 616 where it is noted that the term “organic” was replaced with the term “cognitive disorders” to emphasize that the main feature of these disorders is the impairment of cognitive capacities.

⁴⁰³ Barlow and Durand (1995) *supra* note 344 at 616; DSM-IV-TR (2000) *supra* note 344 at 135-190; DSM-IV (1994) *supra* note 344 at 123-163; LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 221-229; Woo and Keatinge (2008) *supra* note 344 at 331-396; Kaplan and Sadock (2003) *supra* note 344 at 319; First, MB, Frances, A and Pincus, HA “DSM-IV-TR – Handbook of Differential Diagnosis” (2002) at 140-144.

⁴⁰⁴ Woo and Keatinge (2008) *supra* note 344 at 333; DSM-IV-TR (2000) *supra* note 344 at 135-136; DSM-IV (1994) *supra* note 344 at 123-124; Kaplan and Sadock (2003) *supra* note 344 at 319; LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 221-224. See also Volow, MR “Delirium, Dementia and other Organic mental disorders in Cavenar, JO and Brodie, HKH “Signs and Symptoms in Psychiatry” (1983) at 511 where it is stated that “delirium generally refers to acutely developing, but temporary, global disturbance of both consciousness and intellect, an acute confusional state.”

⁴⁰⁵ Woo and Keatinge (2008) *supra* note 344 at 333-334; Kaplan and Sadock (2003) *supra* note 344 at 325-326; DSM-IV-TR (2000) *supra* note 344 at 137-138; DSM-IV (1994) *supra* note 344 at 125.

⁴⁰⁶ *Ibid.*

According to the DSM-IV-TR, an individual with delirium may display emotional disturbances including anxiety, fear, depression, irritability and anger and these individuals may further display rapid and unpredictable emotional changes whilst fear is often accompanied by hallucinations and transient delusions.⁴⁰⁷ Woo and Keatinge in addition note that these hallucinations and illusions are caused by abnormalities in thinking and perception which causes obstacles in meaningfully distinguishing and integrating incoming “stimuli” and these hallucinations within the ambit of delirium consist of visual and/or auditory hallucinations and can range from ordinary shapes to objects or people and delusions often result from hallucinations and are typified by being persecutory.⁴⁰⁸

Due consideration of the diagnostic entity and features of delirium as well as delirium due to a general medical condition leads to the conclusion that these conditions could possibly impact on an accused’s cognitive or conative capacity in such a way as to exclude criminal capacity or possibly diminish criminal capacity.

8.1.1.1 Substance-induced delirium

The essential diagnostic features of substance-induced delirium correspond to those mentioned above for delirium in general save for the additional evidence pertaining the history, physical examination or laboratory findings of substance intoxication or withdrawal or medication side effects related to delirium.⁴⁰⁹ A delirium that occurs during substance intoxication is diagnosed as substance

⁴⁰⁷ DSM-IV-TR (2000) *supra* note 344 at 137-138 and also at 143 where the diagnostic criteria for Delirium due to a general medical condition are listed as follows:

- A. Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention.
- B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.
- C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
- D. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.”

The DSM-IV provides separate diagnostic criteria for both delirium due to general medical condition as well as substance-induced delirium. See also Kaplan and Sadock (2003) *supra* note 344 at 325, Woo and Keatinge (2008) *supra* note 344 at 334-335.

⁴⁰⁸ Woo and Keatinge (2008) *supra* note 344 at 334.

⁴⁰⁹ DSM-IV-TR (2000) *supra* note 344 at 143-144; DSM-IV (1994) *supra* note 344 at 129-130; Kaplan and Sadock (2003) *supra* note 344 at 325.

intoxication delirium whereas a delirium induced during substance withdrawal is coined substance withdrawal delirium. A delirium connected to the side effects of medication or toxin exposure is diagnosed as substance-induced delirium.⁴¹⁰ Substance intoxication delirium can, for example, be caused by the following substances: alcohol, amphetamines, cannabis, cocaine, hallucinogens, opioids and sedatives or hypnotics.⁴¹¹

Substance withdrawal delirium can be caused by the substances of alcohol, (also commonly referred to as “*delirium tremens*”), sedatives, hypnotics as well as anxiolytics and other unknown substances.⁴¹²

Within the context of insanity or pathological criminal incapacity as a defence, substance-induced delirium and substance withdrawal delirium, or “*delirium tremens*” as a result of the chronic consumption of alcohol can result in an accused either lacking cognitive or conative capacity at the time of the offence. According to Snyman the ordinary principles pertaining to the defence of pathological criminal incapacity and mental illness will apply, which entails that the accused will be found not guilty as a result of mental illness.⁴¹³ The latter will avail especially in cases where the alcohol was used over a prolonged period of time.⁴¹⁴

In *R v Kaukakani*⁴¹⁵, Davis AJA also noted the following:⁴¹⁶

“... insanity (e.g. *delirium tremens*) induced by alcohol will fall into the same category as any other form of insanity ...”

⁴¹⁰ *Ibid.*

⁴¹¹ DSM-IV-TR (2000) *supra* note 344 at 144-145; DSM-IV (1994) *supra* note 344 at 130; Kaplan and Sadock *supra* note 344 at 325.

⁴¹² *Ibid.* The DSM-IV-TR (2000) *supra* note 344 at 146 also indicates that a diagnosis of substance withdrawal delirium should only be rendered as an alternative to substance withdrawal when the cognitive symptoms are in excess of those usually connected to withdrawal syndrome and when the symptoms are severe enough to warrant independent clinical appraisal.

⁴¹³ Snyman (2008) *supra* note 3 at 222-223; LAWSA (2004) *supra* note 3 at 72; Hiemstra (2008) *supra* note 3 at 13-17.

⁴¹⁴ *Ibid.*

⁴¹⁵ *R v Kaukakani* 1947 (2) SA 807 (A).

⁴¹⁶ At 813. See also *R v Bourke* 1916 TPD 303 at 307; *R v Holiday* 1924 AD 250 at 257-258.

8.1.2 Dementia

Mental disorders classified under the umbrella term of “dementia” are characterized by the development of multiple cognitive deficits (including memory impairment) that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies (e.g. the combined effects of cerebrovascular disease and Alzheimer’s disease).⁴¹⁷ Bondi, Salmon and Kaszniak similarly state that dementia denotes a syndrome of acquired intellectual impairment of a very severe nature so as to impact on social or occupational functioning which is brought about as a result of brain dysfunction.⁴¹⁸ The main characteristic of dementia is the development of various cognitive deficits including memory impairment as well as particular cognitive impairments which include *aphasia*, *aproxia*, *agnosia* or an impairment in executive functioning.⁴¹⁹ One of the associated features of dementia entails disturbances in executive functioning which relates to the ability to think in an abstract manner and to plan, initiate, monitor and terminate complex activities and behaviour.⁴²⁰

Executive dysfunction is contextualized with a reduced ability to shift mental states, to comprehend new verbal or nonverbal information and to perform particular activities.⁴²¹ Further clinical features of dementia entail the following.⁴²²

⁴¹⁷ DSM-IV-TR (2000) *supra* note 344 at 147; and DSM-IV (1994) *supra* note 344 at 133. See also LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 222-223; Woo and Keatinge (2008) *supra* note 344 at 338; Comer (2008) *supra* note 359 at 448-449.

⁴¹⁸ Bondi, MW, Salmon, DP and Kaszniak, AW “The Neuropsychology of Dementia” in Grant, I and Adams, KM (eds) “Neuropsychological Assessment of Neuropsychiatric Disorders” (1996) at 164-165.

⁴¹⁹ DSM IV-TR (2000) *supra* note 344 at 148-149; DSM-IV (1994) *supra* note 344 at 134-136; Woo and Keatinge (2008) *supra* note 344 at 338-340. *Aphasia* generally denotes an impairment in the language function. *Agnosia* refers to an inability to identify objects irrespective of any sensory perception. *Apraxia* refers to an inability to perform motor activities irrespective of any sensory perception. See also Kaplan and Sadock (2003) *supra* note 300 at 329 where it is noted: “The cognitive functions that can be affected in dementia include general intelligence, learning and memory, language, problem solving, orientation, perception, attention and concentration, judgment and social abilities. A person’s personality is also affected.”

⁴²⁰ DSM-IV-TR (2000) *supra* note 344 at 149; DSM-IV (1994) *supra* note 344 at 135.

⁴²¹ *Ibid.*

⁴²² DSM-IV-TR (2000) *supra* note 344 at 136; Woo and Keatinge (2008) *supra* note 344 at 340-341. See also Kaplan and Sadock (2003) *supra* note 344 at 336-337 where it is stated: “Changes in the personality of a person with dementia are especially disturbing for the families of affected patients. Preexisting personality traits may be accentuated during the

- Poor judgment and insight;
- Unrealistic evaluation of individual abilities;
- Individuals underestimate risks associated with particular activities;
- Individual may become violent;
- Anxiety and mood impairments do occur often;
- Delusions are common as well as hallucinations;
- Sensitivity to physical and psychological stressors is high;
- Lack of judgment and insufficient impulse control are common features.

The DSM-IV-TR distinguishes between five classes of dementias of which dementia as a result of Huntington's disease will be used for illustrative purposes within the context of the defence of pathological criminal incapacity.⁴²³

development of a dementia. Patients with dementia may also become introverted and may seem to be less concerned than they previously were about the effects of their behavior on others. Persons with dementia who have paranoid delusions are generally hostile to family members and caretakers. Patients with frontal and temporal involvement are likely to have marked personality changes and may be irritable and explosive. ... An estimated 20 to 30 percent of patients with dementia ... have hallucinations, and 30 to 40 percent have delusions, primarily of a paranoid or persecutory and unsystematized nature, although complex, sustained, and well-systematized delusions are also reported by these patients. Physical aggression and other forms of violence are common in demented patients who also have psychiatric symptoms."

⁴²³ See LaBruzza and Mendez-Villarubia (1994) *supra* note 344 at 225-226; DSM-IV-TR (2000) *supra* note 344 at 154-171; DSM-IV (1994) *supra* note 344 at 139-155; Volow, MR "Delirium, Dementia and Other Organic Mental Syndromes" in Cavenar, JO and Brodie, HKH (eds) "Signs and Symptoms in Psychiatry" (1983) 511 at 521-532; Bondi, MW, Salmon, DP and Kaszniak, AW "The Neuropsychology of Dementia" in Grant, I and Adams, KM "Neuropsychological Assessment of Neuropsychiatric Disorders" (1996) 164 at 166-171. The specific manifestations of dementia are the following:

1. The Alzheimer's type – this disorder was first coined by German psychiatrist Alois Alzheimer in 1906. The distinctive cognitive impairment found in this form of dementia relates to a loss of memory. Individuals typically tend to forget events and objects. Alzheimer's disease is accordingly a progressive degenerative brain disorder. The cause of dementia of the Alzheimer type remains unknown but genetic factors are considered to play a role in the onset thereof. See also Kaplan and Sadock (2003) *supra* note 344 at 331; Barlow and Durand (1995) *supra* note 344 at 622-623. See also paragraph 5.1 above with reference to the discussion of *R v Kemp* where the accused was suffering from arteriosclerosis.

2. Vascular dementia.

3. Dementias due to other General medical conditions.

Examples of these are:

- Dementia due to HIV disease
 - Head trauma
 - Parkinson's disease
 - Huntington's disease
 - Picks disease
 - Creutzfeldt-Jakob disease
4. Substance-induced Persisting Dementia.

8.1.2.1 Dementia due to Huntington's disease

The DSM-IV-TR defines Huntington's disease as follows:⁴²⁴

"Huntington's disease is an inherited progressive degenerative disease of cognition, emotion and movement".

Huntington's disease is often characterized by changes in behaviour and personality, including depression, irritability and anxiety also often accompanied by abnormalities of movement that resemble increased fidgeting.⁴²⁵ Volow opines that variations between angry and tearful emotional states may result in aggressive outbursts.⁴²⁶ Psychiatric disorders of an advanced nature are also a common feature with reference to clinical depression and less often manic syndromes or paranoid tendencies.⁴²⁷

A decision which specifically dealt with a diagnosis of Huntington's Chorea was *S v Loubser*.⁴²⁸ The salient facts of this case were the following:

5. Dementia due to multiple etiologies.

⁴²⁴ DSM-IV-TR (2000) *supra* note 344 at 165; DSM-IV (1994) *supra* note 344 at 149. See also Bondi, MW, Salmon, DP and Kaszniak AW "The Neuropsychology of Dementia" in Grant, I and Adams, KM (eds) "Neuropsychological Assessment of Neuropsychiatric Disorders" (1996) at 169 where, from a neurological perspective, Huntington's Disease is defined as follows: "Huntington's disease is an inherited, autosomal dominant neurodegenerative disorder that results in movement disturbances and dementia. Neuropathologically, HD is characterized primarily by a progressive deterioration of the neostriatum ... with a selective loss of the spiny neurons and a relative sparing of the aspiny interneurons." See also Bruyn, GW, Bots, G and Dom, R "Huntington's chorea: Current neuropathological status" in Chase, T, Wexler, N, and Barbeau, A (eds) "Advances in Neurology: Huntington's Disease" (1979) at 83-94.

⁴²⁵ DSM-IV-TR (2000) *supra* note 344 at 165; DSM-IV (1994) *supra* note 344 at 149; Bondi *et al* (1996) *supra* note 424 at 169. See also Kaplan and Sadock (2003) *supra* note 344 at 333-334 where it is stated: "As the disease progresses, however, the dementia becomes complete; the features distinguishing it from dementia of the Alzheimer's type are the high incidence of depression and psychosis ..." See also Barlow and Durand (1995) *supra* note 344 at 627.

⁴²⁶ Volow, MR "Delirium, Dementia and other Organic Mental Syndromes" in Cavenar, JO and Brodie, HKH (eds) "Signs and Symptoms in Psychiatry" (1983) at 523. See also McHugh, PR, Folstein, MF: "Psychiatric syndromes of Huntington's Chorea – A Clinical and Phenomenologic Study" in Benson, DF and Blumer, D (eds) "Psychiatric Aspects of Neurologic Disease" (1975) at 267-286.

⁴²⁷ *Ibid.*

⁴²⁸ *S v Loubser* 1979 (3) SA 47 (A).

The accused had been convicted on charges of murder and rape in the trial court and was sentenced to death. On the specific day of the events, the accused travelled by train from Lotusriver to Kenilworth where a certain Noël Roberts resided. The deceased was a sixty-five year old woman who had worked for the Roberts family for nearly fifty years of which the last twenty years were for Noël Roberts. The accused was a bricklayer and plasterer at that stage. In the trial court the evidence disclosed that the accused raped the deceased and thereafter stabbed her in the chest with a knife which resulted in her death. Thereafter the accused appropriated cameras and a radio, put it in a plastic bag and took it to the house of his sister in Concert Boulevard, Retreat where he hid it under a bed. The knife was later found in the accused's house whereafter he made a statement to a magistrate. Leave to appeal was granted to the accused against conviction and sentence and also to adduce additional or novel evidence which was not adduced during the initial trial, which indicated that the accused suffered from a mental illness which led to a state of diminished responsibility. The latter application for further evidence was made in terms of section 316 of the Criminal Procedure Act.

A pivotal aspect of this decision relates to the expert evidence presented in this case. One of the experts, Dr PU Fischer, the district surgeon, stated the following in respect of the mental state of the accused:⁴²⁹

“First looking at him he appears to be quite normal but he has lapses of memory. He has got a family history of Huntington's Chorea. Apparently his mother died in Valkenberg, his brother is still in Valkenberg for treatment and his sister is attending there for treatment ... Huntington's Chorea is a disease that causes mental deterioration and is often related to criminal behaviour. Because of this I recommend that he be sent to Valkenberg for observation for at least 30 days.”

The accused was consequently referred to the Valkenberg Mental Hospital on two occasions for observation. The psychiatrists who were appointed to conduct the observation in terms of section 79(1)(b) of the Criminal Procedure Act were Dr T

⁴²⁹ At 52 C-D.

Zabow, Dr M Moss and Dr BR Lakie. Their unanimous opinion entailed that the accused was fit to stand trial and was not defective or psychotic and accordingly that he was not mentally ill and that he had the ability to appreciate the wrongfulness of the act and his ability to act in accordance with such appreciation of the wrongfulness of the act was not influenced by mental illness or defect at the time of the commission of the offence.⁴³⁰

During the hearing in the trial court it was never advanced on behalf of the accused that his responsibility could have been diminished. On appeal it was advanced on behalf of the accused (appellant) that additional evidence, specifically by one Dr Hayden from the Department of Genetics at the University of Cape Town, indicated that the appellant suffered from Huntington's Chorea and that this evidence proved that the appellant's criminal capacity was diminished at the time of the commission of the offence.⁴³¹ Dr Hayden described Huntington's Chorea as follows:⁴³²

⁴³⁰ At 52F – 53E of the judgment. The clinical report on the accused's mental status reads as follows: "2. Clinical Report: This 26 year old man is in good physical health. He has not previously had psychiatric illness or treatment. He is referred for psychiatric observation on charges of murder, rape and theft. According to a social worker's report his early childhood was one of deprivation and he was committed to a children's home due to an unsatisfactory domestic situation. He received formal education to Std 6 and he is reputed to have been an 'irregular worker with long spells of unemployment'. He has a relationship with his reputed wife and has two children. There is a strong history of Huntington's Chorea. This is an inherited condition of progressive mental deterioration with development of abnormal movements. This dementing condition usually presents after the fourth decade but earlier personality changes and mental changes are frequently present. His late mother and at least two of his sibs are confirmed sufferers of this condition. During an extended period of observation at Valkenberg Hospital as well as Pollsmoor Prison he was able to give a rational, detailed and sequential account of himself which was repeated at various interviews with changes in degree of recall of details. His thought process and talk are normal and his mood state appropriate to the circumstances. There is no evidence of hallucinations of any sort and he does not express delusional ideas. His memory is normal and he is correctly orientated. He is measured as of normal intelligence by psychometric testing. An EEG is reported as normal. He shows good insight and his judgment is satisfactory. There are no features in the comprehensive interviews with his family to indicate personality change of the type associated with early Huntington's Chorea. On Neurological examination he shows no involuntary movements. He is fit to stand trial and is not defective or psychotic in terms of the Mental Health Act." The reason why this report is included in this section is to bring the theoretical discussion on dementia and dementia due to Huntington's Disease in line with an actual assessment presented by mental health experts and to evaluate their opinion in respect of this diagnosis.

⁴³¹ At 55 A-F.

⁴³² At 56 B-D.

“Huntington’s Chorea is an hereditary nervous system disease which has its onset in adulthood. It frequently presents as a social problem with anti-social behaviour, change in personality and promiscuity. In the initial stages of this disorder it is often not easily recognisable as such. After a few years, however, characteristic abnormal movements develop which are severe, incurable and progressive. In fact, this disease is characterized by irregular spasmodic involuntary movements of the limbs and facial muscles, including speech disturbances.

The abnormal muscular movements are also associated with mental retardation. This progresses gradually until the unfortunate person afflicted with this disorder loses his intelligence, becomes demented and incontinent and death usually occurs within 10 to 15 years of onset of the disease.”

Dr Hayden testified that he had found signs of Huntington’s Chorea in the appellant but that these signs were subtle and required expert assessment and that if it was established that he in fact suffered from Huntington’s Chorea, the focus would fall on possible diminished criminal capacity.⁴³³ Dr Hayden went further and quoted authority on Huntington’s Chorea and stated that one of the initial signs of Huntington’s Chorea may relate to a change in personality accompanied by temper outbursts, impulsiveness, emotional instability, aggression and violence.⁴³⁴

Dr Hayden presented the following opinion in respect of the appellant.⁴³⁵

“I am of the opinion that the fact that appellant had become moody, irritable and had lost his temper in a way he had not done before, and that he was easily aroused, depicted a change in his personality which can possibly be associated with the earliest phases of Huntington’s Chorea. Knowing that the appellant suffers from Huntington’s Chorea it is probable that this illness may have made him less capable of appreciating the wrongfulness of his acts ...”.

⁴³³ At 56 E-G.

⁴³⁴ At 56 G-H.

⁴³⁵ At 57 C-D.

Another expert, Dr JM MacGregor, a neurologist, also observed signs of possible Huntington's Chorea in the accused and stated:⁴³⁶

“It is well known that patients with Huntington's Chorea may have emotional instability, excessive outbursts of aggression and violence, and an apathy out of keeping with the circumstances. I am not in the position, not knowing the details of the alleged crime, to say if these factors played a part here ...”.

The main issue in respect of the expert evidence presented in this case was that the experts provided opinions without connecting it to the specific facts of the case. Rumpff CJ also noted that Dr Hayden, who was not a psychiatrist or psychologist, expressed an opinion as to the appellant's possible diminished criminal capacity without connecting it to the specific facts of the case.⁴³⁷ Rumpff CJ further held that experts in these cases should be aware that evidence in respect of the mental state of an accused who has been convicted of murder, can only be evaluated if coupled with the facts of the particular case with due consideration of the circumstances of the murder.⁴³⁸ Rumpff CJ in addition stated:⁴³⁹

“Hulle (experts) weet, of behoort te weet, dat 'n Hof nie staat kan maak op bewerings van 'n algemene aard wat nie in verband gebring word met die feite van die spesifieke geval nie.”

The experts further failed to indicate the role of Huntington's Chorea in respect of the theft charge, also within the context of the accused's previous convictions on

⁴³⁶ At 57 H. See also 59 H-60A where the report of Dr Schubitz, a psychiatrist, is mentioned which noted that the appellant exhibited signs of Huntington's Chorea and that at the time of the commission of the offences the appellant was criminally responsible for his act but that his capacity to appreciate the wrongfulness of the acts or to act in accordance with an appreciation of the wrongfulness was diminished as a result of his neurological and psychiatric status.

⁴³⁷ At 57 F-H.

⁴³⁸ At 60 C.

⁴³⁹ At 60 C-G.

theft and housebreaking.⁴⁴⁰ The admissions by the accused on two occasions made to a magistrate that he killed the deceased out of fear that she would identify him were also not adequately accounted for by the experts.⁴⁴¹ Rumpff CJ similarly held:⁴⁴²

“Die effek van die verklarings van die deskundiges gaan wesenlik nie verder as ‘n algemene bewering dat omdat beskuldigde aan Huntington’s Chorea ly, in ‘n vroeë stadium, hy as verminderd toerekeningsvatbaar beskou moet word. Hoe hierdie moord en motief daarvan in verband staan met Huntington’s Chorea word nie gemeld nie.”

Rumpff CJ held that the criticism levelled towards the experts in this case should be viewed in the light of the need of the jurist that there be adequate cooperation regarding criminal capacity and criminal liability in respect of a crime between the jurist or legal practitioner on the one side, and the psychiatrist or psychologist or even neurologist on the other side with due regard of each of the two profession’s founding approaches and issues.⁴⁴³

Rumpff CJ stated:⁴⁴⁴

“Hiervolgens rus daar ‘n plig op die juris sowel as op die geestesdeskundige en dit is die plig van ‘n geestesdeskundige om in ‘n strafsak nie slegs algemene opinies uit te spreek nie, wat miskien op mediese gebied as verantwoord beskou kan word, maar om sy opinies te lewer met behoorlike inagneming van wat die taak van ‘n verhoorhof is by

⁴⁴⁰ *Ibid.*

⁴⁴¹ *Ibid.*

⁴⁴² At 61 A.

⁴⁴³ At 61 B-C. See also the Rumpff report *supra* note 3 at paragraph 1.19 – 1.20 where it is stated: “1.19 It is these extreme views which call for a coolheaded approach to the problems which are not to be evaded by the psychologist and the psychiatrist, on the one hand, and the jurist on the other, but must be solved by the cooperation of both parties in the best interests of society. 1.20. What is required of the psychiatrist and the psychologist is a sense of responsibility towards the views of society and the purpose and essence of punishment, and what is required of the jurist and the public is appreciation for the development of psychiatric and psychological knowledge.”

⁴⁴⁴ At 61 F.

die toepassing van die Strafreg en veral by die oorweging van toerekeningsvatbaarheid en strafregtelike aanspreeklikheid.”

and further:⁴⁴⁵

“Wat hierdie probleem wesenlik aandui is die noodsaaklikheid dat enige deskundige wat ‘n opinie oor die toerekeningsvatbaarheid van ‘n lyer aan Huntington’s Chorea uitspreek, die geestestoestand van so ‘n persoon ten minste in verband moet bring met die volle besonderhede van die misdaad wat so ‘n persoon gepleeg het.”

It was consequently held that the experts evaded the particulars of the crime and only provided general opinions in respect of criminal capacity and that the requirements for section 316 (3) had not been met. The application for leave to appeal and to adduce further evidence was rejected.⁴⁴⁶

- Reflections on the *Loubscher*-decision

The *Loubscher* decision could be regarded as a yardstick for future cases where mental illness, not necessarily only Huntington’s Chorea, is relied upon in support of the defence of criminal incapacity. The opinion of an expert, however well advanced, remains meaningless if not linked to the specific facts of a case. It could almost be stated that there should always be a *causal nexus* between the expert opinion provided by the mental health expert and the facts and circumstances of the case. Within the context of the *Loubscher* decision the question remains open as to whether the eventual finding could have been different had the mental health experts provided a more comprehensive analysis of the specific effects of the Huntington’s disease on the appellant and how this disease impacted on his cognitive and conative abilities at the time of the alleged offences, also not only to the crime of murder but also to the crime of theft.

⁴⁴⁵ At 62 A-B.

⁴⁴⁶ At 62 E-F.

8.2 Schizophrenia

“Are you lost?”

‘No. But I don’t know where I am.’

‘It is the very error of the moon, she comes more near the earth than she was won’t, and makes men mad.’ (Othello V.2. 110)

“How is’t with me, when every noise appalls me?” (Macbeth II.2.57)⁴⁴⁷

One of the most serious and devastating mental disorders is Schizophrenia⁴⁴⁸. Schizophrenia is one of the most common forms of mental illness and also one of the most highly publicized disorders⁴⁴⁹. Research suggests that one of every 100 people in the world suffers from Schizophrenia at some stage during their lives⁴⁵⁰.

Historically, the German psychiatrist Emil Kraepelin (1855–1926) referred to Schizophrenia by using the term *dementia praecox* which refers to two major

⁴⁴⁷ As quoted in Cox and Theilgaard (1994) *supra* note 395 at 380 and 393.

⁴⁴⁸ Woo and Keatinge (2008) *supra* note 344 at 472; Tarrier, N “Schizophrenia and other Psychotic Disorders” in Barlow, DH (ed.) “Clinical Handbook of Psychological Disorders” 4th ed. (2008) at 463; Comer (2008) *supra* note 344 at 339; Kaplan and Sadock (2003) *supra* note 344 at 471; Barlow and Durand (1995) *supra* note 344 at 553; Freckelton, I and Selby, H “Expert Evidence in Criminal Law” (1999) at 583; Mason, JK “Forensic Medicine for Lawyers” (2001) 4th ed. at 393; Weiner, IB “Adult Psychopathology – Case Studies” (2004) at 295; Bartol and Bartol (2005) *supra* note 3 at 192 – 193; Faulk, M “Basic Forensic Psychiatry” (1994) at 149 – 151; Bartol (1991) *supra* note 3 at 147; Dziegielewski (2002) *supra* note 344 at 247; Goodwin, DW and Guze, SB “Psychiatric Diagnosis” (1989) at 43; Slovenko (1995) *supra* note 3 at 69 – 70; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 20 – 21; Burchell and Milton (2005) *supra* note 3 at 384 – 385; Strauss, SA “The person with Schizophrenia and criminal justice – some aspects” (1996) *Comparative and International Law Journal of South Africa* at 282; Shieber, A, Yecheleskiel, A and Halmosh, AF “The Psychiatric Diagnosis: Is it an Instrument of Help or one of Doom” (1987) *Medicine and Law* at 165; Kendall, PC and Hammen, C “Abnormal Psychology” (1995) at 292.

⁴⁴⁹ Strauss (1996) *CILSA supra* note 448 at 282; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 20; Slovenko (1995) *supra* note 3 at 69; Comer (2008) *supra* note 344 at 339. A classic portrayal of a Schizophrenic personality is found in the film “A Beautiful Mind” where the actor Russel Crowe plays the role of John Forbes Nash. The movie deals with the true story of John Forbes Nash who is a highly intelligent mathematician who developed Schizophrenia early in his career and also suffered from the disorder for 35 years, unable to lead an independent life for most of these years. He was awarded with the Nobel Prize in Economics for his doctoral work on *game theory* which comprised of a mathematical model. The film captures the true essence of Nash’s battle against Schizophrenia. See Comer (2008) *supra* note 300 at 345. Historically it was also alleged that the famous artist Vincent Van Gogh suffered from Schizophrenia and he also stated the following in his own words: (as quoted in Comer (2008) *supra* note 344 at 341) “I shouldn’t precisely have chosen madness if there had been any choice, but once such a thing has taken hold of you, you can’t very well get out of it.” (Vincent van Gogh, 1889).

⁴⁵⁰ Comer (2008) *supra* note 344 at 339; Strauss (1996) *CILSA supra* note 448 at 282. See also Mueser, KT and Gingerich, S “Coping with Schizophrenia” (1994) at 11; Kaplan and Sadock (2003) *supra* note 344 at 471; Mason (2001) *supra* note 448 at 393.

characteristics of the illness, according to Kraepelin, which entails the development or onset of the illness at an early age (*praecox* – premature) and also the deterioration of intellectual abilities (*dementia* which is derived from the Latin word *demens* literally meaning “out of one’s mind”)⁴⁵¹. Kraepelin also brought together the concepts of *catatonia* which refers to alternating immobility and excited agitation, *hebephrenia*, which entails silly and immature reactions, and *paranoia* which denotes delusions of persecution, under the umbrella term of *dementia praecox*⁴⁵². Kraepelin in addition drew a distinction between *dementia praecox* and manic-depressive disorder⁴⁵³.

In 1919, the Swiss psychiatrist, Eugen Bleuler, coined the phrase *Schizophrenia* which replaced the previous term of *dementia praecox*⁴⁵⁴. Bleuler advanced that intellectual deterioration was not the essential feature, but rather emotional disturbances and also disturbance of associative capacities which results in the disturbance of the continuity of the personality with the consequential splitting of the personality and accordingly Bleuler called the illness Schizophrenia derived from the Greek words “*Skhizo*” – to split, and “*phren*” - mind⁴⁵⁵. In layman’s terms Schizophrenia is often erroneously construed to refer to “split personality”, or more

⁴⁵¹ Strauss (1996) *supra* note 448 at 284; Slovenko (1995) *supra* note 3 at 69 – 70; Kaplan and Sadock (2003) *supra* note 344 at 471; Woo and Keatinge (2008) *supra* note 344 at 470.

⁴⁵² Barlow and Durand (1995) *supra* note 344 at 554. See also Woo and Keatinge (2008) *supra* note 344 at 470 where it is stated: “... the German psychiatrist Emil Kraepelin, who classified the different manifestations of dementia praecox into subtypes (e.g.) hebephrenic, paranoid, catatonic and simple) in the early twentieth century, and who described the common threads of frequent relapse and poor prognosis that seemed to link the different subtypes to a single disease entity that was distinguishable from manic-depressive illness. Kraepelin (1919) also advanced the concept that neurological abnormalities or impairment ... were implicated in the genesis of dementia praecox”. See also Kaplan and Sadock (2003) *supra* note 344 at 471.

⁴⁵³ *Ibid.*

⁴⁵⁴ Strauss (1996) *CILSA supra* note 400 at 284; Kaplan and Sadock (2003) *supra* note 344 at 471; Slovenko (1995) *supra* note 3 at 70; Woo and Keatinge (2008) *supra* note 344 at 470; Mueser and Gingerich (1994) *supra* note 450 at 8.

⁴⁵⁵ Strauss (1996) *CILSA supra* note 448 at 284. See also Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 20 where it is stated: “Bleuler in 1911 renamed dementia praecox ‘Schizophrenia’ because of his observation that the cognitive disturbance was not dementia at all but a defect association. ... Bleuler used the term to emphasize dissociation within the stream of consciousness, loss of associational meaning, split of effect from ideation, and loss of integrated functioning of the personality.” See also Kaplan and Sadock (2003) *supra* note 344 at 471 where it is noted that Bleuler identified core symptoms of Schizophrenia which included associational disturbances, affective disturbances, autism and ambivalence, summarized as the four A’s – associations, affect, autism and ambivalence. See also Goodwin and Guze (1989) *supra* note 448 at 43–45.

commonly known as multiple personality disorder which is now termed “dissociative identity disorder” in the DSM-IV-TR⁴⁵⁶.

Within the diagnostic framework of the DSM-IV, Schizophrenia is listed together with other psychotic disorders including Schizophreniform disorder, Schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance induced psychotic disorder and also psychotic disorder not otherwise specified⁴⁵⁷. Schizophrenia is a severe mental illness that is characterized by various symptoms including *hallucinations, delusions, disorganized speech and disorganized behaviour*⁴⁵⁸. *The clinical symptoms* of Schizophrenia are generally

⁴⁵⁶ Kaplan and Sadock (2003) *supra* note 344 at 471; Strauss (1996) *CILSA supra* note 448 at 284; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 20; Slovenko (1995) *supra* note 3 at 70; Freckelton and Selby (1999) *supra* note 448 at 583. See also Rosenhan, DL and Seligman, MEP “Abnormal Psychology” (1995) at 421.

⁴⁵⁷ DSM-IV-TR (2000) *supra* note 344 at 297 – 298; DSM-IV (1994) *supra* note 344 at 273 – 274. The DSM-IV-TR defines the term “psychotic” as follows” (at 297) “The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences. In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term psychotic refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior.” See also Freckelton and Selby (1999) *supra* note 400 at 581 where “*psychosis*” is defined as: “... a serious psychiatric condition in which an individual’s capacity to test his or her external reality is significantly impaired. It may be accompanied by delusions and hallucinations.” See also Schmallegger, F “Criminology Today” (1996) at 210.

⁴⁵⁸ Tarrier (2008) in Barlow (ed.) (2008) *supra* note 448 at 463; DSM-IV-TR (2000) *supra* note 344 at 271–272; Dziegielewski (2002) *supra* note 344 at 247; Comer (2008) *supra* note 344 at 347. With regard to the development of Schizophrenia see Comer (2008) *supra* note 344 at 355 where it is stated that the biological explanations of Schizophrenia indicate that genetic, biochemical, brain structure and viral causes play an important role. The most influential biochemical explanation entails that the brains of people with Schizophrenia experience high volumes of dopamine activity. The leading brain structure explanation takes the view that some brain structures are abnormal in the brains of persons with Schizophrenia as is evident from enlarged ventricles and abnormal blood flow traced in some parts of their brains. The psychological explanations for Schizophrenia are mainly the psychodynamic and cognitive models. With regard to psychodynamic explanations, Freud held that Schizophrenia entails a regression to a state of primary narcissism and attempts to restore ego control, From-Reichmann advanced that Schizophrenogenic mothers assisted to produce this disorder. Cognitive theorists take the view that when people with Schizophrenia propose to comprehend their strange biological sensations, they eventually develop delusional thinking. The socio-cultural view entails that society expects people who are labeled as Schizophrenics to act in a specific way and that these expectations lead to further symptoms, whilst clinical theorists are in agreement that Schizophrenia can be traced to a combination of biological, psychological as well as socio-cultural factors.

divided between positive and negative symptoms and can be summarized as follows:⁴⁵⁹

Positive symptoms	Negative symptoms
<ul style="list-style-type: none"> • Hallucinations • Delusions • Bizarre conduct • Distorted or disorganized thinking 	<ul style="list-style-type: none"> • Affective flattening • Alogia⁴⁶⁰ • Avolition⁴⁶¹ • Anhedonia⁴⁶²

⁴⁵⁹ Woo and Keatinge (2008) *supra* note 344 at 473; Tarrier (2008) in Barlow (ed.) (2008) *supra* note 448 at 463; DSM-IV-TR (2000) *supra* note 344 at 299; DSM-IV (1994) *supra* note 344 at 275; Barlow and Durand (1995) *supra* note 344 at 558. In terms of the DSM-IV-TR (2000) *supra* note 344 at 312, the diagnostic criteria for Schizophrenia are the following:

“Diagnostic criteria for Schizophrenia

A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g. frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior
- (5) negative symptoms, i.e. affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement.)

C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion*: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1(\)) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion*: The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder*: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).”

See also Rosenhan, DL and Seligman, MEP “Abnormal Psychology” (1995) at 419 where they define Schizophrenia as: “... a disorder of thinking and troubled mood. This thought disorder is manifested by difficulties in maintaining and focusing attention and in forming concepts. ... ‘Schizophrenia’ is not a single disorder but rather a group of psychoses.”

	<ul style="list-style-type: none"> • Social withdrawal
--	---

According to the DSM-IV, at least two of these symptoms that have lasted at least for a period of one month, is required to render a diagnosis of Schizophrenia⁴⁶³. In addition, continuous signs of this disease must be present for a total of six months⁴⁶⁴. According to Dziegielewski, the person suffering from Schizophrenia experiences various states of terror that includes changes in behaviour and impacts negatively on daily interactions with other people and as a result the person becomes unable to distinguish fantasy from reality⁴⁶⁵. A classic portrayal of the typical symptoms of Schizophrenia is the following:⁴⁶⁶

“During my drive, I notice I am ‘seeing’ things that are not there. Rabbits, cats, bugs appear and disappear. I see people from my past, whom I know to be dead or hundreds of miles away, driving the vehicles on the highway next to me. I believe the FBI is following me, because I notice that black cars with no license plates are taking turns driving behind me. I am not alarmed. I attribute the sights to fatigue and it makes sense to me that the FBI is tailing me since I am going to a high-security school.”

This quote encapsulates the two major symptoms associated with Schizophrenia – delusions and hallucinations. It is accordingly important to evaluate these symptoms as they could potentially impact on an individual’s cognitive or conative

⁴⁶⁰ See Barlow and Durand (1995) *supra* note 344 at 561 where it is stated that Alogia generally refers to an absence in the amount or content of speech. The DSM-IV-TR (2000) *supra* note 344 at 301 defines Alogia as poverty of speech. This symptom is of less relevance to this study and will not be addressed in detail. See also Comer (2008) *supra* note 344 at 344.

⁴⁶¹ Avolition is contextualized by an inability to initiate and persevere with any goal-directed activity. See the DSM-IV-TR (2000) *supra* note 344 at 301; Barlow and Durand (1995) *supra* note 344 at 561; Comer (2008) *supra* note 344 at 344.

⁴⁶² Anhedonia refers to a lack of pleasure endured or experienced by individuals suffering from Schizophrenia. See Barlow and Durand (1995) *supra* note 448 at 562.

⁴⁶³ DSM-IV-TR (2000) *supra* note 344 at 298; DSM-IV (1994) *supra* note 307 at 274; Woo and Keatinge (2008) *supra* note 344 at 473; Comer (2008) *supra* note 400 at 346.

⁴⁶⁴ Woo and Keatinge (2008) *supra* note 344 at 473; Dziegielewski (2002) *supra* note 344 at 257; Kaplan and Sadock (2003) *supra* note 344 at 484.

⁴⁶⁵ Dziegielewski (2002) *supra* note 344 at 247; Kaplan and Sadock (2003) *supra* note 344 at 476–477.

⁴⁶⁶ Description by an anonymous woman recalling her first psychotic experience which occurred at the age of 19 on her way to a military college as quoted in Woo and Keatinge (2008) *supra* note 344 at 469.

capacities in terms of the test for criminal capacity. Hallucinations and delusions are, as stated above, the positive symptoms of Schizophrenia.

- Delusions

According to the DSM-IV-TR, delusions are false beliefs that entail a misinterpretation of perceptions or experiences including a variety of themes, for example persecutory, referential, somatic religious, or grandiose⁴⁶⁷. Woo and Keatinge summarize the most common delusional themes as follows:⁴⁶⁸

Delusion type	Definition	Examples
Erotomantic	The false belief that another individual is in love with you from afar.	"I know that Robert De Niro is in love with me because when I got his autograph he took extra long to sign it."
Grandiose	The erroneous belief that you possess powers, knowledge or abilities in excess of the actual ones. The belief that you know or are associated with a famous or influential person.	"I have been selected to be God's special emissary on earth and to bring peace to all war-torn countries."
Jealous	The belief that one's partner is unfaithful without any evidence	"I'm sure my husband doesn't have a business meeting on

⁴⁶⁷ DSM-IV-TR (2000) *supra* note 344 at 299; DSM-IV (1994) *supra* note 344 at 275; Woo and Keatinge (2008) *supra* note 344 at 473. See also Barlow and Durand (1995) *supra* note 344 at 559 where a delusion is defined as: "A belief that would be seen by most members of a society as a misrepresentation of reality is called a disorder of thought content, of a delusion. Because of its importance in Schizophrenia, delusion has been called 'the basic characteristic of madness'. If, for example, you believe that squirrels really are aliens to earth on a reconnaissance mission, this belief would be considered a delusion."

⁴⁶⁸ Woo and Keatinge (2008) *supra* note 344 at 474.



	proving this fact.	Monday nights – he’s meeting his mistress and his boss is just covering for him.”
Persecutory	The belief that a specific person, group of persons is intentionally trying to harm you.	“I drink only bottled water because the government is carrying out experiments on people in my town by putting harmful viruses in the water.”
Somatic	The belief that you have a physical ailment or medical condition without any medical evidence in support thereof.	“My intestines are slowly rotting away from gangrene.”
Reference	The belief that individuals, objects, occurrences in your environment have distinct and special meanings.	“When I saw that the sixth slot machine in my row at the casino had a jackpot of \$66,000 I knew it was the Devil trying to tempt me.”
Control	The belief that some force outside of you is controlling your behaviour.	“A satellite is making me move and talk to you.”

The most common delusion is the delusion of persecution also relating to individuals believing they are being plotted against, threatened or victimized⁴⁶⁹.

⁴⁶⁹ Comer (2008) *supra* note 344 at 341; Barlow and Durand (1995) *supra* note 344 at 559; DSM-IV-TR (2000) *supra* note 344 at 299. See also Strauss (1996) *CILSA supra* note 448 at 288; Mueser and Gingerich (1994) *supra* note 450 at 42.

Delusions are generally further divided into the categories of bizarre and non-bizarre delusions. Bizarre delusions are considered more pathological as they denote perceptions that are completely implausible, for example that a computer chip has been implanted in one's brain, whereas non-bizarre delusions refer to events that could possibly happen, for example being followed by the police⁴⁷⁰. The DSM-IV-TR in addition states that delusions are considered bizarre if "they are clearly implausible and not understandable and do not derive from ordinary life experiences."⁴⁷¹

- Hallucinations

Hallucinations are considered to be sensory experiences that take place in the absence of external stimuli and are accordingly false perceptions⁴⁷². Hallucinations can relate to any of the senses, but the most common hallucinations are auditory hallucinations experienced by people with Schizophrenia⁴⁷³. Real hallucinations take place when the patient is in a true state of consciousness and should be distinguished from hallucinatory experiences such as drifting off to sleep and a distinction should also be drawn between hallucinations and sensory misperceptions such as illusions⁴⁷⁴. Auditory hallucinations generally comprise of one or more voices that have a distinct auditory quality similar to hearing actual voices and typically involve a voice that keeps a running commentary of the person's behaviour or actions and voices that

⁴⁷⁰ Woo and Keatinge (2008) *supra* note 344 at 474–475 where it is stated that the distinction between bizarre and non-bizarre delusions has diagnostic relevance in terms of the DSM-IV-TR due to the fact that the presence of a bizarre delusion is sufficient to satisfy the symptom criteria for Schizophrenia, whereas an additional sign or symptom is required if a non-bizarre delusion is present. See also the DSM-IV-TR (2000) *supra* note 344 at 299.

⁴⁷¹ DSM-IV-TR (2000) *supra* note 344 at 299.

⁴⁷² Strauss (1996) CILSA *supra* note 448 at 288–289; Barlow and Durand (1995) *supra* note 344 at 559; Woo and Keatinge (2008) *supra* note 344 at 475; Comer (2008) *supra* note 344 at 343; Kaplan and Sadock (2003) *supra* note 344 at 491–492; DSM-IV-TR (2000) *supra* note 344 at 299–300; DSM-IV (1994) *supra* note 344 at 275.

⁴⁷³ *Ibid.* See also Goodwin and Guze (1989) *supra* note 400 at 47 and Cavenar, JO and Brodie, HKH "Signs and Symptoms in Psychiatry" (1983) at 434.

⁴⁷⁴ Woo and Keatinge (2008) *supra* note 344 at 475. See also Kaplan and Sadock (2003) *supra* note 344 at 492 where illusions are described as follows: "... illusions are distortions of real images or sensations, whereas hallucinations are not based on real images or sensations. Illusions can occur in Schizophrenia patients during active phases, but they can also occur during the prodromal phases and during periods of remission."

communicate with each other⁴⁷⁵. Strauss notes that approximately seventy percent of patients with Schizophrenia experience auditory hallucinations and that these “voices” in effect register directly in the brain itself and do not go through the auditory system even though the patient may experience it as such⁴⁷⁶.

Command hallucinations are extremely problematic as these instruct the individual to act in a specific way and these hallucinations can vary from relatively harmless to extremely dangerous and even though many individuals ignore these hallucinations, research suggests that at least forty percent of patients obeyed them⁴⁷⁷.

Another positive symptom of Schizophrenia include disorganized thinking (“formal thought disorder”) which is also considered by some to be the single most essential feature of Schizophrenia and relates to disorganized thinking processes in which the individual answers questions in a disorganized manner by constantly drifting off the topic and change from one topic to another and eventually the individual become incomprehensible⁴⁷⁸. Grossly disorganized or catatonic behaviour is the fourth positive symptom of Schizophrenia. Interestingly, the DSM-IV-TR lists catatonic behaviour and grossly disorganized behaviour together whilst, however, catatonia is quite different from disorganized behaviour and generally entails motor behaviours contextualized by marked rigidity and resistance to being moved, purposeless activity and bizarre postures and catatonia can also occur in other neurological disorders such as depression and

⁴⁷⁵ Woo and Keatinge (2008) *supra* note 344 at 475; Kaplan and Sadock (2003) *supra* note 344 at 492; Cavenar and Brodie (1983) *supra* note 424 at 434.

⁴⁷⁶ Strauss (1996) *CILSA supra* note 448 at 289. See also Comer (2008) *supra* note 344 at 343 where it is stated: “Research suggests that people with auditory hallucinations actually produce the nerve signals of sound in their brains, ‘hear’ them, and then believe that external sources are responsible.”

⁴⁷⁷ Woo and Keatinge (2008) *supra* note 344 at 475. A typical example of command hallucinations is the words by Christopher Scarver, a prison inmate who beat his fellow prisoner, Jeffrey Dahmer, to death in 1994. When asked why he acted as such he simply stated: “God told me to do it.” See also Cavenar and Brodie (1983) *supra* note 424 at 434 where they state: “Hallucinations conveying a command (command hallucinations) often convincingly compel the individual to self-harm or destructive behaviour.”

⁴⁷⁸ Woo and Keatinge (2008) *supra* note 344 at 476; DSM-IV-TR (2000) *supra* note 344 at 300; Kaplan and Sadock (2003) *supra* note 344 at 492–493; Barlow and Durand (1995) *supra* note 344 at 560; Comer (2008) *supra* note 344 at 343.

can also be characterized by social withdrawal, mutism and refusal to eat⁴⁷⁹. Examples of disorganized behaviour are, for example, acting in unusual ways in public, randomly accosting strangers or standing on a street corner staring at the sun or unpredictable agitation⁴⁸⁰.

The negative symptoms of Schizophrenia include blunted or flattened affect which entails that the individual virtually displays no emotions at all and some also experience anhedonia which, as stated above, relates to a lack of pleasure; loss of volition, social withdrawal and poverty of speech⁴⁸¹. Although the negative symptoms are less conspicuous than the positive symptoms, negative symptoms are regarded as important to the disease of Schizophrenia and tend to be more stable than positive symptoms⁴⁸².

If two or more of these symptoms are consistently present for a period of one month, a diagnosis of Schizophrenia can be rendered save for the situation where the delusions are bizarre or hallucinations entail “voices commenting” or “voices conversing” in which event the presence of only one symptom is sufficient⁴⁸³.

Schizophrenia can further be divided into the following subtypes:

⁴⁷⁹ Woo and Keatinge (2008) *supra* note 344 at 477; DSM-IV-TR (2000) *supra* note 344 at 300–301; Barlow and Durand (1995) *supra* note 344 at 561; Comer (2008) *supra* note 344 at 344.

⁴⁸⁰ *Ibid.*

⁴⁸¹ Woo and Keatinge (2008) *supra* note 344 at 478; Strauss (1996) *CILSA supra* note 448 at 288; Comer (2008) *supra* note 344 at 344; Barlow and Durand (1995) *supra* note 344 at 561–562; DSM-IV-TR (2000) *supra* note 344 at 301–302; DSM-IV (1994) *supra* note 344 at 276–277.

⁴⁸² *Ibid.*

⁴⁸³ DSM-IV-TR (2000) *supra* note 344 at 301–302; Strauss (1996) *CILSA supra* note 448 at 288; Mueser and Gingerich (1994) *supra* note 450 at 42. See also Shieber (1987) *Medicine and Law supra* note 400 at 165 where it is noted that psychiatrists should be sure when rendering a diagnosis of Schizophrenia and also when communicating this news to family members as this is a diagnosis which evokes feelings of despondency, hopelessness and finality to the family. Shieber states at 165: “It is astonishing how relentlessly a diagnosis of Schizophrenia, once written in person’s medical file, probably by a junior resident, is carried over and accepted as valid without question or reexamination by subsequent workers and repeated in correspondence with other agencies demanding information. ... The psychiatrist should refrain from confronting the family with an express diagnosis of Schizophrenia at least in the first phase, not only because it may be a mistake, but especially because Schizophrenia may have an entirely different meaning for the parents than for a psychiatrist with a background of scholarly and emotionally detached experience” and at 170: “We believe that Schizophrenia is not only a diagnosis, but a verdict, which sentences families for life. Thus, we feel that it is ample time to pronounce it when are absolutely certain of its accuracy.”

- Paranoid type

The most important feature of the paranoid type is the presence of delusions or auditory hallucinations whilst cognitive functioning remains intact⁴⁸⁴. Delusions are typically of a persecutory nature and also grandiose and delusions with other themes such as jealousy or religiosity may also occur and these delusions may be multiple but are most often centred around a specific theme⁴⁸⁵. Associated characteristics of this type are anxiety, anger, aloofness, and argumentativeness and in addition the persecutory themes may lead to suicidal behaviour, and a combination of persecutory and grandiose delusions coupled with anger may predispose the Schizophrenic individual to violence⁴⁸⁶. The paranoid Schizophrenic is also the most commonly represented in criminal behaviour⁴⁸⁷.

⁴⁸⁴ DSM-IV-TR (2000) *supra* note 344 at 313–314; DSM-IV (1994) *supra* note 344 at 287; Woo and Keatinge (2008) *supra* note 344 at 478; Barlow and Durand (1995) *supra* note 344 at 562–563; Bartol and Bartol (2005) *supra* note 448 at 194; Kaplan and Sadock (2003) *supra* note 344 at 485.

⁴⁸⁵ *Ibid.*

⁴⁸⁶ *Ibid.*

⁴⁸⁷ *Ibid.* See also Bartol (1991) *supra* note 448 where it is stated: “Paranoid Schizophrenics may be convinced that the FBI is following them with the intent of capturing them and leading them to their death. Or, the paranoid Schizophrenic may believe that the world is inhabited by extraterrestrials who are plotting to take over the world.” See also Jones, DW “Understanding Criminal Behaviour – Psychosocial approaches to criminality” (2008) at 52 – 55 where the case of Peter Sutcliffe or better known as the “Yorkshire Ripper” is discussed. Peter Sutcliffe was arrested and charged with the murder of 13 women and attempted murder of seven women. He pleaded not guilty to murder, but guilty to manslaughter on the grounds of diminished responsibility. The psychiatrists who had interviewed him were in consensus that he was suffering from paranoid Schizophrenia and accordingly the defence argued that he was suffering from this mental disorder and he claimed that he had begun hearing voices and had become deluded. He also claimed that he heard the Voice of God. Peter Sutcliffe stated the following: “Mr Sutcliffe: ‘I was digging and I just paused for a minute. It was very hard ground. I just heard something – it sounded like a voice similar to a human voice – like an echo. I looked round to see if there was anyone there, but there was no one in sight. I was in the grave with my feet about five feet below the surface. There was no one in sight when I looked round from where I was. Then I got out of the grave. The voice was not very clear. I got out and walked – the ground rose up. It was quite a steep slope. I walked to the top, but there was no one there at all. I heard again the same sound. It was like a voice saying something, but the words were all imposed on top of each other. I could not make them out, it was like echoes. The voices were coming directly in front of me from the top of a gravestone (which was Polish. I remember the name on the grave to this day. It was a man called Zipolski. Stanislaw Zipolski. ... It had a terrific impact on me. I went down the slope after standing there for a while. It was starting to rain.). I remember going to the top of the slope overlooking the valley and I felt as though I had just experienced something fantastic. I looked across the valley and all around and thought of heaven and earth and how insignificant we all are. But I felt so important at the moment.” Peter Sutcliffe also stated that he was under an obligation to carry out a mission to rid the world of prostitutes and that he never enjoyed committing the terrible crimes. He in addition stated: “I found it very difficult, and I couldn’t restrain myself. I could not do anything to stop myself” and when asked why he couldn’t stop himself he simply stated: “Because it was God controlling me.” The prosecution

- Disorganized type

They key features of the disorganized type are disorganized speech, disorganized behaviour and inappropriate effect. Disorganized speech may be accompanied by silliness and laughing at the wrong times and in the event of delusions or hallucinations being present, they are fragmented and not centred around a specific theme⁴⁸⁸.

- Catatonic type

The catatonic type is characterized by psychomotor disturbance by means of remaining in fixed positions or engaging in excessive activity which is apparently purposeless and not affected by external stimuli. These individuals also at times display extreme negativism which is characterized by remaining in a rigid posture as well as resistance to all instructions⁴⁸⁹ and often display severe alteration between excitement and stupor. During severe catatonic behaviour, these individuals need supervision in order to prevent them from harming themselves or others⁴⁹⁰.

- Undifferentiated type

Individuals who display the main symptoms of Schizophrenia, but do not meet the specified criteria for paranoid, disorganized or catatonic types of Schizophrenia, are generally classified as the undifferentiated type of Schizophrenia⁴⁹¹.

advanced the argument that Sutcliffe was fabricating his defence. Sutcliffe was eventually found guilty but the question still remains: should he be seen as bad or mad or both?

⁴⁸⁸ DSM-IV-TR (2000) *supra* note 344 at 314; DSM-IV (1994) *supra* note 344 at 287–288; Bartol and Bartol (2005) *supra* note 3 at 193, Bartol (1991) *supra* note 3; Barlow and Durand (1995) *supra* note 344 at 562; Kaplan and Sadock (2003) *supra* note 344 at 486; Woo and Keatinge (2008) *supra* note 344 at 479; Freckelton and Selby (1999) *supra* note 448 at 586. This subtype of Schizophrenia was historically known as the *hebephrenic*.

⁴⁸⁹ Kaplan and Sadock (2003) *supra* note 344 at 487; DSM-IV-TR (2000) *supra* note 344 at 315–316; Barlow and Durand (1995) *supra* note 344 at 562–563; Bartol (1991) *supra* note 344 at 148; Bartol and Bartol (2005) *supra* note 3 at 193.

⁴⁹⁰ *Ibid.*

⁴⁹¹ DSM-IV-TR (2000) *supra* note 344 at 316; DSM-IV (1994) *supra* note 344 at 299; Barlow and Durand (1995) *supra* note 344 at 563; Bartol and Bartol (2005) *supra* note 344 at 194.

- Residual type

An individual who has experienced at least one episode of Schizophrenia, but no longer displays major positive psychotic symptoms such as delusions or hallucinations, but still retain some “residual” symptoms such as unusual ideas that are not completely delusional, will be diagnosed as having the residual type of Schizophrenia⁴⁹².

It is important to take note of the various Schizophrenic subtypes in order to gain more insight into the Schizophrenic personality. As stated above, Schizophrenia is listed together with other psychotic disorders in the DSM-IV. These disorders will not be discussed in this section as they generally share common characteristics with the general description of Schizophrenia⁴⁹³.

⁴⁹² Barlow and Durand (1995) *supra* note 344 at 563; Woo and Keatinge *supra* note 344 at 479; Bartol and Bartol (2005) *supra* note 344 at 194; Kaplan and Sadock (2003) *supra* note 344 at 488; DSM-IV-TR (2000) *supra* note 344 at 316; DSM-IV (1994) *supra* note 344 at 289.

⁴⁹³ See Comer (2008) *supra* note 344 at 348 where the other psychotic disorders are summarized as follows as opposed to Schizophrenia:

Disorder	Key Features	Duration
Schizophrenia	Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia	6 months or more
Brief psychotic disorder	Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia	Less than 1 month
Schizophreniform disorder	Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia	1 to 6 months
Schizoaffective disorder	Marked symptoms of both schizophrenia and a mood disorder	6 months or more
Delusional disorder	Persistent delusions that are not bizarre and not due to schizophrenia; persecutory, jealous, grandiose, and somatic delusions are common	1 month or more
Shared psychotic disorder	Person adopts delusions that are held by another individual, such as a parent or sibling; Also known as <i>folie à deux</i>	No minimum length
Psychotic disorder due to a general medical condition	Hallucinations or delusions caused directly by a medical illness or brain damage	No minimum length
Substance-induced psychotic disorder	Hallucinations or delusions caused directly by a substance, such as an abused drug	No minimum length

See also the DSM-IV-TR (2000) *supra* note 344 at 317–344 for a comprehensive discussion of these psychotic disorders; Woo and Keatinge (2008) *supra* note 344 at 518; Barlow and Durand (1995) *supra* note 344 at 564–566; Kaplan and Sadock (2003) *supra* note 344 at 508–528.

8.2.1 Schizophrenia, violence and criminal capacity

Eysenok submits that psychoticism is said to be linked with criminality at all stages and that psychotics are most likely to engage in criminal behaviour due to the fact that they combine high levels of emotionalism with similarly high levels of extroversion⁴⁹⁴. It is trite that the presence of symptoms similar to those espoused in the diagnostic criteria for Schizophrenia will inadvertently result in a Schizophrenic person to possibly lack the necessary cognitive or conative capacities at the time when an offence is committed. Slovenko notes the following in this regard:⁴⁹⁵

“The Schizophrenic psychotic displays defects in both the cognitive and the volitional spheres, despite displaying great areas of intact mental functioning. The delusions and hallucinations which characterize Schizophrenia, but which are not exclusive to it, represent what is commonly perceived as ‘crazy’ or ‘insane’. The disordered thought processes of the Schizophrenic typify the ‘lack of reason’ all tests of insanity exculpate at least to some degree.”

The specific subtype of Schizophrenia which is most associated with violent behaviour, is paranoid Schizophrenia⁴⁹⁶. Kaplan and Sadock in addition state that Schizophrenic persons are prone to violent behaviour and accordingly delusions of persecution, previous incidents of violence and neurological deficiency are risk factors for violent or impulsive behaviour and in the event of a Schizophrenic person committing an offence it may be due to unpredictable or bizarre reasons as a result of these hallucinations or delusions⁴⁹⁷. Woo and Keatinge state that

⁴⁹⁴ Eysenok, HJ “Personality and Criminality: A Dispositional analysis” in Laufer, WS and Adler, F (“Advances in Criminology Theory” [1989] at 90 as quoted in Schmallegger, F “Criminology Today” (1996) at 205–206.

⁴⁹⁵ Slovenko (1995) *supra* note 3 at 70–71; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 21.

⁴⁹⁶ Slovenko (1995) *supra* note 3 at 71; Slovenko (1984) *Journal of Legal Medicine supra* note 3 at 21–22. See also Kaplan and Sadock (2003) *supra* note 344 at 485 where it is stated: “Patients with paranoid Schizophrenia are typically tense, suspicious, guarded, reserved, and sometimes hostile and aggressive ...”

⁴⁹⁷ See Kaplan and Sadock (2003) *supra* note 344 at 494 where it is in addition stated that predictors of homicide in Schizophrenics are the history of previous violence, dangerous behaviour while hospitalized and hallucinations or delusions involving such violence.

research indicates that Schizophrenic individuals are more likely to engage in assaultive and violent behaviour than persons with other psychiatric disorders and that the potential for dangerousness may be higher in an individual with paranoid delusional disorder⁴⁹⁸.

In respect of Schizophrenia and violence, Taylor came to the following conclusions.⁴⁹⁹

- Although Schizophrenia causes violence in individuals, the overall numbers are limited.
- Paranoid Schizophrenia and catatonic excitement are the specific subtypes mostly connected with violence.
- Violent behaviour is more common in individuals who have recurrent exacerbations than those who are continuously ill.
- At the time when an offence is committed, the individual generally lacks all insight and the offence is often preceded by attempts to substantiate delusional ideas or by steps taken by the individual to protect himself or herself from the alleged “aggressor” and in limited cases the violence may be the direct consequence of command hallucinations⁵⁰⁰.
- Violence is not always directly connected with current psychopathology and as a result other factors such as the individual’s personality makeup and social settings are equally important.

Central to a diagnosis of Schizophrenia stands the mental health professional who will invariably be the forensic psychiatrist who will have to assess the accused in order to determine, firstly, whether the accused suffers from Schizophrenia and secondly, whether he or she as a result of the Schizophrenia is either incompetent

⁴⁹⁸ Woo and Keatinge (2008) *supra* note 344 at 510. See also the DSM-IV-TR (2000) *supra* note 344 at 304 where it is stated: “Many studies have reported that subgroups of individuals diagnosed with Schizophrenia have a higher incidence of assaultive and violent behavior.”

⁴⁹⁹ Taylor, PJ “Schizophrenia and Violence” in Gunn, J and Farrington, DP (eds.) “Abnormal offenders, Delinquency and the Criminal Justice System” (1982) as discussed in Faulk (1994) *supra* note 448 at 150.

⁵⁰⁰ See Rogers, R; Gillis, JR; Turner, RE and Frise-Smith, T “The clinical presentation of command hallucinations in a forensic population” (1990) *American Journal of Psychiatry* at 1304–1307 as discussed in Faulk (1994) *supra* note 448 at 150.

to stand trial or lacked criminal capacity at the time of the offence as a result of the Schizophrenia.

Two classic decisions dealing with Schizophrenia are the *M'Naghten*-decision and the *Tsafendas*-decision⁵⁰¹. In the *M'Naghten*-decision, the accused was subject to delusions of persecution and also hallucinations, but the specific mental illness that he suffered from was not precisely coined as Schizophrenia due to the fact that the science of psychiatry had not yet developed to such an extent to render such diagnosis as the word Schizophrenia had not been invented⁵⁰². In terms of modern psychiatric practice, *M'Naghten* would probably have been diagnosed with paranoid Schizophrenia⁵⁰³. *Tsafendas* was diagnosed with Schizophrenia with paranoid tendencies as he had, as stated in paragraph 3.2 above, a delusion of a tapeworm in his bowels to which he on occasions referred to as the devil, dragon or snake and it was submitted that this tapeworm ruled his conduct⁵⁰⁴.

Another decision where Schizophrenia also featured was the case of *S v Van Niekerk*⁵⁰⁵. The facts of this decision were as follows: The appellant stood trial in the Transvaal Provincial Division on charges of murder, rape and theft. The facts revealed that on 25 August 1989, the appellant stabbed the deceased to death whereafter he had sexual intercourse with her and then took various items from her flat. The appellant pleaded not guilty to the charges and in his plea explanation admitted that he had stabbed the deceased to death, but denied the existence of intention. He further admitted having sexual intercourse with her but stated that it occurred after she had already been dead and also admitted taking various items from her flat but again denied the existence of intention. The appellant was found guilty on the charge of murder but with diminished criminal capacity, not guilty to the charge of rape as it could not be proved beyond reasonable doubt that the deceased was still alive when the intercourse took place and guilty on the charge of theft. The appellant was sentenced to death on the

⁵⁰¹ See paragraph 3.1 and 3.2 *supra* where these decisions are discussed comprehensively.

⁵⁰² Strauss (1996) *CILSA supra* note 448 at 291; Slovenko (1995) *supra* note 3 at 71.

⁵⁰³ *Ibid.*

⁵⁰⁴ Strauss (1996) *supra* note 448 at 292. See also Steyl, GC "Regters aan die Woord" (1971) at 7 where the *Tsafendas*-decision is discussed in detail. *Tsafendas* was found mentally disordered by Beyers JP and two assessors in terms of Section 28 of the Mental Disorders Act 38 of 1916.

⁵⁰⁵ *S v Van Niekerk* 1992 (1) SACR 1 (A).

murder charge and accordingly lodged an appeal against the imposition of the death sentence. The appellant knew the deceased well as a friend and on the particular day of the murder the appellant consumed approximately half a bottle of wine whereafter he visited the deceased. They started arguing about politics which resulted in the deceased chasing the appellant out of her flat. The appellant then took out a knife and stabbed the deceased to death whereafter he allegedly had sexual intercourse with her corpse.

The appellant was referred for observation on several occasions which eventually amounted to three months. Dr Le Roux as well as Dr Verster who observed the appellant took the view that the appellant was not mentally ill, but that his responsibility was possibly diminished. The facts further revealed that the appellant was unhappy in his employment, suffered from depression and generally had very few friends. The appellant also made notes in a notebook of a plan to eliminate people who humiliated him. The appellant wrote the following:⁵⁰⁶

“Ek het ‘n wil teen mense gehad en ek het besluit dat indien mense my gaan te na kom of sleg behandel of iets in dié lyn gaan ek hulle ‘n les leer.”

The appellant also devised a so-called plan “A” which was:⁵⁰⁷

“‘n plan om met mense wat my te na kom af te reken ... (D)it sou seker geëindig het in die dood, maar ek wou hulle verder verneder net soos hulle my verneder het.”

Dr Verster testified that the appellant had a sick personality and the fact that the deceased sworn at him and kicked him could possibly have diminished his powers of resistance⁵⁰⁸.

⁵⁰⁶ At 7 E–F.

⁵⁰⁷ *Ibid.* See also at 9 D where Van den Heever JA describes the clinical picture of the appellant as follows: “Die beeld van appellant wat uit die getuienis blyk, nog voor mens by die psigiatrisse getuienis kom, is van ‘n inkennige, humentige alleenloper, veels te intelligent vir die sleurwerk wat aan hom toevertrou is en derhalwe gefrustreer, sonder die selfvertroue om na iets beter uit te reik. Met ‘n lae eiewaan is hy besonder sensitief vir verwerping deur ander en volgens sy eie getuienis smeul en broei planne vir moorddadige wraak weens vernedering, vir selfs geringe tenakoming, van 1983 al in sy gemoed.”

⁵⁰⁸ At 7 I–J.

In respect of the crimes committed by the appellant, Van den Heever AJA held the following:⁵⁰⁹

“Dat die moord beide bisar en brutaal was, behoef geen betoog nie. Oorledene was jonk, weerloos, intelligent en tot appellant se wete ‘n aanwins vir die samelewing; en het oor ‘n tydperk aan appellant haar vriendskap gegun. ... Haar angsvolle en pynlike laaste oomblikke aan die hande van ‘n geregsdienaar wat met *dolus directus* opgetree het, die vernedering van haar bewustelose liggaam of dalk lyk deur haar broekie af te trek en haar te bekyk en daarna sy geslagsdrif – of nuuskierigheid te bevredig en sy berekende optrede daarna om sy spore te probeer uitwis en skakels tussen hulle wat hom kon verraai – soos sy briewe aan haar – te soek en te verwyder, is alles faktore wat teen hom moet tel ...”.

As stated above, it was held by Van den Heever AJA that the appellant was not certifiably mentally ill. The psychiatrists were of the opinion that the appellant’s powers of restraint were, however, diminished or impaired⁵¹⁰.

The psychiatrists differed in opinion with regards to the specific diagnostic labels to which the appellant’s personality disorder complied.

Dr Le Roux included the following diagnoses in her initial report:⁵¹¹

- Personality disorder with mixed symptoms
- Disthymic disorder
- Adaptability disturbance coupled with depression
- Appellant’s depression was of the neurotic type
- The personality disorder manifested in paranoid tendencies with reference to the appellant’s suspicion and distrust in other people

⁵⁰⁹ At 9 A–C.

⁵¹⁰ At 9 H–J.

⁵¹¹ At 10 A–C.

- Obsessive compulsive tendencies with reference to the appellant's preoccupation with order and detail
- Schizoid symptoms

Dr Verster⁵¹² did not regard the appellant's depression as neurotic but rather symptomatic of the appellant's low self-esteem and the unhappiness of leading an isolated existence. Dr Verster also observed obsessive and compulsive tendencies in the appellant as well as Schizoid and paranoid features. Both experts testified that the appellant's vulnerability for provocation affected his self-control to the extent that he will easier react violently in a given situation than other individuals. It was held that the appellant had exceptional intelligence, but that his emotional problems had to be addressed over a long period of time⁵¹³.

In respect of the dangerousness of the appellant, it was held that there was no guarantee that optimal treatment would eliminate his dangerousness⁵¹⁴. Dr Verster stated that the dangerousness element would decrease with time but in addition stated:⁵¹⁵

“Ek kan nie voorspel dat hy nie in die tronk gaan en ‘n langtermyn wraakgedagte gaan miskien groei desnieteenstaande behandeling nie. Ek kan dit nie heeltetal wegvat nie. Dit is hoekom ek ‘n probleem het met die kwessie van gevaarlikheid. Want tensy hier ‘n totale persoonlikheidsverandering kom kan mens dit nie wegredeneer nie.”

The majority of the Court per Van den Heever AJA and Botha JA held that the only appropriate sentence was the death penalty and accordingly dismissed the appeal.

Before discussing the minority judgment of Milne JA, it is necessary to take note of aspects that Botha JA focused on.

⁵¹² At 10 C–E.

⁵¹³ At 10 G.

⁵¹⁴ At 10 G–N.

⁵¹⁵ At 15 D–E.

Botha JA held that the appellant's personality disorder played a contributory role in the commission of the offence and as a result of his defective personality he is exceptionally susceptible to violent reaction to conduct perceived by him as humiliating or degrading.⁵¹⁶ In addition, it was held that this susceptibility to violence was a characteristic of the appellant's personality and the events were not something of a temporary nature or once off events but could repeat itself⁵¹⁷. Botha JA also emphasized the dangerousness element to which Dr Verster referred and stated: "Hy (Dr Verster) was nie hier besig met 'n vae en spekulatiewe moontlikheid nie. Hy het gepraat van 'n wesenlike gevaar, en van 'n moontlikheid wat stewig gegrond is op die deskundige getuienis aangaande die aard van die appellant se persoonlikheidsversteuring. ... Die appellant se abnormale persoonlikheid hou 'n voortdurende bedreiging in vir almal met wie hy in aanraking kom."

Botha JA accordingly concurred with Van den Heever AJA that the death penalty is the only appropriate sentence.

Milne JA delivered a dissenting judgment focusing on different aspects that were emphasised by the experts. Milne JA held that the appellant perceived the conduct of the deceased toward him as humiliating and degrading specifically when she chased him out of her flat. The latter was confirmed by Dr Verster⁵¹⁸.

⁵¹⁶ At 15 I–16 B. Botha JA specifically referred to two statements by Dr Verster where it was stated: "Ek dink amper dit is 'n onvermydelikheid dat hy vroeër of later sou uitbars en iemand beseer". And later: "Een of ander stadium sou iets tragies plaasgevind het as gevolg van sy persoonlikheid, sy beplanning, sy gevoel teenoor die buitewêreld ensovoorts. En dit het hier plaasgevind, ongelukkig."

⁵¹⁷ At 16 D–E.

⁵¹⁸ At 11 H–12 C where the opinion of Dr Verster is quoted who stated: "Ek dink nie ons kan plan "A" heeltemal uit die weg uit ruim nie. Ek dink dit is deel van sy emosionele samestelling. 'n Deel van hierdie alleenloper wat sit en planne uitwerk, wat dinge probeer doen, wat nie met mense praat oor homself nie. Wat as kind ook nie eintlik kontak, kommunikasiekontak, kameraadskap, kontak met 'n vader gehad het nie, wat nie eintlik maats gehad het nie. As 'n mens kyk na wat hy self gesê het in die sosiale verslag dat hy op laerskool twee maats gehad het, op hoërskool twee maats. Hy het eintlik nie maats gehad in die polisie nie. Ook nie in die wageenheid nie. Hy is 'n alleenloper wat tog manlike behoeftes het. Wat tog seksuele pre-okkupasie het. Wat tog ook by tye gemasturbeer het met seksuele fantasieë, dié het hy duidelik aan my oorgedra, maar sy plan "A" is gemik teen mense wat hom verneder. Mense wat hom verwerp. As ons aanvaar wat hy genoem het dat sy (dit is die oorledene) vir hom gesê het, maar jy is 'n so en so se kafferhater, maak dat jy wegkom uit my woonstel uit, stamp hom weg. Ek dink dit was in 'n sekere mate 'n sneller, want hier is die ding wat hy nie wil hê moet met hom gebeur nie, gebeur nou en hy word kwaad en daar kom 'n moordlus. 'n Bewustheid van 'n moordlus, en dan kan aspekte van plan "A" ten opsigte van vroumense in

The conduct of the deceased was accordingly the trigger for the way in which the appellant reacted⁵¹⁹.

Milne JA also focused in more detail on some of the important findings of Dr Verster, which were the following:⁵²⁰

- The appellant had a mixed personality disorder with obsessive/compulsive and Schizoid tendencies.
- The mixed personality disorder entailed that the appellant displayed signs of various personality disorders and not only a single one.
- The more prominent tendencies were obsessive compulsive.
- The appellant displayed signs and characteristics of Schizophrenia to which there existed a vague possibility of developing into full blown Schizophrenia with specific reference to paranoid tendencies.
- The Schizoid tendencies manifested therein that the appellant was suspicious of other people and their reactions towards him and also believed that other people were against him and rejected him.
- The appellant suffered from depression but the depression was not so severe to render him mentally ill.
- The alleged amnesia of the appellant was simulated with specific reference to the alleged amnesia about having intercourse with the deceased.
- There was very little loss of control when the appellant committed the offences and the cognitive and conative capacities of the appellant were intact with the possibility of diminished criminal capacity.

The abovementioned opinions were accepted by the trial court.

Milne JA held the following:⁵²¹

werking kom. Ek dink wat gebeur het, is dat 'n mens in jou optrede, motivering van jou optrede dan reageer op dit wat onbewustelik vantevore in jou ingegrein was en dit dan deel word. Jy kan miskien dit nie presies doen soos jy dit wou gedoen het deur eers vas te bind ensovoorts, maar dan aangaan met die res daarvan.”

⁵¹⁹ At 12 C–D.

⁵²⁰ At 12 E–13 D.

“Uit die voorafgaande blyk dit duidelik dat die persoonlikheidsversteurings van die appellant ongetwyfeld ‘n bydraende rol gespeel het in die pleging van die misdaad. Die misdaad was ‘n heftige en gewelddadige reaksie op wat hy beskou het as vernederende optrede deur die oorledene. Die feit dat die appellant op so ‘n wrede en bisarre wyse gereageer het en so ver gegaan het om gemeenskap met haar bebloede lyk te hou, ‘... proclaims the very mental illness from which the appellant suffers’ net soos die ‘... ghastly and gruesome manner in which the appellant murdered the deceased ...’ in *S v Lawrence* 1991 (2) SASV 57 (A) op 59i.”

Milne JA held that the appropriate sentence would be lifelong imprisonment instead of the death penalty and that the appeal should be upheld⁵²².

One of the most important aspects of the *Van Niekerk*-decision is the pivotal role of the expert evidence presented by the mental health experts and the weight attached thereto by the court. The minority judgment by Milne JA also indicates that a specific portion of expert evidence and the weight attached thereto can differ and accordingly the eventual role that expert evidence plays remains controversial. Strauss correctly notes that psychiatrists generally feel that the type of questions presented to them in courts cannot be answered by resorting to the methods and concepts of psychiatry and accordingly that the legal criteria for criminal incapacity is regarded as an oversimplification⁵²³.

In *S v Sindane*⁵²⁴ the Appellate Division was confronted with two opposing expert opinions as to the appellant’s mental state and specifically the existence of Schizophrenia. The facts of the decision were that the two appellants were

⁵²¹ At 13 H–I. *S v Lawrence* 1991 (2) SACR 57 (A) will be discussed below.

⁵²² At 15 B–C.

⁵²³ Strauss (1996) *CILSA supra* note 448 at 292. See also Schneider, RD and Bloom, H “*R v Taylor*” A decision not in the best interest of some mentally ill accused” (1995) *Criminal Law Quarterly* at 183 where they indicate the anomaly that occur when the law: “in the course of preserving an interest it holds sacred, tries to reconfigure psychiatric wisdom and expertise to fit its perceived need. Doing so, they state, is akin to forcing the wicked stepsisters’ feet into the glass slipper destined only for Cinderella” (As discussed in Strauss [1996] *CILSA supra* note 448 at 292.

⁵²⁴ *S v Sindane and Another* 1992 (2) SACR 223 (A).

convicted of murder and robbery. The court found no extenuating circumstances and each was sentenced to death on the murder charge. Applications for leave to appeal against the convictions were refused by the court *a quo* and the Appellate Division. Whilst an appeal against the death sentences in terms of Section 19(12) of Act 107 of 1990 was pending, the first appellant, who had conducted his own defence throughout the trial, lodged an application for the setting aside of the sentences imposed on him and the remittal of his case to the trial court for decision after his referral for observation in terms of Section 79 of the Criminal Procedure Act and the hearing of the report of the observation panel. In support of this application reliance was placed on the opinion of State psychiatrist, Dr Grové, who was senior medical superintendent at Weskoppies Hospital. He testified that the first appellant was aggressive, disorientated and exhibited thought disorder and displayed auditory hallucinations and irrational behaviour.⁵²⁵ He further stated.⁵²⁶

“Schizophrenia is a very serious mental illness and is a clear case of psychosis. The prognosis is poor, and the likelihood of complete recovery is not good. Constant medication is required to prevent the recurrence of its symptoms ... A diagnosis of Schizophrenia may have very serious implications for criminal responsibility, and there is a reasonable possibility that a referral of the first appellant for observation in terms of S 79 of Act 51 of 1977 will reveal that at the time of commission of his crimes he was incapable of appreciating the wrongfulness of his acts or of acting in accordance with an appreciation of the wrongfulness of his acts and further that at the time of his trial he was by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence.”

The State opposed the application and relied on the evidence of Dr Pretorius who testified that he observed no mental disorder in the first appellant. It, however, appeared that certain information and documentation were not made available to Dr Pretorius. Dr Pretorius further based his conclusions on consultations with the

⁵²⁵ At 228 F.

⁵²⁶ At 228 G–I.

first appellant in prison. Kumleben JA pointed out that an enquiry in terms of Section 79 is much more comprehensive than mere consultations, especially where the death penalty was involved⁵²⁷. Kumleben JA further held that the test for referral of an accused for observation in terms of Section 79 was a low one and a reasonable possibility suffices to oblige the Court to direct the enquiry⁵²⁸. Kumleben JA held:⁵²⁹

“To my mind such possibility exists. The significant averments of Dr Grove, though general, are not answered or in any way dealt with by Dr Pretorius: they stand uncontradicted.”

The Appellate Division granted the order of the remittal of the matter to the trial court.

It is clear that the Appellate Division attached much weight to the expert opinion of Dr Grové which was not really challenged. Once again the pivotal role of the mental health expert comes to the fore as well as the importance of proper opposing expert opinions.

To conclude the section on Schizophrenia, it is clear that Schizophrenia, being pathological and endogenous, can deprive an individual of either insight (cognitive capacity) or self-control (conative capacity) and thus meets the requirements for the insanity defence⁵³⁰.

8.3 Postpartum psychosis

Early one Saturday morning in a quiet neighbourhood in San Antonio, Texas, Otty Sanchez attacked her newborn baby son with a steak knife and two Samurai swords. She then bit off three of his toes, decapitated him and thereafter ate bits of his brain. She then stabbed herself in the neck and screamed: “I’ve killed him!

⁵²⁷ At 227 G–I.

⁵²⁸ At 228 A.

⁵²⁹ At 228 C.

⁵³⁰ Burchell and Milton (2005) *supra* note 3 at 385.

The devil made me do it.” Little Scotty Sanchez was only four weeks old⁵³¹. Otty Sanchez was later diagnosed with Schizophrenia and also with a rare mental condition that affects 500 to 1 000 new mothers worldwide⁵³². Postpartum psychosis is a very serious condition which could result in a mother of a newborn either lacking insight (cognitive capacity) or self-control (conative capacity) and could satisfy the criteria for pathological criminal incapacity and accordingly warrants discussion.

Kaplan and Sadock note that postpartum psychosis is an example of a psychotic disorder not otherwise accounted for that predominantly occurs in women who recently gave birth to a baby and the syndrome is marked by the mother’s depression, delusions or thoughts of harming herself or her infant⁵³³. Symptoms of postpartum psychosis features within days of delivery with initial complaints of fatigue, insomnia and restlessness⁵³⁴. Individuals later develop emotions of not wanting to care for the infant or not loving the infant or the desire to harm the baby, themselves or both⁵³⁵. Typical delusions include the belief that the baby is dead or defective⁵³⁶.

Macfarlane illustrates the problematic scenario of postpartum psychosis in the following manner:⁵³⁷

“The killing of an infant by its own mother is an act that at once captivates and repels popular attention. Flying in the face of ‘mother love’, infanticide both shocks common notions of decency and calls out for punishment at law. Yet, many infanticides are committed not by women intent on callously ridding themselves of their children but rather by women who are experiencing a psychosis precipitated by gross postpartum mental illness.

⁵³¹ Facts obtained from *You Magazine* 13 August 2009.

⁵³² Comer (2008) *supra* note 344 at 349; Kaplan and Sadock (2003) *supra* note 344 at 526.

⁵³³ Kaplan and Sadock (2003) *supra* note 344 at 526–527; Hammen, C and Watkins, E “Depression” (2008) at 21.

⁵³⁴ Kaplan and Sadock (2003) *supra* note 344 at 526.

⁵³⁵ *Ibid.*

⁵³⁶ *Ibid.*

⁵³⁷ Macfarlane, JD “Criminal Defense in Cases of Infanticide and Neonaticide” in Spinelli, MG (ed) “Infanticide-Psychosocial and Legal perspectives on Mothers who kill” (2003) at 133–134.

That a woman suffered some form of mental illness at the time of the killing calls into question her criminal culpability.”

Postpartum psychosis develops within a few days to at most a few months after childbirth in which event the woman starts displaying signs of losing touch with reality by for example having delusional thoughts, hallucinations, extreme anxiety, confusion, agitation, insomnia, suicidal and homicidal thoughts.⁵³⁸ Women with a history of bipolar disorder, Schizophrenia or depression are generally more susceptible to this form of psychosis⁵³⁹. Wisner *et al* note that postpartum psychosis differs from other psychotic episodes due to variations in cognition and confusion and consequently the confused, delirium-like and disorganized profile of postpartum psychosis has been reported repeatedly⁵⁴⁰. Wisner *et al* in addition note that:⁵⁴¹ “ ... the childbearing psychotic woman had a high score on the factor we named ‘cognitive disorganization/psychosis’ which contained the following symptoms: thought disorganization, bizarre behaviour, lack of insight, delusions of reference, persecution, jealousy, grandiosity, suspiciousness, impaired sensorium/orientation, and self-neglect. These women displayed prominent symptoms of cognitive impairment and bizarre behaviour.”

Typical delusional thoughts in these cases relate to the woman’s belief that she is being controlled by external forces, that her thoughts are not her own and are placed into her mind by other human beings, that the infant is the devil incarnated, or that there is a possibility that the child will be kidnapped⁵⁴². Hallucinations range from auditory, visual, tactile and command hallucinations directing the

⁵³⁸ Comer (2008) *supra* note 344 at 349. See also Wisner, KC, Gracious, BL, Pionrek, CM, Peindl, K and Perel, JM “Postpartum Disorders” in Spinelli, MG (ed.) “Infanticide-Psychosocial and legal perspectives and Mothers who kill” (2003) at 36 where it is stated: “Women are more vulnerable to psychosis in the postbirth period than at any other time during the female life cycle. In the first 30 days after birth, a woman is 21.7 times more likely to develop psychosis than in the 2-year period prior to childbirth.” (hereafter “Wisner *et al*”)

⁵³⁹ Comer ((2008) *supra* note 344 at 349. See also Hammen and Watkins (2008) *supra* note 533 at 21 where they note: “Women who have had one such postpartum psychosis have an elevated risk for subsequent postpartum episodes with psychotic features. It should be noted that such episodes are especially likely to occur among women with histories of bipolar disorder, but may also occur in unipolar depression.”

⁵⁴⁰ Wisner *et al* in Spinelli (ed.) (2003) *supra* note 537 at 41.

⁵⁴¹ *Ibid.*

⁵⁴² Macfarlane, J “Criminal Defense in cases of Infanticide and Neonaticide” in Spinelli (ed) (2003) *supra* note 537 at 136.

woman to kill herself or the infant⁵⁴³. A major obstacle for a mental health professional diagnosing a woman with postpartum psychosis is the fact that postpartum psychosis has not yet been fully acknowledged by the American Psychiatric Association's DSM-IV as a discrete mental illness but rather as a mental disorder with postpartum onset⁵⁴⁴. Due to the fact that postpartum psychosis does not exist as an officially acknowledged mental disorder, it cannot be used to pass the test for insanity⁵⁴⁵. It is submitted that the inclusion of this form of psychosis in future diagnostic systems of classification is pivotal as this rare form of mental illness is a growing phenomenon and does not always satisfy the diagnostic requirements for differential diagnoses such as major depressive disorder, bipolar disorder or Schizophrenia. Macfarlane confirms the latter by stating:⁵⁴⁶

“A woman is left to support her defenses with a recognized disorder, such as Schizophreniform disorder, even though that disorder lends on incomplete and imperfect description of the actual mental state she possessed at the time of the homicide. It is absolutely imperative, therefore, that the psychiatric profession formalizes the aggregate symptoms apparent in the various puerperal mental illnesses so that a woman accused of killing her child in the puerperium may adequately defend herself by way of using a recognized postpartum mental disorder as the basis of her defense.”

It is clear that the diagnostic features of postpartum psychosis could give rise to a mental illness sufficient to meet the criteria for the defence of pathological criminal incapacity. The advancements in psychiatric knowledge with regards to this illness call for a revision of the current DSM-IV-TR to possibly create a distinct

⁵⁴³ *Ibid.*

⁵⁴⁴ Macfarlane in Spinelli (ed)(2003) *supra* note 537 at 147. See also DSM-IV-TR (2000) *supra* note 344 at 422 where it is stated: “Postpartum onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but it can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.” See also Kaplan and Sadock (2003) *supra* note 344 at 526 where it is noted: “Specific diagnostic criteria are not included in the DSM-IV-TR.”

⁵⁴⁵ Macfarlane in Spinelli (ed.) (2003) *supra* note 537 at 147.

⁵⁴⁶ Macfarlane in Spinelli (ed.) (2003) *supra* note 537 at 163.

diagnostic framework for postpartum psychosis which will assist mental health professionals in assessing and detecting this disease in future⁵⁴⁷.

Meyer and Spinelli encapsulate the severity of postpartum psychosis by stating:⁵⁴⁸

⁵⁴⁷ See also Comer (2008) *supra* note 344 at 349; Meyer, CL and Spinelli, MG “Medical and Legal Dilemmas of postpartum Psychiatric Disorders” in Spinelli (ed.) (2003) *supra* note 537 at 167 – 177 where the case of Andrea Yates is discussed which provides a classic example of postpartum psychosis. Andrea Pia Yates was a registered nurse who later became a stay-at-home mom who also home-schooled her children. Whilst being almost consistently pregnant, she provided care to her bedridden father as well as her family which included Noah 7, John 5, Paul 3, Luke 2 and Mary that was 6 months old. Andrea Yates had a history of psychiatric illness. After the birth of Noah she constantly blocked her thoughts when she felt Satan’s presence and when she believed to hear Satan tell her to pick up a knife and stab the child. She didn’t reveal these thoughts to anyone out of fear that Satan would harm her children. She also believed that some of her doctors were Satan or influenced by Satan. Six months after the birth of the fifth child, Andrea Yates began to behave very strangely and her family described her behaviour as “catatonic”. Even after two psychiatric hospitalizations Andrea Yates’s condition worsened. When her psychiatrist discontinued her antipsychotic medication two weeks prior to the tragedy she became more psychotic. On June 20, 2001 Andrea Yates drowned all five of her children in the bathtub whereafter she laid them on a double bed in the master bedroom. She told police officers, without emotion, what had happened. Andrea Yates was charged with capital murder after confessing to the murder of her five children. One psychiatrist, Dr Lucy Puryear, stated that Andrea Yates was “... the sickest person I had ever seen in my life.” Andrea Yates stated to another psychiatrist that she believed God would take her children “up”. Andrea Yates was eventually found competent to stand trial. Andrea Yates pleaded not guilty by reason of insanity and that due to a mental disease or defect she did not understand that what she was doing was wrong. It was contended that she was suffering from postpartum depression with psychotic features. The psychiatrist called for the State, Dr Park Dietz, however, stated that she did not act like a mother who believed she was saving her children from Satan and that she had known that what she was doing was wrong. Dr Dietz further believed that an episode of a famous television show, Law and Order, in which a mother drowned her children, inspired Andrea Yates and the latter led to an inference of premeditation. Andrea Yates was a clear victim of postpartum psychosis, but unfortunately her doctors, her husband and other people close to her failed to appreciate the severity of the disorder. She was initially found guilty of murdering her children and sentenced to life in prison. The Texas Appeals Court later reversed Yates’s conviction as it was found that the television episode upon which Dr Park Dietz had based his expert opinion, had never been broadcasted and accordingly his testimony which played a cardinal role in the outcome of the case, was inaccurate. Mental health experts testifying for Yates stated: “She did what she thought was right in the world she perceived through her psychotic eyes at the time” (Dr P Resnick) which meant that even if she did understand the difference between right and wrong, she was unaware of what she was doing. Yates was accordingly found not guilty by reason of insanity and was sent to a mental health institution for treatment. See also Ramsland, K “Andrea Yates: Ill or Evil” http://www.trutr.com/library/crime/notorious_murders/women/andrea_yates/index.html [accessed on 2009/09/23]. The Andrea Yates case illustrates the detrimental effect that inaccurate expert testimony can have on the outcome of a case – Meyer and Spinelli in Spinelli (ed.) (2003) *supra* note 537 at 177 also state: “Clear-cut diagnostic and legal guidelines for psychiatric illness associated with infanticide could likely assist our legal system with those cases ... reluctance to distinguish postpartum disorders may lead to tragic outcomes for women in the family and society.”

⁵⁴⁸ Meyer and Spinelli in Spinelli (ed.) (2003) *supra* note 537 at 169.

“Postpartum psychosis presents as a psychiatric emergency. Whether mood changeability is associated with bipolar disorder or organic delirium, or both, this presentation may disarm even the psychiatric professional. Because moments of complete lucidity are followed by frightening psychosis for the new mother, the illness may go unrecognized and untreated. Out of shame, guilt, or a paranoid delusional system, the new mother may not share her bizarre thoughts and fears.”

8.4 Depression

“(By October) the fading evening light ... had none of its autumnal loveliness, but ensnared me in a suffocating gloom ... I felt an immense and aching solitude. I could no longer concentrate during those afternoon hours, which for years had been my working time ...

Soon evident are the slowed-down responses, near paralysis, psychic energy throttled back close to zero. Ultimately, the body is affected and feels sapped, drained ... I found myself eating only for subsistence (and) exhaustion combined with sleeplessness is a rare torture ... What I had begun to discover is that, mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain ... it is entirely natural that the victim begins to think ceaselessly of oblivion.”⁵⁴⁹

The abovementioned quote encapsulates the experience that has been referred to by some individuals as the black curtain of despair coming down on your life, but the more commonly acknowledged term for this experience is depression. Depression is a universal, timeless and ageless phenomenon and within the context of diagnostic classification is categorized as one of the manifestations of mood disorders⁵⁵⁰. Mood disorders generally refer to sustained emotional states

⁵⁴⁹ Styron, W “Darkness Visible” (1990) as quoted in Hammen and Watkins (2008) *supra* note 533 at 1–2.

⁵⁵⁰ DMS-IV-TR (2000) *supra* note 344 at 345; DSM-IV (1994) *supra* note 344 at 317; Hammen and Watkins (2008) *supra* note 533 at 1–13; Comer (2008) *supra* note 344 at 187; Mason, JK “Forensic Medicine for Lawyers” (2001) at 394; Barlow and Durand (1995) *supra* note 344 at 240–144; Kaplan and Sadock (2003) *supra* note 344 at 534–572; Kendall, PC and Hammen, C “Abnormal Psychology” (1995) at 222 – 250; Slovenko (1995) *supra* note 3 at 71–72;

and are considered syndromes consisting of a cluster of signs and symptoms encountered over several weeks or months which indicate a marked change in a person's normal functioning and tend to recur either periodically or in a cyclical fashion⁵⁵¹. A person's mood can be either normal, elevated or depressed. Individuals who suffer only from a major depressive episode are said to suffer from major depressive disorder or unipolar depression, whereas individuals who suffer from both manic and depressive episodes or manic episodes alone are said to have bipolar disorder⁵⁵². Depression and mania are the key features or emotions

Freckelton, I and Selby, H "Expert evidence in Criminal Law (1999) at 586–591; Bleiberg, KL and Markowitz, JC "Interpersonal Psychotherapy for Depression" in Barlow, DH "Clinical Handbook of Psychological Disorders" (2008) at 306 – 307; Woo and Keatinge (2008) *supra* note 344 at 533–544; LaBruzza and Mendez Villarubia (1994) *supra* note 344 at 275–290; Taska, RJ and Sullivan, JL "Depression" in Cavenar, JO and Brodie, HKH "Signs and Symptoms in Psychiatry" (1983) at 201–220; Caine, ED and King, DA "Cognitive Impairment and Major Depression: Beyond the Pseudodementia Syndrome" in Grant, I and Adams, KM (eds) "Neuropsychological Assessment of Neuropsychiatric Disorders" (1996) at 200–213; Burchell and Milton (2005) *supra* note 3 at 385–386.

⁵⁵¹ Kaplan and Sadock (2003) *supra* note 344 at 534.

⁵⁵² Kaplan and Sadock (2003) *supra* note 344 at 534; Hammen and Watkins (2008) *supra* note 533 at 8; Barlow and Durand (1995) *supra* note 344 at 243; Kendall and Hammen (1995) *supra* note 550 at 221. For purposes of this discussion, primary focus will fall on unipolar or major depressive disorder. Bipolar disorder is generally much rare and involves not only depression, but also mania or hypomania. Mania is marked by a distinct period of abnormally and persistently elevated or irritable mood lasting at least one week in conjunction with at least three of the following symptoms: inflated self-esteem or grandiosity, decreased need for sleep, increased talkativeness, flight of ideas or racing thoughts, distractibility and poor concentration, increase in goal-directed activity or psychomotor agitation as well as excessive participation in enjoyable but risky activities such as overspending or sexual indiscretions. Hypomania is a milder form of mania lasting four days or more. Similar to an episode of depression, episodes of mania or hypomania entails an abnormal pattern of affective, cognitive, behavioural, as well as physical symptoms. The essential difference between depression and mania lies in the fact that whereas depression is typically signified by reduced arousal as well as sensitivity to reward and pleasure, mania is classified by increased arousal and sensitivity to reward and pleasure. See Hammen and Watkins (2008) *supra* note 550 at 8 where they state: "Bipolar disorder is diagnosed when an individual has at least one lifetime manic episode and, as such, the diagnosis does not require the individual to have had an episode of depression. Nonetheless, the majority of individuals with bipolar affective disorder experience cycles of both depression and mania/hypomania, with a subset of 20 % to 30 % of individuals with bipolar disorder not experiencing depression. Bipolar affective disorder is a chronic problem of recurrent symptoms, often marked not only by extreme mood swings but even by psychotic experiences including delusions and hallucinations. Psychotic features are relatively common in the manic phase of bipolar disorder, with rates as high as 65 %." Barlow and Durand (1995) *supra* note 344 describes Bipolar disorder as follows: "The key identifying feature of bipolar disorders is a tendency for manic episodes to alternate with major depressive episodes in an unending roller coaster from the peaks of elation to the depths of despair." In terms of the DSM-IV-TR, Bipolar disorder is further subdivided into the categories of Bipolar I and Bipolar II disorder. Bipolar I disorder generally relates to a history of episodes of depression and mania whilst depression combined with a history of hypomania is referred to as Bipolar II disorder. Kaplan and Sadock (2003) *supra* note 344 at 544–545 state the following: "The designation Bipolar I disorder is synonymous with what was formerly known as bipolar disorder – a syndrome in which a complete set of mania symptoms occurs during the course of the disorder. ... The diagnostic criteria for Bipolar II disorder specify a particular

in mood disorders. Most people with mood disorders suffer only from unipolar depression with no signs of mania⁵⁵³. Mood disorders have always fascinated and captured community interest and are also a phenomenon with a strong historical foundation⁵⁵⁴.

In order to fully understand the various effects that depression may have on an individual's cognitive or conative abilities, it is necessary to take a closer look at the clinical description and phenomenology of this disorder. Within the forensic paradigm, the forensic mental health professional will have to assess an accused in order to ascertain firstly whether an accused who committed an offence and subsequently relies on the defence of pathological criminal incapacity, suffered from depression and secondly whether and to what extent depression impacted on the criminal capacity of the accused.

Hammen and Watkins define depression as “a constellation of experiences including not only mood, but also physical, mental and behavioural experiences that define more prolonged, impairing and severe conditions that may be clinically diagnosable as a syndrome of depression⁵⁵⁵. The essential behavioural phenomena of depression include affective, cognitive, behavioural and physical symptoms. These symptoms of depression will be discussed and summarized below.

severity, frequency, and duration of the hypomanic symptoms.” See also Freckelton and Selby (1999) *supra* note 550 at 587.

⁵⁵³ Comer (2008) *supra* note 344 at 187.

⁵⁵⁴ See Comer (2008) *supra* note 344 at 187 where it is stated that many famous people suffered from mood disorders. It is noted that the Bible speaks of the severe depressions of Nebuchadnezzar, Saul and Moses. Queen Victoria of England and Abraham Lincoln also experienced recurring depressions. In addition mood disorders also affected writers such as Ernest Hemingway, Eugene O'Neill, Virginia Woolf and Sylvia Plath. See also Kaplan and Sadock (2003) *supra* note 344 where it is noted that already in 1854, Jules Falret described a condition known as *folie circulaire* in which patients experience fluctuating moods of depression and mania. In 1882, the German psychiatrist Karl Kahlbaum used the phrase *cyclothymia* to refer to mania and depression as stages in the same illness. In 1899 Emil Kraepelin, perpetuating the knowledge of previous French and German psychosis similar to terminology and definitions ascribed to establish what is commonly referred to today as Bipolar I disorder. Kraepelin submitted that the absence of dementing and deteriorating course in manic depressive psychosis differentiated it from dementia praecox. See also Kendal and Hammen (1995) *supra* note 550 at 228–229.

⁵⁵⁵ Hammen and Watkins (2008) *supra* note 550 at 3. See also Comer (2008) *supra* note 344 at 189 where depression is defined as “a low, sad state marked by significant levels of sadness, lack of energy, low self-worth, guilt or related symptoms.”

- Affective/emotional symptoms – Most people suffering from depression generally display feelings of sadness, depressed mood, feeling “low”, “down in the dumps”, “empty” and dejected⁵⁵⁶. Comer states that some depressed individuals experience mild to severe forms of anxiety, anger, or agitation⁵⁵⁷. Hammen and Watkins conclude that not all depressed people will necessarily exhibit symptoms of sadness or depression but may also display feelings of listlessness, apathy and general loss of pleasure in activities that previously elicited feelings of enjoyment⁵⁵⁸.
- Cognitive symptoms – Depressed individuals generally view themselves, their lives and their future very negatively. Depressed people in addition experience themselves as incompetent and worthless and are extremely critical of their own behaviour and accordingly a low self-esteem is a common characteristic in depressed persons⁵⁵⁹. Additional cognitive characteristics include that depressed people are very pessimistic and believe that their situation is unlikely to improve and the sense of hopelessness and helplessness make them prone to suicidal thinking or even homicide⁵⁶⁰. Chiswick states that the person most at risk of harm in depression is the sufferer⁵⁶¹. In cases of depression, despair sometimes extend to the extent that the depressed individual imagines that he or she must save his or her nearest or dearest further “suffering” which is often accompanied by suicide or attempted suicide⁵⁶². The tragic killing of one

⁵⁵⁶ Comer (2008) *supra* note 344 at 189; Hammen and Watkins (2008) *supra* note 533 at 4; Kendall and Hammen (1995) *supra* note 550 at 223; Barlow and Durand (1995) *supra* note 344 at 241; DSM-IV-TR (2000) *supra* note 344 at 349–352.

⁵⁵⁷ Comer (2008) *supra* note 344 at 189. See also Constantino, MJ, Lembke, A, Fischer, C and Arnow, BA “Adult depression: features, burdens, models and interventions” in Plante, TG (ed.) “Mental disorders of the new millennium: Behavioral issues” (2006).

⁵⁵⁸ Hammen and Watkins (2008) *supra* note 533 at 4.

⁵⁵⁹ Hammen and Watkins (2008) *supra* note 533; Comer (2008) *supra* note 344 at 191; Bleiberg and Markowitz “Interpersonal Psychotherapy for Depression” in Barlow, DH (ed.) “Clinical Handbook of Psychological Disorders – A step-by-step treatment Manual” (2008) at 344; Kendall and Hammen (1995) *supra* note 550 at 223; Barlow and Durand (1995) *supra* note 344 at 243.

⁵⁶⁰ *Ibid.* See also Slovenko (1995) *supra* note 3 at 72 where he states: “In states of depression, underlying rage may be turned outward (homicide) or inward (suicide).”

⁵⁶¹ Chiswick, D “Forensic Psychiatry” in Mason, JK “Forensic Medicine for Lawyers” (2001) at 394.

⁵⁶² *Ibid.*

or more family members consequently follows in the form of an “altruistic homicide.”⁵⁶³

Chiswick notes that depressed women after enduring years of physical abuse at the hands of their partners may kill the abusers in an attempt to put an end to the intolerable abuse⁵⁶⁴. It could be argued that when battered women kill their abusive partners, depression could be the leading cause for the homicide and the question arises as to whether pathological criminal incapacity should not be the appropriate defence to rely on.⁵⁶⁵ In addition to negative thought processes, depressed individuals also experience difficulties in concentration, decision-making and memory⁵⁶⁶. Taska and Sullivan state that severely depressed persons may experience impaired reality testing accompanied by delusions of guilt, poverty and somatic delusions. Auditory and visual hallucinations may also occur⁵⁶⁷.

- Behavioural symptoms and Physical symptoms – Depressed individuals typically withdraw from social activities and minimize social interactions. Changes in behaviour could range from either being slowed down, agitated or restless and sleep disturbances are common⁵⁶⁸. Within the forensic paradigm these symptoms tend to be of less importance than the cognitive symptoms.

⁵⁶³ *Ibid.* See also *S v Kavin supra* at paragraph 5.2 for an excellent example of a case where the accused’s desire to protect his family as a result of reactive depression resulted in the killing of three of his family members.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ See Kendall and Hammen (1995) *supra* note 550 at 229 where it is noted that women are more than twice as likely to be depressed than men. In addition women do not only have higher rates of depression but also appear to have more severe forms of depression. Hammen and Watkins (2008) *supra* note 533 note that in the United States adults aged between 15 and 54 delivered statistics of 12.7% men suffering from depression as opposed to women who presented 21.3%. Hammen and Watkins *supra* note that these differences could be attributed to biological and psychosocial differences between men and women.

⁵⁶⁶ Hammen and Watkins (2008) *supra* note 533 at 6; Comer (2008) *supra* note 344 at 191; Kendall and Hammen (1995) *supra* note 550 at 223; Barlow and Durand (1995) *supra* note 344 at 245; Kaplan and Sadock (2003) *supra* note 344 at 542.

⁵⁶⁷ Taska, RJ and Sullivan, JL “Depression” in Cavenar, JO and Brodie, HKH “Signs and Symptoms in Psychiatry” (1983) at 203.

⁵⁶⁸ Hammen and Watkins (2008) *supra* note 533 at 6–7; Comer (2008) *supra* note 344 at 189–190; Kendall and Hammen (1995) *supra* note 550 at 224; Barlow and Durand (1995) *supra* note 344 at 245.

In terms of diagnosing unipolar depression, the DSM-IV-TR distinguishes between a major depressive episode and major depressive disorder. In terms of the DSM-IV-TR a major depressive episode is a period of at least two weeks in terms of which at least five symptoms of depression manifest⁵⁶⁹. Comer notes that in extreme cases, the major depressive episode may include psychotic symptoms with concomitant loss of touch with reality accompanied by delusions or hallucinations⁵⁷⁰. Persons who experience one or more major depressive episodes without a history of manic or hypomanic episodes are diagnosed with major depressive disorder⁵⁷¹.

⁵⁶⁹ See the DSM-IV-TR (2000) *supra* note 344 at 356 where the diagnostic criteria for a major depressive episode is set forth in the following way:

“Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5 % of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.”

See also DSM-IV (1994) *supra* note 344 at 327; Woo and Keatinge (2008) *supra* note 344 at 535; Comer (2008) *supra* note 344 at 191; Kaplan and Sadock (2003) *supra* note 344 at 542; Barlow and Durand (1995) *supra* note 344 at 241; Hammen and Watkins (2008) *supra* note 533 at 10–11.

⁵⁷⁰ Comer (2008) *supra* note 344 at 191.

⁵⁷¹ See the DSM-IV-TR (2000) *supra* note 344 at 375–376 where the diagnostic criteria for Major Depressive Disorder is enunciated as follows:

“Diagnostic criteria for 296.2x Major Depressive Disorder, Single Episodes

Unipolar depression is often set in motion by stressful events and research suggests that depressed people endure more stressful life events during the month prior to the onset of their disorder than other people⁵⁷². Comer notes that some mental health professionals find it useful to distinguish between “reactive” depression following stressful events, and “endogenous” depression which is the result of internal factors⁵⁷³. Due to the fact that it is often difficult to determine whether depression is in fact reactive or not, mental health professionals currently focus on identifying both situational as well as internal factors of any case of unipolar depression⁵⁷⁴. Within the ambit of South African Criminal Law, pathological criminal incapacity as a result of depression has been raised successfully and it is clear that depression are capable of depriving the sufferer of insight or self-control⁵⁷⁵.

A. Presence of a single Major Depressive Episode (see p 356).

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p 362), a Mixed Episode (see p 365), or a Hypomanic Episode (see p 368). Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Diagnostic criteria for 296.3x Major Depressive Disorder, Recurrent

A. Presence of two or more Major Depressive Episodes (see p 356).

Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p 362), a Mixed Episode (see p 365), or a Hypomanic Episode (see p 368). Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.”

See also DSM-IV (1994) *supra* note 344 at 344- 345; Woo and Keatinge (2008) *supra* note 344 at 535–536; Bleiberg and Markowitz in Barlow (ed.) (2008) *supra* note 550 at 307.

⁵⁷² Comer (2008) *supra* note 344 at 192.

⁵⁷³ *Ibid.* See *S v Kavin supra* paragraph 5.2 which is an example of reactive depression and *S v McBride supra* paragraph 5.2 where the accused suffered from endogenous depression.

⁵⁷⁴ *Ibid.* See also Hammen and Watkins (2008) *supra* note 533 at 16–17 where they state the following in respect of distinctions or labels attached to the various types of depression: “Labels for ‘endogenous’ depression have included vital, severe, major, incapacitating, psychotic, primary, retarded, melancholic, autonomous, and endogenomorphic, while ‘nonendogenous’ depressions have been variously termed neurotic, reactive, characterologic, atypical, secondary, mild, psychogenic, situational, and nonmelancholic.”

⁵⁷⁵ Burchell and Milton (2005) *supra* note 3 at 385; *S v Kavin supra* paragraph 5.2; *S v McBride supra* paragraph 5.2; Snyman (2008) *supra* note 3 at 173.

8.5 Anxiety disorders: post-traumatic stress disorder

Traumatic experiences can produce serious emotional response. Post-traumatic stress disorder is not a novel phenomenon except in respect of its name. During World War I many war veterans suffered from what was referred to as “shell shock” and during World War II many war veterans had “battle fatigue”⁵⁷⁶. The term that was commonly used to refer to these symptoms was “traumatic neurosis”. It was only in 1980 with the publication of the DSM-III that post-traumatic stress disorder was classified as one of the anxiety disorders⁵⁷⁷. Before embarking on a discussion in respect of specific scenarios where Post-Traumatic Stress Disorder can lead to pathological criminal incapacity, it is necessary to reflect on the diagnostic features of this disorder.

According to the DSM-IV-TR, the essential characteristic of PTSD is the development of specific symptoms as a result of exposure to an extreme traumatic incident involving direct personal experience of an event involving actual or threatened death or serious injury or a threat to a person’s physical integrity or the witnessing of an event that involves death, injury or a threat to another’s physical integrity; or learning about the unexpected or violent death, harm or threat of death experienced by a family member⁵⁷⁸. The individual’s response to the

⁵⁷⁶ Slovenko (1995) *supra* note 3 at 87; Slovenko (1984) *supra* note 3 at 28–29 (hereafter referred to as “PTSD”).

⁵⁷⁷ *Ibid.*

⁵⁷⁸ DSM-IV-TR (2000) *supra* note 344 at 463; DSM-IV (1994) *supra* note 344 at 424; Woo and Keatinge (2008) *supra* note 344 at 624–625; Kaplan and Sadock (2003) *supra* note 344 at 623–624; Resick, PA, Monson, CM and Rizvi, SL “Posttraumatic Stress Disorder” in Barlow, DH (ed.) “Clinical Handbook of Psychological Disorders” (2008) at 65; Barlow and Durand (1995) *supra* note 344 at 189; Hammen and Watkins (1995) *supra* note 550 at 184. According to the DSM-IV-TR, (2000) *supra* note 344 at 467–468 the diagnostic criteria for PTSD are as follows:

“Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person’s response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

specific event must involve intense fear, helplessness, or horror⁵⁷⁹. The essential symptoms following from exposure to the trauma include persistent re-experiencing of the traumatic event, avoidance of stimuli related to the trauma and symptoms of increased arousal⁵⁸⁰. The symptoms must be present for more than one month and cause significant distress and impairment⁵⁸¹. The traumatic event

-
- (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g. unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outburst of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- See also Ludsin, H and Vetten, L “Spiral of Entrapment – Abused Women in conflict with the law” (2005) at 167 – 168.

579

Ibid.

580

Ibid. Woo and Keatinge (2008) *supra* note 344 at 626. Note that the following stressors can produce PTSD: Natural disasters, war, torture, transportation accidents, terrorist attacks, emergency worker trauma exposure, crime victimization, child abuse, domestic violence, rape and sexual assault, life threatening illness, sex trafficking.

581

DSM-IV-TR (2000) *supra* note 344 at 463. For persons whose symptoms have been present for less than one month, the appropriate diagnosis will be “acute stress disorder.” The latter disorder is in essence, PTSD which occurs within the first month after the traumatic incident although it is described differently in order to denounce its severity. The reaction is similar to PTSD symptoms but with more emphasis on severe dissociative symptoms. See Barlow and Durand (1995) *supra* note 344 at 191; Kaplan and Sadock (2003) *supra* note 344 at 626. Slovenko (1995) *supra* note 3 at 88 notes that for a diagnosis of “acute stress disorder”, three of five dissociative symptoms (derealization, depersonalization, numbing, amnesia, or reduced awareness of surroundings) must be present accompanied by the severe re-experience of the event, avoidance and hyperarousal. Slovenko in addition states: “One-fourth to one-third of the people who undergo severe trauma will develop acute stress disorder. It signals the high risk of later PTSD.”

can be re-experienced in numerous ways and generally the individual has recurrent and intrusive recollections of the event or disturbing dreams⁵⁸². Less often, the individual experiences a “dissociative state” lasting from a few seconds to several hours during which aspects of the event are relived and the person behaves in a manner consistent with the actual experience of the event⁵⁸³. The latter is often referred to as “flashbacks” associated with heightened arousal and intense psychological distress or physiological reactivity occurs when the individual is again exposed to an event similar to the traumatic experience⁵⁸⁴. The person suffering from PTSD constantly avoids stimuli associated with the traumatic event and diminished responsiveness to the outside world also referred to as “psychic numbing” usually commence shortly after the trauma⁵⁸⁵. Sufferers from PTSD also have persistent symptoms of anxiety or elevated arousal that were not present before the traumatic event with additional symptoms of recurrent nightmares, hypervigilance, exaggerated startle response, irritability and outbursts of anger⁵⁸⁶. Kaplan and Sadock note that associated symptoms of PTSD include aggression, violence, poor impulse control, depression and substance-related disorders⁵⁸⁷. These associated symptoms could impact on an accused’s cognitive or conative capacity for purposes of pathological criminal incapacity. One of the most common examples where PTSD can occur, is in the case of war veterans. Slovenko states that many Vietnam veterans claim they suffer from nightmares, flashbacks, emotional unresponsiveness, panic and guilt for surviving the war⁵⁸⁸. Kendall and Watkins state that in the United States, the Centres for Disease Control conducted an epidemiological study of approximately fifteen thousand Vietnam veterans and concluded that fifteen percent suffered from combat-related PTSD⁵⁸⁹. Slovenko further submits that many veterans have been found not guilty

⁵⁸² DSM-IV-TR (2000) *supra* note 344 at 464; DSM-IV (1994) *supra* note 344 at 424; Woo and Keatinge (2008) *supra* note 344 at 626; Barlow and Durand (1995) *supra* note 344 at 192–193; Resick, Monson and Rizvi in Barlow (ed) (2008) *supra* note 578 at 66.

⁵⁸³ *Ibid.*

⁵⁸⁴ *Ibid.*

⁵⁸⁵ Woo and Keatinge (2008) *supra* note 344 at 627; DSM-IV-TR (2000) *supra* note 344 at 464; DSM-IV (1994) *supra* note 344 at 425.

⁵⁸⁶ Kaplan and Sadock (2003) *supra* note 344 at 627; DSM-IV-TR (2000) *supra* note 344 at 464, DSM-IV (1994) *supra* note 344 at 425; Resick, Monson and Rizvi in Barlow (ed) (2008) *supra* note 578 at 66; Kendall and Hammen (1995) *supra* note 550 at 184.

⁵⁸⁷ Kaplan and Sadock (2003) *supra* note 344 at 627.

⁵⁸⁸ Slovenko (1995) *supra* note 3 at 88; Slovenko (1984) *supra* note 3 at 28.

⁵⁸⁹ Kendall and Watkins (1995) *supra* note 550 at 185. See also Resick, Monson and Rizvi in Barlow (ed) (2008) *supra* note 578 at 68; Barlow and Durand (1995) *supra* note 344 at 193.

by reason of insanity as a result of PTSD or claimed diminished responsibility and received a lighter sentence⁵⁹⁰. In each case it had to be proved that the veteran served in heavy combat, was suffering from PTSD and that there was a link between the combat experience and the criminal behaviour⁵⁹¹.

A further aspect of PTSD is that some veterans experience flashbacks which occur as “dissociative-like states” and accordingly persons who believe that they are in combat, behave violently and even in the absence of a flashback, a veteran can commit a violent act⁵⁹². Symptoms such as startle reactions, nightmares and irritability are also more severe in combat veterans. Slovenko in addition notes:⁵⁹³

“The delayed ‘stressors’ (traumatic triggering factors) are fragments of the original stress situation. The individuals these stressors act on are in a chronic state of subclinical autonomic-endocrine arousal.”

PTSD can also be advanced in cases of domestic violence and also in cases where abused women kill their abusive partners provided that the diagnostic criteria for PTSD are met. The DSM-IV-TR also mentions that a number of associated symptoms may occur in connection with an interpersonal stressor, for example domestic battering, including self-destructive and impulsive behaviour, dissociative symptoms, feelings of ineffectiveness, shame, despair, hopelessness and a change in the individual’s previous personality characteristics⁵⁹⁴. Battered women often display common features associated with the criteria listed for PTSD, such as recurrent and intrusive recollections of the battering event, distressing dreams, feelings of re-experiencing the traumatic event and also persistent

⁵⁹⁰ See Slovenko (1995) *supra* note 3 at 89 where the case of *State of Louisiana v Heads*, 370 S0.2d 564 (La.1979) is discussed. The facts and decision are briefly the following: Charles Heads, a Marine Corps combat veteran of Vietnam, was charged and put to trial on two occasions for fatally shooting his brother-in-law. Ten years after his return from Vietnam, Heads suffered from nightmares, depressions and flashbacks. One day he gazed into a fog-covered field across the street from his brother-in-law’s house. Suddenly he re-experienced a combat situation. He grabbed a firearm from his car, ran into the house as if it were a combat situation and shot his brother-in-law. During his first trial his defence of insanity was rejected. At the second trial the jury found him not guilty by reason of temporary insanity following his war experiences. This was the first time PTSD had been successfully raised as a defence.

⁵⁹¹ Slovenko (1995) *supra* note 3 at 88; Slovenko (1984) *supra* note 3 at 28.

⁵⁹² *Ibid.*

⁵⁹³ *Ibid.*

⁵⁹⁴ DSM-IV-TR (2000) *supra* note 344 at 465. See also Johann, SL and Osanka, F “Representing Battered Women who kill” (1989) at 108–109.

symptoms of increased arousal for example hypervigilance or exaggerated startle response. Jones, Hughes and Unterstaller found in a study concluded on battered women, that symptoms of battered women are consistent with symptoms of PTSD symptoms and that the intensity, duration and perception of the battering experience are important factors in determining the severity of the PTSD symptoms⁵⁹⁵.

Humphreys, Lee, Neylan and Marmar in addition note that post-traumatic stress disorder has been conceived as a possible model in explaining symptomatology experienced by individuals in response to traumatic events such as battering and that battered women experience a variety of symptoms similar to the criteria for PTSD⁵⁹⁶.

Hughes and Jones conducted a study in order to determine the correlation of domestic violence and PTSD and reached the following conclusions:⁵⁹⁷

- PTSD has been diagnosed mostly in cases of rape, child sexual abuse and war victims, but recent studies indicate that experiences of battered women satisfy the criteria for PTSD.

⁵⁹⁵ Jones, L, Hughes, M and Unterstaller, U “Post-Traumatic Stress Disorder (PTSD) in Victims of Domestic Violence” (2001) *Trauma, Violence and Abuse* at 99–119. See also Dutton, MA “Pathways linking Intimate Partner Violence and Post-Traumatic Stress Disorder” (2009) *Trauma, Violence and Abuse* at 211–224; Astin, MC, Lawrence, KJ and Foy, DW “Post-Traumatic stress disorder among battered women: risk and resiliency factors” (1993) *Violence and Victims* at 17–28; Carmen, EH, Rieker, PP and Mills, T “Victims of violence and psychiatric illness” (1984) *American Journal of Psychiatry* at 378–383; Gelles, RJ and Harrop, JW “Violence, battering and psychological distress among women” (1989) *Journal of interpersonal violence* at 400–420; Kemp, A, Rawlings, EI and Green, BL “Post-traumatic stress disorder in Battered Women: A shelter sample” (1991) *Journal of Traumatic Stress* at 137–148; Mueser, KJ, Goodman, LB, Trumbetta, SL, Rosenberg, SD, Osher, C, Vidaver, R, Auciello, P and Foy, DW “Trauma and posttraumatic stress disorder in severe mental illness” (1998) *Journal of Consulting and Clinical Psychology* at 493–499; Street, AE and Arias, I “Psychological abuse and posttraumatic stress disorder in battered women: examining the roles of shame and guilt” (2001) *Violence and Victims* at 65–78.

⁵⁹⁶ Humphreys, J, Lee, K, Neylan, J and Marmar, C “Psychological and physical distress of sheltered battered women” (2001) *Health care for women International* 401–414 at 402–403.

⁵⁹⁷ Hughes, MJ and Jones, L “Women, Domestic Violence, and Posttraumatic Stress Disorder” (2000) at 5–8. See also Foa, E and Meadows, E “Psychosocial Treatments for Post-Traumatic Stress Disorder: A Critical Review (1997) *Annual Review of Psychology: A Critical Review* at 449–490; Saunders, DG “Posttraumatic Stress Symptom profiles of battered women: A comparison of survivors in two settings: (1994) *Violence and Victims* at 31–44. See also Bargai, N, Ben-Shakhar, G and Shalev, AY “Posttraumatic Stress Disorder and Depression in Battered Women: The mediating Role of learned Helplessness” (2007) *Journal of Family Violence* at 267–275.

- Whereas Battered Woman Syndrome is subjectively defined, PTSD is objectively defined.
- Research suggests that the symptoms displayed by battered women are consistent with the major criteria for PTSD as defined in the DSM-IV.
- Multiple experiences of abuse increase the likelihood of PTSD.
- The extent, severity and type of abuse are connected to the intensity of PTSD. The more severe the abuse the more traumatic the impact and sexual abuse, severe physical abuse, and psychological abuse are factors known to increase the trauma among victims.
- Depression often accompanies PTSD.

PTSD can accordingly be used in support of a defence of pathological criminal incapacity as well as in support of a claim of diminished criminal capacity provided the criteria for PTSD are met and it can be proved that the symptoms caused the accused to lack cognitive or conative capacity. Melton *et al* notes that the mental status evaluation of a person alleging to be suffering from PTSD poses several challenges for forensic mental health professionals. These challenges are the following:⁵⁹⁸

- Establishing the validity of a diagnosis of PTSD can be problematic as most of the structured measures that have been developed to assess PTSD are founded on self-report and open to manipulation.
- Establishing retrospectively that a “flashback” occurred is complicated by the fact that flashbacks are generally unconscious occurrences and it is thus difficult to obtain clear accounts of the accused’s true thoughts, feelings and perceptions during the specific episode.
- A further complication relates to the interaction of drugs with PTSD.

These are some aspects forensic mental health professionals will have to “battle” with when assessing an accused allegedly suffering from PTSD.

⁵⁹⁸ Melton *et al* (2008) *supra* note 3 at 240–241.

8.6 Dissociative disorders: dissociative identity disorder/“multiple personality disorder”⁵⁹⁹

“The horror of that moment” the king went on, “I shall never, never forget!”
“You will though” the Queen said, “Unless you make a memorandum of it”.
(Lewis Carrol [1832–1898] (Through the Looking Glass))

According to the DSM-IV, the essential characteristic of dissociative disorders relates to a disturbance or alteration in normal interrelated functions of identity, memory or consciousness⁶⁰⁰. This disturbance or alteration may be sudden or slow, transient or chronic and if it relates primarily to a person’s identity, the person’s own identity is temporarily forgotten and a new and distinct identity may be assumed⁶⁰¹.

⁵⁹⁹ For purposes of this chapter only dissociative identity disorder will be addressed in depth. It is notable that the DSM-IV-TR (2000) *supra* note 344 at 519 lists Dissociative Personality Disorder with various other dissociative disorders which can briefly be summarized as follows:

- Dissociative amnesia, which is in essence the inability to remember important personal information usually relating to a traumatic or stressful event, and this inability is too extensive to be coined as ordinary forgetfulness. This disorder is often referred to as psychogenic amnesia. For a discussion of psychogenic amnesia, see chapter 2 above.
- Dissociative fugue which is characterized by sudden, unexpected travel away from home or a person’s ordinary place of work, accompanied by an inability to remember one’s past and confusion relating to one’s personal identity or the assumption of a new identity.
- Depersonalization disorder which entails the continuous and recurrent feeling of being removed from one’s body or mental processes which is accompanied by reality testing.

See also DSM-IV (1994) *supra* note 344 at 477; Lerner, PM “Dissociative Identity Disorder” in Weiner, IB (ed.) “Adult Psychopathology – Case Studies” (2004) at 183; LaBruzza and Mendez-Villarubia (1994) *supra* note 3 at 329–338; Bartol and Bartol (2005) *supra* note 3 at 191; Comer (2008) *supra* note 344 at 159; Kaplan and Sadock (2003) at *supra* note 344 at 680; Barlow and Durand (1995) *supra* note 344 at 203 and 228–234.

⁶⁰⁰ Slovenko (1995) *supra* note 3 at 73; Slovenko (1984) *supra* note 3 at 23.

⁶⁰¹ *Ibid.* See also DSM-IV-TR (2000) *supra* note 344 at 529 where the diagnostic criteria for dissociative identity disorder are listed as follows:

- “A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person’s behaviour.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct physiological effects of substance ...”

The essential distinctive feature of dissociative identity disorder is the presence of two or more identities⁶⁰². Dissociative identity disorder relates to a failure to integrate various aspects of identity, memory and consciousness and each separate personality has a distinct history, self-portrait and identity and also a separate name⁶⁰³. There is usually one subpersonality called the “primary identity” which carries the person’s name and is usually passive, dependent, guilty or depressed, whilst the alternate identities have different names and characteristics and these identities are experienced as taking control in a specific order, one at the expense of the other and may deny knowledge of one another or appear to be in conflict⁶⁰⁴. Kaplan and Sadock note that in classic cases of dissociative identity disorder, each personality has a fully integrated and complex set of memories and attitude as well as behavioural patterns⁶⁰⁵. Persons with this disorder generally display gaps in memory for personal history and consequently the more passive identities have more restricted memories, whilst the more hostile or so-called “protector” identities have more complete memories⁶⁰⁶. A specific identity that is not in control may gain access to consciousness by producing auditory or visual hallucinations⁶⁰⁷. The transition or “switching” between identities are often set in motion as a result of psychosocial stress and may be sudden and dramatic and behaviour associated with such transition include rapid blinking, facial changes, changes in voice or demeanor or disruption of thought⁶⁰⁸. The number of identities can range between two to more than a hundred.

Research suggests that persons with dissociative identity disorder often report having experienced severe physical and sexual abuse and addition that persons responsible for acts of physical and sexual abuse may be prone to deny their

⁶⁰² DSM-IV-TR (2000) *supra* note 344 at 526; DSM-IV (1994) *supra* note 344 at 484; Barlow and Durand (1995) *supra* note 344 at 229; Comer (2008) *supra* note 344 at 176; Kaplan and Sadock (2003) *supra* note 344 at 682.

⁶⁰³ *Ibid.*

⁶⁰⁴ *Ibid.*

⁶⁰⁵ Kaplan and Sadock (2003) *supra* note 344 at 682.

⁶⁰⁶ DSM-IV-TR (2000) *supra* note 344 at 526; DSM-IV (1994) *supra* note 344 at 484–485.

⁶⁰⁷ *Ibid.*

⁶⁰⁸ Comer (2008) *supra* note 491 at 176; DSM-IV-TR (2000) *supra* note 344 at 527; DSM-IV (1994) *supra* note 344 at 485; Kaplan and Sadock (2003) *supra* note 344 at 682; Barlow and Durand (1995) *supra* note 344 at 229.

behaviour⁶⁰⁹. Individuals with dissociative identity disorder may also manifest post-traumatic symptoms or post-traumatic stress disorder⁶¹⁰. Slovenko in addition notes that many researchers believe that multiple personality develops as a coping mechanism to early childhood trauma⁶¹¹. Slovenko submits the following:⁶¹²

“The theory is that the individual dissociated during the traumatic experiences of childhood in order to avoid the pain of the experience. One or more spontaneously conceived personalities arise and intervene to hold the pain, feel the grief, experience the event and keep the memories.”

Each personality of the multiple personality has a distinct identity, ego or superego with a strong separation between each sub-personality⁶¹³. Physiologically it is as if there are various persons in one individual’s body and these different personalities differ frequently in handwriting, talents and languages⁶¹⁴.

The forensic mental health professional requested to assess an accused alleging to suffer or to have suffered from multiple personality disorder, is confronted with various issues. The first issue that arises is whether an accused suffering from multiple personality disorder should be deemed competent to stand trial. If so, which of the numerous personalities should be deemed to be competent to stand trial? The second issue relates to the threshold requirement for the insanity defence – mental illness or mental defect – does multiple personality qualify as mental disease or defect for purposes of section 78 of the Criminal Procedure Act? If multiple personality is regarded as a mental illness, was it of such severity as to

⁶⁰⁹ Comer (2008) *supra* note 344 at 179; Barlow and Durand (1995) *supra* note 344 at 532–533; Kaplan and Sadock (2003) *supra* note 344 at 682 – 684; DSM-IV-TR (2000) *supra* note 344 at 527; DSM-IV (1994) *supra* note 344 at 485.

⁶¹⁰ DSM-IV-TR (2000) *supra* note 344 at 527. See also Slovenko (1995) *supra* note 3 at 75 where he notes that according to some researchers, multiple personality disorder can be classified as a type of posttraumatic dissociative disorder; for example an overwhelmed child who is unable to flee or fight his or her abuser in reality escapes mentally from the danger by shifting from one state of consciousness to another.

⁶¹¹ Slovenko, R “The Multiple Personality and the Criminal Law” (1993) *Medicine and Law* at 329–340 at 330.

⁶¹² *Ibid.*

⁶¹³ *Ibid.*

⁶¹⁴ Slovenko (1993) *Medicine and Law supra* note 611 at 331. See also Slovenko, R “Multiple Personality: Perplexities about the Law” (1995) *Medicine and Law* at 623–629.

impair the accused's cognitive or conative abilities at the time of the commission of the offence? One of the most effective ways of exposing multiple personality is by means of hypnosis but this treatment carries the risk of actually causing multiple personality disorder⁶¹⁵. According to Slovenko, courts generally tend to focus on the specific personality who allegedly committed the offence rather than focusing on the accused as a composite of a severely disturbed personality with absence of psychological integration⁶¹⁶. Forensic experts are often confronted with the issue as to whether the unlawful act was committed by the primary or sub-personality and in cases where there is a long history of chaotic conduct, the unlawful behaviour is often ascribed to a sub-personality⁶¹⁷. Davidson also states the following in respect of the criminal responsibility of accused persons allegedly suffering from multiple personality disorder:⁶¹⁸

“Concede that the patient had two personalities. One, the ‘main’ personality, was good; the other, the ‘secondary’ personality, was evil. The offence is now judged within the framework of the secondary personality, and the responsibility is then assigned to the ‘main’ personality.”

Kaplan and Sadock note that generally most courts have not found dissociation as a sufficient ground for incompetency and have held the whole human being accountable for criminal behaviour⁶¹⁹. They also state the following in respect of the problematic nature of a defence of criminal incapacity based on multiple personality disorder.⁶²⁰

⁶¹⁵ Slovenko (1993) *Medicine and Law supra* note 611 at 334. See also Comer (2008) *supra* note 344 at 180 where it is noted that some theorists believe that dissociative disorders are a form of self-hypnosis where individuals hypnotize themselves to forget traumatic or unpleasant events. This often manifests in children who experienced abuse and attempts to escape their threatening world by means of self-induced hypnosis thereby distancing themselves from their bodies and becoming a new person.

⁶¹⁶ Slovenko (1993) *Medicine and Law supra* note 611 at 337.

⁶¹⁷ *Ibid.*

⁶¹⁸ Davidson, HA “Forensic Psychiatry” (1952) at 15 as quoted in Slovenko (1993) *Medicine and Law supra* note 611 at 338.

⁶¹⁹ Kaplan and Sadock (2003) *supra* note 344 at 685.

⁶²⁰ *Ibid.*

“Issues of competency to stand trial and degree of responsibility for the behavior of different alter personality states have received contradictory judicial opinions ...

.....

Evidentiary questions, such as the admissibility of hypnotic or amobarbital interviews and the independence of testimony by different alter personalities have proved problematic.”

The defence of pathological criminal incapacity founded on the alleged existence of multiple personality disorder is accordingly problematic. Inadvertently, the expert forensic evidence in support of such a defence will have to be of an exceptional quality for this defence to succeed either completely or as a possibility for a finding of diminished criminal capacity. The high risk of malingering or faking multiple personality disorder will further result in courts subjecting expert forensic evidence in support of this defence to high scrutiny. Barlow and Durand in addition note that research confirms that it is very easy to simulate or fake an “alter” personality⁶²¹.

Within the framework of South African Criminal Law, reliance was placed on multiple personality disorder in mitigation of sentence in the case of *S v Olivier*⁶²². The tragic and horrific facts of this case were as follows: The deceased, Steven Hans Siebert (Steven) who was six years old, was holidaying with his family in Plettenberg Bay during the festive season of December 2005. On 23 December 2005, little Steven was playing in and around the holiday home. His father, Thomas Siebert, saw him through the window of the house just before he went to shower. Little Steven’s mother, Etrechia Elaine Siebert, while attending to Steven’s younger brother, saw Steven through the window playing outside the house. After Mr Siebert had showered, he went looking for Steven but could not find him. A search was launched for Steven. The police, with the help of

⁶²¹ Barlow and Durand (1995) *supra* note 344 at 230.

⁶²² *S v Olivier* 2007 (2) SACR 596 (CPD). Judgment was delivered on sentence on 8 August 2007. See also Du Toit *et al* (2008) *supra* note 3 at 13–19; *S v Olivier* (2007) 4 ALL SA 1029 (T).

members of the community, conducted a coordinated search for Steven. The following day, at approximately 9:45, a member of the search team, Mr William Bosman, found the body of Steven lying in the bushes located near the dwelling of 13 Cordovan Street, Plettenberg Bay. The accused, Theunis Christiaan Olivier was staying at the address while he assisted with the renovation of the house. The evidence gathered during the post-mortem performed on little Steven by Dr Van der Heyde revealed that the sexual assault perpetrated by the accused was of terribly severe and serious nature. The accused was arrested on 25 December 2005 and made a confession to the following effect: On Friday 23 December 2005 the accused saw a young child playing in a tree in the front garden. He approached the child whose name was Steven. He attempted to persuade Steven to come to his home that was not far away, to climb trees. Steven agreed. The accused picked him up and carried him through a shortcut through bushes so that no one would see them. He took Steven to his home where he sexually abused him in the bedroom for ten to fifteen minutes. He thereafter strangled him to death with a telephone cord. He placed the body in a cupboard and went and took a shower. He eventually took the body and hid it in bushes on the other side of the garage. The accused was charged with one count of kidnapping, one count of indecent assault and one count of murder. Before the charges were put to the accused he was sent to Valkenberg Hospital for observation in terms of section 79(2) of the Criminal Procedure Act. Prof Kaliski and Dr Panieri-Peter reported on the outcome of the observation in terms of section 79(4). They reached a unanimous conclusion that the accused was not mentally ill and not certifiable in terms of Mental Health legislation. They further found the accused fit to stand trial and also reported that he was able to appreciate the wrongfulness of the alleged offences and act accordingly⁶²³. Dr Czech made similar findings. The accused initially pleaded not guilty to the charges and averred that he did so in terms of section 78(1)(b) of the Criminal Procedure Act to the effect that he suffered from a mental illness. The defence, however, later changed the plea of not guilty to one of guilty and the State accepted it as such. The court per Moosa J was satisfied with the plea of guilty and held that all the elements of the three charges had been established. The accused was found guilty as charged. The trial then resumed for

⁶²³ At 599 E–G (paragraph 3).

sentence on 8 August 2007. In mitigation of sentence, the accused acknowledged to be a paedophile but disputed the findings of Prof Kaliski and Dr Panieri-Peter that he did not suffer from multiple personality disorder. The testimony of Prof Kaliski and Dr Panieri-Peter stated the following:⁶²⁴

“Mr Olivier has a long history of paedophilia and is not mentally ill. He will continue to be at high risk of engaging behaviours related to this assessment. He does not suffer from multiple personality (dissociative) disorder.”

Czech stated the following:⁶²⁵

“Mr Olivier gives an inconsistent and sporadic account of auditory hallucinations at the time of the incident. His account of auditory hallucinations is inconsistent and vague. In contrast he gives a clear history of having acted systematically and under his own volition during the incident.”

Moosa J held that save for the *ipse dixit* of the accused, there was no independent evidence that the accused suffered from multiple personality disorder. The accused alleged that the offences were not committed by himself but by his alter ego, “Theo”.

Moosa J stated the following in respect of the accused’s defence:⁶²⁶

“The only inference the Court can draw is that your alleged multiple personality disorder is an afterthought and you adapted your evidence to coincide with such alleged disorder.”

⁶²⁴ At 603 D (paragraph 13).

⁶²⁵ At 603 E (paragraph 13).

⁶²⁶ At 604 F (paragraph 17).

The accused contested the report by the psychiatrists on the basis that they were unprofessional. Moosa J held the following in respect of the expert evidence by Prof Kaliski:⁶²⁷

“Professor Kaliski has testified in this and other courts on numerous occasions in his capacity as a forensic psychiatrist. Professionally, he is held in high regard by his colleagues as well as by the courts. His evidence and findings are reported in many cases. His professional integrity, as far as this court is concerned, is beyond reproach. His evidence is accordingly accepted without any reservation.”

Moosa J held that the accused was a confirmed paedophile with psychotic tendencies and that he did not suffer from multiple personality disorder but that he simulated the condition of multiple personality disorder in order to apportion the blame of his conduct on the day of the incident to his alter ego, “Theo”. Moosa J held the following:⁶²⁸

“You testified that at the time of the incident ‘Theo’ was the dominant personality and that you were the host personality and that you accepted joint responsibility for the commission of the crimes. I am also convinced that you simulated multiple personality disorder in order to distance yourself, at least partially, from your unequivocal confession of guilt.”

Moosa J in addition held that if multiple personality disorder is relied upon, the usual tests in determining criminal capacity will apply and also left the question open as to whether diminished responsibility would arise if found that the accused has such a disorder.⁶²⁹ It was held that the accused was able to appreciate the wrongfulness of the offences and act in terms of such appreciation and accordingly that the accused had the necessary criminal capacity⁶³⁰. Moosa J held that the accused violated little Steven’s right to life, his right to human dignity,

⁶²⁷ At 605 G–H (paragraph 21).

⁶²⁸ At 605 J–606 A (paragraph 22).

⁶²⁹ At 606 B–C (paragraph 23).

⁶³⁰ At 606 D–E (paragraph 24).

his right to security of the person and the right not to be subjected to torture, abuse, cruel, inhuman or degrading punishment⁶³¹.

The evidence disclosed that the accused's past history was punctuated by sexual, physical and emotional abuse. Thereafter the accused became the abuser. In 1980 he was arrested for two counts of indecent assault on two eleven-year old victims. In 1985 he was arrested for rape and multiple charges of indecent assault and declared a State President's patient. After being released as a State President's patient the paedophiliac acts continued. He was again later arrested on five counts of indecent assault. After release from prison, the accused found his way to Plettenberg Bay where he took the life of little Steven. According to the accused he spent approximately fifteen years in a psychiatric hospital.

Moosa J in delivering judgment also referred to the public outrage and disapproval of the accused's conduct⁶³². Moosa J further held:⁶³³

"The violent crimes of which you have been convicted, have become a common feature in our country.

... Courts need to send a clear message that it will act firmly against the offenders of such heinous crimes less the members of the community take the law into their own hands. Something the Court cannot tolerate and allow as that would lead to anarchy and chaos in our society."

It was also held:⁶³⁴

⁶³¹ At 608 A–B (paragraph 30). In respect of the horrific nature of these crimes, Moosa J at paragraph 31–32 held: "Little Steven must have endured excruciating suffering and pain when you indecently assaulted him. This was evident from the gaping anus. ... I am sure he could not make any sense of what was happening to him. He was too innocent, too young to realise what was happening. A man, who could have been his grandfather, spoke to him to win his trust and confidence. Little did he know the evil designs that person had in his mind. ... The sexual assault, according to you, lasted between 15 and 20 minutes. To little Steven it must have been an eternity ... After defiling little Steven you set about strangling him with a telephone cord and watched him die. After you killed him you had the temerity to stash his body in a cupboard and later dumped it in the bushes. Your conduct has been cold, callous, cunning and calculated ... Little Steven died a lonely and terrible death. His parents were not there to protect and comfort him – they were near, yet so far!"

⁶³² At 609 H–J (paragraph 35).

⁶³³ At 610 A–B (paragraph 36).

“The Court needs to take cognizance of the fact that you are a paedophile and that you have psychopathic tendencies. The psychiatrists who testified *ad idem* that the prognosis for recovery is poor, you yourself have admitted that if you do not receive effective treatment, you will become a repeat offender. Both Professor Kaliski and Dr Czech testified that you are a danger to children and you must be kept away from them permanently. The only way to keep you away from them is to remove you permanently from society.”

The accused was sentenced to ten years’ imprisonment in respect of the charge of kidnapping, fourteen years’ in respect of the indecent assault and life imprisonment in respect of the murder charge.

This decision is important in respect of various aspects. It clearly illustrates that multiple personality disorder will not easily succeed in support of a defence of pathological criminal incapacity. The decision also illustrates the value of a unanimous body of expert evidence not necessarily in support of a defence of pathological criminal incapacity by reason of multiple personality disorder, but also in rebuttal of such defences especially if simulated or malingered. The decision, however, confirms that if multiple personality disorder is claimed, the appropriate defence will be one of criminal incapacity. Melton *et al* state that surveys from both psychiatrists and psychologists reveal that in respect of dissociative disorder diagnoses, controversy exists pertaining to the precise origin of multiple personality disorder but that a number of instruments such as the Dissociative Experiences Scale have been implemented to assist mental health professionals in the diagnosis of this disorder⁶³⁵.

⁶³⁴ At 611 B–C (paragraph 40).

⁶³⁵ Melton *et al* (2008) *supra* note 3 at 239.

8.7 Psychopathy and antisocial personality disorder

“A pure sociopath, that’s obviously what he is. But he’s impenetrable, much too sophisticated for the standard tests. And, my, does he hate us. He thinks I’m his nemesis ...”

“Nothing happened to me, Officer Starling. I happened. You can’t reduce me to a set of influences. You’ve given up good and evil for behaviorism Officer Starling. You’ve got everybody in moral dignity pants – nothing is ever anybody’s fault. Look at me, Officer Starling. Can you stand to say I’m evil? Am I evil, Officer Starling?”⁶³⁶

Psychopathy and its relation to criminal behaviour has been the focus of clinical research for many years⁶³⁷. Currently, psychopathy is not listed as one of the

⁶³⁶ These excerpts are extracted from the international bestseller by Harris, T “The Silence of the Lambs” (1989) at 10 and 20 dealing with the infamous Dr Hannibal Lecter who was a psychiatrist, serial murderer and sociopath. The first excerpt is a description of Dr Hannibal Lecter by a Dr Chilton and the second excerpt are the words of Dr Hannibal Lecter himself.

⁶³⁷ See Patrick, CJ “Antisocial Personality Disorder and Psychopathy” in O’Donohue, W, Fowler, KA and Lilienfeld, SO (eds) “Personality Disorders – Towards the DSM-V” (2007) at 109–112 where it is noted that more than 200 years ago, Philippe Pinel noted examples of persons “who at no period gave evidence of any lesion of understanding but who were under the dominion of instinctive and abstract fury, as if the faculties of affect alone had sustained injury.” Pinel labeled this syndrome as *manie sans delire* (“insanity without delirium”) as these persons were repeatedly involved in acts injurious to themselves or others lacking the ability to perceive the irrationality thereof. Pinel’s theory in such cases was founded on the inability to exercise control over emotion in contrast to a deficit in reason. American physician Benjamin Rush hypothesized the problem as one of moral weakness. Rush emphasized the manipulative and deceitful characteristics of psychopathic individuals. British psychiatric JC Pritchard followed a broader interpretation of Rush’s “moral insanity” to include most conditions regarded as mental disorders currently. In 1891, German psychiatrist JL Koch introduced the term “psychopathic inferiority” to refer to conditions of a permanent nature which reflected an underlying organic cause. Kohn made this term applicable to wide variety of clinical conditions some of which would not conform to current conceptualizations of psychopathy. In the seventh edition of Koch’s book entitled “*Psychiatrie: Ein lehrbuch*” (“Psychiatry: A Textbook”), Emil Kraepelin made use of the term “psychopathic personalities” thereby narrowing the range of conditions characterized as chronic. The term “sociopathic” was later developed by German psychiatrist Karl Birnbaum and later the terms psychopathic and sociopathic were used interchangeably. The first edition of the DSM used the term “Sociopathic personality disorder”. The current DSM-IV-TR, however, provides for “Antisocial Personality Disorder” which will be discussed below. See also Bartol and Bartol (2005) *supra* note 344 at 118–120; Schechter, H “The Serial Killer Files” (2003) at 15–16; Barlow and Durand (1995) *supra* note 344 at 529–530; Kaliski (2006) *supra* note 3 at 114; Comer (2008) *supra* note 344 at 381; Slovenko (1995) *supra* note 3 at 104–106; Slovenko (1984) *Journal of Legal Medicine* at 41; Mcauley (1993) *supra* note 3 at 85–92; Woo and Keatinge *supra* note 344 at 816–818; Kendall and Hammen (1995) *supra* note 550 at 469–470; Kantor, MK “Diagnosis and Treatment of the Personality Disorders” (1992) at 267; Faulk, M “Basic forensic Psychiatry” (1994) at 193–194; Bartol (1991) *supra* note 3 at 59 – 62; Gunn, J and

disorders within the framework of the DSM-IV-TR. The DSM-IV-TR includes within the diagnostic framework of mental disorders the antisocial personality disorder (APD). Despite the fact that psychopathy and APD are often used interchangeably, these two phenomena differ in various respects and these differences will be assessed briefly. Patrick notes that although antisocial personality disorder has received emphasis within the psychiatric community for over twenty five years, the concept of psychopathy preceded it historically and can be regarded as an umbrella construct also including antisocial personality disorder⁶³⁸. It is accordingly necessary to assess these two phenomena separately.

Taylor, PJ "Forensic Psychiatry – Clinical legal and Ethical Issues" (1993) at 384–387; Slovenko, R "Responsibility of the Psychopath" (1999) *Philosophy, Psychiatry and Psychology* at 53–55.

⁶³⁸ Patrick in O'Donohue, Fowler and Lilienfeld (2007) *supra* note 637 at 109. It is notable that Antisocial personality disorder is listed in the DSM-IV-TR (2000) *supra* note 344 at 685 in conjunction with other personality disorder that are the following:

- Paranoid personality disorder which is characterized by a pattern of distrust and suspiciousness of other people and their behaviour;
- Schizoid personality disorder which entails detachment from social relationships and limited emotional responses;
- Schizotypal personality disorder which involves discomfort in close relationships, cognitive and perceptual distortions and eccentric conduct;
- Borderline personality disorder which involves general instability in personal relationships, self image with impulsive behaviour;
- Histrionic personality disorder which entails elated emotionality and attention seeking;
- Narcissistic personality disorder that refers to signs of grandiosity and a need to be admired by others coupled with a lack of empathy;
- Avoidant personality disorder that involves social inhibition, emotions of inadequacy and hypersensitivity to any negative assessment or evaluation;
- Dependent personality disorder which entails submissive and clinging behaviour with constant need to be taken care of;
- Obsessive compulsive disorder which involves a preoccupation with orderliness, perfectionism and control.

These personality disorders are very seldomly regarded as mental illnesses by psychiatrists. Kaliski (2006) *supra* note 3 at 244 also note that most psychiatrists use a diagnosis of personality disorder to deny an individual access to psychiatric facilities. Kaliski states "No psychiatric institution in South Africa would admit under certification anyone whose only diagnosis was that of a personality disorder, nor would any accused be found incompetent in court based on that diagnosis alone" (at 244). According to Kaliski, the reasons for excluding personality disorders of fulfilling the "legal criteria" for mental illness include:

- The features used to diagnose these disorders do not differ from those found in all people, but are accepted to be more severe in disordered persons – in contrast other psychiatric disorders reveal symptoms that are never found in healthy persons.
- Personality disorder is not associated with cognitive impairment.
- Individuals with personality disorders often exploit manipulate or just simply lack empathy for others.

Mental health professionals will, however, always assess whether a person meets the criteria for a personality disorder, as it enhances an understanding of the specific person (Kaliski [2006] *supra* note 3 at 246). Due to the fact that these disorders do not qualify for the insanity defence, they will not be addressed in this study. For further reading see Sperry, L "Cognitive

- Antisocial Personality Disorder

According to the DSM-IV-TR, the essential characteristic of APD is “a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood⁶³⁹. Persons with APD fail to conform with social norms with regard to lawful behaviour and may repeatedly perform acts that are grounds for arrest⁶⁴⁰. Individuals with APD completely disregard the wishes or feelings of others and are frequently deceitful and manipulative for personal gain⁶⁴¹. Persons with APD are often seen to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault and they generally display a reckless disregard for the safety of others⁶⁴². Individuals with APD tend to be irresponsible and show little remorse for their conduct and tend to be callous, cynical and contemptuous to the feelings and

Behavior Therapy at DSM-IV-TR Personality Disorders” (2006); Kendall and Hammen (1995) *supra* note 550 at 440–465; O’Donohue, W, Fowler, KA and Lilienfeld, SC “Personality Disorders – Toward the DSM-V” (2007); Barlow and Durand (1995) *supra* note 344 at 515–551; Comer (2008) *supra* note 344 at 373–405; Woo and Keatinge (2008) *supra* note 344 at 801–877; Kantor, M “Diagnosis and treatment of the Personality disorders” (1992); Kaplan and Sadock (2003) *supra* note 344 at 800–821. See also Kendall, RE “The distinction between personality disorder and mental illness” (2002) *The British Journal of Psychiatry* at 110– 115.

⁶³⁹ DSM-IV-TR (2000) *supra* note 344 at 701–702; DSM-IV (1994) *supra* note 344 at 645; Kaplan and Sadock (2003) *supra* note 344 at 807; Barlow and Durand (1995) *supra* note 344 at 528–529. The diagnostic criteria for APD as contained in the DSM-IV-TR (2000) *supra* note 344 for APD at 706 include the following:

“A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

- (1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
- (2) deceitfulness, as indicated by repeated lying, use of aliases or conning others for personal profit or pleasure;
- (3) impulsivity or failure to plan ahead;
- (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- (5) reckless disregard for self or others;
- (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
- (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.”

It will become clear that many of these characteristics overflow with those of psychopathy.

⁶⁴⁰ *Ibid.* See also Patrick in O’Donohue, Fowler and Lilienfeld (eds) (2007) *supra* note 637 at 117.

⁶⁴¹ *Ibid.*

⁶⁴² *Ibid.* See also Comer (2008) *supra* note 344 at 383; Kendall and Hammen (1995) *supra* note 550 at 469.

emotions of others⁶⁴³. These individuals display an inflated self-esteem and superficial charm and may be excessively opinionated and arrogant.

Persons with APD are generally considered to be more involved in criminal behaviour and activities than people with psychopathy. It is doubtful whether APD will satisfy the legal criteria for the insanity defence. It could, however, be argued that such disorder and the presence thereof in an accused should be regarded as a factor when considering diminished responsibility. A further anomaly associated with a diagnosis of APD lies inherently in the similarities between APD and psychopathy which will inadvertently affect the expert evidence provided by the mental health professional⁶⁴⁴.

- Psychopathy

A prominent psychiatrist, Hervey Cleckley, who spent most of his career studying psychopaths, identified the “psychopathic personality” in his well known publication “The Mask of Sanity” which initially appeared in 1941 and identified sixteen specific characteristics that could be used to identify psychopathic personalities⁶⁴⁵. These characteristics can be summarized as follows.⁶⁴⁶

- Superficial charm and good “intelligence”

Superficial charm and above average to good intelligence are, according to Cleckley, two of the core characteristics of a psychopath. Most psychopaths come across as friendly, outgoing, well educated and knowledgeable and can often talk their way out of difficult situations. A closer study of their communications often reveal that psychopaths tend to jump from one topic to another and often repeat

⁶⁴³ Barlow and Durand (1995) *supra* note 344 at 529; Comer (2008) *supra* note 344 at 383; Woo and Keatinge (2008) *supra* note 344 at 816–817.

⁶⁴⁴ See Bartol and Bartol (2005) *supra* note 344 at 197.

⁶⁴⁵ Patrick in O’Donohue, Fowler and Lilienfeld (eds)(2007) *supra* note 637 at 113–115; Barlow and Durand (1995) *supra* note 344 at 529–530; Bartol (1991) *supra* note 3 at 63–66; Schechter (2003) *supra* note 637 at 15; Bartol and Bartol (2005) *supra* note 344 at 123–126; Woo and Keatinge (2008) *supra* note 344 at 817–818; Kendall and Hammen (1995) *supra* note 550 at 469–470; Kantor (1992) *supra* note 637 at 267–278.

⁶⁴⁶ *Ibid.* These are the characteristics as discussed in Cleckley, HM “The Mask of Sanity” (1982) 6th ed at 204.

their ideas and tend to communicate inconsistently and superficially. Their charm and manipulative tactics, however, result in these shortcomings often being concealed to the layman.

- Absence of delusions and other signs of irrational thinking

Psychopaths generally do not display mental disorders either in a mild or severe form and in addition lack symptoms of anxiety, psychotic thoughts, delusions, depressions or hallucinations.

- Absence of “nervousness” or psychoneurotic signs

When under pressure, psychopaths remain cool, calm and collected and display no signs of nervousness. A good example of this trait is the case of Jeffrey Dahmer. When one of his victims that he had handcuffed escaped and ran out into the street, Dahmer convincingly persuaded the police to return the man to his custody whereafter he slaughtered him⁶⁴⁷.

Melville encapsulates the even temper of the psychopath as follows:⁶⁴⁸

“Though the man’s even temper and discreet bearing would seem to intimate a mind peculiarly subject to the law of reason, not the less in heart he would seem to riot in complete exemption from that law, having apparently little to do with reason further than to employ it as an ambidexter implement for effecting the irrational. That is to say: Toward the accomplishment of an aim which in wantonness of atrocity would seem to partake of the insane, he will direct a cool judgment sagacious and sound. These men are madmen, and of the most dangerous sort, for their lunacy is not continuous but occasional, evoked by some special object.”

- Unreliability

⁶⁴⁷ See Schechter (2003) *supra* note 637 at 16.

⁶⁴⁸ Melville, H as quoted in Schechter (2003) *supra* note 637 at 16.

Psychopaths are generally unreliable, irresponsible, and unpredictable irrespective of the consequences of their actions or impulsive conduct. The pattern of unreliable behaviour is often cyclical in the sense of the psychopath being reliable for a certain period achieving great successes but later becoming irresponsible.

- Untruthfulness and insincerity

Psychopaths have a complete disregard for truth and are often referred to as “pathological liars” and in addition lack a sense of morality and comprehension of the importance of honesty.

- Lack of remorse or shame

One of the essential features of a psychopath is the absolute lack of remorse or guilt for anything they are responsible for. Bartol and Bartol explain the lack of remorse as follows:⁶⁴⁹

“They may readily admit culpability and take considerable pleasure in the shock these admissions produce in others. Whether they have bashed in someone’s head, ruined a car, or tortured a child, psychopaths may well remark that they did it ‘for the hell of it’ ”.

- Inadequately motivated antisocial behaviour

Psychopaths generally project blame onto the community and family for their own misfortunes and lack insight into their own antisocial behaviour.

- Poor judgment and failure to learn by experience

Psychopaths often become irresponsible and may later apologise for their behaviour and plead for another chance but unfortunately in the case of especially a young psychopath, the irresponsible behaviour will repeat itself.

⁶⁴⁹ Bartol and Bartol (2005) *supra* note 3 at 126.

- Pathologic egocentricity and incapacity for love

Psychopaths are characterized by selfishness and an inability to love or give affection to another and although they are often likeable, they seldom retain close friendships and find it difficult to comprehend love in others. Psychopaths are also often classified in terms of flat emotional reaction and affect. They also maintain little contact with their families.

- General poverty in major affective reactions

Psychopaths are usually very skillful of pretending to be deeply affectionate and they often mimic specific emotions, but true loyalty, warmth and compassion are absent in psychopaths.

- Specific loss of insight

Psychopaths have a very superficial insight and generally their insights are applied for tactical purposes and not for moral purposes.

- Unresponsiveness in general interpersonal relations

As stated above, psychopaths have very little need to receive or provide love and they usually do not respond to acts of generosity and display only superficial appreciation.

- Fantastic and uninviting behaviour with alcohol and sometimes without

Alcohol, however small the quantity may be, prompt many psychopaths to become vulgar, “boisterous” and domineering and engage in jokes generally not appealing for most people but rather bizarre and inappropriate.

- Suicide rarely carried out

- Sex life impersonal, trivial and poorly integrated
- Failure to follow any life plan

The life of the psychopath in general displays minimal goal-directed behaviour. The psychopath does not plan or work towards achieving directives of a long-term nature but rather acts for immediate profit or gain⁶⁵⁰.

The abovementioned characteristics are the sixteen major features underlying psychopathy as espoused by Cleckley. Patrick notes that Cleckley's construct of psychopathy was influential as it provided an exact definition of the syndrome which was absent at that stage⁶⁵¹. His concept of psychopathy further focused on the emotional-interpersonal characteristics which distinguished psychopaths from other criminals⁶⁵².

Patrick in addition notes:⁶⁵³

“Cleckley characterized psychopathy as a severe behavioral pathology masked by a veneer of normalcy. The ‘mask’ component of the disorder includes aspects of positive psychological functioning and a superficial but engaging affective-interpersonal style.”

Psychologist Robert Hare, one of the leading experts on psychopathy, introduced a scheme in terms of which psychopaths are divided into three categories⁶⁵⁴. The first category is referred to as the “primary” or “true” psychopath and this individual has distinguishable psychological, emotional cognitive and biological traits which

⁶⁵⁰ See *S v Mnyanda* 1976 (2) SA 751 (A) at 756 H.

⁶⁵¹ Patrick in O'Donohue, Fowler and Lilienfeld (eds.) (2007) *supra* note 637 at 114.

⁶⁵² *Ibid.*

⁶⁵³ Patrick in O'Donohue, Fowler and Lilienfeld (eds.) (2007) *supra* note 637 at 146.

⁶⁵⁴ Bartol and Bartol (2005) *supra* note 3 at 120; Barlow and Durand (1995) *supra* note 344 at 530; Bartol (1991) *supra* note 3 at 64–66; Gunn and Taylor (1993) *supra* note 637 at 385. See also Martens, WHJ “The Problem with Robert Hare's psychopathy checklist: Incorrect conclusions, High risk of misuse, and lack of reliability” (2008) *Medicine and Law* 449 at 451 where the author argues that psychopaths are treatable. The author also states that the PCL-R is not a reliable tool for the prediction of future violent behaviour in psychopaths and should not be used in these settings.

distinguishes him or her from the general community. The second category of psychopaths commit violent acts as a result of severe emotional problems and are often referred to as symptomatic psychopaths or emotionally disturbed criminals. The third category, the so-called “dyssocial psychopaths” display aggressive or antisocial behaviour they have learned from other people, such as gangs or their own families. Robert Hare further developed the Cleckley criteria for psychopathy by devising a checklist called the psychopathy checklist revised (PCL-R)⁶⁵⁵. The PCL-R is used to assess the emotional, behavioral and social deviance aspects of criminal psychopathy from numerous sources which can assist in determining the credibility of self-reports⁶⁵⁶. The PCL-R has been reported to be highly reliable in distinguishing criminal psychopaths from criminal non-psychopaths and also in assisting in correctional and forensic settings in the assessment of risk in criminals⁶⁵⁷. The question that inadvertently arises concerns the difference between a diagnosis of APD in terms of the DSM-IV-TR and one of psychopathy. Barlow and Durand note that the DSM-IV criteria for APD focus exclusively on specific behaviours, whilst the Cleckley/Hare criteria for psychopathy focus on underlying personality traits⁶⁵⁸. The reason for the latter is that the drafters of the

⁶⁵⁵ Barlow and Durand (1995) *supra* note 344 at 530. The PCL-R checklist developed by Robert Hare provide for the following characteristics that are used to assess psychopathy:

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Proneness to boredom/need for stimulation
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse
7. Shallow affect
8. Lack of empathy
9. Parasitic lifestyle
10. Poor behavioral controls
11. Promiscuous sexual behaviour
12. Early behaviour problems
13. Lack of realistic long-term plans
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for actions
17. Many marital relationships
18. Juvenile delinquency
19. Poor risk for conditional release
20. Criminal versatility

See also Gunn and Taylor (1993) *supra* note 637 at 385; Kendall and Hammen (1995) *supra* note 550 at 469; Bartol and Bartol (2005) *supra* note 3 at 120 and 128–129.

⁶⁵⁶ Bartol and Bartol (2005) *supra* note 3 at 130; Patrick in O’Donohue, Fowler and Lilienfeld (eds)(2007) *supra* note 637 at 126–137.

⁶⁵⁷ *Ibid.*

⁶⁵⁸ Barlow and Durand (1995) *supra* note 344 at 530.

DSM-IV criteria were of the opinion that assessing for a specific personality trait could prove more difficult than assessing whether the individual engaged in specific behaviour⁶⁵⁹.

Kendall and Hammen state that most criminals are not necessarily psychopaths and most psychopaths are not criminals. The psychopathy checklist defines a much narrower range of offenders as opposed to the APD diagnosis in terms of the DSM-IV⁶⁶⁰. Patrick explains the relation between APD and psychopathy as follows:⁶⁶¹

“APD and psychopathy are related but distinctive phenomena. APD as defined in the DSM can be seen as one behavioral expression of a broader underlying vulnerability to problems of impulse control. Among disorders within the externalizing spectrum, APD is characterized particularly by irritability and aggressiveness along with impulsiveness and irresponsibility. Psychopathy as defined by Hare’s PCL-R intersects with APD through its social deviance component, which taps the broad externalizing factor of which APD is an indicator.”

In respect of the criminality of psychopaths, the following should be noted:⁶⁶²

- Psychopaths are inclined to make use of intimidation and violence to satisfy their selfish needs.
- Offences by psychopathic sex offenders are inclined to be more brutal, unemotional and sadistic than those committed by other sexual offenders.

⁶⁵⁹ *Ibid.* See also Kaliski (2006) *supra* note 3 at 247 where it is noted that although many psychopaths can also be diagnosed with antisocial personality disorder, and vice versa, the one category does not encompass the other category and accordingly many psychopaths do not satisfy the DSM-IV criteria for antisocial personality disorder due to the fact that antisocial personality disorder focus on observable behaviours and psychopathy focuses more on observable personality traits.

⁶⁶⁰ Kendall and Hammen (1995) *supra* note 550 at 470; Barlow and Durand (1995) *supra* note 344 at 530; Bartol and Bartol (2005) *supra* note 3 at 160.

⁶⁶¹ Patrick in O’Donohue, Fowler and Lilienfeld (eds)(2007) *supra* note 637 at 151–152.

⁶⁶² Bartol and Bartol (2005) *supra* note 3 at 128–132; Schechter (2003) *supra* note 637 at 16; Woo and Keatinge (2008) *supra* note 344 at 817–818; Kendall and Hammen (1995) *supra* note 550 at 469–470; Barlow and Durand (1995) *supra* note 344 at 530–531. It is also important to distinguish the psychopath from the sociopath. The sociopath habitually breaks the law whereas the psychopath may or may not break the law. See Bartol (1991) *supra* note 3 at 89. The term sociopath is often used to describe the criminal psychopath.

- Psychopaths are more sadistic than other criminals.
- Serial killers who are sadistic and brutal display many psychopathic personality traits.
- Psychopaths are often involved in violence as a form of revenge or retribution.
- The recidivism (re-offending) rate of psychopaths is very high.

Within the context of criminal incapacity, a forensic mental health professional assessing an accused for psychopathy or APD will face a difficult task in proving that such disorder completely deprived an accused of his or her cognitive or conative capacities to such a degree to warrant a successful defence of pathological criminal incapacity. Within the framework of South African Criminal Law, the Interim Report of the Commission of Enquiry into the continued Inclusion of Psychopathy as Certifiable Mental illness and the Dealing with Psychopathic and Other Violent Offenders⁶⁶³, conducted under the chairpersonship of Mr Justice WH Booysen, recommended that psychopathy should not be retained as a mental illness in terms of the Mental Health Act due to the inefficacy thereof⁶⁶⁴. The Commission recommended that an indeterminate sentence of imprisonment be created in respect of “dangerous offenders” which inadvertently refers to psychopaths⁶⁶⁵. Within the South African context, psychopathy in itself does not constitute a mental illness or mental defect which could result in criminal incapacity or non-responsibility⁶⁶⁶. Psychopathy can, however, in conjunction with other factors, result in a finding of diminished responsibility provided that there is a causal *nexus* between the psychopathy and the crime. The psychopathy should

⁶⁶³ March 1994 as discussed in Burchell and Milton (2005) *supra* note 3 at 387.

⁶⁶⁴ Paragraph 7.2.7. The previous Mental Health Act 18 of 1973 defined “psychopathic disorder” in section 1 as:

“(A)ny persistent disorder or disability of the mind (whether or not subnormality of intelligence is present) which has existed in the patient from an age prior to that of eighteen years and which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient.”

See also Van Oosten, FFW “Psychopathic violent and sex offenders: A legal appraisal” (1992) *De Jure* 1–22; Burchell and Milton (2005) *supra* note 3 at 387; Snyman (2008) *supra* note 3 at 177; Rumpff report *supra* note 3 at paragraph 8.1–8.40.

⁶⁶⁵ Section 286A and 286B of the Criminal Procedure Act provides for the declaration of persons as dangerous criminals and for the imprisonment for an indefinite period of such individuals. See also Kaliski (2006) *supra* note 3 at 114. See also Snyman (2008) *supra* note 3 at 177.

⁶⁶⁶ LAWSA (2004) *supra* note 3 at 69; Snyman (2008) *supra* note 3 at 177; Burchell and Milton (2005) *supra* note 3 at 388.

also be of a severe degree to the extent that the psychopath's self-control is weakened in such a manner as to render him or her morally less blameworthy than a normal person⁶⁶⁷. The mere fact that the accused is clinically deemed as a psychopath, does not, however, warrant a finding of diminished responsibility⁶⁶⁸.

- Specific case law dealing with psychopathy⁶⁶⁹

In *R v Roberts*⁶⁷⁰, the issue of a sex murder perpetrated by a psychopath was raised. The facts of the decision are as follows: The appellant was charged with murder and sentenced to death. Leave to appeal against conviction was rejected. Leave to appeal against sentence was, however, allowed. The facts revealed that the appellant was a sailor. His home life as a child was fairly unpleasant. His father was bad-tempered and cruel towards animals and his mother drank excessively and later deserted his father. He was severely distressed when his father assaulted his mother. At about twelve years of age he had intercourse with a woman of eighteen or nineteen years of age and thereafter frequently had intercourse with women. When he was only seven or eight years old he had a homosexual experience. He often exposed his person to native women and had intercourse with them. He masturbated and during the act pictured himself as having intercourse with a woman and then strangling her, or driving her over a cliff in a car, or stabbing her to death. He also shot his own dog and killed two house cats, one by hanging and the other by throwing a pair of pliers at it and in both cases he cut the corpse of the cat to pieces with his knife. These acts aroused a feeling of excitement in the accused. When at one stage he lived in Johannesburg, he smothered a cat which used to lie on his bed; an act which also made him feel intensely excited and he described it as a "nice feeling". At the age of fifteen he used to telephone women and asked them to have intercourse with

⁶⁶⁷ Snyman (2008) *supra* note 3 at 177; LAWSA (2004) *supra* note 3 at 69; Van Oosten (1992) *De Jure supra* note 665 at 1. See also Mcauley, F "Insanity, Psychiatry and Criminal Responsibility" (1993) at 92 where he argues in favour of the creation of a defence of diminished responsibility in cases of psychopathic killers in order for courts to take cognizance of proper treatment plans and appropriate punishment depending on the specific individual case.

⁶⁶⁸ LAWSA (2004) *supra* note 3 at 69.

⁶⁶⁹ See also Carstens, PA "Paraphilia in South African Criminal Cases Law" (2002) *SALJ* 603–621; Van Oosten (1992) *De Jure supra* note 665 at 1–22.

⁶⁷⁰ *R v Roberts* 1957 (4) SA 265 (A).

him. On a few occasions he also experience excitement by dressing as a woman. He started drinking wine and beer at the age of fourteen and the effect of liquor was to arouse a desire for intercourse with women accompanied by an urge to do violence to them. One evening he filled a handkerchief with sand and prowled about lonely streets looking for an unprotected woman in order to assault her with his sandbag and then to have intercourse with her. Fortunately he did not find one. He also raped a woman in a field near a station. On 29 December 1956 the appellant met the deceased. The deceased was a spinster aged forty-seven and she and the deceased met at a bar in Cape Town. After enjoying drinks at the bar, the deceased invited the appellant to her flat. Hereafter she refused to have sexual intercourse with the appellant. The appellant hit the deceased in her face with his fist and smothered her with a pillow. He then went to the kitchen and got hold of a table knife, threw her on the floor, cut her throat and dragged her into the bathroom. He also bit one of her breasts and cut open her stomach. He got hold of her intestines and pulled them out. The appellant also stated during his examination in chief that he had been very excited while holding the intestines⁶⁷¹. The defence that was raised was one of insanity but it was rejected by the jury at that stage, who returned a verdict of guilty of murder. The appeal was dismissed and in doing so, the Appellate Division relied strongly on the judgment of the trial court⁶⁷². In imposing the death penalty, the trial judge took into consideration that the accused suffered from sexual desires and experienced desires to rape and to do violence to women and that these tendencies made him a dangerous killer. It was further held by the trial court that it had an inherent duty to protect the public against the accused and other would-be killers and that the death penalty had the strongest deterring effect. The trial judge also expressed the view that if the accused were ever to be set free again, his desire to rape and do violence to women would manifest itself again and that granting the accused his liberty would be risking someone else's life.

Of particular importance for the present discussion is the judgment of Steyn JA, although concurring, where he noted that this case was an example of a recognized pathological reaction as a result of an extraordinary strong and

⁶⁷¹ At 269 B-C the accused described it as a "nice, excited feeling".

⁶⁷² At 269 G-H.

uncontrollable urge on the part of the appellant⁶⁷³. One of the experts, Dr McGregor, testified that the appellant was unable to control his actions. Steyn JA stated the following⁶⁷⁴:

“Wat ons dus hier het, is ‘n erkende patologiese reaksie wat, hoewel dit voortgespruit het uit ‘n besonder sterk drang, nie onbedwingbaar was nie. Dit plaas die geval in die middel, tussen kranksinnigheid aan die een kant, en gesonde geestesvermoëns aan die ander kant.”

Steyn JA stated that in cases such as this one, diminished responsibility should be considered and also reiterated that the onus falls on the appellant to prove insanity on a preponderance of probabilities. In the instant case there was scope for an argument that there was doubt as to the mental state of the appellant at the time of the commission of the murder⁶⁷⁵. The Appellate Division, however, held that the trial court exercised its discretion judicially.

It is thus clear that the expert evidence in this case was not strong enough as to save the accused from the gallows. It is submitted that a finding of diminished responsibility would have been more appropriate with due consideration of the appellant’s manifestly abnormal personality makeup.

⁶⁷³ At 272 E–F.

⁶⁷⁴ At 272 E–F.

⁶⁷⁵ At 272 F–273 B.

In *S v Lehnberg and Another*⁶⁷⁶ the question of mitigating circumstances as a result of psychopathy was raised. The facts of the decision are as follows: The two appellants were convicted in the Cape Provincial Division on a charge of murder. After conviction, appellant number two presented evidence in mitigation of sentence. Appellant number one did not do the same. The trial court, however, held that there were no mitigating circumstances and sentenced both appellants to death. The facts revealed that on 4 November 1974 the deceased was murdered at her home in Boston Estate, Cape Town. It became evident that Lehnberg (appellant number one) then nineteen years old, picked up Choegoe (appellant number two) at his home and took him to the home of the deceased in order for Choegoe to murder the deceased. The deceased was hit with a blunt object, most probably a pistol, whereafter she was strangled. Whilst lying on the floor, she was stabbed seven times with a pair of scissors, four of which penetrated the heart. In mitigation of sentence, Choegoe admitted to strangling and stabbing the deceased with a pair of scissors. The motive for the murder stemmed from a love triangle. Lehnberg had formed a relationship with one Van der Linde, the husband of the deceased. Lehnberg offered Choegoe various rewards in exchange for the murder, including money, a car, a house and even sexual intercourse. When Lehnberg wanted to leave Cape Town, Van der Linde persuaded her to stay. She later faked being pregnant in order to gain his affection. After the murder had

⁶⁷⁶ *S v Lehnberg and Another* 1975(4) SA 553 (A). Another decision where a youthful psychopathic personality was concerned, was the decision of *S v J* 1975 (3) SA 146 (EPD). The accused had been convicted of murder. The evidence revealed that he had entered the deceased's compartment on a train with the intention of having sexual intercourse with her and, when the deceased resisted, he assaulted her, ripped her clothes off and threw her out of the train window. The accused was sixteen and a half years old. The evidence further revealed that at the time of the commission of the offence the accused was under the influence of liquor and was a psychopath. A Mr Kruger testified on psychopathy and stated at 150 H: "Die psigopaat het uitgesproke kenmerke wat dui òf op 'n verwronge ontwikkeling van die emosionele en geestelike deel van sy persoonlikheid, òf op 'n gebrek aan ontwikkeling ...". He further summarized the three main features of a psychopath as: (1) lack of conscience (2) often misleads others to satisfy his own selfish needs and (3) lack of empathy. Steyn J at 151 A – B also compares the psychopath with a motorcar with defective brakes – once he is on his way he cannot be stopped before a collision occurs. At 158 CD Steyn J notes: "Want in my estimasie is 'n psigopaat geestelik net so gebrekkig soos 'n persoon wat gebore word sonder hande of sonder voete; sy beweeglikheid in die sfeer van emosie en in die sfeer van selfbeheersing is net so aan bande gelê soos die beweeglikheid van 'n kreupele wat sonder 'n voet of hand of sonder 'n been moet klaarkom, in die fisiese sfeer aan bande gelê is." Steyn J held that the incomplete personality of the accused, intake of alcohol as well as his youthfulness resulted in the accused's responsibility being diminished. He was sentenced to fifteen years' imprisonment of which three were suspended.

been committed, Lehnberg took Choegoe back to his home. In respect of mitigating or extenuating circumstances, the trial court held the following:⁶⁷⁷

“I accept that this young woman became infatuated by a middle-aged man. I accept that he must have had some influence over her and that he may even have encouraged her to hope that they might at some time get married. And I accept that this infatuation was what led to what counsel described as a crime of passion. ..., but it was planned over a matter of months and it must be remembered that the accused was not the innocent party in this triangle. She knew that Van der Linde was married, she knew he had a wife and two sons and a daughter. She was the one who took the initiative and tried to persuade Mrs Van der Linde to give up her husband ... When this was refused, she decided to satisfy her passion by killing the woman who stood in her way.”

The trial court accordingly refused to accept Lehnberg’s youth or immaturity as a mitigating circumstances. Two experts, Dr Shubitz, a psychiatrist and Dr Strydom, a psychiatric social worker and lecturer from the University of Cape Town, testified in support of the defence. Dr Pascoe from Valkenberg Hospital and Mrs Swanepoel, a welfare officer, testified in support of the prosecution. Dr Pascoe testified that Van der Linde became the central driving force in Lehnberg’s life⁶⁷⁸. On appeal Rumpff CJ held that the central question for the existence or not of extenuating circumstances, was not whether she (Lehnberg) was mentally incapable of solving her problem in another way than the way in which she in fact decided to solve it, but rather whether the influence that Van der Linde had on her youthful personality was such that she was willing to act in a manner inconsistent with how she would normally have acted and whether her youthful age in conjunction with the immoral influence Van der Linde had on her, should be deemed extenuating circumstances⁶⁷⁹. Dr Morgan as well as Dr Shubitz testified

⁶⁷⁷ At 557 F–H.

⁶⁷⁸ At 558 E.

⁶⁷⁹ At 559 B–D.

that Lehnberg displayed psychopathic tendencies but declined to coin her as a classic psychopath⁶⁸⁰. Rumpff CJ held the following in respect of psychopathy:⁶⁸¹

“Wel is dit nodig om op te merk dat die vraagstuk van psigopatie as versagtende omstandigheid met groot omsigtigheid behandel behoort te word omdat dit anders maklik sou wees om daardeur die leerstuk van die determinisme by die agterdeur in ons strafreg in te bring. ‘n Volwaardige psigopaat mag miskien ‘n aangebore en verworwe swakheid hê maar hy sal nie ‘n vrou in die publiek probeer verkrag nie. In dié opsig verskil hy nie van ‘n persoon met sterk seksdrange, wat geen psigopaat is nie, en wat ook nie ‘n vrou in die publiek sal probeer verkrag nie. Aan die ander kant is dit moontlik dat ‘n psigopaat in sekere gevalle nie in staat is om dieselfde weerstand te bied as wat volkome normale persone sou kon bied nie en dan sou in sulke gevalle die swakheid tereg as ‘n versagtende omstandigheid in aanmerking geneem kan word.”

In respect of the pivotal role of expert evidence, Rumpff CJ noted:⁶⁸²

“... maar sou wel deskundige getuienis vereis, wanneer dit oor psigopatie gaan.”

It was further held that where mitigation was in issue, teenagers should be regarded as immature and should be entitled to mitigation of sentence unless the facts necessitate the imposition of the death penalty⁶⁸³. It was held that youthfulness includes immaturity, lack of life experience and also a mental state susceptible to influence especially by adults, and accordingly that youthfulness is regarded as a mitigating factor by courts. Rumpff CJ held that Lehnberg acted in a cold, callous and premeditated fashion⁶⁸⁴. Rumpff CJ, however, held that Lehnberg’s immature personality as well as her youthfulness should be regarded

⁶⁸⁰ At 559 D–F.

⁶⁸¹ At 559 G–H. See also *R v Hugo* 1940 WLD at 285.

⁶⁸² At 560 B.

⁶⁸³ At 561 A–C.

⁶⁸⁴ At 561 H.

as mitigating circumstances⁶⁸⁵. The appeal against sentence accordingly succeeded and appellant number one received a sentence of twenty years' imprisonment and appellant number two received fifteen years' imprisonment.

This decision confirms the pivotal role of expert evidence where psychopathy is raised. It further establishes that psychopathy could be regarded as a mitigating factor depending on the circumstances of the case, albeit in conjunction with youthfulness in the *Lehnberg* case.

In *S v Mnyanda*,⁶⁸⁶ the Appellate Division was once again required to assess whether psychopathy should act as a mitigating or extenuating circumstance. The facts of this decision can be summarized as follows: The appellant together with a co-accused was convicted of murder and sentenced to death in the court *a quo*. The appellant was granted leave to appeal and the specific grounds of appeal were, amongst others, the following:

- That the court had erred in finding that the appellant had not suffered from a psychopathic disorder as defined in section 1 of the Mental Health Act 18 of 1973;
- That the court had erred in finding that no extenuating circumstances were present.

The facts disclosed that the appellant and two other persons entered a jewellery shop in Brooklyn, Cape Town. One of them was armed with an axe. The appellant then hit the jeweller with the blunt side of the axe on his forehead and on the bridge of his nose to such a severe extent that the jeweller sustained a skull fracture which caused his death. The appellant together with the others ran from the scene with various watches from the shop. After the appellant and the others were convicted in the trial court, the trial judge heard psychiatric evidence in order to ascertain whether the appellant or the others were psychopaths and whether such diagnosis, if positive, could act as an extenuating circumstance. Dr Pascoe, Superintendent of the Valkenberg Hospital, testified on behalf of the

⁶⁸⁵ At 562 B–C.

⁶⁸⁶ *S v Mnyanda* 1976 (2) SA 751 (A). See also Burchell and Milton (2007) *supra* note 3 at 358.

State. In his report he noted that the appellant did not suffer from any mental abnormality. In his report Dr Pascoe stated, *inter alia*, the following:⁶⁸⁷

“... most psychiatrists would accept that psychopathy may manifest itself for the first time after the age of 18 years. It is also clear from the use of such words as ‘persistent’, ‘abnormally’, and ‘seriously’ that a question of degree of disorder is important. I infer that only certain psychopaths are covered by the legal definition, namely those whose behaviour has manifested psychopathy early, persistently, and in a severe degree.”

Dr Pascoe further testified that abnormally aggressive or seriously irresponsible conduct must be indicated in a manner which was not deliberately chosen or planned, but was rather only minimally subject to willed control and that this form of reaction to certain situations has been persistent and accordingly results from a persistent disorder or disability of the mind⁶⁸⁸. Dr Pascoe concluded by stating:

“Having regard to all the information at my disposal, and applying the criteria set out above, I have come to the conclusion that he should not be regarded as a psychopath in terms of the Mental Health Act, and I am satisfied that he is not psychotic or mentally defective.”

Dr Pascoe summarized the true description of a classic psychopath as follows:⁶⁸⁹

“He is someone who is unreliable, untruthful, who shows little remorse and does not learn adequately from experience, egocentric and selfish. He forms few meaningful and warm emotional relationships with other people. He often acts impulsively without apparent thought for the consequences of his acts. He frequently abuses alcohol or drugs, that his behaviour under their influence is extremely bad at times; that his sexual pattern is often an amorphous one and a self-gratificatory one without an adequate warmth of emotion in it. And that his life pattern as a whole shows minimal goal-

⁶⁸⁷ At 755 H–756 F.

⁶⁸⁸ At 756 B–C.

⁶⁸⁹ At 756 H.

directed behaviour. He does not plan and work towards objectives of a long-term nature but acts for immediate pleasure or profit ...”

Dr Pascoe further conceded that in cases of psychopathy there was considerable room for difference of opinion between psychiatrists as to whether a particular individual was or was not a psychopath⁶⁹⁰. The court questioned Dr Pascoe as to whether the appellant’s (accused number one in the trial court) psychopathy in the “clinical” sense could have diminished his responsibility in respect of the offence committed. Dr Pascoe replied by stating:⁶⁹¹

“... I think that he was capable of knowing the difference between right and wrong and capable of knowing that the act that was carried out, that was planned, was wrong and I think he has the capacity, had he cared to exercise it, to stop himself from carrying out his act. His handicap in my opinion would be more accurately described as one of a social nature having been brought up under unfortunate circumstances and subject to unfortunate influences rather than being directly attributable to a mental illness or mental disorder.”

Dr Pascoe stated that, in his view, the appellant would experience greater difficulty in resisting the temptation of the gain or benefit he would achieve from his unlawful act than other persons. Rumpff CJ noted the following in respect of diminished criminal capacity as a result of psychopathy:⁶⁹²

“... iemand wat aan ‘n geestesversteuring soos psigopatie ly, se toerekenbaarheid verminder kan wees na gelang van die omstandighede van elke geval, maar die feit dat ‘n persoon ‘n psigopaat is, nie noodwendig beteken nie dat, sonder oorweging van die besondere misdaad en die rol wat die persoonlikheidsversteuring by pleeg van die misdaad gespeel het, sy toerekenbaarheid met betrekking tot die bepaalde misdaad as verminderd beskou moet word.”

⁶⁹⁰ At 757 B–C.

⁶⁹¹ At 757 D–E.

⁶⁹² At 759 F–G.

Rumpff CJ rejected the argument raised by the appellant that the trial court erred in not finding that the appellant was a psychopath. The only psychiatric evidence that was advanced, however, was that of Dr Pascoe and his evidence was accordingly accepted and not challenged. Rumpff CJ noted the following in respect of the expert evidence and lack thereof from the defence's perspective:⁶⁹³

“Dit was nie die plig van die Verhoorregter om aan te hou soek totdat hy ‘n psigiater kan vind wat van Dr Pascoe verskil het nie.”

and further:⁶⁹⁴

“Hier moet opgemerk word dat ‘n hof nie sonder meer ‘n vertolking van ‘n psigiater sal aanvaar nie, wanneer dit van die Hof self verwag word om die term te vertolk. Wat wel kan gebeur, is dat psigiatrisse getuienis omtrent die aard van psigopatie ‘n Hof kan help om, vir doeleindes van die Wet, die term te vertolk. Dat hierdie getuienis gebruik kan word, spreek m.i. vanself omdat die term ‘geestesverstoring’ in die omskrywing van ‘psigopatiese steuring’ ‘n psigiatrisse of klinies-sielkundige term is.”

Rumpff CJ in addition held, having regard to the evidence of Dr Pascoe, that in the absence of an extraordinary symptom, a full-blown psychopath will not lack criminal capacity. He or she is capable of appreciating what is lawful or not and does have the capacity to act in accordance with an appreciation of unlawfulness⁶⁹⁵. Rumpff CJ further noted:

“Wat die volwaardige psigopaat egter skynbaar anders maak as gewone mense, is die feit dat sy wilskrag om te stry teen die pleeg van onetiese dade of misdade minder sterk is as dié van normale mense en dat daardie verswakte wilskrag deel is van ‘n eiesoortige persoonlikheid. Hoewel ‘n ‘normale’ gewoonte misdadiger ook ‘n verminderde wilskrag het om teen

⁶⁹³ At 760 D–E.

⁶⁹⁴ At 760 E–G.

⁶⁹⁵ At 763 E–F.

die pleeg van misdade te stry kan, volgens die psigiatrie, onderskei word tussen ‘n psigopaat en so ‘n misdadiger.”

It was held that when a court has to consider whether a person had criminal capacity or when the question of diminished criminal capacity is raised, the person’s self-control has to be assessed with the assistance of psychiatric and psychological evidence⁶⁹⁶.

Rumpff CJ held the following:⁶⁹⁷

“Alleen dan wanneer ten opsigte van ‘n bepaalde misdaad bevind word dat die psigopatiese steuring van so ‘n graad was dat die wilsbeheervermoë tot so ‘n mate verswak was dat hy volgens ‘n morele beoordeling, minder verwytbaar is as wanneer hy nie so ‘n verswakking van wilsbeheervermoë sou gehad het nie, bestaan daar verminderde toerekenbaarheid.”

The Appellate Division dismissed the appeal and held that there were no extenuating circumstances present in this case as the crime was planned.

What becomes clear from this decision is firstly the need for expert evidence when psychopathy is advanced in support of either a defence of criminal incapacity or reliance on a finding of diminished criminal capacity. The fact that the appellant in this case had not advanced any expert psychiatric evidence to challenge the evidence of Dr Pascoe could be regarded as a substantial flaw. Secondly it becomes clear that psychopathy is approached by our legal system with great circumspection.

In *S v Pieterse*⁶⁹⁸, a more rigid application of the diminished responsibility doctrine was applied to psychopathic criminals. The facts of the decision were briefly the following: The appellant, a twenty-one-year old certified psychopath and father of a child, viciously raped and murdered a nine-year-old girl. He was subsequently

⁶⁹⁶ At 766 G.

⁶⁹⁷ At 766 H.

⁶⁹⁸ *S v Pieterse* 1982 (3) SA 678 (A). See also Van Oosten (1992) *De Jure supra* note 665 12–13; Carstens (2002) *SALJ supra* note 669 at 612.

convicted of murder and rape in the trial court. Despite a finding of extenuating circumstances on the murder charge, the judge nevertheless imposed a double death sentence. On appeal against sentence, the Appellate Division held that there was no connection between the psychopathic condition of the appellant and the subsequent rape and murder of the deceased and confirmed the sentence on both counts. The facts revealed that the appellant had from an early age displayed a very aggressive nature. He also assaulted some of his family members. When he was a child, he was hit over the head with a pipe by one of his schoolmates, causing a form of epilepsy⁶⁹⁹. The appellant had an unstable employment history after his discharge from the army. Whilst living with his parents, he watched or peeped at the neighbour's wife while she was undressing. He also exposed himself to young girls. He was married and had normal sexual relations with his wife. The appellant had strong sexual urges and six months prior to the murder he no longer felt attracted to mature women but felt emotionally attracted to young children although it had nothing to do with sex. On the day of the murder the appellant saw the deceased walking home from a public swimming pool. She was barefoot and dressed in a frock which covered her bathing costume. The appellant lured the deceased into his car under the pretext that her parents had asked him to take her to their farm. He stopped at a cafe and bought her a coldrink. He then drove to a quiet spot close to the highway. The appellant then stripped her naked, strangled her with the bathing costume and brutally raped her. The nature of the rape was extremely brutal and vicious. Afterwards the appellant drove around for some kilometres and then left the deceased's naked body next to the gravel road. The appellant went back to his parents' home in an intoxicated state and covered in blood. His explanation was that he had assaulted a black man and had to take him to hospital⁷⁰⁰.

In respect of psychopathy, Rumpff CJ held the following:⁷⁰¹

“Wat die psigopaat betref, kan ‘n Hof bevind dat ten opsigte van ‘n bepaalde misdaad die psigopaat minder verwytbaar is as wat ‘n nie-

⁶⁹⁹ At 685 H.

⁷⁰⁰ At 686 H.

⁷⁰¹ At 683 H–684 B.

psigopaat sou wees, en sou 'n hof dus kon versagtende omstandighede bevind in geval van 'n moord en 'n vonnis anders as die doodstraf oplê. Ek dink dit spreek vanself dat in elke geval die hof veral sal let op die graad van die psigopatie wat aanwesig is, die aard van die misdaad wat gepleeg is en die omstandighede waarin die misdaad gepleeg is. Beklemtoon moet word dat dit die Verhoorhof se taak is om te beslis of 'n beskuldigde minder toerekenbaar is of nie en of die verminderde toerekenbaarheid wel as versagtende omstandigheid sal geld, en nie die taak van mediese deskundiges nie. Natuurlik sal die verhoorregter die menings van psigiaters of kliniese sielkundiges aangaande die betrokke geestesafwyking van 'n beskuldigde deeglik in aanmerking neem, veral indien die feite waarop daardie mening gebaseer is, die opinies van die mediese deskundiges steun.”

Rumpff CJ also held that the fact that a psychopath is indifferent to others and shows no feeling towards other people does not in itself distinguish the psychopath from other people as far as criminal liability is concerned, but if the accused has strong urges which as a result of his mental state is less controllable than those of a normal person, a court could find it to be a mitigating factor⁷⁰². There is, however, no formula in terms of which diminished responsibility can be assessed. The appeal was dismissed as a result of a lack of a *causal* connection between psychopathy and the murder and rape of the child.

The expert evidence in this decision almost exclusively included the opinion of Prof Dr Plomp who testified for the State. He testified that the appellant had strong sexual urges but that neither his epilepsy nor his psychopathic tendencies were sufficiently linked to the murder or rape. The fact that no body of expert evidence was advanced in support of the appellant's mental state, is once again a major obstacle in this case as there was no expert evidence which could challenge the evidence of the State. This could impact on an accused's right to a fair trial as his or her right to adduce and challenge evidence as provided for in terms of section 35(3)(i) of the Constitution is severely compromised.

⁷⁰² At 684 A–B.

Another decision where the issue of psychopathy was raised, was in *S v Phillips and Another*⁷⁰³. In this case a nineteen-year old accused and her thirty-seven year old co-accused who were at that stage living together as man and wife, killed and robbed four persons over a period of sixteen weeks. Their *modus operandi* was to lure men whom they believed to have cash or funds readily available, to a lonely or secluded spot for the purpose of robbing them or killing them in order to effect the robbery or to conceal it. Both the accused were unemployed during the said period and relatively short of money. On charges of *inter alia* murder and robbery, Milne JP conceded that appellant number one suffered from a severe psychopathic condition⁷⁰⁴, but went further to state the following in respect of psychopathy:⁷⁰⁵

“The whole question of psychopathy and its application in criminal law is a somewhat difficult one. It is even questioned whether it is desirable to use the term ‘psychopath’. The term is apparently no longer used in the DSM-III. Dr Simonz considers that there is a difference between psychopathy and an anti-social personality disorder. Professor Plomp does not. A more important question is whether the classification of a person as a psychopath or as a person with anti-social personality disorder serves any useful purpose in the criminal law ... One of the questions which has to be asked is whether psychopathy is a ‘mental illness’ or ‘mental defect’ within the meaning of S78 of the Criminal Procedure Act. ... It does not, with respect, necessarily seem to follow that such person should not be criminally responsible or that such a person should have diminished responsibility within the meaning of S78(7) of the Criminal Procedure Act. The characteristics of psychopaths, even to the extent that there is agreement amongst experts as to what those characteristics are, seem simply to be a basket of characteristics that exist in a number of criminals who have had criminal and aggressive tendencies from a comparatively young age.”

⁷⁰³ *S v Phillips and Another* 1985 (2) SA 727 (NPD).

⁷⁰⁴ At 739 A–B.

⁷⁰⁵ At 739 B–J.

The two psychiatrists who testified were, as indicated in the quote above, Dr Plomp and Dr Simonz. When Dr Plomp was asked why psychopathy was regarded as a mental illness, he states the following:⁷⁰⁶

“My antwoord, U Edele, was dat ons moet ook die graad daarvan in aanmerking neem en nie net die kwaliteit van die toestand nie en ek dink ‘n geringe psigopatie of psigopatiëse tendense wat ons by ‘n mens vind is nie voldoende om dan te sê daardie persoon is geestesversteur nie. As dit in die uiterste mate teenwoordig is, dan dink ek sou ‘n mens ‘n saak daarvoor kon maak dat dit ‘n geestesongesteldheid is maar daar’s baie dinge wat daarvoor hinder want ons weet, onder andere, nie wat die oorsaak van psigopatie is nie. Ons weet nie of dit behandelbaar is nie of waar dit vandaan kom. Daar is selfs gepraat van inherente boosheid en somtyds wonder ek of ons beskrywing van die psigopaat nie juis dan is die persoon wat inherent boos is nie.”

Milne JP held that psychopathy is a well-defined condition which is capable of constituting a mental illness or defect within the meaning of S78 of the Criminal Procedure Act and which is also capable of constituting extenuating circumstances⁷⁰⁷. Milne JP in addition, relying strongly on the expert evidence of Dr Plomp, that accused number one was definitely a psychopath, but that there was doubt as to whether it reduced her controllability of will to such an extent that her condition could have been described as bordering on a mental illness⁷⁰⁸. There was no connection between her psychopathic condition and the commission of premeditated murders. Accused number one was sentenced to life imprisonment. Accused number two was sentenced to death.

It is evident from this decision that psychopathy poses a challenge not only for the legal system but also the psychiatrists who present expert evidence with regard to psychopathy. It can, nevertheless, still act as an extenuating circumstance.

⁷⁰⁶ At 740 B–D.

⁷⁰⁷ At 740 F–G.

⁷⁰⁸ At 742 E–F.

In *S v Kosztur*⁷⁰⁹ the Appellate Division was once again called to assess the question of extenuating circumstances as a result of psychopathy. The facts were the following: The appellant stood trial on four charges all relating to events that took place at his stepfather's home at Toby Street in the Johannesburg suburb of Triomf. The deceased was employed by the appellant's stepfather as houseworker and she was twenty-two years of age. The appellant was charged with the murder of the deceased and with the robbery under aggravating circumstances of one shotgun, about thirty-eight rounds of ammunition, fifteen bottles of liquor, two men's suits, a radio and a pair of boots. He was further charged with unlawful possession of the shotgun and ammunition. The facts revealed that at the time of the offences the appellant was unemployed. According to the appellant he tied the deceased with belts and covered her with a bedspread and ordered her to remain in that position until he left. He then left the bedroom to search the house for items and when he returned he noticed that the deceased was attempting to cut herself free with a letter opener. She looked at the appellant and he started panicking and feared that she would identify him. He then stabbed her to death and robbed her of the said items mentioned above. The appellant was sentenced to death and the trial court held that there were no extenuating circumstances. The appellant was sent for observation in terms of section 78(2) of the Criminal Procedure Act. The enquiry was conducted pursuant to the provisions of section 79 of the Criminal Procedure Act by Dr Berman and two private psychiatrists, Dr Fine and Dr Wolf. They subsequently prepared a joint report and it was found that the appellant was a psychopath, but nevertheless competent to stand trial. Dr Berman stated that there was nothing:⁷¹⁰

“... to suggest that either his ability to appreciate the wrongfulness of the acts in question or his ability to act in accordance with an appreciation of such wrongfulness was affected by mental illness or defect at the time of the alleged commission.”

It was further found that the appellant had a focal brain disorder but it was stated by Dr Berman that this disorder did not affect the appellant's criminal

⁷⁰⁹ *S v Kosztur* 1988 (3) SA 926 (A).

⁷¹⁰ At 930 D–E.

responsibility. Dr Berman testified that the appellant's psychopathy was of a severe degree and he defined a psychopath as:⁷¹¹

“a person with a personality disorder which manifests in the repeated perpetrating of antisocial acts and which manifests before the age 18 years.”

Dr Berman quoted the eminent work of Cleckley as discussed above and stated that a severe psychopath does not have a moral feeling but is capable of thinking coherently and knowing ‘that a thing is wrong’ and that ‘there is a penalty and punishment if one commits a certain thing’ even if he does not feel it morally⁷¹². In respect of a psychopath's ability to act in accordance with an appreciation of the wrongfulness on an act, Dr Berman stated the following:⁷¹³

“One of the features of psychopaths is that they have poorer control over impulses than non-psychopaths, so that if an act were committed in an instantaneous way in seconds in response to some triggering factor, one could argue that there is perhaps a lesser ability to control himself. If an act is such that it requires summing up a situation and then with clear logic formulating a plan, there I would see a psychopath in the same light as any non-psychopath.”

Dr Berman found nine of the sixteen features of psychopathy to be present in the appellant. These included lack of remorse and shame, intelligence, absence of delusion and other irrational thinking, inadequately motivated antisocial behaviour, failure to learn by experience, general poverty in major affective reactions, unresponsiveness in general inter-personal relations and the taking of drugs; impersonal, trivial sex life, as well as the failure to follow any life plan⁷¹⁴. Dr Berman in addition stated that the psychopathy did not result in diminished

⁷¹¹ At 930 G–H.

⁷¹² At 931 D.

⁷¹³ At 931 E.

⁷¹⁴ At 931 F–H.

responsibility in the appellant.⁷¹⁵ Steyn JA held that a psychopathic condition is not by itself an extenuating circumstance.⁷¹⁶

Steyn JA stated the following in respect of the appellant:⁷¹⁷

“Dr Berman’s evidence is clearly to the effect that appellant did not impulsively kill the deceased, that he acted rationally throughout, in the execution of a pre-conceived plan, as a normal person would have done, that he killed her because she had recognised him, that he gave a clear, detailed and rational account of what he had done and that neither his personal background, nor his psychopathic condition nor any drugs he may have taken, had played any role in the commission of the offences.”

In respect of Dr Berman’s evidence, Steyn JA noted the following:⁷¹⁸

“The whole corpus of evidence was carefully considered by the trial Court. It accepted the evidence of Dr Berman, rightly so to my mind. The facts testified to by him were not challenged in any material respect. He stated them fully and fairly. He supported his evidence with authority (Cleckley); his analysis of the facts was fair and thorough and his opinions were cogent – they were clearly stated, well reasoned and related to the facts. His examination of appellant was thorough and his evidence as to what appellant had told him was not disputed.”

and further:⁷¹⁹

“Dr Berman pertinently refrained from expressing any opinion as to whether appellant’s psychopathic condition and the other relevant factors amounted, or could amount, to extenuating circumstances and expressly left that decision in the hands of the Court.”

⁷¹⁵ At 931 I–J.

⁷¹⁶ At 938 D.

⁷¹⁷ At 939 F–G.

⁷¹⁸ At 940 F–H.

⁷¹⁹ At 941 A–B.

The appeal was accordingly dismissed and Steyn JA held that the appellant failed to satisfy the court that there were any grounds for a finding that extenuating circumstances existed.

In this decision the court was much impressed with the expert opinions advanced by Dr Berman. As was indicated in the previous decisions above, no expert evidence was presented on behalf of the accused to challenge the expert evidence of the State. It could be argued that expert evidence should always be advanced, also on behalf of the accused or appellant, in order to test and weigh the evidence of the State against the expert evidence of the defense. The latter will invariably result in a fairer trial.

In *S v Lawrence*⁷²⁰, the Appellate Division addressed the issue of a *causal* connection between psychopathy and the crime in question. The facts of this decision were the following: The appellant was charged with murder and rape in the Witwatersrand Local Division. The evidence revealed that the appellant, after attending a discotheque, had taken the deceased, a nineteen-year old woman, to a house that was under construction. According to the appellant he and the deceased had intercourse after which he told the deceased about his ex-wife. When the deceased referred to his ex-wife, he lost his temper. The appellant testified that he pulled the deceased up and when she fell down, he picked up a stone which he thrust up her vagina. He withdrew the hand with the stone and then re-inserted his hand into her body – this action he may have repeated several times. When the victim showed no signs of life he took fright and ran off. The *post mortem* report revealed that, apart from several abrasions and bruises to the head, face and both arms, the district surgeon found that the deceased had been eviscerated through her vagina and perineum. The vagina appeared to have been cut, or torn, from top to bottom, destroying the anterior aspect of the vulva, the perineum and the rectum. The intestines and the uterus had been pulled through this gaping hole. The photographs displayed the pool of blood in which the body was found, as well as the blood-spattered wall in front of the body. The appellant

⁷²⁰ *S v Lawrence* 1991 (2) SACR 57 (A). See also Carstens (2002) *SALJ supra* note 669 at 613.

was committed to Weskoppies Mental Hospital and was examined by Dr Holloway who diagnosed him as being a dangerous psychopath and recommended his reception in an institution for treatment. The appellant, however, jumped through a window and absconded. The appellant was later again sent to Weskoppies Mental Hospital for an observation in terms of section 77 of the Criminal Procedure Act. Two psychiatrists, Dr Plomp and Dr Le Roux, found that although he had antisocial personality disorder he was capable of understanding court proceedings so as to make a proper defence and that at the time of the commission of the offence he was not affected by any mental disturbance or defect so as to prevent him from appreciating the wrongfulness of his act or from restraining him from the commission of the offence⁷²¹. Another psychiatrist, Dr Verster, reached the same conclusion as the other two experts with regards to the appellant's mental state. Dr Plomp testified during the trial. The evidence revealed that at the time of the murder, the appellant was, to a certain extent, under the influence of alcohol and drugs. The appellant also had a number of previous convictions, one for sexual assault on his estranged wife whom he had on occasion dragged into a room of a boarding house where she was residing and after having forcibly had intercourse with her, tied her hands to the bed and pushed a half-litre Coca-Cola bottle up her vagina. The trial court held that the psychopathy coupled with the intake of alcohol and the use of drugs on the day of the commission of the offence, had diminished the appellant's moral as opposed to his legal culpability for the crime⁷²². The trial court sentenced the appellant to death. Dr Plomp classified the appellant as a "severe case of psychopathy" and stated the following in respect of psychopathy:⁷²³

"(Psychopathy is) a pattern of irresponsible and antisocial behaviour beginning in childhood or early adolescence and continuing into adulthood ... People with antisocial personality disorder tend to be irritable and aggressive and get repeatedly into physical fights and assaults ... They generally have no remorse about the effect of their behaviour on others."

⁷²¹ At 64 E–G.

⁷²² At 66 B–C.

⁷²³ At 66 H–J.

The majority of the Appellate Division per Goldstone JA and Hoexter JA concurring, upheld the appeal against the death sentence and sentenced the appellant to imprisonment for life. In delivering judgment, Goldstone JA held the following:⁷²⁴

“In my opinion the ghastly and gruesome manner in which the appellant murdered the deceased and the particular way in which he indecently assaulted his former wife proclaim the very mental illness from which the appellant suffers. Here there is no question but that there is a direct causal connection between the psychopathy of the appellant and his behaviour on the night of the murder.”

Eksteen JA delivered a dissenting minority judgment and dismissed the appeal. Eksteen JA held that despite the fact that the appellant was a psychopath, he did not suffer from delusions or another comparable mental illness which could deprive him of the responsibility of appreciating the wrongfulness of his act or of acting in accordance with such appreciation⁷²⁵. Eksteen JA noted the following:⁷²⁶

“What makes him different from other people is that his will to resist the temptation to commit unethical or criminal acts is less strong than in an ordinary person. He succumbs more easily to his wrong or evil desires due to his insensitivity to the feelings of other people. In this sense his personality may be said to be impaired and antisocial. But he is not psychotic or insane, and he can control his emotions and antisocial impulses. That is why psychopathy – and even severe psychopathy – does not relieve him from criminal responsibility for his actions, and at most can serve as a feature which to some extent may diminish his moral culpability.”

Eksteen JA held that the appellant was a dangerous and unpredictable person and a threat to society and should be removed from society. It was further held that

⁷²⁴ At 59 H–60 A.

⁷²⁵ At 67 D–E.

⁷²⁶ At 68 C–F.

due to the enormity of the heinous and brutal murder of the deceased, these acts were so clamant for extreme retribution:⁷²⁷

“... that society demands the appellant’s destruction as the only expiation for his wrongdoing.”

In the aftermath of an evaluation of the case law dealing with psychopathy the following factors become evident:

- Courts generally impose extremely stringent scrutiny whenever psychopathy is raised in support of either the defence of pathological criminal incapacity or in support of diminished responsibility.
- Psychopathy can, dependent on the circumstances of each case, act as an extenuating circumstance as far as sentencing is concerned⁷²⁸.
- Courts generally view both the severity and degree of psychopathy in order to determine the possible effect, if any, on the accused’s mental state at the time of the commission of the offence.

⁷²⁷ At 69 B–C.

⁷²⁸ Compare the *Lehnberg* and *Roberts* decisions where both of the accused were youthful offenders. *Lehnberg* did not receive the death penalty whereas *Roberts* was sentenced to death. See Van Oosten (1992) *De Jure supra* note 665 at 18. See also *S v Sibiyi* 1984 (1) SA 73 (A) where the appellant within a short period of time committed a series of senseless crimes of violence, including assaults, murder and rape. The evidence of Dr Ramsundhar, a psychiatrist, was to the effect that the appellant was a person who suffered from a persistent disorder of the mind which resulted in abnormally aggressive or seriously irresponsible conduct in the appellant. Dr Lind, another psychiatrist, took the view that, although the appellant might have been suffering from a personality disorder, he could not be regarded as mentally ill in terms of the Mental Health Act 18 of 1973 and the Criminal Procedure Act unless he was classifiable as a psychopath. The appellant was sentenced to death in the trial Court. On appeal, the Appellate Division held that there were extenuating circumstances. Hoexter JA held the following at 97 A–B: “Looking both at the nature of the appellant’s crimes and at Dr Ramsundhar’s assessment of the appellant’s mental condition I conclude that in the instant case it has been established on a balance of probabilities (1) that when he murdered the deceased the appellant, although he knew what he was doing, suffered from a mental defect which was substantial and (2) that such mental defect diminished his moral as opposed to his legal culpability for the crime. It follows, in my view, that the appellant discharged the onus of showing extenuating circumstances.” The appeal was upheld and the sentence altered to one of life imprisonment. See also *S v Nell* 1968 (2) SA 577 (A) where it was held by Ogilvie Thomson JA at 580 H: “Whether or not a convicted murderer’s psychopathic personality is to be regarded as an extenuating circumstance falls to be decided by the trial Court in the light of the particular case before it.”

- Whenever psychopathy is advanced either in support of the defence of pathological criminal incapacity, or in support of diminished responsibility, expert psychiatric evidence is pivotal.
- Both the State as well as the defence should retain their own body of expert evidence in order to provide a balanced view of the accused's mental state and also to test the credibility and validity of each experts' evidence.
- It is crucial to establish a *causal nexus* between the accused's psychopathic mental state and the commission of the crime in question.
- In cases of psychopathy, the so-called "battle of the experts" will invariably ensue as a result of the controversy surrounding the concept of psychopathy and propounding an exact definition to the concept. Wootton notes the following in this regard:⁷²⁹

"Both psychiatrists and the courts are still walking warily, and the psychopathic label is normally only applied to offenders with exceptionally bad records. This, however, seems to bring us to the paradoxical conclusion that, if a man's crimes are by ordinary standards only moderately objectionable, we are prepared to regard him as wicked, and therefore a suitable subject for punishment; but if his wickedness goes beyond a certain point, it ceases to be wickedness at all and becomes mental disorder."

Davis in addition notes that whenever deviant behaviour is intentional, or willful, such deviance is regarded as a criminal, but when the deviance is unwillful, the

⁷²⁹ Wootton, B "Crime and Penal Policy" (1978) 231 as quoted in Davis, DM "The psychopath and criminal justice – a critical review" (1983) SACC 259 at 260. See also Davies, W and Feldman, P "The diagnosis of psychopathy by forensic specialists" (1981) *British Journal of Psychiatry* 329 at 330 where they state: "The first is that the diagnosis of psychopathy can be made on the basis of a large number of signs, and for such a diagnosis a person would either have to exhibit a high proportion of them to some extent or small number of them to a very large extent. This would correspond with diagnosis in the traditional medical fashion. The second is to suppose that psychopathy is a label which may be attached to a person for a variety of reasons, and that subsequently a large number of signs may be drawn upon to substantiate the application of the label. It is unclear which explanation is to be preferred." See also Davis, DM "Are psychopaths for real – or just another ideological obfuscation" (1982) SACC at 143; Jonker, GJ "A treatment programme for certified psychopathic offenders" (1983) SACC 271 – 279.

medical profession is required to provide answers⁷³⁰. Davis renders the following remarks in respect of psychopathy:⁷³¹

“The use of the psychopathic dispensation may only be modest in South Africa, but inherent in the clinical entity of the psychopath is the very process by which deviance is medicalized with the result that the more fundamental sociological explanations of crime which are so important, particularly in an exploitative society such as South Africa, are hidden under the ideological smokescreen of the so-called psychopathic offender.”

The question as to whether psychopathy can affect an accused’s mental state to such a degree as to completely deprive him or her of insight or self-control in support of a defence of pathological criminal incapacity remains an open one on which even the Appellate Division has not reached complete consensus. Only time will tell whether reliance on the specific diagnostic criteria for antisocial personality disorder will provide answers in future. The problem of expert psychiatric evidence is once again exacerbated as some mental health professionals will diagnose an accused with anti-social personality disorder, whilst others will prefer psychopathy. It will in each case depend on the specific personality makeup of the accused to determine the most appropriate diagnosis. Expert evidence nevertheless remains crucial in assisting the court in the assessment of such mental disorders.

8.8 Paraphilias and sex offending

“Actus non facit nisi mens sit rea”

(“The deed does not make a man guilty unless his mind is guilty”)

It has been described by some as “abnormal sexual behaviour” and by others simply coined as “kinky sex”. Paraphilia, however, involves a much more severe form of mental abnormality than meets the eye and is most often predominantly present in criminals committing sexual offences. The link between paraphilia and

⁷³⁰ Davis, DM “The psychopath and criminal justice – a critical review” (1983) SACC 259 at 270.

⁷³¹ *Ibid.*

sex crimes is often overlooked. In terms of the DSM-IV-TR, paraphilia is defined as:⁷³²

“... recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other nonconsenting persons that occur over a period of at least 6 months.”

The features and characteristics of paraphilic individuals as included within the DSM-IV-TR can be summarised as follows:⁷³³

- Paraphilic fantasies are often performed on nonconsenting partners in a manner which could be both dangerous and injurious;
- Paraphilic fantasies are often obligatory for the achievement of erotosexual arousal in some individuals, whilst others will only display these desires episodically;
- These sexual urges or fantasies cause significant distress and impairment to the accused;
- Sexual offences perpetrated against children present a significant proportion of all reported criminal sexual offences;
- It is not unusual for the abnormal behaviour to become the major sexual activity in the individual’s life;
- The preferred stimulus of the paraphilic offender is highly specific;
- Paraphilics often select an occupation or hobby which brings them closer or into direct contact with the desired paraphilic fantasy.

⁷³² DSM-IV-TR (2000) *supra* note 344 at 566; DSM-IV (1994) *supra* note 344 at 522; Marvasti, J “Psychiatric Treatment of Sexual Offenders – Treating the Past Traumas in Traumatizers – A Bio-Psycho-Social Perspective” (2004) at 3; Kaplan and Sadock (2003) *supra* note 344 at 718; Comer (2008) *supra* note 344 at 325–326; Woo and Keatinge (2008) *supra* note 344 at 792; Kendall and Hammen (1995) *supra* note 550 at 422; Barlow and Durand (1995) *supra* note 344 at 443–444, *supra* note 3; Malin, HM and Saleh, FM “Paraphilias: Clinical and Forensic considerations” (2007) *Psychiatric Times* as discussed on <http://www.psychiatryonline.com/display/article/10168/55266> [accessed on 2009/08/04] where it is also noted that the term “paraphilia” was adopted from the Greek prefix “*para*” which means “around” or “beside” and “*philia*” which means “love”. See also Greenfield, DP “Organic approaches to the treatment of paraphilics and sex offenders” (2006) *Journal of Psychiatry and Law* at 437.

⁷³³ DSM-IV-TR (2000) *supra* note 344 at 566–567.

Carstens notes that paraphilic sex offenders generally lack criminal expertise in order to avoid being apprehended and that the primary goal of the paraphilic ritual is to achieve arousal or orgasm and not to avoid apprehension⁷³⁴. Paraphilias constitute Axis I mental disorders and sex offences as a result of paraphilia are generally motivated by behaviour connected to sex hormones⁷³⁵. Berlin, Saleh and Malin in addition observe that paraphilia may be a manifestation of a mental disorder due to the fact that the desires or cravings for a specific “partner” is highly abnormal and the presence of those cravings can lead to impaired sexual functioning and, in addition, paraphilias are often associated with either cognitive or volitional impairment⁷³⁶. Lehne describes paraphilia as follows:⁷³⁷

“I propose that the phenomenology of paraphilia is characterized by the specificity of the sexual content combined with the intensing of the sexual arousal/motivation.”

Paraphilias are associated with elevated levels of of sexual arousal. The performance of a paraphilia is often connected with high levels autonomic arousal and fugue-like states are a common feature in terms of which external stimuli are blocked due to the intense focus on the paraphilic act. The behaviour accordingly signifies automatic behaviour⁷³⁸. Lehne explains in his “lovemap theory” that every human being has a distinct and individualised lovemap exemplifying the variety of features of partners and activities that are sexually arousing to them⁷³⁹. These lovemaps are diverse because human sexuality is diverse and individuals spend their lives exploring their lovemaps⁷⁴⁰. A diagnosis of paraphilia may be

⁷³⁴ Carstens (2002) *SALJ supra* note 669 at 605.

⁷³⁵ Berlin, FS, Saleh, FM and Malin, HM “Mental illness and sex offending” in Saleh, FM, Grudzinskas, AJ, Bradford, JM and Brodsky, DJ (eds) “Sex Offenders – Identification, Risk Assessment Treatment and Legal issues” (2009) at 121 (hereafter ‘Saleh *et al*').

⁷³⁶ *Ibid.*

⁷³⁷ Lehne, GK “Phenomenology of Paraphilia: Lovemap Theory” in Saleh *et al* (eds)(2009) *supra* note 735 at 13.

⁷³⁸ Lehne, GK “Phenomenology of Paraphilia: Lovemap Theory” in Saleh *et al* (eds)(2009) *supra* note 735 at 16. See also Carstens (2002) *SALJ supra* note 669 at 605 where it is noted that paraphilias should be regarded as automatism rather than voluntary controllable behaviour.

⁷³⁹ Lehne in Saleh *et al* (eds)(2009) *supra* note 735 at 23. See also Dietz, PA and Evans, B “Pornographic imagery and prevalence of paraphilia” (1982) *The American Journal of Psychiatry* 1493–1495, Carstens (2002) *SALJ supra* note 669 at 604–605.

⁷⁴⁰ *Ibid.*

associated with sex offending in many repeated sexual offenders and in addition paraphilias contribute to sexual offences due to the gravity of the sexual urges which the individual cannot inhibit⁷⁴¹. According to Lehne, paraphilias are unique forms of “vandalised lovemaps” personified by very high specificity of sexual content and an elevated sexual drive⁷⁴². The following paraphilias are listed in the DSM-IV-TR: exhibitionism⁷⁴³, fetishism⁷⁴⁴, frotteurism⁷⁴⁵, transvestic fetishism⁷⁴⁶, voyeurism⁷⁴⁷, paedophilia, sexual masochism and sexual sadism⁷⁴⁸. The latter three are of more importance to the criminal justice system and will be discussed briefly below.

- Paedophilia

Paedophilia is defined as “*an intense sexual arousal invoked by fantasies or sexual acts involving prepubertal children*”⁷⁴⁹. An individual with paedophilia (pedophilia) obtains sexual arousal by either watching, touching or being involved

⁷⁴¹ *Ibid.*

⁷⁴² *Ibid.*

⁷⁴³ This paraphilic focus entails the exposure of one’s genitals to a stranger. Often the individual has a desire to surprise or shock the observer. See DSM-IV-TR (2000) *supra* note 344 at 569; DSM-IV (1994) *supra* note 344 at 525; Kaplan and Sadock (2003) *supra* note 344 at 720; Comer (2008) *supra* note 344 at 328; Woo and Keatinge (2008) *supra* note 344 at 793; Kendall and Hammen (1995) *supra* note 550 at 423; Barlow and Durand (1995) *supra* note 344 at 445.

⁷⁴⁴ In fetishism the paraphilic focus falls on objects that are intimately related to the human body for example underwear, shoes or stockings. See Kaplan and Sadock (2003) *supra* note 344 at 720; Comer (2008) *supra* note 344 at 326; Woo and Keatinge (2008) *supra* note 344 at 793; Kendall and Hammen (1995) *supra* note 550 at 424; Barlow and Durand (1995) *supra* note 344 at 444; DSM-IV-TR (2000) *supra* note 344 at 569; DSM-IV (1994) *supra* note 344 at 526; Faulk, M “Basic Forensic Psychiatry” (1994) at 234.

⁷⁴⁵ The paraphilic entity entails touching and rubbing against a nonconsenting individual usually in crowded places. See DSM-IV-TR (2000) *supra* note 344 at 370; DSM-IV (1994) *supra* note 344 at 527; Kaplan and Sadock (2003) *supra* note 344 at 721; Comer (2008) *supra* note 344 at 329; Woo and Keatinge (2008) *supra* note 344 at 793.

⁷⁴⁶ This form of paraphilia is also known as transvestism or cross-dressing which involves a desire to dress in clothing of the opposite sex in order to attain sexual arousal. See Comer (2008) *supra* note 344 at 327–328; Barlow and Durand (1995) *supra* note 344 at 446–447; Woo and Keatinge (2008) *supra* note 344 at 793; Kaplan and Sadock (2003) *supra* note 344 at 722; DSM-IV-TR (2000) *supra* note 344 at 574; DSM-IV (1994) *supra* note 344 at 530–531.

⁷⁴⁷ The paraphilic tendency involves the act of observing unsuspecting individuals usually strangers, who are naked either in the process of disrobing or having sexual intercourse. The act of looking “peeping” provides the desired sexual arousal. See DSM-IV-TR (2000) *supra* note 344 at 575; DSM-IV (1994) *supra* note 344 at 532; Kaplan and Sadock (2003) *supra* note 344 at 722; Comer (2008) *supra* note 344 at 328–329; Woo and Keatinge (2008) *supra* note 344 at 793; Kendall and Hammen (1995) *supra* note 550 at 424.

⁷⁴⁸ DSM-IV-TR (2000) *supra* note 344 at 571–574.

⁷⁴⁹ Marvasti (2004) *supra* note 732 at 6.

in sexual acts with prepubescent children usually under the age of thirteen⁷⁵⁰. Both boys and girls can be victims but research suggests that the majority of cases involve girls.

The paraphilic with paedophilia must be at least sixteen years old and at least five years older than the child⁷⁵¹. Paedophiles generally feel attracted to children of a specific age and paedophiles prefer either boys or girls or both⁷⁵².

The actions of paedophiles range from undressing the child, exposing themselves, fondling or touching or masturbating in front of the children to more serious acts of penetration and sexual sadism⁷⁵³. The course of paedophilia is chronic and the prognosis for rehabilitation is poor. The recidivism rate for paedophiles with a preference for males is double that of those who prefer females⁷⁵⁴. Most paedophiles were themselves sexually abused as children⁷⁵⁵. Paedophilia is an extremely disturbing form of paraphilia and with the concomitant poor recovery rate, such offenders should preferably be detained in psychiatric institutions or prisons depending on the severity of the disorder, as this disorder can exclude an offender's conative capacity. Such offenders also pose a grave danger to society.

In *S v M*⁷⁵⁶, the appellant was convicted on two counts of rape, one on girl ("F") aged seven years and the other on a girl ("N") aged eight years. The appellant was sentenced to death on both counts. The facts revealed that the appellant had one morning when F's mother had sent her to her father's place of employment stopped next to her in his car and pulled her into the vehicle. He then drove off to a deserted area and raped her in a hut. He then left her there and drove away.

⁷⁵⁰ Comer (2008) *supra* note 344 at 329; Kaplan and Sadock (2003) *supra* note 344 at 721; Kendall and Hammen (1995) *supra* note 550 at 425. The DSM-IV-TR lists the following diagnostic criteria for pedophilia: (at 572)

"A. Over a period of at least 6 months, recurrent intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger).

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children."

⁷⁵¹ DSM-IV-TR (2000) *supra* note 344 at 571.

⁷⁵² *Ibid.*

⁷⁵³ *Ibid.* See *S v Olivier supra* paragraph 7.6 and *S v Pieterse supra* paragraph 7.7.

⁷⁵⁴ *Ibid.* See also Kendall and Hammen (1995) *supra* note 550 at 426.

⁷⁵⁵ Comer (2008) *supra* note 344 at 329.

⁷⁵⁶ *S v M* 1985 (1) SA 1 (A).

She was later found by a farm worker. On appeal Vivier JA held that it had not been established beyond reasonable doubt that the appellant was in fact F's attacker and that the appellant should have been acquitted on that charge. In respect of the rape on N the facts were the following: The appellant had one morning stopped next to N and pulled her into his car and drove off with her. He stopped on a gravel road, pulled her out of the car, assisted her to climb over a fence and took her into a maize field where he raped her. He left her there and drove away. N was severely traumatised as a result of what had happened. Dr Salmond testified on behalf of the State. She and Dr Walt compiled a joint report in which they unanimously found that the appellant had not suffered from any mental disorder at the time of the commission of the offence which excluded either his cognitive or conative capacities⁷⁵⁷. When asked whether the appellant had the capacity to control himself, Dr Salmond stated that the appellant had very strong urges to commit aggressive acts which rendered him in a less favorable position to control himself⁷⁵⁸. A Mr Overton testified that the appellant had stated to him that he had previously over the preceding three years raped many other girls under the age of twelve years. This aspect could, however, not be proved and was not elaborated on further by the Appellante Division.

Vivier AJA held the following:⁷⁵⁹

“Wanneer die diskresionêre doodvonnis vir verkragting oorweeg word, sou enige geestestoestand wat tot gevolg het dat 'n beskuldigde nie dieselfde weerstand teen sy drange kan bied as wat 'n normale persoon sou kon bied nie, egter relevant wees, al spruit dit nie uit 'n geestesongesteldheid of geestesgebrek nie.”

Vivier AJA accordingly held that the trial court had not placed sufficient weight on the psychological evidence of Dr Salmond to the effect that the appellant had

⁷⁵⁷ At 6 E–F.

⁷⁵⁸ At 6 G–I.

⁷⁵⁹ At 8 H–I.

strong urges to commit aggressive acts⁷⁶⁰. The death sentence was consequently substituted with a sentence of twenty years' imprisonment.

This case illustrates the value of expert evidence and is also an example where paedophilia, although the specific terminology was never used, served as a mitigating factor in imposing a lesser sentence.

- Sexual Masochism

Sexual masochism involves the intense sexual arousal induced by the thought of being humiliated, beaten, bound or otherwise being subjected to suffering⁷⁶¹. Typical masochistic fantasies involve being raped while being held by others with no possible escape or being forced into sexual acts against the person's will and specific acts include blindfolding, paddling, whipping, beating, electrical shocks, "pinning and piercing" and humiliation⁷⁶². The effect of this form of paraphilia on criminal capacity is questionable and has never been decided upon by a domestic criminal court.

- Sexual Sadism

Sexual sadism involves the intense sexual arousal from psychological or physical suffering of another person⁷⁶³. The core feature of sexual sadism relates to the suffering of the victim and it is precisely this suffering that is sexually exciting to

⁷⁶⁰ At 8 I–9 E.

⁷⁶¹ DSM-IV-TR (2000) *supra* note 344 at 572; DSM-IV (1994) *supra* note 344 at 529; Comer (2008) *supra* note 344 at 330–331; Kendall and Hammen (1995) *supra* note 550 at 424–425; Barlow and Durand (1995) *supra* note 344 at 448–449.

⁷⁶² *Ibid.*

⁷⁶³ DSM-IV-TR (2000) *supra* note 344 at 573 – 574. The diagnostic criteria for sexual sadism are the following (as provided in the DSM-IV-TR [2000] *supra* note 344 at 574):

"A. Over a period of at least 6 months recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person;

B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty."

See also DSM-IV (1994) *supra* note 344 at 530; Kendall and Hammen (1995) *supra* note 344 at 424–425; Kaplan and Sadock (2003) *supra* note 344 at 722; Hucker, SJ "Manifestations of sexual sadism: Sexual homicide, Sadistic rape and Necrophilia" in Saleh *et al* (eds.) (2009) *supra* note 735 at 342; Comer (2008) *supra* note 344 at 331; Barlow and Durand (1995) *supra* note 344 at 448–450.

the perpetrator. Sadistic fantasies most predominantly relate to the dominance of an individual over a victim. Sexual sadism is a chronic condition which increases in severity over time especially when related to antisocial personality disorder and these paraphilics may seriously injure or kill their victims⁷⁶⁴. A typical example of a sexual sadist was Jeffrey Dahmer, as discussed at the beginning of this chapter who gained sexual arousal from the mutilation of his victims. Kendall and Hammen note that severe forms of sexual sadism involve rape, assault and murder and that many rapes occur due to sexual sadism and the force applied in these cases most often exceeds the amount necessary to gain compliance from the victim⁷⁶⁵. Faulk notes that sadistic psychopaths generally have no guilt, limited self restraint and display violence in their behaviour. This sadistic behaviour is often associated with severely disturbed previous relationships⁷⁶⁶.

The paraphilias discussed above are not a *numerus clausus* of paraphilias but are the most important ones for purposes of this discussion⁷⁶⁷.

⁷⁶⁴ *Ibid.*

⁷⁶⁵ Kendall and Hammen (1995) *supra* note 550 at 425.

⁷⁶⁶ Faulk, M “Basic forensic psychiatry” (1994) at 240. See also *S v Roberts supra* paragraph 8.7; *S v Pieterse supra* paragraph 8.7; *S v Lawrence supra* paragraph 8.7.

⁷⁶⁷ See also <http://en.wikipedia.org/wiki/list-of-paraphilias> [accessed on 2009/08/04] where the other paraphilias are listed as follows:

Formal name	Source of arousal
Abasiophilia	People with impaired mobility
Acrotomophilia	People with amputations
Agalmatophilia	Statues, mannequins and immobility
Algolagnia	Pain, particularly involving an erogenous zone; differs from masochism as there is a biologically different interpretation of the sensation rather than a subjective interpretation
Andromimetophilia	Female-to-male transsexuals; also known as gynemimetophilia
Apotemnophilia	Having an amputation
Asphyxiophilia	Asphyxiation or strangulation
Autagonistophilia	Being on stage or on camera
Autassassinophilia	Being in life-threatening situations
Autoandrophilia	Being male
Autoerotic asphyxiation	Self-induced asphyxiation, sometimes to the point of near unconsciousness
Autogynephilia	Being female
Autopedophilia	Being prepubescent
Blastophilia	Arousal based on the rape of an unconsenting person
Chremastistophilia	Being robbed or held up
Chronophilia	Partners of a widely differing chronological age
Coprophilia	Feces; also known as scat, scatophilia or fecophilia
Dacryphilia	Tears or crying
Dendrophilia	Trees
Dippoldism	Spanking
Emetophilia	Vomit



Erotic asphyxiation	Asphyxia of oneself or others
Erotophonophilia	Murder
Exhibitionism	Exposing oneself sexually to others, with or without their consent
Formicophilia	Being crawled on by insects
Frotteurism	Rubbing against a non-consenting person
Gerontophilia	Elderly people
Gynandromorphophilia	Women with penises, men cross-dressed as women, or male-to-female transsexuals
Hebephilia	Pubescent children
Homeovestism	Wearing clothing emblematic of one's own sex
Hybristophilia	Criminals, particularly for cruel or outrageous crimes
Infantophilia	Children five years old or younger
Kleptophilia	Stealing; also known as kleptolagnia
Klismaphilia	Enemas
Lactaphilia	Breast milk
Liquidophilia	Attracting, or desire to immerse genitals in liquids
Macrophilia	Giants, primarily domination by giant women or men
Mammaphilia	Breasts; also known as mammagynophilia and mastofact
Masochism	The desire to suffer, be beaten, bound or otherwise humiliated
Menophilia	Menstruation
Morphophilia	Particular body shapes or sizes
Mucophilia	Mucus
Mysophilia	Dirtiness, soiled or decaying things
Narratophilia	Obscene words, colloquially known as "talking dirty"
Nasophilia	Noses
Necrophilia	Cadavers
Olfactophilia	Smells
Paraphilic infantilism	Being a baby; also referred to as autonepiophilia
Partialism	Specific, non-genital body parts
Pedophilia	Prepubescent children, also spelled <i>paedophilia</i>
Peodeiktophilia	Exposing one's penis
Pedovestism	Dressing like a child
Pictophilia	Pornography or erotic art, particularly pictures
Pyrophilia	Fire
Raptophilia	Committing rape
Sadism	Inflicting pain on others
Salirophilia	Soiling or dirtying others
Scotophilia	Observing others' sexual activities; also known as scopophilia and more commonly as voyeurism
Sexual fetishism	Nonliving objects
Somnophilia	Sleeping or unconscious people
Sthenolagnia	Muscles and displays of strength
Stigmatophilia	Body piercings and tattoos
Symphorophilia	Witnessing or staging disasters such as car accidents
Telephone scatologia	Obscene phone calls, particularly to strangers; also known as telephonicophilia
Transvestic fetishism	Wearing clothes associated with the opposite sex; also known as transvestism
Transvestophilia	A transvestite sexual partner
Trichophilia	Hair
Troilism	Cuckoldism, watching one's partner have sex with someone else, possibly without the third party's knowledge; also known as triolism
Urolagnia	Urination, particularly in public, on others, and/or being urinated on
Ursusagalmatophilia	Teddy bears
Vampirism	Drawing or drinking blood; also known as murphyism

The recognition of paraphilia as a mental illness is an area where law and medicine have not reached consensus yet. As indicated above, paraphilias have been present in various sex offending case law in South Africa although the terminology and criteria of paraphilia have not received judicial recognition. Carstens points out that in the various case law where paraphilias were present, the phenomenon was also not addressed by the psychiatrists⁷⁶⁸. The focus in these cases were placed more on psychopathy. Sexual homicide case law reveals that the sexual homicide is usually motivated by paraphilia⁷⁶⁹. The role of expert psychiatric evidence in the diagnosis of paraphilia is crucial and essential. First and Halon note that often mental health professionals render a DSM-IV-TR diagnosis of paraphilia in the absence of justifiable evidence for such diagnosis by mainly placing reliance on the presence of deviant sexual behaviour in order to render the diagnosis⁷⁷⁰. First and Halon suggest a three-step approach in assisting mental health experts in effecting a proper diagnosis:⁷⁷¹

- Firstly it is pivotal to ascertain whether a paraphilia is present in the accused and to provide reasonable and credible evidence of the existence in the accused of recurrent, intense, sexually arousing fantasies or urges that are the “*sine qua non*” for the existence of paraphilia. It is essential to connect the criminal sexual behaviour to the paraphilic arousal pattern⁷⁷².
- Secondly it is important, once it is established that paraphilia is present, to ascertain whether the accused’s sexually violent crimes were the result of that paraphilia.

Vorarephilia	Eating or being eaten by others; usually swallowed whole, in one piece
Voyeurism	Watching others while naked or having sex, generally without their knowledge
Zoophilia	Animals (actual, not anthropomorphic as in furry fandom)
Zoosadism	Inflicting pain on or seeing animals in pair

⁷⁶⁸ Carstens (2002) *SALJ supra* note 669 at 619.

⁷⁶⁹ *Ibid.*

⁷⁷⁰ First, MB and Halon, R L “Use of DSM Paraphilia Diagnoses in Sexually Violent Predator Commitment Cases” (2008) *The Journal of the American Academy of Psychiatry and the Law* 443 at 445.

⁷⁷¹ *Ibid.*

⁷⁷² *Ibid.*

- Thirdly it is pivotal to present positive evidence as to whether the accused is volitionally impaired to committing sexual offences. First and Halon note that this step is very difficult for a mental health professional and it is essential to provide the courts with as much objective evidence as possible without placing too much emphasis on whether this evidence will meet legal criteria as there are no valid scientific techniques for measuring volitional impairment in an individual's capacity to control his or her behaviour⁷⁷³. First and Halon note:⁷⁷⁴

“Whether the expert information fits the legal criteria is a decision for triers of fact to make, just as they make the ultimate decisions whether the psychiatric evidence presented to them is adequate for establishing that the defendant was legally insane at the time of the commission of the crime or incompetent to assist in a defence.”

This three-step approach could be useful in the assessment of paraphilia and its role in sex offending in future.

9 Towards a plea of non-triability and criminal incapacity

It is trite that the Criminal Procedure Act in its current form does not provide for a plea of either non-triability or criminal incapacity⁷⁷⁵. Section 106 of the Criminal Procedure Act provides for the different pleas which may be raised by an accused⁷⁷⁶. It could be argued that the time has arrived for a change in the

⁷⁷³ First and Halon (2008) *Journal of the American Academy of Psychiatry and the Law* *supra* note 770 at 445 and 450.

⁷⁷⁴ First and Halon (2008) *Journal of the American Academy of Psychiatry and the Law* *supra* note 770 at 445.

⁷⁷⁵ See Hiemstra (2008) *supra* note 3 at 13-22; Kruger, A “Tekortkominge in Wetgewing oor Geestesongesteldes” (1983) *TRW* 182 at 184.

⁷⁷⁶ Section 106 provides that an accused may plead:

- (1) that he is guilty of the offence charged or of any offence of which he may be convicted on the charge;
- (2) that he is not guilty;
- (3) that he has already been convicted of the offence with which he is charged (*autrefois convict*);
- (4) that he has already been acquitted of the offence with which he is charged (*autrefois acquit*);
- (5) that he has received a free pardon from the President for the offence charged;
- (6) that the court has no jurisdiction to try the offence;

current form of section 106 in that two additional pleas – one of non-triability and one of criminal incapacity – should be added. By effecting the latter each plea could be developed to provide for its own unique and distinct set of rules similar to the pleas of *autrefois acquit* and *autrefois convict* and these rules could provide for the prerequisite of expert evidence whenever either of these pleas are raised. Section 106 (2) currently provides that two pleas may be raised simultaneously and this will in effect result in the possibility that an accused will also be able to raise non-triability and lack of criminal capacity simultaneously⁷⁷⁷.

10 The causal *nexus* between mental illness and impairment of the cognitive and conative capacities in the incapacity enquiry

Establishing that an accused suffered from a mental illness or mental defect at the time of the offence is but one step in the enquiry in assessing the alleged criminal incapacity of an accused. To succeed with a defence of pathological criminal incapacity, it has to be indicated that there is a causal *nexus* between the mental illness and the offence committed. In this sense it could be stated that the mental illness is almost a *conditio sine qua non* for the offence. In other words the question to be asked is whether the offence would still have been committed had it not been for the mental illness. There thus has to be a sufficient link between the mental illness or mental defect and the offence. Melton *et al* correctly note that courts have emphasised that if a particular disorder does not directly affect an accused's behaviour at the time of the offence, it is irrelevant as a person's mental abnormality cannot be presumed to be the cause of all of the person's actions⁷⁷⁸. Melton *et al* further state that causation within the ambit of the insanity defence can be conceptualised in terms of both factual as well as legal causation or "proximate cause" with due consideration of the following:⁷⁷⁹

-
- (7) that he has been discharged from prosecution in terms of section 204 after giving satisfactory evidence for the State;
 - (8) that the prosecutor has no title to prosecute, or
 - (9) that the prosecution may not be resumed or instituted owing to an order by a court under section 342 A(3)(c).

See also Bekker *et al* (2009) *supra* note 3 at 223–224.

⁷⁷⁷ Kruger (1983) *TRW supra* note 775 at 184.

⁷⁷⁸ Melton *et al* (2008) *supra* note 3 at 213; Slovenko (1995) *supra* note 3 at 119.

⁷⁷⁹ Melton *et al* (2008) *supra* note 3 at 214.

- Firstly it should be evaluated as to which mental illness or mental defect, if any, the offence is associated or linked with.
- Secondly, if a strong link is identified between a legally significant mental disorder and the offence, an inquiry should be conducted to determine whether the disorder is the primary or “proximate” cause of the offence.

Mental health professionals thus have to take cognizance of the fact that although a severe mental disorder may contribute to an offence, it may in cases not be the main precipitant and the clinician should accordingly identify all the possible causes with a recommendation of the strongest one(s)⁷⁸⁰. Psychologists Monahan and Steadman in addition note:⁷⁸¹

“... (1) mental disorder may simply coexist with criminality, without having any causal significance, much as an offender may have a toothache without suspicions of dental determinism; (2) mental disorder may predispose toward criminality, as in the case of M’Naghten’s delusion that he was the victim of persecution by the prime minister of England..”

It is essential that the specific mental illness or mental defect impaired the accused’s cognitive or conative capacities at the time of the offence. The presence of a specific mental illness will only be relevant if the alleged mental illness affected one of these capacities. Slovenko also states that an act is not pathological merely as a result of the presence of some form of pathology and accordingly correlation does not imply causation.⁷⁸² In the American decision of *Carter v United States*⁷⁸³ the Court of Appeals encapsulated the requirement of causation as follows:⁷⁸⁴

“When we say the defence of insanity requires that the act be a “product of” a disease, we mean that the facts on the record are such that the trier of the

⁷⁸⁰ *Ibid.*

⁷⁸¹ Monahan, J and Steadman, HJ “Crime and Mental Disorder: An Epidemiological Approach” in Tonry, M and Morris, N (eds) *Crime and Justice: An Annual Review of Research* (1983) 145; Slovenko (1995) *supra* note 3 at 119-120.

⁷⁸² Slovenko (1995) *supra* note 3 at 119.

⁷⁸³ *Carter v United States*, 252 F.2d 608, 617 (D.C Cir. 1957).

⁷⁸⁴ At 617 as discussed in Slovenko (1995) *supra* note 3 at 121.

facts is enabled to draw a reasonable inference that the accused would not have committed the act he did commit if he had not been diseased as he was. There must be a relationship between the disease and the act, and that relationship, whatever it may be in degree, must be, as we have already said, critical in its effect in respect of the act. By “critical” we mean decisive, determinative, causal; we mean to convey the idea inherent in the phrases “because of”, “except for”, “without which”, “but for”, “effect of”, “result of”, “causative factor”; the disease made the effective or decisive difference between doing and not doing the act”.

11 Burden of proof

Section 78 (1A) of the Criminal Procedure Act reads as follows:⁷⁸⁵

“Every person is presumed not to suffer from a mental illness or mental defect so as not to be criminally responsible in terms of section 78 (1), until the contrary is proved on a balance of probabilities.”

This section inadvertently creates the presumption of sanity within South African Criminal Law. In chapter two it was stated that section 78 (1B) of the Criminal Procedure Act provides that when the criminal responsibility of an accused is in issue, the burden of proof with reference to the criminal responsibility will fall on the party who raises the issue⁷⁸⁶. Section 78 (1B) has the result that either the State or the defence can raise the issue of criminal responsibility at any stage during the proceedings. If an accused raises the defence of pathological criminal incapacity, he or she will bear the burden of establishing the defence on a balance of probabilities⁷⁸⁷. The underlying reason for the accused bearing the burden of proof, rests in the fundamental presumption of sanity provided for in section 78

⁷⁸⁵ Section 78(1A) of the Criminal Procedure Act.

⁷⁸⁶ See chapter 2 above paragraph 7. Section 78(A1) and 78(1B) were inserted by section 5(b) of Act 68 of 1998. See also Milton, J “Law reform: The Criminal Matters Amendment Act 1998 brings some sanity (but only some) to the defence of insanity” (1999) *SACJ* 41–48 where it is submitted that the current reverse onus is not justified.

⁷⁸⁷ Snyman (2008) *supra* note 3 at 175; Burchell and Milton (2005) *supra* note 3 at 390; Hiemstra (2008) *supra* note 3 at 13 – 23; LAWSA (2004) *supra* note 3 at 65; Du Toit *et al* (2008) *supra* note 3 at 13 – 20; Strauss (1991) *supra* note 3 at 132.

(1A)⁷⁸⁸. If, on the other hand, the State or prosecution raises the issue of criminal responsibility or put differently, alleges mental illness, the prosecution will have to prove such mental illness on a balance of probabilities⁷⁸⁹. It is, however, only in rare instances that the State or prosecution will raise the issue of mental illness⁷⁹⁰. The defence of pathological criminal incapacity represents an exception to the general rule that the burden of proof rests on the prosecution to prove all the elements of an offence beyond reasonable doubt. Placing the burden of proof on an accused in cases of insanity, undoubtedly raises constitutional dilemmas. Firstly, section 9 (1) of the Constitution provides that everyone is equal before the law and has a right to equal protection and benefit of the law⁷⁹¹. Section 35 (3)(h) in addition states that every accused person has a right to a fair trial which inadvertently includes the right to remain silent and to be presumed innocent⁷⁹². The question which falls to be determined is whether this burden of proof is unconstitutional or whether it could be justified in terms of the limitation clause provided for in section 36 of the Constitution⁷⁹³. It was stated in chapter two that the burden of proof should be the same in both cases of pathological and non-pathological criminal incapacity as uniformity in this regard is essential. The question that then has to be assessed is whether the burden of proof should fall on the accused who raised the defence of criminal incapacity, regardless of whether it amounts to pathological or non-pathological criminal incapacity, or whether the time for an alternative approach has not arrived. Inherent in a burden of proof lies the evidentiary aspect which refers to adducing proper evidence to relieve such burden. The latter consequently emphasises the pivotal role of the mental health professional in adducing evidence to raise doubt on a balance of probabilities as to the mental state of the accused at the time of the offence.

In the highly acclaimed case of *R v Chaulk*⁷⁹⁴, the Canadian Supreme Court was called to consider the constitutionality of the reverse onus provisions in cases of

⁷⁸⁸ See LAWSA (2004) *supra* note 3 at 65 where it is noted that the presumption is part of the general presumption of criminal responsibility.

⁷⁸⁹ Snyman (2008) *supra* note 3 at 175; LAWSA (2004) *supra* note 3 at 65; Du Toit *et al supra* note 3 at 13–20.

⁷⁹⁰ *Ibid.*

⁷⁹¹ Section 9(1) of the Constitution of South Africa, 1996.

⁷⁹² Section 35(3)(h) of the Constitution of South Africa, 1996.

⁷⁹³ See chapter 2 paragraph 3.4.7.

⁷⁹⁴ *R v Chaulk* (1991) 1 CRR (2d) 1 (SCC).

insanity. This case is briefly discussed in this section to evaluate the presumption of innocence weighed against the reverse onus provision. The facts of the decision were the following: The two appellants were tried and convicted of first-degree murder. The only defence raised was insanity within the ambit of section 16 of the Criminal Code. The expert evidence presented during the trial revealed that the appellants suffered from paranoid psychosis which made them believe that they had the power to rule the world and that the killing was a necessary means to that end. The main constitutional issues that were raised on appeal were whether section 16(4) of the Criminal Code of Canada which provides for the presumption of sanity, was inconsistent with section 11(d) of the Canadian Charter of Rights and Freedoms. Section 11(d) deals with the presumption of innocence. The second issue was whether, if section 16(4) was found to be irreconcilable with section 11(d), whether it was a reasonable limitation which could be demonstrably justified in a free and democratic society. The majority of the court, per Lamer CJC, held that the presumption of sanity as embodied in section 16(4) violated the presumption of innocence in terms of section 11(d), but that it constituted a justifiable limitation as its objective was to relieve the Crown of the impossibly onerous burden of proving an accused's sanity in order to secure a conviction. It was further held that there was a "rational connection" between the objective of section 16(4) and the means employed to achieve the objective and that section 16(4) violated section 11(d) as little as possible. It was held that there was sufficient proportionality between the effects of section 16(4) and its intended objectives.

Wilson J dissented and held that the persuasive burden imposed on the accused by virtue of section 16(4) allows for an accused to be convicted of a crime despite the existence of a reasonable doubt as to his or her guilt and that the provision in section 16(4) violated the presumption of innocence. Wilson J favoured an evidentiary burden being placed on an accused as opposed to a burden of proof and took the view that such approach would be more in line with fundamental principles of criminal law and would further provide a sufficiently high threshold to curb insanity pleas in cases with a lack of adequate support for such defences.

This case provides a good example of the weighing of the right to be presumed innocent against the presumption of sanity in conjunction with the reverse onus provision. The following suggestions could be proposed in respect of the burden of proof in cases of pathological criminal incapacity:

- It could be argued that the burden of proof in cases of pathological criminal incapacity should remain on the accused or the party raising the issue to prove the alleged incapacity on a balance of probabilities. The burden of proof should, it is submitted, then in addition be the same in any case of criminal incapacity as suggested in chapter two above regardless of the cause of the alleged incapacity. In justification of the violation of the presumption of innocence contained in section 35 (3) (h) of the Constitution, it could be argued that the burden of proof constitutes a reasonable and justifiable limitation of the right of an accused to be presumed innocent. This construction will be similar to the position as espoused by the majority of the court in the *Chaulk* decision and will also resemble the *status quo* in respect of the burden of proof within the South African context in terms of section 78 (1A) read with 78 (1B) of the Criminal Procedure Act.
- An alternative approach would be to do away with the burden of proof required in cases of criminal incapacity and more specifically pathological criminal incapacity, and to place a mere evidential burden on an accused to adduce evidence to rebut the *prima facie* case of the prosecution. This solution is propounded by Burchell and Milton who suggest the following:⁷⁹⁵

“A practical solution to this problem would be to realise that the presumption of sanity has its origin in a system of law in which a clear distinction was not often drawn between a presumption which casts a burden of proof on a balance of probabilities onto the accused and a presumption which casts merely an evidential burden onto the accused. It is surely consistent with principle, equal treatment of accused persons and compatible with both the

⁷⁹⁵ Burchell and Milton (2005) *supra* note 3 at 392–393; Burchell and Hunt (1997) *supra* note 3 at 179–180.

reasoning behind the presumption of sanity (or capacity) and the presumption of innocence to say that everyone is presumed to be sane and that this means that anyone who wishes to refute this presumption must lead compelling evidence to the contrary.”

Burchell and Milton in addition note that this approach would almost resemble the foundation required in cases of non-pathological criminal incapacity⁷⁹⁶. Requiring an accused person raising the defence of criminal incapacity to relieve an evidential burden seems to be more in line with constitutional values. This approach was also suggested by Wilson J in the *Chaulk* decision. Schwikkard notes that although placing an evidential burden on an accused will not alleviate the *prima facie* unconstitutionality of the presumption of sanity it seems to be more in line with the limitation clause⁷⁹⁷. Inherent in the evidential burden placed on the accused, will be a proper body of expert psychiatric and psychological evidence to support the evidential burden. Once again expert evidence becomes essential.

- A third approach, suggested by Schwikkard, would be to merely require an accused raising the defence of insanity to lay a factual foundation for such defence⁷⁹⁸. This approach is currently the position in cases of sane automatism and non-pathological criminal incapacity⁷⁹⁹. This approach, it is submitted, should once again be the same in both cases of pathological and non-pathological criminal incapacity. It is submitted that the requirement of a factual foundation could also be incorporated into a special plea of criminal incapacity as suggested in paragraph 9 above.

Irrespective of the approach followed, the one facet emphasised in each approach is the fundamental need for expert evidence whether it be to satisfy a burden of

⁷⁹⁶ *Ibid.*

⁷⁹⁷ Schwikkard, PJ and Van der Merwe, SE “Beginsels van die Bewysreg” (2006) at 548–549. See also Jones, TH “Insanity, automatism, and the burden of proof on the accused” (1995) *L.Q.R.* 475–516 at 509 where it is stated: “What lies behind the argument that the accused should bear no more than an evidential burden in respect of insanity is the belief that he or she should receive the benefit of doubt on the issue ...”

See also Jeffries, JC and Stephan, PB “Defenses, Presumptions, and Burden of Proof in Criminal Law” (1979), *Yale. L. R.* 1325; Robinson, PH “Criminal Law Defenses: a systematic analysis” (1982) *Columbia L.Rev.* at 199.

⁷⁹⁸ *Ibid.*

⁷⁹⁹ See chapter 2 *supra*.

proof on a balance of probabilities, an evidential burden or to lay a factual foundation.

12 Procedural aspects of the defence of pathological criminal incapacity

It is important to take note of the following procedural aspects pertaining to the defence of pathological criminal incapacity.⁸⁰⁰

- As stated above, the Criminal Procedure Act does not currently provide for a plea of criminal incapacity and if an accused raises the defence of insanity, the appropriate plea is one of not guilty in terms of section 115 of the Criminal Procedure Act. The plea of not guilty will be accompanied by a plea explanation in terms of which the defence of the accused will be set forth.
- The defence should give notice as soon as possible that mental illness will be relied on as a defence.
- If the issue of criminal responsibility is raised by the prosecution, both parties should be afforded an opportunity to state their views.
- The question of criminal incapacity is, in contrast with an assessment for triability, part of the main points in issue and is not assessed as a point *in limine*, but as part of the whole case.
- A referral for observation can also be made after conviction.
- An order in terms of section 78(6) cannot be rendered without the assistance of expert psychiatric evidence⁸⁰¹.

In *S v Magongo*⁸⁰² the accused had been charged in a Circuit Court with murder. At the closure of the accused's case, the court analysed the evidence and rendered a finding in terms of section 78 (6) of the Criminal Procedure Act that the accused was not criminally responsible and ordered him to be detained in a mental hospital. The order was made despite the fact that no application had been made therefor and in the absence of a report by two psychiatrists in terms of

⁸⁰⁰ Hiemstra (2008) *supra* note 3 at 13–22–13–23. See also Du Toit *et al* (2008) *supra* note 3 at 13-8–13-22.

⁸⁰¹ Hiemstra (2008) *supra* note 3 at 13–23.

⁸⁰² *S v Magongo* 1987 (3) SA 519 (A).

section 79. On Appeal by the State against the validity of this order Jansen JA held:⁸⁰³ “Hieruit blyk met watter erns die Wetgewer ‘n bevinding ingevolge artikel 78(6) bejeën. Dit is begryplik aangesien ‘n bevinding van ontoerekeningsvatbaarheid ernstige gevolge kan hê vir die Staat, dat moontlik ‘n misdadiger verkeerdelik onskuldig ingevolge art. 78 (6) bevind word; en vir die beskuldigde, dat hy moontlik onbepaald aangehou kan word ingevolge ‘n bevel kragtens daardie subartikel. Hiermee is nie te versoen dat ‘n Hof ‘n bevinding ingevolge art. 78 (6), nl dat ‘n beskuldigde vanweë ‘geestesongesteldheid’ of ‘geestesgebrek’ ontoerekeningsvatbaar is sonder die hulp van psigiatriese getuienis sou kon maak nie.” The order was accordingly set aside and the case was remitted to the trial court so that the procedure in terms of section 78(2) of the Criminal Procedure Act, which provision is peremptory, could be applied.

- An accused can be found not guilty by reason of mental illness after conviction but before sentence⁸⁰⁴.
- An accused can appeal against a finding made in terms of section 78 (6) except where the finding is the result of an allegation of criminal incapacity by the accused⁸⁰⁵. Where such an appeal is allowed, the finding is set aside and the case is remitted to the court which rendered the finding and the proceedings are continued in the ordinary manner⁸⁰⁶.

13 Referral for observation by the panel of experts for purposes of the enquiry and the role of expert evidence

The Rumpff report noted that the most important function of the psychiatrist is to assist the judge to determine whether the accused was suffering from a mental illness or disease which impaired his insight or self-control⁸⁰⁷. This function of the psychiatrist becomes abundantly clear upon an analysis of section 79 read with section 78 of the Criminal Procedure Act. Section 78 (2) of the Criminal Procedure Act states that if it is alleged during criminal proceedings that an accused is by

⁸⁰³ At 521 I–522 B.

⁸⁰⁴ Du Toit *et al* (2008) *supra* note 3 at 13–23.

⁸⁰⁵ See section 78(8) of the Criminal Procedure Act. See also Hiemstra (2008) *supra* note 3 at 13–24; Du Toit *et al* (2008) *supra* note 3 at 13-8. Section 78(6) will be discussed below.

⁸⁰⁶ Section 78(8)(b) of the Criminal Procedure Act.

⁸⁰⁷ Rumpff report *supra* note 3 at paragraph 9–38.

reason of mental illness or mental defect, or for any other reason, not criminally responsible for the offence in question, or if it appears to the court during criminal proceedings that the accused might not be responsible, the court shall direct that the matter be enquired into and be reported on in terms of the provision of section 79 of the Criminal Procedure Act⁸⁰⁸. Section 78 (3) in addition states that if the finding contained in the relevant report represents the unanimous finding of the experts who enquired into the mental condition of the accused in terms of section 79 and is not disputed by either the prosecution or the accused, the court may determine the matter in terms of such report without further evidence⁸⁰⁹. If the finding is not unanimous or if the finding is disputed, the court will determine the matter after hearing further evidence which could include evidence of any of the experts who enquired into the mental state of the accused in terms of section 79⁸¹⁰. This position is similar to the position where competency to stand trial is assessed. Section 79 of the Criminal Procedure Act deals with the panel of experts that are required to conduct the enquiry into the mental state of the accused in respect of criminal capacity. Section 79 distinguishes between crimes involving serious violence and those that are non-violent. In cases of non-violent offences, the relevant enquiry is conducted by the medical superintendent⁸¹¹. In cases of murder, culpable homicide, rape or compelled rape or any other charge involving serious violence or if deemed in the public interest, the enquiry is conducted by:⁸¹²

- the medical superintendent at a psychiatric hospital or by a psychiatrist designated by the medical superintendent at the request of the court;
- a psychiatrist appointed by the court who is not in full-time service of the State;

⁸⁰⁸ Section 78(2) of the Criminal Procedure Act.

⁸⁰⁹ Section 78(3) of the Criminal Procedure Act.

⁸¹⁰ Section 78(4) of the Criminal Procedure Act. Section 79 has already been discussed in terms of the discussion on competency to stand trial. This section, however, applies to both competency assessments and assessments of criminal capacity and accordingly some of the provisions may overlap.

⁸¹¹ Section 79(1)(a). See also Du Toit *et al* (2008) *supra* note 3 at 13-24–13-26A. See also paragraph 4.2 above where section 79 is quoted.

⁸¹² Section 79(1)(b). It is important to note that the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 replaced common law rape with rape or compelled rape. See also Du Toit *et al* (2008) *supra* note 3 at 13-26A; Hiemstra (2008) *supra* note 3 at 13–27; Kaliski (2006) *supra* note 3 at 95; Tredoux *et al* (2005) *supra* note 3 at 388.

- a psychiatrist appointed for the accused by the court, and
- a clinical psychologist “where the court so directs”.

A court may not act in terms of section 77(6) or 78(6) of the Criminal Procedure Act in the absence of a report⁸¹³. The prosecutor conducting the prosecution of an accused must provide the panel with the following information:⁸¹⁴

- whether the accused is being evaluated for fitness to stand trial or criminal capacity or both;
- at whose request or on whose initiative the referral was ordered;
- the nature of the charge against the accused;
- the stage of the proceedings at which the referral took place;
- the ambit and scope of any statements made by the accused before or during the court proceedings that are relevant to the assessment of his or her mental condition;
- the scope of evidence that has been presented relevant to the accused’s mental condition;
- information pertaining to the accused’s social background and family composition as well as the names and addresses of near relatives;
- any other additional information that in the opinion of the prosecutor could be relevant in the assessment of the accused’s mental condition.

The period of observation is thirty days at a time⁸¹⁵. After the expiration of the first period of thirty days the period may be extended and such extension may be granted in the absence of the accused unless the accused or his or her legal representative requests otherwise⁸¹⁶. An accused is generally admitted to a state

⁸¹³ Du Toit *et al* (2008) *supra* note 3 at 13–26A.

⁸¹⁴ Section 79 (1A) of the Criminal Procedure Act; Du Toit *et al* (2008) *supra* note 3 at 13–27; Hiemstra (2008) *supra* note 3 at 13–27; Kaliski (2006) *supra* note 3 at 95.

⁸¹⁵ See Kaliski (2006) *supra* note 3 at 96. Kaliski notes that it is not a prerequisite that an accused remain for a full period of thirty days and often accused persons leave after twelve days.

⁸¹⁶ Section 79(2)(a) and (b) of the Criminal Procedure Act; Kaliski (2006) *supra* note 3 at 95; Du Toit *et al* (2008) *supra* note 3 at 13–27.

psychiatric hospital in terms of a warrant known as the “J 138”⁸¹⁷. The subsequent report by the expert panel should provide for the following:⁸¹⁸

- a description of the nature of the enquiry;
- a diagnosis of the mental state of the accused;
- an opinion as to the extent to which the capacity of the accused to appreciate the wrongfulness of the act in question or his or her capacity to act in accordance with an appreciation of the wrongfulness of that act was, at the time of the commission of the act, affected by the mental illness or mental defect.

Du Toit *et al* in addition note that a psychiatrist should state his or her opinion in the report as well as in the presentation of evidence in court, as clearly and comprehensively as possible and also provide clarity as to his or her level of certainty with regards to the particular issue⁸¹⁹. Du Toit *et al* note:⁸²⁰

“In compiling his report the psychiatrist should avoid ‘own theory’ as to what happened, he should declare the limits of his skill, and not overmedicalize social or moral deterrents.”

If the experts conducting an enquiry are not unanimous in their opinion, such fact must be mentioned in the report and consequently each expert must provide his or her finding in respect of the issue⁸²¹. Subject to section 79 (7), the contents of the report shall be admissible as evidence during the trial⁸²². Du Toit *et al* state that a court may only accept reports compiled by psychiatrists and not clinical psychologists even in the event that they are registered. Section 79 (1) (6) (iv)

⁸¹⁷ Kaliski (2006) *supra* note 3 at 95.

⁸¹⁸ Section 79(4) of the Criminal Procedure Act. See also Hiemstra (2008) *supra* note 3 at 13–28; Du Toit *et al* (2008) *supra* note 3 at 13–25.

⁸¹⁹ Du Toit *et al* (2008) *supra* note 3 at 13–28.

⁸²⁰ *Ibid.*

⁸²¹ Section 79(5) of the Criminal Procedure Act. See also Du Toit *et al* (2008) *supra* note 3 at 13–25.

⁸²² Section 79(6) of the Criminal Procedure Act.

further confers a discretion on a court to appoint a clinical psychologist⁸²³. The validity of this discretion could be questioned especially in cases where a forensic psychologist could provide useful testimony in respect of the mental state of an accused. It was further indicated in chapter two that the defence of non-pathological criminal incapacity is most often rooted fundamentally in psychology due to the specific nature of the defence.

Expert evidence is pivotal in assessing the defence of pathological criminal incapacity. Strauss correctly notes that a finding that an accused lacked criminal capacity can only be rendered with the support of expert psychiatric evidence⁸²⁴. In the event of conflicting expert opinions, the court has to determine which of the views are the most credible⁸²⁵. Strauss in addition notes that a court is under no obligation to accept psychiatric evidence as the final proof of insanity and if it is established that the evidence relating to the facts upon which the psychiatric opinion is founded is not credible, the court retains a discretion to refuse such evidence⁸²⁶. A crucial aspect of expert psychiatric evidence is that the evidence should be related to the facts of the case. The latter principle was specifically enunciated per O'Linn J in *S v Mngomezulu*⁸²⁷ where it was stated:⁸²⁸

“Psigiatrie (ook psigologie) is nie ‘n eksakte wetenskap nie en daarom moet, om reg te laat geskied, by die aanhoor van psigiatrise of psigologiese getuienis, ‘n grondslag gelê word van feite wat deur die hof as aanvaarbaar beskou kan word waarop die psigiatrise of psigologiese opinie gebaseer kan word. By die verhoor word die mening van ‘n deskundige, in hierdie geval ‘n psigiater, ingeroep en sy mening omtrent die geestestoestand van die beskuldigde is vir die hof alleen van belang vir sover dit feite betref wat voor die hof gelê word en wat die hof gevra word

⁸²³ Du Toit *et al* (2008) *supra* note 3 at 13–30. See also section 79 (12) of the Criminal Procedure Act.

⁸²⁴ Strauss (1991) *supra* note 3 at 131. See also Greenspan, EL “The role of the psychiatrist in the criminal justice system” (1978) *Can Psychiatr Assoc. J* 137 at 142 where it is stated that the role of the psychiatrist in aiding the court in the determination of issues is extremely important.

⁸²⁵ Strauss (1991) *supra* note 3 at 131.

⁸²⁶ *Ibid.*

⁸²⁷ *S v Mngomezulu* 1972 (1) SA 797 (A).

⁸²⁸ At 798 F–799 A. See also Strauss (1991) *supra* note 3 at 131; *S v Shilvute* 1991 (1) SACR 656 (NM).

om te aanvaar. Dit geld by iedere stadium van 'n verhoor waarby die geestestoestand van die beskuldigde beoordeel moet word, ditsy by sy verhoor op die aanklag teen hom of by die ondersoek in verband met versagende omstandighede. Wanneer die psigiatriese getuienis in verband staan met feite wat deur die hof aanvaar is, volg dit nie noodwendig dat die Hof die psigiatriese opinie moet aanvaar nie. In die lig van die getuienis as geheel is dit nog die taak van die Hof om te beoordeel of die psigiatriese of psigologiese getuienis self aanvaarbaar is of nie, maar sonder skakeling met die feite wat voor die Hof gelê word, is psigiatriese en psigologiese opinie abstrakte teorie. Die advokaat van die beskuldigde sowel as die aanklaer, behoort dus by die uitoefening van hulle respektiewe pligte, nooit uit die oog te verloor nie dat die Hof alleen dan die reg kan laat geskied wanneer daar getuienis omtrent feite aan die hof voorgelê word, wat die Hof moet beoordeel, en wanneer die deskundige opinie van die psigiater aan daardie feite vasgeknoop word.”

Kaliski notes that assessment of pathological criminal incapacity, from a mental health professional's view, involves a three-stage process in terms of which a mental health professional first has to establish whether an accused suffered from a mental illness or mental defect⁸²⁹. The mental health professional then has to evaluate whether the disorder affected the accused's cognitive or conative capacities and finally it has to be assessed whether the impairment of any of these two capacities had a bearing on the accused's actions during the commission of the offence⁸³⁰. During the period of assessment of the accused, each mental health expert from the panel will conduct an inquiry and the process in effect involves multiple assessment in conjunction with daily observations of the accused's behaviour⁸³¹. Kaliski further notes:⁸³²

⁸²⁹ Kaliski (2006) *supra* note 3 at 103.

⁸³⁰ *Ibid.* See also Africa in Tredoux *et al* (eds.) (2005) *supra* note 3 at 395; Halleck, S “Law in the Practice of Psychiatry – A Handbook for Clinicians” (1980) at 195–198.

⁸³¹ *Ibid.*

⁸³² *Ibid.*

“A crucial aspect is that apart from answering the critical juridical issues, a comprehensive assessment should be undertaken to achieve as deep an understanding of the accused as possible.”

Plomp notes that it is crucial for a psychiatrist to bear in mind that psychiatrists should never present an opinion as to whether an accused lacked criminal capacity as criminal capacity is a legal term of which the psychiatrist is not competent to deliver an opinion on⁸³³. The psychiatrist should rather present an opinion as to whether an accused, as a result of mental illness, could not appreciate the wrongfulness of his act or act in accordance with such appreciation⁸³⁴. A psychiatrist accordingly lays the foundation and the court draws the final conclusion⁸³⁵. Plomp notes that it is important to ascertain whether an accused suffered from a mental illness at the time of the offence. Even though the fact that the accused was mentally ill before the offence or is currently mentally ill is relevant to the determination, the mental state at the time of the offence is crucial⁸³⁶. During the observation the psychiatrist gathers information by means of:⁸³⁷

- interviews
- observation of the accused often without the accused being aware of the fact that he or she is being observed
- physical examination
- special examinations of his or her physical health
- examinations regarding his or her mental functions.

⁸³³ Plomp, J “Die psigiater en die vasstelling van toerekeningsvatbaarheid” (1983) *TRW* 154 at 156–157.

⁸³⁴ *Ibid.*

⁸³⁵ *Ibid.*

⁸³⁶ *Ibid.* See also Africa in Tredoux *et al* (2005). See also Viljoen, G “Toerekeningsvatbaarheid, Wrywingspunte en raakvlakke tussen die reg en die psigiatrie” (1983) *TRW* 121 at 129 where it is noted: “It is freely acknowledged by the law that in issues relating to the criminal responsibility of accused persons (which is a legal concept) judges, as laymen, have to rely on psychiatrists and psychologists, but at the same time it must be realised that it is the court which has ultimately to decide, as a question of fact, whether the accused is criminally responsible or not and, in so endeavouring to decide it, has to take into account all the facts of the particular case and not only the psychiatrist’s opinion which is sometimes, in large measure, based upon what the person concerned told him.” See also Kruger, A “Mental health law in South Africa” (1980) at 106–207.

⁸³⁷ *Ibid.* See also Kaliski (2006) *supra* note 3 at 96; Monroe, RR “The psychiatric examination” in Slovenko, R (ed.) “Crime, Law and Corrections” (1966) at 439–444.

Plomp suggests the following criteria which could assist a psychiatrist in forming an opinion that may serve as the foundation for a finding as to criminal capacity.⁸³⁸

- The accused had to have suffered from a mental illness or mental defect at the time of the commission of the offence which is an accepted nosological entity;
- The mental illness or mental defect must have been such as to impair either the accused's cognitive or conative capacities;
- The mental aberration should have been of such severity and degree as to have affected the said capacities;
- The conduct of the accused at the time of the commission of the offence must be brought in line with the nature and degree of the mental illness or mental defect;
- The abovementioned criteria only goes as far as creating the possibility of impairment of the said capacities. Whether the possibility will become a probability will depend on the degree of mental disturbance which is a question dependent on the conviction, expertise, objectivity and sound reason of the psychiatrist.

Melton *et al* note that the clinical assessment of an accused's mental state at the time of the offence is one of the more difficult tasks facing the forensic mental health professional due to the fact that the governing legal doctrine is amorphous, the emphasis in a mental status evaluation is retrospective and third-party information is often unavailable or unreliable⁸³⁹. Melton *et al* suggest that forensic mental health professionals should focus on being systematic in considering the use of information from three broad domains which include third-party information; the accused's own report of his or her mental state at the time of the offence and the use of psychological tests and techniques⁸⁴⁰. In respect of third-party information, information as to the accused's behaviour should be gathered from all

⁸³⁸ Plomp (1983) *TRW supra* note 833 at 160–161.

⁸³⁹ Melton *et al* (2008) *supra* note 3 at 249.

⁸⁴⁰ *Ibid.*

possible sources. Melton *et al* identify five main categories from which information can be gathered together with additional information in each case:⁸⁴¹

- Information regarding the evaluation
 - Source of referral
 - Referral questions
 - The reason why the evaluation was requested
 - Who is the report going to?
 - When is report to be used?

- Offence-related information
 - Information from attorney
 - Information gathered from witnesses and/or victims
 - Any confessions made
 - Post mortem reports

- Developmental or historical information
 - Personal information from accused
 - Family history
 - Marital history
 - Education, and/or employment
 - Psychosexual history
 - Media and psychiatric records

- “Signs of trouble”
 - Possible juvenile criminal records

- Statistical information

Melton *et al* note that the information gathered in this manner becomes crucial but the mental health professional should be cautious as to the admissibility and

⁸⁴¹ *Ibid.*

validity of such information⁸⁴². In terms of the accused's own recall of the events, the mental health professional will focus on the crime itself and the accused's recall of his or her thoughts, feelings and behaviour at the time of the offence⁸⁴³.

Africa notes that during a retrospective assessment the psychologist will carefully put together all the information gathered in order to formulate an opinion as to whether the accused's mental capacities were impaired by specific symptoms and to what extent⁸⁴⁴. These findings are recorded in a report and submitted to the court.

What becomes abundantly clear from the discussion above is the pivotal role of psychiatrists and psychologists in the assessment of criminal incapacity. The statutory embodiment of expert evidence in support of criminal incapacity is one step towards a fairer trial. The second step is the proper acceptance and recognition of this evidence.

14 Admissibility of statements by an accused during the enquiry

Section 79(7) provides that a statement made by an accused during the enquiry into his or her mental condition shall not be admissible in evidence against the accused at criminal proceedings, except to the extent to which it may be relevant to the determination of the mental condition of the accused⁸⁴⁵. This section is contentious as it fundamentally infringes on an accused's constitutional right to privacy envisaged in section 14 of the Constitution⁸⁴⁶. In *S v Forbes*⁸⁴⁷ the question as to the admissibility of a statement was in issue. The facts of the decision were briefly the following: The accused stood trial on charges of housebreaking with intent to steal and theft, arson and murder. The evidence

⁸⁴² Melton *et al* (2008) *supra* note 3 at 254.

⁸⁴³ *Ibid.* See also Africa in Tredoux *et al* (2005) *supra* note 3 at 397.

⁸⁴⁴ Africa in Tredoux *et al* (2005) *supra* note 3 at 397; Milton *et al* (2008) *supra* note 3 at 254. See also Golding, SL, Skeem, JL, Roesch, R and Zapf, PA "The Assessment of Criminal Responsibility – Current Controversies" in Hess, K and Weiner, IB (eds.) "The Handbook of Forensic Psychology" (1999) at 379.

⁸⁴⁵ Section 79(7) of the Criminal Procedure Act. This section was also discussed in chapter two above at paragraph 12 with reference to non-pathological criminal incapacity.

⁸⁴⁶ Section 14(d) of the Constitution.

⁸⁴⁷ *S v Forbes and Another* 1970 (2) SA 594 (C). See also Du Toit *et al* (2008) *supra* note 3 at 13–29; Hiemstra (2008) *supra* note 3 at 13–27.

revealed that after his arrest in connection with the alleged offences, accused number one was taken to the police and subsequently to a magistrate to whom he voluntarily made a statement amounting to a confession of the commission of the crime of housebreaking with the intent and theft but a denial of guilt in respect of the murder and arson charges. He further denied responsibility for the fire which was started and stated:⁸⁴⁸

“We didn’t put alight to nothing [sic] – we had a torch with us.”

The accused (number one) was initially evaluated by Dr Pascoe who testified that the accused (number one) did not suffer from a mental disorder or defect at the time of the commission of the offence⁸⁴⁹. Later during the trial, the State sought to have the testimony of a Dr Munnik allowed. Dr Munnik was a qualified medical practitioner who was studying under Dr Pascoe. Dr Munnik interviewed the accused (number one) and the accused testified freely and voluntarily but it was never suggested to him that any of the details given by him might subsequently be used as evidence at the trial. The State wished to put before the court a statement by the accused which in effect boiled down to an admission that he was the cause of the fire on the day of the offence. This statement was in direct conflict with the accused’s statement to a magistrate earlier. Thereon J refused to admit the statement and held:⁸⁵⁰

“It seems to me highly undesirable that any statements made by accused persons in the course of enquiries into their mental condition held in terms of the Mental Disorders Act – whether such statements constitute confessions of the crimes with which they are charged or admissions falling short of confessions – should ever be allowed to be put before the Court in evidence for the purpose of establishing the truth of any facts referred to in such statements, save possibly facts having a direct bearing upon the mental condition into which the enquiry was being conducted.”

⁸⁴⁸ At 595 H–I.

⁸⁴⁹ At 596 D.

⁸⁵⁰ At 599 A–C.

Theron J further held that the State wanted the evidence to be admitted, not to cast light upon the general mental condition of the accused but to try and establish the existence of certain facts unconnected with the issue of mental disorder or disease⁸⁵¹. Theron J also held that even if the statement of Dr Munnik was admissible, a trial judge still retained a discretion to exclude it if unfairly obtained⁸⁵². Theron J in addition refused to admit the statement on grounds of public policy⁸⁵³.

If the facts in the *Forbes* decision had to be assessed in the light of section 79 (7), the outcome would invariably be the same. It is clear that reliance was placed by the State on the relevance of the statement, not for purposes of ascertaining the mental state of the accused, but to establish the contradiction between the confession and the statement made to Dr Munnik.

In *S v Webb (1)*⁸⁵⁴ a more coherent approach was followed in respect of a statement by the accused. The facts of the decision entailed that before closing its case, the State called Dr Morgan, acting superintendent of the Weskoppies Hospital, to testify. Her evidence amounted to the fact that the accused in the matter was not mentally disordered and thus fit to stand trial. The accused's defence was that at the time of the commission of the offence he suffered from a mental illness leading to criminal incapacity⁸⁵⁵. The defence objected to the admission of Dr Morgan's evidence and contended that the State is not entitled to make use of statements by the accused amounting to confessions or admissions. Human J held that Dr Morgan had sufficiently warned the accused that he was under no obligation to say anything and that the accused was in his sound and sober senses at the time of the interrogation⁸⁵⁶. The State contended that the statements were needed solely insofar as it was relevant to the accused's mental condition. The State referred to the *Forbes* decision and contrasted it with the present case in that admission of the statement was sought, not to indicate

⁸⁵¹ *Ibid.*

⁸⁵² At 600 A–B.

⁸⁵³ At 599 A.

⁸⁵⁴ 1971 (2) SA 340 (T). See specifically 341 C–D.

⁸⁵⁵ *Ibid.*

⁸⁵⁶ At 341 E–G.

contradictions in statements as in the *Forbes* decision, but for determining the mental state of the accused⁸⁵⁷. Human J held:⁸⁵⁸

“It is apparent at once that this case and the case referred to are not in *pari materia*. The evidence in the present case is offered to rebut the defence of the accused that he was mentally disordered or defective at the time of the alleged murder.”

The evidence was accordingly ruled admissible.

This decision illustrates the fundamental exception to the rule that statements made by an accused are inadmissible. The statements relied on should be relevant to the determination of the mental state of the accused. Due to complexity of the defence of criminal incapacity this rule contained in section 79 (7) of the Criminal Procedure Act, if it is submitted, constitutes a reasonable and justifiable limitation of the right to privacy contained in the Constitution.

15 Disposition of the insanity acquittee

Section 78(6) of the Criminal Procedure Act pertinently deals with the disposition of an accused found not guilty by reason of mental illness or intellectual disability. Section 78(6) entails that if a court finds that an accused committed the crime in question but that he or she at the time of the commission was by reason of mental illness or intellectual disability (mental defect) not criminally responsible for the crime, the court shall find the accused not guilty and if the accused has already been convicted, set the conviction aside and find the accused not guilty as a result of mental illness or intellectual disability (mental defect)⁸⁵⁹. The possible orders a court can grant are the following:

⁸⁵⁷ At 341 H–342 F.

⁸⁵⁸ At 342 F–G.

⁸⁵⁹ Section 78(6)(a) and (b) of the Criminal Procedure Act. See also Du Toit *et al* (2008) *supra* note 3 at 13-21–13-22; Kruger, A “Mental Health Law in South Africa” (1982) at 182.

- If the accused is charged with murder, culpable homicide, rape or compelled rape or any other charge involving serious violence, the court can order that the accused:
 - be detained in a psychiatric hospital or prison pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act⁸⁶⁰;
 - be admitted to and detained in an institution stated in the order and treated as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act;
 - be released conditionally;
 - be released unconditionally.

- In cases of any other offences than those referred to above, the court may order that the accused:
 - be admitted to and detained in an institution stated in the order and treated as if he or she were an involuntary mental health care user as provided for in section 37 of the Mental Health Care Act⁸⁶¹;
 - be released conditionally;
 - be released unconditionally.

In respect of the conditional release of an accused, the court will have regard to the safety of the public as well as the propensity of the accused to commit crime as well as the prognosis to commit further crime⁸⁶². Suitable conditions may include the condition that the acquitted accused resides with his or her family or

⁸⁶⁰ Mental Health Care Act 17 of 2002. It is notable that section 47 of the Mental Health Care Act 17 of 2002 deals with the application for discharge of State patients and deals with the specific persons who are entitled to apply to a judge in chambers and include the State patient, curator *ad litem*, administrator, spouse or any other person. The said section further prescribes the procedure for application and the requirements that have to be met. These sections will for purposes of this discussion not be addressed further. See also Du Toit *et al* (2008) *supra* note 3 at 13-22; Snyman (2008) *supra* note 3 at 176; Hiemstra (2008) *supra* note 3 at 13-24; Burchell and Milton (2005) *supra* note 3 at 399. See also Oosthuizen, H and Verschoor, J "Verlof en ontslag van staatspasiënte (1994) SACJ 358-363; Henning, PH "Beleid ten Opsigte van die ontslag van Presidents-pasiënte" (1983) TRW 132-141; Fraser, IS "Psychiatry and Law" (1992) at 18-19.

⁸⁶¹ Section 37 of the Mental Health Care Act 17 of 2002 pertains to the periodic review of annual reports relating to involuntary mental health care users.

⁸⁶² Du Toit *et al* (2008) *supra* note 3 at 13-22.

submits to appropriate treatment⁸⁶³. Expert evidence will also play an important role in the determination of the dangerousness of the criminal or to determine appropriate conditions⁸⁶⁴. An order of unconditional release will be suitable where there are no prospects that the mental illness, which existed at the time of the commission of the act, will resurface again⁸⁶⁵. The latter will be assessed on the basis of expert psychiatric evidence⁸⁶⁶. It is further important to note that the special directives in terms of section 78 (6) are also applicable to cases of insane automatism. Although a different element of criminal liability is at issue, the verdict in cases of automatism caused by a mental illness, is similar to those rendered in cases of pathological criminal incapacity⁸⁶⁷. In these cases expert medical evidence will be crucial to establish whether the accused acted involuntarily as a result of a mental illness or whether he or she lacked criminal capacity.

16 Diminished criminal capacity

South African Criminal Law does not, as yet, have a specific defence of diminished criminal capacity. The principle of diminished criminal capacity or responsibility is, however, enshrined in section 78(7) of the Criminal Procedure Act⁸⁶⁸. Section 78(7) in essence provides that if a court finds that an accused was criminally responsible, but his or her capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation was diminished as a result of the mental illness or mental defect, the court shall have regard to such diminished responsibility during sentencing⁸⁶⁹. A person may very well suffer from a mental illness or mental defect but may still be able to appreciate the wrongfulness of the

⁸⁶³ *Ibid.*

⁸⁶⁴ Dangerousness as well as the role of psychiatry in the prediction of future dangerousness will not be addressed in this study.

⁸⁶⁵ *Ibid.*

⁸⁶⁶ *Ibid.*

⁸⁶⁷ Hiemstra (2008) *supra* note 3 at 13–24; LAWSA (2004) *supra* note 3 at 68; Kaliski (2006) *supra* note 3 at 107; Snyman (2008) *supra* note 3 at 56.

⁸⁶⁸ See chapters 1 paragraph 2.7 and 2 paragraph 17.

⁸⁶⁹ Burchell and Milton (2005) *supra* note 3 at 400–402; Snyman (2008) *supra* note 3 at 176; Burchell and Hunt (1997) *supra* note 3 at 175–176; Kaliski (2006) *supra* note 3 at 105; Africa in Tredoux (ed.) *supra* note 3 at 399; LAWSA (2004) *supra* note 3 at 69; Hiemstra (2008) *supra* note 3 at 13–24; Lansdown, AO and Campbell, J “South African Criminal Law and Procedure” (“Gardiner and Lansdown”) (1982) at 358 – 359; Van der Merwe, DP “Die Begrip verminderde Toerekeningsvatbaarheid en die Implementering daarvan” (1983) *TRW* at 172–181.

act or to act in accordance with such appreciation. Such person may, however, find it more difficult to act in accordance with such appreciation of the wrongfulness of his or her act and his or her powers of resistance may be less than the normal person⁸⁷⁰. In the discussion of psychopathy above, it was illustrated that in many of the cases where the accused persons suffered from psychopathy, this disorder was sufficient to establish extenuating circumstances⁸⁷¹. The principle is, however, not limited to psychopathy and accordingly all of the mental disorders discussed above which could perhaps not pass the insanity threshold, could nevertheless be sufficient to establish diminished criminal capacity. Diminished criminal capacity will thus not exculpate or exonerate, but will mitigate. In determining whether a finding of diminished criminal capacity should be rendered, a court will inadvertently turn to specialist psychiatric evidence in conjunction with all the other relevant evidence⁸⁷².

In respect of expert psychiatric evidence in extenuation, Zabow notes:⁸⁷³

“It is possible that recognising this patch of grey is consistent with psychiatric testimony which finds, sometimes to the frustration of lawyers, that a line cannot always be drawn between the various circumstances of human motivation and its consequent action.”

According to Zabow, the role of the forensic psychiatrist with regard to motivating extenuating circumstances can be found in the following areas:⁸⁷⁴

- The psychiatrist should provide a report providing guidelines to counsel to assess and detect psychological phenomena in an accused;
- Factors which diminish control in normal persons should be clarified and investigated as intensively as the factors in abnormal or insane persons;

⁸⁷⁰ Snyman (2008) *supra* note 3 at 176.

⁸⁷¹ See *S v J* *supra* note 676; *S v Lawrence* 1991 (2) PH (H) 74; *S v Lehnberg and Another* 1975(4) SA 553 (A); Du Toit *et al* (2008) *supra* note 3 at 13–23.

⁸⁷² Zabow, T “Psychiatric evidence in Extenuation: Assessment and Testimony in Homicide Defendants” (1989) *Medicine and Law* at 631-639.

⁸⁷³ Burchell and Milton (2005) *supra* note 3 at 401; *S v McBride* 1979 (4) SA 313 (W) at 319–320, 323 B–E.

⁸⁷⁴ Zabow (1989) *Medicine and Law* *supra* note 872 at 631–639.

- The possibility of brain dysfunction should be emphasised and assessed;
- Psychopathy and its specific personality traits must be assessed in each case;
- Emotional factors in serious violent offences are extremely important;
- Each individual has to be assessed in the light of anger, rage, irritability and fear;
- The effects of alcohol and drugs must be assessed;
- The extent of automatism and the role of amnesia should be assessed;
- The issue of remorse and its assessment becomes crucial;
- Each individual case must be studied on the backdrop of psychosocial history in order to assess possible psychiatric extenuation.

Zabow states that mitigating circumstances must relate to possible psychological abnormality but must also require a due consideration of the nature of impairment⁸⁷⁵.

Zabow encapsulates the fundamental role of expert evidence as follows:⁸⁷⁶

“Despite criticism, the active and continued use of mental health experts and facilities in the legal process remains of utmost importance. Both lawyers and psychiatric experts must understand that it is not the function of the expert witness, psychiatrist or psychologist to decide the question at issue. The decisions are legal issues to be determined by the court. Psychiatrists must continue to give evidence on what they know best, the psychiatric state of the accused.”

Slovenko states that the DSM-IV and the concomitant multiaxial system could also be useful in assessing diminished capacity⁸⁷⁷. Expert psychiatric and psychological evidence play a pivotal role in assessing extenuating circumstances for purposes of diminished criminal capacity. This fact was illustrated specifically

⁸⁷⁵ Zabow (1989) *Medicine and Law* *supra* note 872 at 636.

⁸⁷⁶ *Ibid.*

⁸⁷⁷ Slovenko (1995) *supra* note 3 at 166; Slovenko (2000) *supra* note 3 at 269. See also Melton *et al* (2008) *supra* note 3 at 220–225.

with regards to psychopathy. One substantial problem noticed in case law dealing with psychopathy was that often only one mental health expert testified. The latter results in an unbalanced view of the accused and could be detrimental for both the prosecution and the defence especially in the light of the fact that the court will only have one expert view to base its decision on. In the event of diminished criminal capacity the prosecution as well as the defence should also retain their own expert witnesses to provide a balanced view as to whether extenuating circumstances exist.

17 Conclusion

In this chapter the author illustrated the fundamental role of expert evidence in support of an assessment of competency to stand trial as well as the assessment of pathological criminal incapacity as a defence in criminal law. The present and the past roles of the mental health expert was extensively disseminated and assessed. The following conclusions can be drawn from the research presented in this chapter:

- Mental health professionals fulfill a vital and a crucial role in the assessment of competency to stand trial;
- The establishment of a fitness assessment unit could provide a useful alternative to referrals for observation and could prove to be less costly and time efficient. This unit could also provide a useful means to curb unsubstantiated referrals;
- Expert evidence plays a crucial role in the assessment of pathological criminal incapacity ;
- Defining the concept of “mental illness” or “mental defect” as threshold requirements for the establishment of pathological criminal incapacity remains controversial and constitutes a field where law and medicine do not always have consensus on;
- The DSM-IV plays a pivotal role in the definition and assessment of mental disorders as one of the main diagnostic references employed to diagnose an accused with a particular mental disorder or the identification of a

specific mental disorder which was present at the time of the commission of the offence;

- The recognition of specific diagnostic categories of disorders within the legal framework of the defence of pathological criminal incapacity is controversial and poses a problem to the proper application of the defence;
- Various mental disorders could be relevant for establishing the defence of pathological criminal incapacity. Reconciliation of diagnostic criteria with legal requirements for the defence is difficult and the need for proper and efficient expert evidence in respect of this issue is exacerbated;
- Despite the fact that statutory recognition of expert evidence in cases of pathological criminal incapacity is embodied statutorily, the application of the said expert evidence is often inconsistent;
- The diagnosis of psychopathy in conjunction with antisocial personality disorder remains controversial;
- Expert psychiatric evidence further plays a crucial role in establishing extenuating circumstances in support of diminished criminal capacity;
- The incorporation of two distinct pleas of incompetence to stand trial as well as criminal incapacity could provide an alternative to the current position in respect of competency to stand trial and criminal incapacity;
- Mental health professionals fulfill an indispensable function in the assessment of competency to stand trial as well as the defence of pathological criminal incapacity and the judicial recognition of this fact remains crucial in the determination and evaluation of this defence.

In the following chapter the author will evaluate the scientific nature and entity of psychiatric and psychological evidence in support of the defence of criminal incapacity.

“I think that in dealing with matters so obscure and difficult the two great professions of law and medicine ought rather to feel for each other’s difficulties than to speak harshly of each other’s shortcomings” (Sir James Fitzjames Stephen, 1883)