

**THE ROLE OF EXPERT EVIDENCE IN SUPPORT
OF THE DEFENCE OF CRIMINAL INCAPACITY**

BY GEERT PHILIP STEVENS

**SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS OF THE DEGREE**

DOCTOR LEGUM

DEPARTMENT OF PUBLIC LAW

THE FACULTY OF LAW

UNIVERSITY OF PRETORIA

PREPARED UNDER THE SUPERVISION OF

PROFESSOR J LE ROUX-BOUWER

FEBRUARY 2011

I (full names and surname): **Geert Philip Stevens**

Student number: 99069858

Module and subject of the assignment: LLD Thesis

Declaration:

1. I understand what plagiarism entails and am aware of the University's policy in this regard.
2. I declare that this LLD thesis (eg essay, report, project, assignment etc) is my own, original work. Where someone else's work was used (whether from a printed source, the internet or any other source) due acknowledgement was given and reference was made according to the requirements of the Faculty.
3. I did not make use of another student's previous work and submitted it as my own.
4. I did not allow and will not allow anyone to copy my work with the intention of presenting it as his or her own work.

SIGNED THIS DAY OF FEBRUARY 2011.

.....

“Some psychiatrists say that psychiatry and the law should never get into bed together and that the psychiatrist should keep completely away from the legal process. However, psychiatry, like other branches of medicine, has a great deal to offer in service of the administration of justice. Ensuring that it is a proper professional relationship and avoiding the risk of abuse, or accusations of prostitution, depend on the two professions learning each other’s language, paying attention to their respective codes of ethics, discovering their histories and customs and speaking to and listening to each other as a matter of course and not just when difficulties arise. The reward will be a mutually beneficial, fulfilling and lasting relationship between the medical and the legal profession and the delivery of justice.” (Rix, KJB “Psychiatry and Law: Uneasy Bedfellows” (2006) *Medico-Legal Journal* 158)

ACKNOWLEDGEMENTS

First and foremost I would like to thank God, my Lord and my Saviour who granted me the intellectual and emotional strength to accomplish this dream. *Soli Deo Gloria!*

I would like to thank my promoter, Professor Doctor Jolandi le Roux-Bouwer for her constant guidance, meticulous attention to detail and encouragement throughout the course of this study. Her strive for academic excellence was a constant source of inspiration for the completion of this dream.

To the three most important people in my life – my parents and my sister – words will never do justice in expressing my heartfelt gratitude for the love, support and encouragement you conveyed to me during the course of the completion of this dream – especially during the toughest and most challenging stages – this dream is dedicated in its entirety to you. Thank you for constantly being the *wind beneath my wings*.

I would like to thank my best friends Anne and Susan for constantly supporting me and encouraging me during the course of this study.

My special thanks to Wilna and Juanita for their joint efforts in the typing of this dissertation. My heartfelt gratitude especially goes out to Juanita for her assistance with the editing of this dissertation.

My special thanks to Nico for his expert assistance in the preparation of the bibliography.

To all my friends and colleagues at both the University of Pretoria as well as the University of South Africa who supported me during the course of this study – thank you.

I would also like to thank Doctor Paul De Wet at Weskoppies Hospital for providing me with invaluable practical insights pertaining to various aspects of this study.

As it is virtually impossible to thank each and every individual role player who played a role in my life during the years of finalisation of this dream, my gratitude also extends to all my friends and every individual who supported and encouraged me during the course of this study.

“May this dream be an inspiration to all those dreaming to achieve a dream!”

MODE OF CITATION AND REFERENCE TO SOURCES

In order to make the current thesis more user-friendly, the author has elected to abide by the following mode of citation and reference to sources relied upon in support of this study:

- Footnotes will be used throughout the course of this study in order to provide the requisite recognition to the various authorities used and also to ensure that the various sources are more accessible to other authors;
- In every chapter the footnotes will resume from footnote 1 with the implicit aim of making the reading of the respective chapters easier and more user-friendly;
- A complete list of authorities used during the course of this study is supplied at the end of this thesis by means of a bibliography. The latter will assist in rendering the sources more accessible to the reader, especially where more than one source of the same author is utilised (e.g Reddi, M);
- In the event of a specific source being utilised in a subsequent chapter, the full reference of such source will again be provided within the context of the subsequent chapter in order to render the source easier accessible to the reader.

SUMMARY

THE ROLE OF EXPERT EVIDENCE IN SUPPORT OF THE DEFENCE OF CRIMINAL INCAPACITY

by

GEERT PHILIP STEVENS

PROMOTER: PROF DR J LE ROUX-BOUWER

DEPARTMENT: PUBLIC LAW

DEGREE: *DOCTOR LEGUM*

The current study addresses the fundamental role of expert evidence advanced in support of the defence of criminal incapacity. It was endeavoured to illustrate that the scientific entities of forensic psychiatry and psychology fulfil an essential and pivotal role in establishing and assessing the defence of criminal incapacity. The study proposed to illustrate the interaction between the professions of law and medicine on the backdrop of the defence of criminal incapacity. Recommendations were provided with the aim of enhancing the dialogue between the professions of law and medicine when the defence of criminal incapacity falls to be assessed. The study was approached from a dual dimensional perspective illustrating both the need for mental health experts as well as the need for adequately trained and experienced mental health experts to provide expert testimony as to an accused's mental state when the defence of criminal incapacity is raised. The motivation for the current study is enumerated and the concepts of "criminal capacity", "non-pathological criminal incapacity", "pathological criminal incapacity" and "expert evidence" are, amongst others, conceptualized. It is indicated that expert evidence plays an essential role not only in cases where pathological criminal incapacity, or put differently, criminal incapacity attributable to mental illness or mental defect is raised, but also in instances where non-pathological criminal incapacity is raised as a defence. The role of the mental health expert is addressed with reference to battered woman syndrome evidence advanced in support of the defence of non-pathological criminal incapacity. It is illustrated that the defence of non-pathological criminal incapacity is in need of reform. It is in addition illustrated that legislative reform is essential to establish the defence of non-pathological criminal incapacity and to create legal certainty. The inconsistent approach in the application of expert evidence to the defence of criminal incapacity is emphasized

with specific focus on the semantic distinction between the defences of non-pathological criminal incapacity and pathological criminal incapacity. The role and application of the DSM-IV in the definition and assessment of mental disorders is addressed in conjunction with the various obstacles associated with the application of the DSM-IV to the defence of criminal incapacity. The nature and scope of the basic rules of expert evidence as they would apply to mental health professionals acting as expert witnesses in support of the defence of criminal incapacity are addressed. The assessment of the probative value of expert evidence is addressed and the complexities associated therewith are espoused. The numerous ethical dilemmas faced by mental health experts are illustrated and recommendations are provided aimed at eliminating these dilemmas. A comparative study of selected principles pertaining to expert evidence in the United States of America is embarked upon to illustrate the need for a codification of the rules of expert evidence as well as effective guidelines aimed at enhancing the scientific reliability and validity of expert evidence advanced in support of the defence of criminal incapacity. Finally, conclusions are drawn and motivated recommendations are made. Law reform is proposed in the form of draft proposals for legislative reform in respect of the defence of criminal incapacity as well as a draft ethical code of conduct for mental health experts providing expert testimony in cases where the defence of criminal incapacity is raised.

Key terms: criminal capacity; non-pathological criminal incapacity; pathological criminal incapacity; expert evidence; psychiatry; forensic psychiatry; psychology; forensic psychology.

SAMEVATTING

DIE ROL VAN DESKUNDIGE GETUIENIS TER ONDERSTEUNING VAN DIE VERWEER VAN ONTOEREKENINGSVATBAARHEID

deur

GEERT PHILIP STEVENS

PROMOTOR: PROF DR J LE ROUX-BOUWER

DEPARTEMENT: PUBLIEKREG

GRAAD: *DOCTOR LEGUM*

Die onderhawige studie ondersoek die fundamentele rol wat deskundige getuienis vervul ter ondersteuning van die verweer van ontoerekeningsvatbaarheid. Daar is gepoog om aan te toon dat die wetenskaplike entiteite van forensiese psigiatrie en sielkunde 'n wesentlike rol vervul ten einde die verweer van ontoerekeningsvatbaarheid te bewerkstellig. Die studie illustreer die wisselwerking tussen die reg en die medici teen die agtergrond van die verweer van ontoerekeningsvatbaarheid. Aanbevelings word verskaf met die oogmerk om die dialoog tussen die regslui en die mediese wetenskappe te bevorder in gevalle waar die verweer van ontoerekeningsvatbaarheid beoordeel moet word. Die studie is vanuit 'n tweeledig-dimensionele perspektief benader ten einde beide die behoefte aan geestesdeskundiges sowel as die behoefte aan genoegsaam gekwalifiseerde geestesdeskundiges te illustreer ten einde deskundige getuienis te lewer aangaande die geestestoestand van 'n beskuldigde in gevalle waar die verweer van ontoerekeningsvatbaarheid geopper word. Die motivering vir die onderhawige studie word uiteengesit en die begrippe "toerekeningsvatbaarheid"; "nie-patologiese ontoerekeningsvatbaarheid" en "deskundige getuienis" word, onder meer, gekonseptualiseer. Daar is aangetoon dat deskundige getuienis nie alleenlik 'n onmisbare funksie vervul in gevalle waar patologiese ontoerekeningsvatbaarheid, oftewel ontoerekeningsvatbaarheid wat toegeskryf word aan 'n geestesversteuring, geopper word nie, maar ook in gevalle waar die verweer van nie-patologiese ontoerekeningsvatbaarheid geopper word. Die rol van die geestesdeskundige word aangespreek ook met verwysing na mishandelde vrou sindroom-getuienis wat aangevoer word ter ondersteuning van die verweer van nie-patologiese ontoerekeningsvatbaarheid. Dit word geïllustreer dat die verweer van nie-patologiese ontoerekeningsvatbaarheid hervorming benodig. Dit

word aangetoon dat wets-hervorming noodsaaklik is ten einde die verweer van nie-patologiese ontoerekeningsvatbaarheid te bewerkstellig en regsekerheid te skep. Die teenstrydige benaderings tot die toepassing van deskundige getuienis tot die verweer van ontoerekeningsvatbaarheid word toegelig met spesifieke klem op die semantiese onderskeid wat getref word tussen die verweere van nie-patologiese – en patologiese ontoerekeningsvatbaarheid. Die rol en toepassing van die DSM-IV in die omskrywing en beoordeling van geestesversteurings word bespreek tesame met 'n toeligting van die verskeie struikelblokke verwant aan die toepassing van die DSM-IV ten aansien van die verweer van ontoerekeningsvatbaarheid. Die aard en omvang van die basiese reëls van deskundige getuienis word toegelig met spesifieke verwysing na die toepassing daarvan op geestesdeskundiges wat deskundige getuienis aflê ter ondersteuning van die verweer van ontoerekeningsvatbaarheid. Die beoordeling van die bewyswaarde van deskundige getuienis word toegelig en die problematiek daaraan verbonde word bespreek. Die onderskeie etiese vraagstukke wat geestesdeskundiges in die gesig staar word toegelig tesame met aanbevelings wat daarop gemik is om hierdie vraagstukke op te los. 'n Regsvergelykende studie ten aansien van geselekteerde beginsels rakende deskundige getuienis in die Verenigde State van Amerika word onderneem ten einde die waarde van 'n gekodifiseerde stel reëls van deskundige getuienis toe te lig asook om riglyne voor te stel wat daarop gemik is om die wetenskaplike betroubaarheid en geldigheid van deskundige getuienis te bevorder. Ten slotte is daar tot enkele gevolgtrekkings gekom en gemotiveerde aanbevelings is gemaak. Regshervorming word voorgestel in die vorm van konsepwets-hervormings rakende die verweer van ontoerekeningsvatbaarheid, asook 'n konsep etiese kode vir geestesdeskundiges wat deskundige getuienis lewer ter ondersteuning van die verweer van ontoerekeningsvatbaarheid.

Sleutelbegrippe: toerekeningsvatbaarheid; nie-patologiese ontoerekeningsvatbaarheid; patologiese ontoerekeningsvatbaarheid; deskundige getuienis; psigiatrie; forensiese psigiatrie; sielkunde; forensiese sielkunde.

TABLE OF CONTENTS

Acknowledgements.....	iii
Mode of citation and reference to sources	iv
Summary & Samevatting	v
Table of contents.....	ix
List of abbreviations	xviii

CHAPTER 1	
CONCEPTUALIZATION AND PROBLEM STATEMENT	
1	Introduction and orientation..... 1
2	Conceptualization..... 16
2.1	Criminal capacity..... 16
2.2	Non-pathological criminal incapacity..... 23
2.2.1	Emotional stress..... 27
2.2.2	Provocation..... 30
2.2.3	Battered woman syndrome..... 32
2.3	Pathological criminal incapacity..... 36
2.4	Diminished criminal capacity..... 38
2.5	Automatism..... 43
2.5.1	Sane automatism..... 47
2.5.2	Insane automatism..... 49
2.6	Expert evidence..... 50
2.7	Psychiatry..... 56
2.8	Forensic psychiatry..... 60
2.9	Clinical psychology..... 62
2.10	Forensic psychology..... 69
3	Problem statement and hypotheses..... 74
4	Central theoretical statement..... 76
5	Methodology..... 76

CHAPTER 2

**THE DEFENCE OF NON-PATHOLOGICAL CRIMINAL INCAPACITY:
ASSESSING THE FUNDAMENTAL NEED FOR EXPERT EVIDENCE AND
LEGAL CERTAINTY**

1	Introduction.....	79
2	Mode of discussion	85
3	Constitutional foundation	86
3.1	Introductory remarks.....	86
3.2	Development of the common law in terms of the indirect application of the Bill of Rights: section 39(2).....	97
3.3	Development of the common law in terms of the direct application of the Bill of Rights: section 8(3).....	104
3.4	Other rights in the Bill of Rights relevant to the defence of non-pathological criminal incapacity	108
3.4.1	Human dignity.....	108
3.4.2	Freedom and security of the person.....	109
3.4.3	Privacy.....	111
3.4.4	Access to information	112
3.4.5	Right to a fair trial.....	113
3.4.6	Limitation of rights	116
4	Reflections on the history and development of the defence of non-pathological criminal incapacity	117
4.1	Position before <i>S v Chretien</i>.....	117
4.2	Position after <i>S v Chretien</i>.....	117
5	Reflections on a general defence of criminal incapacity: Description of cause of mental inability irrelevant.....	120
6	Lack of criminal capacity to be distinguished from sane automatism ..	125
7	Burden of proof	137
8	Defence of non-pathological criminal incapacity ought not to succeed easily.....	143
9	Expert evidence	144
9.1	Traditional approach in respect of expert evidence	144
9.2	Essential need for expert evidence in support of the defence of non-pathological criminal incapacity	152

10	Referral in terms of section 78(2) and 79 of the Criminal Procedure Act where the defence of non-pathological criminal incapacity is raised....	161
11	Principles of expert evidence through the cases	170
11.1	Expert evidence should consist of scientific and specialized knowledge.....	170
11.2	Value of expert evidence dependent on the cogency and truthfulness of the accused’s version of the events.....	179
11.3	Expert evidence well established.....	189
11.4	Personality and character of the accused irrelevant when assessing the merit of the defence of non-pathological criminal incapacity	196
11.5	Sane automatism distinguished from non-pathological criminal incapacity – expert evidence should pertain to the particular defence raised	205
11.6	Criminal incapacity should not be confined to a state where mental illness or mental defect is present – emotional factors can also lead to a lack of criminal incapacity	220
11.7	Lapse of time between commission of crime and mental health assessment – a factor to take into account when assessing the value of expert evidence	227
11.8	Accused’s conduct after the commission of the crime.....	233
12	The impact of section 79(7) on the defence of non-pathological criminal incapacity	237
13	Provocation and non-pathological criminal incapacity.....	241
13.1	General background on provocation as a defence.....	241
13.2	The controversial decision of <i>S v Eadie</i> 2002 (3) SA 719 (SCA).....	247
13.2.1	Academic opinion advanced in respect of the <i>Eadie</i> -decision	259
13.2.2	The future of the defence of non-pathological criminal incapacity.....	273
13.2.3	The role of expert evidence in provocation as per the <i>Eadie</i> -decision..	275
14	Intoxication and non-pathological criminal incapacity	282
14.1	General background on intoxication as a defence	282
14.2	The role of expert evidence in cases of intoxication.....	290
15	Battered woman syndrome and non-pathological criminal incapacity .	298
15.1	General background on battered woman syndrome	299
15.2	The psychosocial dynamics of an abusive relationship	303

15.2.1	Domestic violence and manifestations of abuse.....	303
15.2.2	Myths and misconceptions surrounding the battered woman.....	310
15.2.3	The psychological profile of the battered woman <i>versus</i> the batterer ..	316
15.2.4	The cycle of violence.....	318
15.2.5	The theory of learned helplessness.....	321
15.2.6	The theory of coercive control	324
15.2.6.1	Methodology and techniques of coercive control	330
15.2.6.2	The Stockholm syndrome.....	334
15.2.7	The compliant victim of coercive persuasion or “brainwashing”	336
15.2.7.1	The history of brainwashing.....	337
15.2.7.2	Brainwashing defined	337
15.2.7.3	Brainwashing and the battered woman.....	339
15.2.7.4	The compliant victim of the sexual sadist.....	342
15.3	The role of expert evidence in cases of battered woman syndrome	353
16	Amnesia and non-pathological criminal incapacity	379
16.1	Sources of amnesia.....	382
16.1.1	Alcohol	382
16.1.2	Epilepsy.....	383
16.1.3	Head trauma.....	384
16.1.4	Psychogenic amnesia or “dissociative amnesia”	384
16.2	The legal approach to amnesia	392
16.3	Malingering or “simulated amnesia”	397
16.4	Assessment of amnesia.....	398
17	Diminished criminal capacity	400
18	Conclusion	411

CHAPTER 3

PATHOLOGICAL CRIMINAL INCAPACITY AND THE CONCEPTUAL INTERFACE BETWEEN LAW AND MEDICINE

1	Introduction.....	413
2	Constitutional foundation	423
2.1	Equality.....	423
2.2	Privacy.....	424
2.3	Access to information	425

2.4	Arrested, detained and accused persons.....	426
3	Historical development of the defence of pathological criminal incapacity	426
3.1	Position before 1977.....	426
3.2	Reflections on the recommendations of the Rumpff-Commission	431
4	Defining and assessing competency to stand trial	441
4.1	General	441
4.2.1	The role of the mental health expert in the observation and report on the accused’s mental status.....	453
4.3	Appeal and review	464
4.4	Re-establishing triability by means of psychotropic medication	465
4.5	Guidelines in assessing competency to stand trial.....	469
4.6	Cost implications of a referral for observation and the establishment of a fitness assessment unit.....	474
5	Analysis and assessment of pathological criminal incapacity	476
5.1	Capacity to appreciate the wrongfulness of the act (insight or cognitive capacity)	481
5.1.1	The meaning of “appreciation”	483
5.2	The capacity to act in accordance with an appreciation of the wrongfulness of an act (self-control or conative capacity)	484
6	Defining and assessing “mental illness” and “mental defect” as threshold requirements in support of the defence of pathological criminal incapacity	493
6.1	A conceptual analysis of mental illness and mental defect.....	496
6.2	The medical model of mental illness	511
6.3	The legal model of mental illness.....	517
6.4	A cross dimensional concept of mental illness.....	518
7	The role and application of the DSM-IV and the ICD-10 in assessing pathological criminal incapacity	520
7.1	The DSM definition of mental disorder	527
7.2	The DSM cautionary statement and the use of the DSM in forensic settings	529
7.3	Multiaxial assessment.....	531
8	Clinical disorders of legal significance	535

8.1	Delirium and dementia as manifestations of cognitive disorders.....	537
8.1.1	Delirium	538
8.1.1.1	Substance induced delirium.....	539
8.1.2	Dementia	541
8.1.2.1	Dementia due to Huntington’s disease	543
8.2	Schizophrenia	550
8.2.1	Schizophrenia, violence and criminal capacity	563
8.3	Postpartum psychosis	573
8.4	Depression	578
8.5	Anxiety disorders: post-traumatic stress disorder.....	585
8.6	Dissociative disorders: dissociative identity disorder/“multiple personality disorder”	591
8.7	Psychopathy and antisocial personality disorder	601
8.8	Paraphilias and sex offending.....	635
9	Towards a plea of non-triability and criminal incapacity	645
10	The causal <i>nexus</i> between mental illness and impairment of the cognitive and conative capacities in the incapacity enquiry	645
11	Burden of proof	647
12	Procedural aspects of the defence of pathological criminal incapacity.....	652
13	Referral for observation by the panel of experts for purposes of the enquiry and the role of expert evidence	654
14	Admissibility of statements by an accused during the enquiry	663
15	Disposition of the insanity acquittee	666
16	Diminished criminal capacity	668
17	Conclusion	670

<p>CHAPTER 4</p> <p>THE ROLE OF FORENSIC EXPERT EVIDENCE IN ESTABLISHING CRIMINAL INCAPACITY</p>
--

1	Introduction.....	673
2	Constitutional foundation	680
3	The foundational principles of expert evidence	681
3.1	Relevance and the rules of expert evidence	681
3.2	The Expertise rule.....	684

3.3	The Common knowledge rule.....	688
3.4	The Ultimate issue rule	690
3.5	The Basis rule	702
4	The probative value and weight of expert evidence	709
5	The presentation and evaluation of expert evidence	715
5.1	Adversarial <i>versus</i> Inquisitorial systems of justice	715
5.2	The role of the expert	719
5.3	Pre-trial consultations and disclosure.....	724
5.4	Oral <i>versus</i> documentary evidence	727
5.5	Cross-examination of expert witnesses	729
6	Ethical issues pertaining to the forensic assessment conducted by experts.....	734
6.1	Bias and the so-called “hired guns”	734
6.2	Dual relationships.....	737
6.3	Confidentiality.....	742
7	The forensic report	744
7.1	Content of the forensic report	745
7.1.1	Reason for referral.....	745
7.1.2	Collateral data and sources of information.....	746
7.1.3	Personal background information	746
7.1.4	Mental status examination, clinical findings and the psychiatric diagnosis.....	747
7.1.5	The forensic opinion	747
7.2	Style and structure of the forensic report	748
8	A draft ethical code for mental health professionals serving as expert witnesses	751
9	Conclusion	754

<p>CHAPTER 5</p> <p>MASTERING FORENSIC EXPERT EVIDENCE: REFLECTIONS FROM THE UNITED STATES OF AMERICA</p>

1	Introduction.....	756
2	Mode of discussion	760
3	Constitutional foundation	761

4	Setting the stage: From Frye to the Federal Rules of Evidence.....	763
4.1	Relevance.....	767
4.2	The Expertise Rule	769
4.3	The Basis Rule.....	771
4.4	The Ultimate Issue Rule	774
5	Scientific reliability and validity of expert evidence by mental health experts – applying the <i>Daubert</i> resolutions	784
6	Ethical considerations pertaining to forensic psychiatry and psychology.....	801
6.1	Forensic psychiatry and the ethical guidelines for the practice of forensic psychiatry.....	801
6.1.1	Preamble to the ethics guidelines for the practice of forensic psychiatry.....	802
6.1.2	Confidentiality.....	803
6.1.3	Consent	803
6.1.4	Honesty and striving for objectivity.....	804
6.1.5	Qualifications	805
6.2	Forensic psychology and the ethical guidelines for the practice of forensic psychology.....	805
6.2.1	Purpose and scope of the speciality guidelines for forensic psychologists	806
6.2.2	Responsibility	807
6.2.3	Competence	807
6.2.4	Relationships	808
6.2.5	Confidentiality and privilege.....	810
6.2.6	Methods and procedures	810
6.2.7	Public and professional communications.....	811
7	Conclusion	813

<p>CHAPTER 6</p> <p>CONCLUSION AND RECOMMENDATIONS</p>
--

1	Introduction	815
2	Synopsis	819
2.1	Chapter 1	819



2.2	Chapter 2	820
2.3	Chapter 3	821
2.4	Chapter 4	823
2.5	Chapter 5	824
3	Conclusions.....	825
4	Recommendations	828
5	Proposals.....	839
6	Possible criticisms and <i>lacunae</i> in respect of research	848
7	Implications and possibilities for further research	850
8	Synthesis	851
	 Bibliography	 853

LIST OF ABBREVIATIONS

A.2d	Atlantic 2 nd series
AAPL	American Academy of Psychiatry and the Law
All ER	All England Reports
Am Psychiatr Assoc. J	American Psychiatric Association Journal
Aust NZ J Psychiatry	Australia/New Zealand Journal of Psychiatry
B	Botswana Supreme Court
BCLR	Butterworths Constitutional Law Reports
Bot	Botswana (Appeal Court)
Bull Am Acad Psychiatry	Bulletin of the American Academy for Psychiatry
Calif. L. Rev	California Law Review
CC	Constitutional Court
CCC	Canadian Criminal Cases
CILSA	Comparative and International Law Journal of South Africa
Columbia L Rev.	Columbia Law Review
CPD	Cape Provincial Division

Crim. L. Bull.	Criminal Law Bulletin
CRR	Criminal Record Report
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders 4 th ed.
EDLD	Eastern District Local Division
EPD	Eastern Provincial Division
ER	English Reports
F. 2d	Federal 2 nd series
F. Supp	Federal Supplement
GNR	Government notice regulation
HPCSA	Health Professions Council of South Africa
LAWSA	(Joubert) The Law of South Africa
Louisiana L. Rev.	Louisiana Law Review
LRQ	Law Review Quarterly
Med Sci Law	Medicine, Science and the Law
Merc. L. Rev.	Mercer Law Review
Nm	Namibia High Court
NPD	Natal Provincial Division

P.2d	Pacific 2 nd series
PH H	Prentice-Hall Reports section H
POWA	People Opposing Women Abuse
R	Rhodesia
RA	Rhodesia, Appellate Division
RAU	Rand Afrikaans University (now called University of Johannesburg (UJ))
Rutgers L. Rev.	Rutgers Law Review
SA	South African Law Reports
SACC	South African Journal of Criminal Law and Criminology
SACJ	South African Journal of Criminal Justice
SACR	South African Criminal Reports
SAJHR	South African Journal of Human Rights
SALJ	South African Law Journal
SAPM	South African Practice Management
SC	Supreme Court
SCA	Supreme Court of Appeal

SCC	Supreme Court of Canada
SCR	Supreme Court Reports (of Canada)
SE	South Eastern Cape Local Division
SMU Law Review	Southern Methodist University Law Review
So.2d	Southern Reporter
Stell LR	Stellenbosch Law Review
S.W.	South Western
SWA	South West Africa
THRHR	Tydskrif vir Hedendaagse Romeins-Hollandse Reg
TPD	Transvaal Provincial Division
TRW	Tydskrif vir Regswetenskap
TSAR	Tydskrif vir die Suid-Afrikaanse Reg
UC Davis L. Rev	University College of Davis Law Review
U. Chi. L. Rev.	University of Chicago Law Review
U. Chi. L. Sch.	University of Chicago Law School
Unisa	University of South Africa
UP	University of Pretoria

US	United States
VA L. Rev	Virginia Law Review
WITS	University of the Witwatersrand
WLD	Witwatersrand Local Division
W. Res. L. Rev.	Western Reserve Law Review
Yale LR	Yale Law Review
ZH	Zimbabwe High Court

CHAPTER 1

CONCEPTUALIZATION AND PROBLEM STATEMENT

1 Introduction and orientation

“Where law ends, discretion begins.
And the exercise of discretion may mean either
beneficence or tyranny, either justice or injustice,
either reasonableness or arbitrariness.”

(Davis, 1984)

There is a growing awareness of the need for exploring the fundamental goals of the legal profession as opposed to the professions of psychiatry and psychology. The social, ethical and legal implications of their interaction within a constitutional framework have become a critical issue. Within the context of the defence of criminal incapacity the interface between law and medicine is a subject of considerable debate and controversy.

Presently the defence of criminal incapacity is becoming a popular defence, but many substantive, procedural and evidential questions about this defence remain unresolved. One area in particular where the defence of criminal incapacity becomes controversial is the question as to the role that mental health professionals, and more particular, psychiatrists and psychologists, should play in the assessment, evaluation and support of this defence.¹ The defence of criminal incapacity and the role of psychiatric and psychological evidence present a multifaceted challenge to the South African criminal justice system. This study is aimed at providing a dissemination of the interaction between law, psychiatry and psychology within the framework of the defence of criminal incapacity.

¹ The defence of criminal incapacity is embodied in sections 77–79 of the Criminal Procedure Act 51 of 1977 (hereafter the “Criminal Procedure Act”). In terms of these sections only a psychiatrist and psychologist are mentioned with reference to mental health professionals conducting a psycho-legal assessment. See also Snyman, CR “Criminal Law” 5th ed. (2008) at 159–178.

The defence of criminal incapacity necessarily manifests in one of two particular defences, being “non-pathological criminal incapacity” and “pathological criminal incapacity.”² Non-pathological criminal incapacity, in brief, denotes those situations of incapacity not attributable to a mental illness or mental defect or a pathological disturbance of the mental faculties, whereas “pathological” criminal incapacity means “emanating from a disease”.³ It is precisely within this distinction between these two classifications of criminal incapacity where the interface between law and mental health becomes blurred, as will clearly be explained later.

Psychiatrists and psychologists are generally sceptical as to the validity and necessity of the defence of non-pathological criminal incapacity.⁴ In terms of the Criminal Procedure Act, expert evidence from a psychiatrist or psychologist is not imperative in cases where the defence of non-pathological criminal incapacity is relied upon.⁵ A court in the latter instance merely retains a discretionary power to refer an accused for observation.⁶

In cases where pathological criminal incapacity is raised, a court is obliged to refer an accused for observation in terms of the Criminal Procedure Act. In the case of pathological criminal incapacity, expert psychiatric and psychological evidence is thus provided for within a legislative framework, whereas the same does not inadvertently apply to cases of non-pathological incapacity, where expert evidence is not a prerequisite for the defence to succeed. The question that arises is whether this distinction with reference to the necessity of psychiatric and psychological evidence in support of a defence of criminal incapacity, is a valid

² Van Oosten, FFW “Non-pathological criminal incapacity versus pathological criminal incapacity” SACJ (1993) at 127. The terms “non-pathological” and “pathological” criminal incapacity will be discussed later in this chapter. See also Kaliski, SZ “Psycholegal Assessment in South Africa” (2006) at 38.

³ Snyman (2008) *supra* note 1 at 163.

⁴ *S v Eadie* 2002 (1) SACR 663 (SCA). At 669 Navsa JA stated the following in respect of psychiatric evidence led by Dr Sean Kaliski: “It is clear from his evidence that he is sceptical of the defence in question. In 90 percent of the cases in which he testified the defence was the same as the one raised in the present case. In his experience the defence has never been successfully established”.

⁵ See s 78(2) of the Criminal Procedure Act 51 of 1977. This section will be discussed comprehensively in chapter 2 *infra*.

⁶ Such a referral occurs in terms of s 79 of the Criminal Procedure Act. This section could also be construed as the foundational principle for empowering the interaction of law with the fields of psychiatry and psychology.

one. Should expert evidence, and more particularly, the need for expert evidence, be dependent on the alleged cause of criminal incapacity? Can a defence of criminal incapacity ever be successfully established in the absence of psychiatric and psychological evidence in support thereof?

The author submits that, due to the inherent nature and complexity of the defence, expert evidence should be a prerequisite in any case where the defence of criminal incapacity is raised, regardless of the cause of the incapacity.

Requiring expert evidence is, however, not the only obstacle. In order for psychiatric and psychological evidence to render value in cases of criminal incapacity, the defence of criminal incapacity in all spheres should be acknowledged within the medical profession. If the defence of non-pathological criminal incapacity is not fully recognized and comprehended within the medical field, it suffices to state that the expert evidence in support of such defence will lack probative value. Within the domain of pathological criminal incapacity, the threshold requirement for the defence is “mental illness” or “mental defect”. The question to be asked is: What constitutes a mental disease or defect?⁷ According to Slovenko a proper definition of mental disease or defect is problematic as a result of the simultaneous need to have the concept governed by legal concepts of responsibility and blame, and also to have it governed by medical criteria of mental disorder.⁸ The concept of mental disease or mental defect is fundamental to the practice of psychiatry. The term “mental illness or defect” is a legal term and not a medical term.⁹ Thus what a psychiatrist or a psychologist might deem as a mental disorder or mental illness, will not necessarily be in line with statutory requirements for the presence of a “mental illness” or “mental defect”.¹⁰ The question that arises is: Should the process of defining a “mental illness” or “mental defect” be a legal prerogative or essentially a medical one?

⁷ Slovenko, R “Psychiatry in law – Law in Psychiatry” (2002) 189 at 248; Slovenko, R “Psychiatry and Criminal Culpability” (1995) at 133.

⁸ Slovenko (2002) *supra* note 7 at 247.

⁹ Louw, R “Principles of Criminal Law: Pathological and Non-pathological criminal incapacity” in Kaliski (ed)(2006) *supra* note 2 at 47.

¹⁰ Louw in Kaliski (ed)(2006) *supra* note 2 at 46.

The Mental Health Care Act¹¹ defines mental illness as:

“‘Mental illness’ means 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.”

Psychiatrists and psychologists usually assess an accused in terms of the diagnostic criteria as set forth in the Diagnostic and Statistical Manual of Mental Disorders.¹² The Diagnostic and Statistical Manual of Mental Disorders, however, contains the following *caveat*:¹³

“The purpose (of the DSM) is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigations to diagnose, communicate about, study, and treat the 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 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.”

This *caveat* provides an example of one of the areas where law and medicine go separate ways. Incorporating psychiatric methodologies and diagnostic categories into the framework of the defence of criminal incapacity presents substantive as well as evidentiary obstacles. One of the core areas where the latter statement proves to be true is with reference to the battered woman who kills her abusive partner.¹⁴ The legal position of an abused woman who kills her abusive partner is

¹¹ 17 of 2002. This definition is not binding in a criminal trial. See Louw in Kaliski (ed)(2006) *supra* note 2 at 46.

¹² American Psychiatric Association. “Diagnostic and Statistical Manual of Mental Disorders” DSM-IV edition revised. Hereafter “DSM-IV”.

¹³ DSM-IV p xxiii. See also Slovenko (2002) *supra* note 8 at 258.

¹⁴ For purposes of this discussion the term “battered woman” will be used as this is the term generally used to refer to situations of the battered woman syndrome. Reference to this term should not be construed as being gender specific.

an area within the South African criminal justice system that is clouded with controversy.¹⁵ This controversy becomes evident especially in cases where a woman is charged with the murder of her abusive partner or husband in a non-confrontational situation. Criminal incapacity is one of the defences available to an abused woman who kills her abusive partner.

The phenomenon of battered women who kill their abusive husbands or partners is increasing rapidly. The majority of battered women who kill, do so in the wake of defending themselves against an attack by their partners.¹⁶ A smaller percentage of women who kill their abusers are more passive or hire third parties to carry out the killings on their behalf.¹⁷

The former group of women generally rely on the defence of private defence. It is, however, the latter group that currently pose a challenge to the criminal justice system. If the defence of non-pathological criminal incapacity is available to battered women, the question that arises is why this defence is not achieving more success in practice? The battered woman syndrome is not classified as a mental disorder in terms of the DSM-IV which excludes reliance on pathological criminal incapacity. Because of the fact that non-pathological incapacity is not caused by a mental illness or mental defect but rather by some altered mental state, the accused cannot rely on a known mental illness as a defence.¹⁸

Due to the fact that battered woman syndrome is not a recognized mental illness in terms of diagnostic criteria, the only possible route at this stage is for the battered woman to introduce evidence in support of a claim that she suffers from

¹⁵ See *S v Campher* 1987 (1) SA 940 (A); *S v Engelbrecht* 2005 (2) SACR 41 (WLD); *S v Ferreira* 2004 (2) SACR 454 (SCA); *S v Wiid* 1990 (1) SACR 561 (A).

¹⁶ Ludsin, H and Vetten, L "Spiral of Entrapment – Abused women in Conflict with the Law" (2005) at 7.

¹⁷ Ludsin and Vetten (2005) *supra* note 16 at 11. See also *S v Ferreira* 2004 (2) SACR 454 (SCA).

¹⁸ Carstens, PA and Le Roux J "The defence of non-pathological incapacity with reference to the battered wife who kills her abusive husband" (2000) SACJ at 180. See also Strauss, SA "Nie-Patologiese ontoerekeningsvatbaarheid as verweer in die Strafreg: 'n Nuwe uitdaging vir deskundige mediese getuienis" (1995) SAPM at 14.

post-traumatic stress disorder.¹⁹ Browne²⁰ notes that most battered women who kill do not appear to be mentally ill. Ludsin and Vetten summarise the difficult plight of the battered woman by stating:²¹

“Women suffering from BWS or PTSD, however, may find that their disorders are too pathological for a finding of non-pathological criminal incapacity and yet not sufficiently pathological for insanity. They could be excluded from both defences on the basis of such diagnosis.”

This quote strikingly summarizes the difficult situation that battered women find themselves in and accordingly emphasizes the need for research in this regard. The central issue with reference to the battered woman syndrome controversy centres not so much in searching for the most appropriate defence for the battered woman, but rather on the expert psychiatric and psychological evidence in support of such defence. In the absence of such evidence, it is submitted that any defence relied upon in support of the battered woman syndrome will be difficult to prove. In the light of psychiatric scepticism regarding non-pathological criminal incapacity the problem is further exacerbated. The question that accordingly arises is whether psychologists and more importantly, forensic psychologists with experience and training in respect of the battered woman syndrome, would not serve a more vital role in explaining the intrinsic phenomena associated with the battered woman syndrome.²²

Walker also states that the evidence, and more specifically, the expert evidence, has a crucial bearing on the outcome of any homicide case in which the accused

¹⁹ Ludsin and Vetten (2005) *supra* note 16 at 168; Walker, LE “The Battered Woman” (1979) at 265-270; Carstens and Le Roux (2000) *SACJ supra* note 18 at 185–186.

²⁰ Brown, A “When Battered Women kill” (1987) at 176.

²¹ Ludsin and Vetten (2005) *supra* note 16 at 168.

²² In *S v Kensley* 1995 (1) SACR 646 (A) the court on appeal referred to the following evidence of a psychiatrist who testified: “The main thrust of Dr G’s work and experience is forensic psychiatry. He made it clear that he was *au fait* with the content of the term “criminal capacity” but that that, and the word ‘automatism’ in relation to persons not suffering from any pathology were legal terms not psychiatric ones ... He was satisfied that at the time of the events in question, the appellant suffered from **no pathology recognized in psychiatry**, he knew what he was doing and was capable of controlling his actions” (at 652i–653b).

is a battered woman.²³ Walker notes that in her experience as an expert witness, admissibility issues concerning expert evidence are problematic.²⁴ She explains:²⁵

“The informed expert witness is the only person, in these cases, qualified to point out that the psychological reality of these women justifies their actions.”

Walker takes the view that battered women kill because they perceive it as the only way to escape a physically life-threatening and emotionally and psychologically unbearable situation.²⁶

It is submitted that expert psychological evidence plays a pivotal role in support of battered woman syndrome.

Ludsin and Vetten state:²⁷

“Abused women who kill who are charged with murder need to provide expert testimony of the psychological effects of abuse on women generally, and the accused particularly, in order to provide the factual foundation for a defence or mitigation of sentence. Without this information, it may be impossible for a court to understand how a woman’s actions fit within any of the defences or why her circumstances justify mitigation of sentence.”

Ludsin and Vetten state that the context in which abused women resort to killing their abusive partners, is crucial in aiding and assisting courts in understanding the multifarious circumstances trapping abused women within abusive relationships.²⁸ It is accordingly the role of the expert witness to take this information and apply it

²³ Walker, LE “Terrifying Love – Why Battered Women kill and How society responds” (1989) at 267. Dr Lenore Walker is referred to as the “mother” of the Battered woman syndrome.

²⁴ Walker (1989) *supra* note 23 at 266.

²⁵ Walker (1989) *supra* note 23 at 267.

²⁶ *Ibid.*

²⁷ Ludsin and Vetten (2005) *supra* note 16 at 192.

²⁸ Ludsin and Vetten (2005) *supra* note 16 at 93.

to the specific circumstances of the case in order for the court to properly and adequately understand the abused woman's actions.²⁹

From the above it is clear that expert evidence in support of the battered woman syndrome is pivotal. The battered woman syndrome and the crucial necessity of expert evidence in support thereof will also be used as an example in this study to canvass the need for expert evidence in support of the defence of non-pathological criminal incapacity as battered women will in many instances of abuse that results in killing, rely on the defence of non-pathological criminal incapacity as a defence. The Criminal Procedure Act currently affords a court a discretionary capacity to refer an accused person for observation when reliance is placed on the defence of non-pathological criminal incapacity.³⁰ A question that arises is whether provision should not be made in terms of a diagnostic framework for the battered woman syndrome? This will inevitably provide for the defence of pathological criminal incapacity in terms of which a court is obliged to refer an accused for observation by medical experts.³¹

A contributory factor to the controversial nature of the defence of criminal incapacity, specifically with reference to non-pathological criminal incapacity, lies in the acknowledgement of the fundamental differences between the professions of psychiatry and psychology.

Psychiatrists are primarily orientated to assess, evaluate and treat mental disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders IV.³² Psychiatry is thus a medical specialty. Within the defence of criminal incapacity, psychiatry will play a pivotal role in support of the defence of

²⁹ *Ibid.*

³⁰ S 78(2). This section will be discussed in detail in chapter 2 *infra*.

³¹ Carstens and Le Roux (2000) *SACJ supra* note 18 at 189. It is interesting to note that Walker states that she was asked whether there were any typologies or classification systems which list battered women as a category. She replied that the DSM revision group, which is authorised to develop the then new DSM III were considering including it as a new category. Walker also notes that there was debate about listing various subcategories under the Post Traumatic Stress Disorder diagnosis. See Walker (1989) *supra* note 23 at 269–270. The current DSM-IV does, however, not contain these subcategories. The question can be asked whether the time has not arrived for medicine to meet law halfway in this regard.

³² Kaliski (2006) *supra* note 2 at 377.

pathological criminal incapacity. Psychiatry is also probably one of the most complex fields of medical specialisation.³³ Psychologists, and more specifically, clinical psychologists, are more involved with the emotional and psychological factors that contribute to mental states.³⁴

Tredoux also states that the main difference between psychiatry and psychology is that psychiatry is a medical specialisation which is more likely to approach psychological problems and phenomena from a biological and chemical treatment perspective.³⁵ According to Tredoux, psychiatry is generally interested in a narrower range of mental and behavioural phenomena than psychology.³⁶

With the abovementioned distinction in mind, the question that inevitably falls to be determined is whether the particular type of mental health professional who presents expert evidence in a case where criminal incapacity is raised, does not necessarily determine the quality and probative value of the testimony? Is a psychologist not a more appropriate mental health professional to evaluate a battered woman as battered woman syndrome is not a listed category constituting a mental illness?

Law and Medicine are probably two of the oldest professions. The investigation and exploration of the human mind is fascinating and intriguing, but also highly specialized and complex. This becomes evident whenever the defence of criminal incapacity is raised. Because of the complexity of this defence, the interface between law and medicine in the support and assessment of this defence becomes a zone of conflict.

Redmayne states:³⁷

³³ Carstens, PA and Pearmain, D "Foundational Principles of South African Medical Law" (2007) at 745. (Hereafter referred to as "Carstens and Pearmain").

³⁴ Kaliski (2006) *supra* note 2 at 378.

³⁵ Tredoux, C, Foster, D, Allan, A, Cohen, A and Wassenaar, D "Psychology and Law" (2005) at 8. (Hereafter "Tredoux *et al*").

³⁶ *Ibid.*

³⁷ Redmayne, M "Expert Evidence and Scientific Disagreement" (1997) *U C Davis L. Rev* at 1027.

“The relationship between Science and Law (is) ... a marriage of opposites, ... a conflict between rival systems, ... a clash of cultures.”

A possible reason for the conflict could be traced to the challenges posed by system specialization.³⁸

The disciplines of psychiatry, psychology and law have different traditions and methods of reasoning.³⁹ Kaliski notes:⁴⁰

“Clinicians and Lawyers are like long-married couples that still struggle to understand each other despite their mutual dependence.”

Kaliski in addition notes that the interaction of mental health professionals within the legal domain has shaped the development and interpretation of the law and its practice.⁴¹ Kaliski is of the view, and this view is supported, that forensic mental health issues are currently contributing to the difficulties in achieving a successful interface between the professions of law and medicine.⁴²

In respect of the conflict between psychology and law, Tredoux states:⁴³

“Psychology and law are disciplines that are, from several vantage points, worlds apart. One is a Maverick johnny-come-lately, born out of sheer curiosity in the nineteenth century European laboratories, and always ready to tackle apparently imponderable questions with empirical methods. The other is an august order that traces its lineage to the writings of the ancients, and steers itself through a profound reverence for authority, an anachronism perhaps in a world dominated by Sciences and technologies.

³⁸ Wolff, N “Interactions between Mental Health and Law Enforcement Systems, Problems and Prospects for Cooperation” *Journal of Health Politics, Policy and Law* (1998) at 133 as accessed on <http://jhppl.dukejournals.org/cgi/content/abstract/23/1/133>. [Accessed on 2008/07/03].

³⁹ Mandalo, MJ “Towards a Standard for the admissibility and Evaluation of Psychiatric Evidence in War Crimes” (2000) LLM dissertation Georgetown University Law Centre at 10.

⁴⁰ Kaliski (2006) *supra* note 2 at 1.

⁴¹ *Ibid.*

⁴² *Ibid*

⁴³ Tredoux *et al* (2005) *supra* note 35 at iii.

These are strange but habitual bedfellows. Their interaction are many, and take various forms.”

The disciplines of psychiatry, psychology and law have somewhat different traditions and methodologies and have as such often been referred to as “a highly neurotic, conflict ridden ambivalent affair”.⁴⁴ Rix⁴⁵ takes the view that some of the causes of the uneasiness between medicine and law can be identified as lack of proper communication, different models, unrealistic expectations and role conflict. Rix in addition states that mental health professionals and legal practitioners come from different backgrounds.⁴⁶ Mental health professionals have their medical model and legal practitioners have their legal model.⁴⁷ Rix indicates that a possible cause of the conflict between law and medicine could also be traced to the fact that the medical model is both holistic and deterministic as opposed to the legal model that is essentially based on free will.⁴⁸

Melton, Petrilla, Poythress and Slobogin state that there are various attitudinal differences between medicine and law specifically pertaining to the perception that

⁴⁴ Redding, R “Psychology and the law: How common-sense Psychology can inform Law and Psycholegal Research” (1998) U. Chi. L. Sch. Roundtable 107 at 111 as quoted in Mandalo (2000) *supra* note 39 at 10. With reference to the value of psychiatry, Mandalo also states: “It can define for the law those mental functions that need to be studied for a meaningful and sophisticated understanding of the operations of the human mind. In this interaction, it can seek the answers to questions related to diagnosis and treatment of mental disorders and pose the behavioral questions that biology needs to answer if we are to have an advanced understanding of the functioning of mental processes.”

⁴⁵ Rix, KJ “Psychiatry and the Law: Uneasy Bedfellows” (2006) *Medico-legal Journal* vol 74 Part 4, 148–159 at 148.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ Rix (2006) *supra* note 45 at 149. Determinism is a doctrine in terms of which the fate of human beings is determined by factors beyond their control. An individual’s destiny, according to this doctrine is already decided for him. Within the criminal law context this entails that the individual’s psychological make-up establishes whether he or she will be a criminal or not. A person’s psychological make-up is thus the inevitable product of the cells of one’s body. See Strauss, SA “Doctor, Patient and the law: A Selection of Practical Issues” 3rd ed (1991) at 121–135. The extreme form of determinism argues that all mentally ill persons are incapable of making free choices because of their unconscious and neurotic impulses and if all criminal behaviour is equated with mental illness, the criminal is sick and not responsible for his actions. Rix (2006) *supra* note 45 at 149. Opposite to the doctrine of determinism stands the doctrine of indeterminism according to which the human will is essentially free and is not predestined to any particular line of conduct. Human beings are accordingly responsible for their conduct. The traditional system of criminal justice is based on this premise. See Strauss (1991) *supra* note 48 at 121. See also Strauss, SA “Rechtsaspekte van geestesversteurdheid – Legal aspects of mental disorder” (1971) *THRHR* at 1. See also Snyman (2008) *supra* note 1 at 157.

often exists that lawyers tend to be concerned mainly with the sanctity of legal principles in the abstract and with the protection of civil liberties for persons.⁴⁹ Mental health professionals, on the other hand, are often perceived as paternalistic and prone to be motivated by a need to help and to cure regardless of the effect this has on liberty.⁵⁰

Melton *et al* also state that one of the main problem areas between law and mental health can be found in the differing interpretations they support pertaining to the role of probability assessments.⁵¹ Although the Sciences are inherently probabilistic in their understanding of truth, the law demands at least the appearance of certainty as the result of the magnitude and irrevocability of decisions that have to be delivered in law.⁵²

Strauss notes that law is essentially a normative science that would generally aim to establish its own norms for defining legally relevant facts, but that modern science should be fully acknowledged in all spheres of law.⁵³ Strauss notes further that psychiatry is in essence a therapeutic science and that neither the law nor the medical profession should be granted the sole prerogative of determining the definition and assessment of criminal responsibility.⁵⁴ Strauss correctly states that a balance has to be struck between law and medicine.⁵⁵

The relationship between psychiatric concepts and legal concepts is indicative of how psychiatry and the law are increasingly making an advance in speaking in the

⁴⁹ Melton, G, Petrilla, J, Poythress, N, Slobogin, C “Psychological Evaluations for the Courts – A Handbook for Mental Health Professionals and lawyers” 3rd ed (2007) at 6. (Hereafter Melton *et al*).

⁵⁰ Melton *et al* (2007) *supra* note 49 at 6.

⁵¹ Melton *et al* (2007) *supra* note 49 at 11.

⁵² Melton *et al* (2007) *supra* note 49 at 11 express the following caution: “There is a danger that, because of the law’s preference for certainty, experts will overreify their observations and reach beyond legitimate interpretations of the data in order both to appear “expert” and to provide usable opinions. Similarly, legal decision-makers may discard testimony properly given in terms of probabilities as “speculative”, and may defer instead to experts whose judgments are expressed in concrete opinions of what did or will happen. The result is a less properly informed court. The risk of distorting the fact-finding process is particularly great in the behavioral Sciences ...” (at 11).

⁵³ Strauss (1971) *THRHR supra* note 48 at 8.

⁵⁴ Strauss (1971) *THRHR supra* note 48 at 8.

⁵⁵ *Ibid.*

same or similar terms. Mandalo notes that the law is essentially aimed at achieving social policy goals and the protection of the community against those who violate societal norms.⁵⁶ Psychiatry, on the other hand, is primarily concerned with the causes of human behaviour.⁵⁷ These fundamental differences in these disciplines pose serious obstacles for the legal system. Mandalo correctly notes that “the intersection of psychiatry and law is a very difficult and delicate balance.”⁵⁸

Samuels notes that there is frequently a degree of tension between doctors and legal professionals which is not always negative, but more often than not there exists a level of ignorance, frustration, aggression and rejection which can be prejudicial and counterproductive to the interests of the accused, the public as well as these two professions respectively.⁵⁹

The purpose and aim of this study is to enhance the understanding of the interface between psychiatry, psychology and law within the context of the defence of criminal incapacity. This study aims at providing a framework for a more cooperative dialogue between law and medicine when the defence of criminal incapacity has to be determined. This study will provide a contribution to the current legal jurisprudence on contemporary issues and also serve as a dissemination of important research findings in respect of the role of expert

⁵⁶ Mandalo (2000) *supra* note 39 at 12.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.* See also Dahl, P “Legal and Psychiatric Concepts and the Use of Psychiatric Evidence in Criminal Trials” (1985) *Cal. L. Rev* at 411.

⁵⁹ Samuels, A “Mental Condition as a defence in Criminal Law: A lawyer addresses medical men” (1988) *Med-Sci. Law* vol 28 no 1. See also Bromberg, W “Psychiatrists in Court: The psychiatrist’s view” (1969) *American Journal of Psychiatry* no 125 1343–1347 at 1343 where it is stated with reference to the different philosophical approaches: “The one must find ‘blame’ and subsequent punishment for the offender, the other wishes to help the individual.” See also Glueck, S “Law and Psychiatry – Cold War or *Entente Cordiale*” (1962) as quoted in the “Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters” RP 69/1967 paragraph 1-12 (hereafter “The Rumpff Report”) where he states: “Lawyers tend to look upon psychiatrists as fuzzy apologists for criminals, while psychiatrists tend to regard lawyers as devious and cunning phrasemongers.” Kriegler, J and Kruger, A “Hiemstra - Suid-Afrikaanse Strafproses” 6th ed (2007) at 204 (hereafter “Hiemstra”) state: “Die psigiatrie sien die mens as ‘n geheel en dinamies, die psigiatrie wil behandel, nie veroordeel nie. Die Straffreg wil weet of dit regverdigbaar is om ‘n persoon strafbaar te hou vir sy daad.”

psychiatric and psychological evidence in support of the defence of criminal incapacity.

A further crucial issue at the crossroads of law, psychiatry and psychology is the weight and probative value attached to the expert evidence of the particular psychiatrist or psychologist.

Within the domain of the defence of criminal incapacity, psychiatrists and psychologists testifying in respect of these defences are expert witnesses. Expert evidence is a form of opinion evidence which is generally inadmissible unless the subject enquiry and the facts in dispute are of such a nature that the Court is in need of assistance from experts in the field in order to arrive at an informed judgment. The question as to the admissibility of such evidence is dependent on the relevance of such opinion.⁶⁰ The exclusion of opinion evidence is predicated upon the premise of protecting the function of the fact-finder or judicial authority and accordingly that a witness delivering an opinion should not usurp the function of the Court.⁶¹ The latter theory is also often referred to as the “Ultimate issue” principle.⁶² This principle entails that a witness cannot express an opinion about final issues which only the Court can decide upon.⁶³ The question to be asked is whether the “ultimate issue” principle is of any relevance when considering the admissibility of expert opinion? The fact remains that it is still within the Court’s own discretion to decide what weight should be attached to such evidence. Within the domain of the defence of criminal incapacity, expert witnesses can educate jurors about scientific or other technical or specialised information that is unlikely to be known by jurors and that will help them decide a case more fairly. In this type of testimony, the expert is not specifically addressing whether an accused did

⁶⁰ Schwikkard, PJ and Van der Merwe, SE “Principles of Evidence” (2009) at 83-103; Zeffert, DT and Paizes, AP “The South African law of Evidence” (2009) at 309.

⁶¹ Schwikkard and Van der Merwe (2009) *supra* note 60 at 83.

⁶² *Ibid.*

⁶³ Schwikkard and Van der Merwe (2009) *supra* note 60 at 83; Zeffert and Paizes (2009) *supra* note 60 at 309-310; *R v Vilbro and Another* 1957(3) SA 223 (A); *Holtzhauzen v Roodt* 1997 (4) SA 766 (W); *S v Kalogoropoulos* 1993 (1) SACR 12 (A) at 22 D-E.

or did not do something, but rather educating the Court about expert knowledge relevant to the disputed facts.⁶⁴

A further aim of this study is to conduct an examination of the rules of opinion evidence and more specifically, expert evidence within the domain of the defence of criminal incapacity. The proper role and place of the psychiatrists and psychologists serving as expert witnesses within the ambit of psycholegal assessments will be carefully analysed and dissected followed by scientifically substantiated recommendations for improving the roles of these professions with reference to the defence of criminal incapacity. Rules regarding the admissibility, reliability and validity of expert psychiatric and psychological evidence will be scrutinized.

Probably one of the most important cornerstones of this study will be a thorough exposition of the Constitutional relevance of this topic.⁶⁵ In order for this study to render a valuable contribution to current South African legal jurisprudence, the Constitutional relevance of this research will be addressed throughout this study.⁶⁶

With reference to the Constitutional underpinning of this study, the following quote from Burchell is important:⁶⁷

⁶⁴ Sales, BD and Shuman, DW “Experts in Court – Reconciling Law, Science and Professional knowledge” (2005) at 3.

⁶⁵ Constitution of the Republic of South Africa 108 of 1996.

⁶⁶ Specifically with reference to chapter 2 of the Constitution – “Bill of Rights”. Various fundamental rights contained in the Bill of Rights will be addressed in this study. The relevant sections are:

S 8 “Application”

S 9 “Equality”

S 10 “Human dignity”

S 12 “Freedom and Security of the Person”

S 14 “Privacy”

S 32 “Access to information”

S 35 “Arrested, detained and accused persons”

S 36 “Limitation of Rights”

S 39 “Interpretation of Bill of Rights”

These sections, or the relevant portions thereof, will be discussed throughout this study where applicable.

⁶⁷ Burchell, J “Criminal Justice at the Crossroads” (2002) *SALJ* 579 at 590.

“The values carved in Constitutional Stone provide the template for the system of criminal justice both in its existing and any future form. There is no question about the applicability of the Bill of Rights in the 1996 Constitution to the Criminal law.”

The Rumpff report correctly asserts that it is essentially required from the psychologist and psychiatrist, on the one hand, to display a sense of responsibility in respect of the views of society and the purpose and essence of punishment. On the other hand, it is required of the jurist and the public to display a sense of acknowledgment for the development of psychiatric and psychological knowledge.⁶⁸

2 Conceptualization

Before a clear demarcation of the various aspects pertaining to expert evidence in support of the defence of criminal incapacity can be embarked upon, a precise definition of the essential concepts that will be encountered in this study, will be provided.

2.1 Criminal Capacity

In the criminal law *mens rea* (culpability or fault) on the part of the perpetrator is a prerequisite for criminal liability. *Mens rea* within this context refers to a blameworthy state of mind with which a perpetrator acts.⁶⁹

In the Roman law as well as the Roman-Dutch law the principle of *nulla poena sine culpa* prevailed that entailed that there would be no punishment without *mens rea*.⁷⁰

⁶⁸ Rumpff Report *supra* note 59 at paragraph 1.20.

⁶⁹ Rumpff Report *supra* note 59 at paragraph 2.1. See also Du Plessis, JR “The Extension of the Ambit of Ontoerekeningsvatbaarheid to the Defence of Provocation – A Strafrekwetenskaplike Development of Doubtful Practical Value” (1987) SACJ vol 104 at 539. Du Plessis notes at 539 that criminal capacity or “Toerekeningsvatbaarheid” as it is described in the article has several different translations such as criminal accountability, criminal responsibility, criminal capacity, the ability to attract criminal liability and criminal imputability. Du Plessis also notes that the term is derived from the German term “Zurechnungsfähigkeit”.

Criminal law is further concerned with the question of responsibility which entails the accountability of a specific individual for a crime by reason of his or her *mens rea*.⁷¹ *Mens rea* presupposes the presence of mental faculties that enable the person refrain from acting with the necessary *mens rea*.⁷²

Before it can be said that a person acted with culpability, he or she must have possessed the necessary criminal capacity.⁷³ Criminal capacity is accordingly an important prerequisite for criminal liability.⁷⁴

In LAWSA⁷⁵ the following is stated:

“South African criminal law is based on the doctrine of indetermination. It proceeds from the premise that the human will is essentially free and that people can accordingly be held liable for their unlawful conduct. Criminal responsibility, however, forms the basis of and is an absolute prerequisite for criminal liability for any offence. More particularly, criminal responsibility is generally viewed as being a prerequisite for *mens rea*.”

It was not until the nineteenth century that the question of responsibility or criminal capacity was regarded as a separate doctrine.⁷⁶

Visser and Maré note:⁷⁷

⁷⁰ Rumpff Report *supra* note 59 at paragraph 2.1.

⁷¹ Rumpff Report *supra* note 59 at paragraph 9.1.

⁷² Rumpff Report *supra* note 59 at paragraph 9.1.

⁷³ Snyman (2008) *supra* note 1 at 159; Burchell, J and Milton, J “Principles of Criminal Law” (2005) at 358.

⁷⁴ Hiemstra (2007) *supra* note 59 at 202; *S v Laubscher* 1988 (1) SA 163 (A); *S v Lesch* 1983 (1) SA 814 (EPD).

⁷⁵ Joubert, WA and Faris, JA “The Law of South Africa” 2nd ed vol 6 (2004) at 61 paragraph 72. (Hereafter “LAWSA”).

⁷⁶ Rumpff Report *supra* note 59 at paragraph 2.7. See also De Wet, JC and Swanepoel, HL “Strafreg” (1975) at 106 where it is noted: “Eers in die negentiende eeu is die leerstuk van toerekeningsvatbaarheid as ‘n selfstandige onder-afdeling van die skuldleer erken, altans deur Vastelandse kriminaliste.”

⁷⁷ Visser, PJ and Maré, MC “Visser and Vorster’s General Principles of Criminal Law through the Cases” 3rd ed (1990) at 305.

“In our opinion criminal accountability is a separate element of every offence: It may well be directly connected to culpability but it does not form part of culpability.”

De Wet and Swanepoel draw a clear distinction between criminal capacity and *mens rea*.⁷⁸

“Die toerekeningsvatbaarheidsvraag het te doen met die persoon se geestesvermoëns, en is ‘n selfstandige vraag naas die vraag of die persoon met die een of ander gesindheid gehandel het. Om skuld te hê moet die persoon toerekeningsvatbaar wees en met ‘n bepaalde gesindheid handel.”

It is accordingly clear from the above that the concept of criminal capacity should be distinguished from culpability.⁷⁹

Snyman defines criminal capacity as follows:⁸⁰

“A person is endowed with capacity if he has the mental abilities required by the law to be held responsible and liable for his unlawful conduct.”

and further:

“The mental abilities which a person must have in order to have criminal capacity, are:

- (1) the ability to appreciate the wrongfulness of his conduct, and
- (2) the ability to conduct himself in accordance with such an appreciation of the wrongfulness of his conduct.”

Criminal capacity is defined in LAWSA in similar terms:⁸¹

⁷⁸ De Wet and Swanepoel (1975) *supra* note 76 at 106-107.

⁷⁹ In *S v Adams* 1986 (4) SA 882 (A) at 889 Viljoen JA also noted that criminal capacity is a prerequisite for criminal liability and should be distinguished from intention. See also *S v Lesch* 1983 (1) SA 814 (EPD) at D–E.

⁸⁰ Snyman (2008) *supra* note 1 at 160.

⁸¹ LAWSA (2004) *supra* note 75 at 62 paragraph 73.

“Criminal responsibility or criminal capacity (*toerekeningsvatbaarheid*), is a concept relating to the mental ability of an accused at the time of the alleged offence. An accused is generally said to be criminally responsible if at the time of the alleged offence his or her mental ability was such that he or she could distinguish between right and wrong and act in accordance with the insight.”

Burchell and Milton state:⁸²

“Persons are responsible for their criminal conduct only if the prosecution proves, beyond reasonable doubt, that at the time the conduct was perpetrated they possessed criminal capacity or, in other words, the psychological capacities of insight and for self-control.”

The Rumpff report states that psychology perceives the composition of the human personality as:⁸³

“... a dynamic integration of psychophysical functions by which purposeful behaviour is made possible. This means in the first place that mind and body constitute a whole: the mental functions are very closely integrated with the physiological and biochemical reactions in the body.”

As such the physical changes within the body can alter mental functions and conversely, mental processes can result in physical changes.⁸⁴ The Rumpff report in addition notes that the majority of physical reactions are reflexive and the individual will in most instances have no control over these reactions.⁸⁵ The Rumpff report, however, states the following:⁸⁶

⁸² Burchell and Milton (2005) *supra* note 73 at 358.

⁸³ Rumpff Report *supra* note 59 at paragraph 9.7.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

“But when it comes to a voluntary muscular activity it is a different matter altogether, for then the person is able to control his behaviour by exercising his will. The normal personality is therefore not the slave of morbid urges or impulses welling up within him. He is able deliberately to inhibit them.”

The Rumpff report distinguishes three categories of mental function that are of relevance to the concept of criminal capacity: the cognitive, conative and affective mental functions.⁸⁷

- (i) Cognitive functions: these functions include one’s ability of perceiving, thinking, reasoning, remembering, insight and conceiving.
- (ii) Conative or Volitional functions: these functions relate to a person’s ability or capacity to control his or her behaviour by the voluntary exercise of his or her free will.
- (iii) Affective functions: these functions relate to the capacity for emotional feelings such as anger, hatred, mercy or jealousy.⁸⁸

According to the Rumpff report in the conduct of a normal person the cognitive, conative and affective functions form an integrated unit.⁸⁹

With reference to the psychological foundation of responsibility, the Rumpff report states:⁹⁰

“Two psychological factors render a person responsible for his voluntary acts: first, the free choice, decision and voluntary action of which he is capable, and secondly, his capacity to distinguish between right and wrong, good and evil (insight) before committing the act.”

⁸⁷ Rumpff Report *supra* note 59 at paragraph 9.9; Burchell, J and Milton, J “Cases and Materials on Criminal Law” 3rd ed (2007) at 336; Hiemstra (2007) *supra* note 59 at 204. See also Snyman (2008) *supra* note 1 at 161-162; Burchell and Milton (2005) *supra* note 73 at 358.

⁸⁸ Burchell and Milton (2005) *supra* note 73 at 358.

⁸⁹ Rumpff Report *supra* note 59 at paragraph 9.10.

⁹⁰ Rumpff Report *supra* note 59 at paragraph 9.30.

As such the two psychological factors which render a person responsible for his voluntary actions, namely free choice and the capacity to distinguish between right and wrong, are factors which have resulted in the fundamental two psychological criteria of criminal responsibility, namely insight and self-control or powers of resistance, being established in numerous legal systems.⁹¹

The Rumpff report defines “self-control” as:⁹²

“... a disposition of the perpetrator through which his insight into the unlawful nature of a particular act can restrain him from, and thus set up a counter-motive to, its execution. Self-control is simply the force which insight into the unlawfulness of the proposed act can exercise in that it constitutes a counter-motive.”

A person, whose cognitive or conative capacities were significantly impaired, will accordingly not be held criminally liable.⁹³

Burchell and Milton state the following:⁹⁴

“Therefore the test for determining whether an accused had criminal capacity is whether the accused had the capacity to appreciate the wrongfulness of his or her conduct and the capacity to act in accordance with this appreciation.”

In *S v Laubscher*⁹⁵ Joubert J A confirmed the definition of criminal capacity by stating the following:⁹⁶

⁹¹ Rumpff Report *supra* note 59 at paragraph 9.32. See also Van Oosten (1993) *SACJ* at 127. See also Snyman (2008) *supra* note 1 at 160-162; *S v Johnson* 1969 (1) SA 201 (A) at 204 E; *S v Lesch* 1983 (1) SA 814 (O) at 823 A-B; *S v Campher* 1987 (1) SA 940 (A) at 965 D-E; *S v Calitz* 1990 (1) SACR 119 (A) at 126 D; Burchell and Milton (2005) *supra* note 73 at 358.

⁹² Rumpff Report *supra* note 59 at paragraph 9.33.

⁹³ Burchell and Milton (2005) *supra* note 73 at 358.

⁹⁴ *Ibid.*

⁹⁵ *S v Laubscher* 1988 (1) SA 163 (A).

⁹⁶ At 166 G–167 A. See also *S v Eadie* (1) 2001 (1) SACR 172 (CPD) at 177 C-H; *S v Lesch* 1983 (1) SA 814 (O) at 823 A-B; *S v Calitz* 1990 (1) SACR 119 (A) at 126 D; *S v Mahlinza* 1967 (1) SA 408 (A) at 414 G-H.

“Om toerekeningsvatbaar te wees, moet ‘n dader se geestesvermoëns of psigiese gesteldheid sodanig wees dat hy regtens vir sy gedrag geblameer kan word. Die erkende psigologiese kenmerke van toerekeningsvatbaarheid is:

1. Die vermoë om tussen reg en verkeerd te onderskei. Die dader het die onderskeidingsvermoë om die regmatigheid of onregmatigheid van sy handeling in te sien. Met ander woorde, hy het die vermoë om te besef dat hy wederregtelik optree.
2. Die vermoë om ooreenkomstig daardie onderskeidingsvermoë te handel deurdat hy die *weerstandkrag* (wilsbeheervermoë) het om die versoeking om wederregtelik te handel, te weerstaan. Met ander woorde, hy het die vermoë tot vrye keuse om regmatig of onregmatig te handel, onderworpe aan sy wil.

Ontbreek een van hierdie twee psigologiese kenmerke dan is die dader ontoerekeningsvatbaar, bv. waar hy nie die onderskeidingsvermoë het om die ongeoorlooftheid van sy handeling te besef nie. Insgelyks is die dader tog ontoerekeningsvatbaar waar sy geestesvermoë sodanig is dat hy nie die weerstandkrag het nie ten spyte daarvan dat hy wel die onderskeidingsvermoë het.”⁹⁷

For purposes of this study, criminal capacity will be defined as:

⁹⁷ See also *S v Mahliha* 1967 (1) SA 408 (A) at 414 G–H; *S v Chretien* 1981 (1) SA 1097 (A) at 1106 E–F; *S v Van Vuuren* 1983 (1) SA 12 (A) at 17 G–H; Lambrechts, H “‘n Ondersoek na nie-patologiese ontoerekeningsvatbaarheid en die regverdiging vir die voortbestaan van gesonde outomatisme en aan-verwante verwere in die Suid-Afrikaanse Strafreë” (2005) - Unpublished LLD thesis University of the Free State at 24; Nel, PW “Toerekeningsvatbaarheid in die Suid-Afrikaanse Strafreë” (2008) - Unpublished LLM dissertation at 7–10. See also *S v Lesch* 1983 (1) SA 814 (EPD) at 823 A–H. See also Burchell, EM and Hunt, PMA “South African Criminal Law and Procedure – General Principles of Criminal Law” (1997) vol 1 at 35 where they state: “The accused must have the requisite criminal capacity (or capacity for fault) before he or she can be convicted. Capacity means the capacity to appreciate the wrongfulness of the conduct and the capacity to act in accordance with that appreciation.” See also De Wet, JC and Swanepoel, HL “Die Suid-Afrikaanse Strafreë” (1960) 2nd ed at 99 where it is stated: “Vandag word in ons reg, net soos in die Nederlandse, Duitse, Oostenrykse en Switserse reg, die houding ingeneem dat die geestesvermoëns, waarop dit aankom, die vermoë is om tussen reg en onreg te onderskei en die vermoë om ooreenkomstig daardie insig te handel.”

- (i) The mental ability to distinguish between right and wrong, and
- (ii) the mental ability of appreciating the wrongfulness of an act or omission, and
- (iii) the mental ability of acting in accordance with an appreciation of the wrongfulness of an act or omission.⁹⁸

2.2 Non-Pathological Criminal Incapacity

Non-pathological criminal incapacity denotes those situations where an accused relies on the defence of criminal incapacity where the cause of the incapacity was not attributable to some term or manifestation of a mental illness or other pathological disturbance of the mind.

Snyman defines non-pathological criminal incapacity as follows:⁹⁹

“Non-pathological criminal incapacity’ refers to cases in which X alleges that, although he lacked capacity at the time of the act, the incapacity was not attributable to a pathological (‘emanating from a disease’) mental disturbance.”

In *S v Laubscher*¹⁰⁰, the term “non-pathological criminal incapacity” was coined for the first time by Joubert J A:¹⁰¹

“Afgesien van statutêre ontoerekeningsvatbaarheid kan ‘n mens ook nie-patologiese ontoerekeningsvatbaarheid van ‘n tydelike aard ten tyde van die pleeg van die misdaad kry wat aan ‘n nie-patologiese toestand, d.w.s.

⁹⁸ This definition also denotes the current defence of pathological criminal incapacity as set forth in section 78(1) of the Criminal Procedure Act 51 of 1977. This defence will be discussed comprehensively in chapter 3 *infra*. See Bergenthuin, JG “Die algemene toerekeningsvatbaarheids-maatstaf” (1985) *De Jure* 273 at 282 where criminal capacity is defined: “Iemand wat ‘n handeling verrig wat ‘n misdryf uitmaak en wat ten tye van so ‘n verrigting nie oor die vermoë beskik om – (a) die ongeoorlooftheid van sy handeling te besef nie, of (b) ooreenkomstig ‘n besef van die ongeoorlooftheid van sy handeling op te tree nie, is nie vir so ‘n handeling strafregtelik toerekenbaar nie.”

⁹⁹ Snyman, CR “Criminal Law” (2002) at 163.

¹⁰⁰ *S v Laubscher* 1988 (1) SA 163 (A).

¹⁰¹ At 167 F–H.

nie aan 'n geestesongesteldheid of geestesgebrek in die vorm van 'n patologiese versteuring van sy geestesvermoëns toe te skryf is nie, te wyte sodat hy nie die onderskeidingsvermoë óf die weerstandskrag (wilsbeheervermoë) gehad het nie.”

Synonymous terminology that have also been used by our courts to describe this condition are also “non-pathological criminal incapacity of a temporary nature”¹⁰² as well as “temporary mental disturbance”.¹⁰³

In *S v Arnold*¹⁰⁴, Burger J noted:¹⁰⁵

“It is therefore logical to say that it is not only youth, mental disorder or intoxication which could lead to a state of criminal incapacity, but also incapacity caused by other factors such as extreme emotional stress.”

In *S v Gesualdo*,¹⁰⁶ Borchers J held:¹⁰⁷

“For many years the courts of this country and of others have accepted that a sane individual (i.e. one free from mental illness), who can distinguish between right and wrong, may be subjected to such mental or emotional pressures that he may not be able to control his actions.”

In *S v Kok*¹⁰⁸, Scott JA stated the following in respect of the distinctive nature of the defence of non-pathological criminal incapacity:¹⁰⁹

¹⁰² *S v Campher* 1987 (1) SA 940 (A) at 954 F–G the phrase “tydelike aantasting van die geestesvermoëns” was used.

¹⁰³ As translated from the phrase “tydelike geestesversteuring”. In *S v Campher supra* note 102 the terminology of “tydelike verstandelike beneweling” was also used (at 965 H and 966 F–G). See also Van der Merwe, FW “Nie-Patologiese Ontoerekeningsvatbaarheid as Verweer in die Suid-Afrikaanse Strafreg” (1996) - Unpublished LLM dissertation Unisa at 15. See also *S v Calitz* 1990 (1) SACR 119 (A) at 127 D-I.

¹⁰⁴ *S v Arnold* 1985 (3) SA 256 CPD.

¹⁰⁵ At 264 C – D.

¹⁰⁶ *S v Gesualdo* 1997 (2) SACR 68 (WLD).

¹⁰⁷ At I-J.

¹⁰⁸ *S v Kok* 2001 (2) SACR 106 (SCA).

¹⁰⁹ At 110 H-J.

“At common law a distinction has been drawn in the past between lack of criminal capacity arising from a pathological disturbance of the mental faculties, whether temporary or permanent, on the one hand, and lack of criminal capacity arising from some non-pathological cause which is of a temporary nature on the other.”

In *S v Eadie*¹¹⁰, Griesel J held that traditionally in our common law there existed only two distinct categories of persons who lacked criminal incapacity, namely children under the age of seven years and persons who were found to be insane.¹¹¹ Since the 1980's, however, the latter categories have been extended first in respect of intoxicated persons and later to persons who acted under severe provocation.¹¹² The latter category became known as non-pathological criminal incapacity which Griesel J described as follows:¹¹³

“Such incapacity can arise from a variety of causes, which have variously been described as ‘emotional collapse’, ‘emotional stress’, total disintegration of the personality, or it may be attributed to factors such as shock, fear, anger or tension.”

Hector supports an alternative definition to the abovementioned description, by stating the following:¹¹⁴

“In South African law a two-fold classification exists for incapacity, based on the source of the incapacity. Where the incapacity is due to mental illness, it is classified as pathological incapacity. All other sources of incapacity – the sources identified up to this point in South African law are youthfulness, intoxication, provocation and emotional stress – fall within the classification of non-pathological incapacity.”

Van der Merwe also states:¹¹⁵

¹¹⁰ *S v Eadie* 2001 (1) SACR 172 (CPD).

¹¹¹ At 177 D-F. See also *S v Eadie* (2) 2002 (1) SACR 663 at 673 J–674 G.

¹¹² *Ibid.*

¹¹³ *Ibid.*

¹¹⁴ Hector, S “Road rage and reasoning about responsibility” (2001) *SACJ* vol 14 195 at 199.

“Dit gaan dus om die persoon se geestesvermoë of geestestoestand ten tye van die pleeg van die beweerde misdaad. Bogenoemde geestestoestand moet van ‘n tydelike aard wees (wat nie aan ‘n geestessiekte of –afwyking toe te skryf is nie) ...”

Strauss defines non-pathological criminal incapacity as follows:¹¹⁶

“Dit word nou as ‘n selfstandige verweer in strafsake erken en kom daarop neer dat ‘n heftige gemoedsbeweging in uiterste omstandighede ‘n beskuldigde volkome van strafregtelike aanspreeklikheid kan onthef selfs wanneer ‘n ernstige misdaad soos moord hom ten laste gelê is en hy beslis nie geestesongesteld is nie.”

Snyman further states the following:¹¹⁷

“... ontoerekeningsvatbaarheid wat nie te wyte is aan ‘n patologiese toestand nie, maar aan ‘n tydelike wanfunksionering van die dader se geestesvermoëns, welke wanfunksionering ‘n verskeidenheid van oorsake kan hê, soos provokasie, dronkenskap, skok, emosionele spanning of vrees.”

In *S v Eadie*¹¹⁸, Navsa J A held:¹¹⁹

“In our law, criminal incapacity due to mental illness is classified as pathological incapacity. Where it is due to factors such as intoxication, provocation and emotional stress, it is termed non-pathological incapacity.”

¹¹⁵ Van der Merwe, RP “Sielkundige Perspektiewe op Tydelike Nie-patologiese Ontoerekeningsvatbaarheid” (1997) *Obiter* 139 at 139.

¹¹⁶ Strauss (1995) *SAPM supra* note 18 at 14.

¹¹⁷ Snyman, CR “Die Verweer van nie-patologiese ontoerekeningsvatbaarheid in die Strafreg” (1989) *TRW* at 4; Meintjes-Van der Walt, L “Making a muddle into a mess?: The Amendment of s 78 of the Criminal Procedure Act” (2002) *SACJ* at 242; Carstens and Le Roux (2000) *SACJ supra* note 18 at 180.

¹¹⁸ *S v Eadie* 2002 (1) SACR 663 (SCA).

¹¹⁹ At 673 J–674 A.

For purposes of this study non-pathological criminal incapacity will be defined as: The temporary inability or incapacity of a person to distinguish between right and wrong in order to appreciate the wrongfulness of his or her conduct and the inability or incapacity to act in accordance with such an appreciation as a result of factors that are not attributable to a mental illness in the form of a pathological disturbance of a person's mental faculties.

2.2.1 Emotional Stress

Aristotle (384 – 322 BC) provides one of the earliest definitions of emotion by stating:¹²⁰

“Emotion is that which leads one's condition to become so transformed that his judgment is affected, and which is accompanied by pleasure and pain. Examples of emotion include anger, fear, pity, and the like, as well as opposites of these.”

As Reily¹²¹ correctly observes, emotion is very important as it displays a person's character. This is achieved in a negative sense to the extent that a person's character reveals an inability to control impulsive behaviour. If a person's moral training and ethical principles are strong, the stronger his or her control over his or her emotion will be.¹²²

The term “emotional stress” is frequently encountered within the ambit of the defence of non-pathological criminal incapacity and a proper understanding of this term is thus necessary. The term is usually phrased within the context of either “emotion” or “stress”.

¹²⁰ As quoted in Reily, A “The heart of the matter: Emotion in Criminal Defences” (1997) *Ottawa Law Review* vol 29 p 117 at 123. For a discussion on the interaction between law and emotion see Maroney, T “Law and Emotion: A Proposed Taxonomy of an Emerging Field” (2006) *Law and Human Behaviour* at 119–142 where it is argued that the legal relevance of emotion is significant and also deserving of close scrutiny and assessment.

¹²¹ Reily (1997) *supra* note 120 at 123.

¹²² *Ibid.*

Black defines emotion as:¹²³

“A strong feeling of hate, love, sorrow and the like arising within a person and not as a result, necessarily, of conscious activity of the mind.”

Stress is defined as:¹²⁴

“the consequence of the failure to adapt to change. It is, in medical terms, the consequence of the disruption of homeostasis through physical or psychological stimuli. Less simply: it’s the condition that results when person-environment interaction leads someone to perceive a painful discrepancy, real or imagined, between the demands of a situation on the one hand and their social, biological, or psychological resources on the other. Stressful stimuli can be mental, physiological, anatomical or physical.”

Low defines emotional stress as follows:¹²⁵

“... emotional stress suggests a build-up of stressful circumstances over a period of time.”

Low also states correctly that the concepts of provocation and emotional stress should be distinguished.¹²⁶ It is submitted that this view is correct.

In *McClellan v Commonwealth*¹²⁷ the concept of “extreme emotional disturbance” was defined as follows:

¹²³ Black, HC “Black’s Law Dictionary” (1990) 6th ed at 524.

¹²⁴ Wikipedia Encyclopaedia as accessed on <http://en.wikipedia.org/wiki/stress> - (medicine) [accessed on 2009/03/02].

¹²⁵ Low in Kaliski (ed) (2006) *supra* note 2 at 51.

¹²⁶ Low in Kaliski (ed) (2006) *supra* note 2 at 51.

¹²⁷ *McClellan v Commonwealth* 715 SW 2d 464 at 468–469 (k y 1986).

“Extreme emotional disturbance is a temporary state of mind so enraged, inflamed, or disturbed as to overcome one’s judgment, and to cause one to act uncontrollably from the impelling force of the extreme emotional disturbance rather than from evil or malicious purposes. It is not a mental disease in itself, and an enraged, inflamed, or disturbed emotional state does not constitute an extreme emotional disturbance unless there is a reasonable explanation or excuse therefore, the reasonableness of which is to be determined from the viewpoint of a person in the defendant’s situation under circumstances as defendant believed them to be.”¹²⁸

In *S v Arnold*¹²⁹ Dr Gittelsohn, a psychiatrist on behalf of the accused, stated the following in respect of the accused’s emotional state:

“His conscious mind was so ‘flooded’ by emotions that it interfered with his capacity to appreciate what was right or wrong and, because of his emotional state, he may have lost the capacity to exercise control over his actions.”

Burchell and Hunt note that emotional stress usually involves an accumulation of events over a reasonable period of time as opposed to an isolated event and is often the result of surrounding circumstances.

Burchell and Hunt further state:¹³⁰

“In principle, the origin of the stressful condition in which the individual is placed does not matter, but it may affect the intensity of the ultimate condition. The stressful condition which causes an individual to lack criminal capacity could be caused by, for instance, insulting or oppressive conduct

¹²⁸ See also *Hudson v Commonwealth* 979 SW 2d 106, at 108 (1998) and *Dean v Commonwealth* 777 SW 2d 900 at 909 (Ky 1989).

¹²⁹ *S v Arnold* 1985 (3) SA 256 (CPD) at 263 C–D.

¹³⁰ Burchell, EM and Hunt, PMA “South African Criminal Law and Procedure – General Principles of Criminal Law” (1997) 3rd ed at 211 (Hereafter “Burchell and Hunt”).

of another person, by pre-menstrual stress suffered by a woman or by overwhelming and debilitating social conditions.”¹³¹

Emotional stress for purposes of this study will denote a temporary state of mind inflamed or disturbed as a result of stressful circumstance accumulating over a period of time resulting in a person lacking either the capacity to appreciate the wrongfulness of his or her actions or the capacity to act in accordance with such an appreciation.

2.2.2 Provocation

When an accused person is charged with murder the evidence often reveals that the accused’s conduct was immediately preceded by provocative behaviour by another which in effect gave rise to the accused’s aggressive conduct.¹³² The question which will be addressed in this study is to what extent provocation has a bearing on criminal capacity.

The term “provocation” is deduced from the Latin phrases “provocatio” and “provocare” which is defined¹³³ as the:

“act of provoking, something that provokes, arouses or stimulates.

Tredoux *et al* define provocation as follows:¹³⁴

“The act of inciting another to do something by words or behaviour, and accompanying extreme emotional state.”

In criminal law, provocation is a defence by either excuse or exculpation alleging a sudden or temporary loss of control as a result of another’s provocative conduct

¹³¹ Burchell and Hunt (1997) *supra* note 130 at 211.

¹³² Snyman (2008) *supra* note 1 at 234.

¹³³ Definition extracted from the Merriam-Webster Online Dictionary <http://www.merriam/webster.com/dictionary/provocation> [accessed on 2008/07/21].

¹³⁴ Tredoux *et al* (2005) *supra* note 35 at 424.

sufficient to justify either an acquittal, a mitigated sentence or a conviction for a lesser charge.¹³⁵

Black defines provocation as follows:¹³⁶

“The act of inciting another to do a particular deed. That which arouses, moves, calls forth, causes, or occasions. Such conduct or actions on the part of one person towards another as tend to arouse rage, resentment, or fury in the latter against the former, and thereby cause him to do some illegal act against or in relation to the person offering the provocation.”

And further:¹³⁷

“There must be a state of passion without time to cool placing defendant beyond control of his reason. Provocation carries with it the idea of some physical aggression or some assault which suddenly arouses heat and passion in the person assaulted.”

The Oxford Dictionary of Law defines provocation as:¹³⁸

“Conduct or words causing someone to lose his self control.”

Burchell and Milton state that provocation of a sufficient degree can have a bearing on criminal liability in the sense that it can lead to a complete defence to any type of criminal conduct.¹³⁹

According to Burchell and Milton provocation can exclude either the voluntariness of conduct, criminal capacity or intention.¹⁴⁰

¹³⁵ Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/provocation> - (legal) [accessed on 2008/07/21].

¹³⁶ Black, HC “Black’s Law Dictionary” (1990) 6th ed at 1225.

¹³⁷ Black *supra* note 136 at 1225.

¹³⁸ Oxford Dictionary of Law 6th ed 2006.

¹³⁹ Burchell and Milton (2005) *supra* note 73 at 425.

¹⁴⁰ Burchell and Milton (2005) *supra* note 73 at 235.

Bergenthuin defines provocation as follows:¹⁴¹

“The concept ‘provocation’ indicates a situation in which a provoker elicits the anger or wrath of the provoked by means of provocative, challenging or defiant behaviour, and the latter in reaction to the provocative behaviour commits a criminal act.”

2.2.3 Battered Woman Syndrome

“Week by week and month by month, women are kicked, beaten, jumped on until they are crushed, chopped, stabbed, seamed with vitriol, bitten, eviscerated with red hot pokers and deliberately set on fire – and this sort of outrage, if the woman dies, is called ‘manslaughter’: if she lives it is common assault.”¹⁴²

One of the central themes of this study will be to evaluate the controversy surrounding the battered woman syndrome within the ambit of the defence of criminal incapacity. The widespread occurrence of physical, sexual and psychological abuse of women by men in intimate relationships will be addressed with specific emphasis on the role that psychiatrists and psychologists play in educating judges as to the world of violence inhabited by battered women who are accused of murdering their abusive husbands or partners.

Walker correctly states:¹⁴³

“There is a continuing debate within the feminist community about the proper role of an expert witness in trials of battered women who kill.”

¹⁴¹ Bergenthuin, JG “Provokasie in die Suid-Afrikaanse Strafreë” (1986) *De Jure* at 98. See also Bergenthuin, JG “Provokasie as verweer in die Suid-Afrikaanse Strafreë” (1985) - Unpublished LLD thesis (UP) at 3–4.

¹⁴² Letter from Mrs Fenwick Miller to the Daily News, reported by the Pall Mall Gazette, 2 October 1988 as quoted in Horder, J “Provocation and Responsibility” (1992) at 188.

¹⁴³ Walker (1989) *supra* note 23 at 10.

For many centuries men had the right to abuse and beat their wives.¹⁴⁴ It is a trite fact that women continue to be abused at an increasing rate.¹⁴⁵ What is even more shocking is the fact that many abused women remain in abusive relationships.¹⁴⁶

In assessing and understanding the complex emotional and social landscape inhabited by battered women, expert evidence plays a pivotal role.¹⁴⁷

In order to understand the discussions pertaining to battered women in the course of this study, it is necessary to define the concept of “battered woman syndrome.”

Walker defines a battered woman as follows:¹⁴⁸

“A battered woman is a woman who is repeatedly subjected to any forceful physical or psychological behaviour by a man in order to coerce her to do something he wants her to do without any concern for her rights. Battered women include wives or women in any form of intimate relationships with men. Furthermore, in order to be classified as a battered woman, the couple must go through the battering cycle at least twice. Any woman may find herself in an abusive relationship with a man once. If it occurs a second time, and she remains in the situation, she is defined as a battered woman.”

Moore states that the majority of material on battered woman syndrome relate to the physical abuse suffered by women which denotes:

“... deliberate, severe and repeated physical injury ... with the minimal injury being severe bruising.”¹⁴⁹

¹⁴⁴ Pistorius, M “Fatal Females – Women who kill” (2004) at 15.

¹⁴⁵ Reddi, M “Battered woman syndrome: some reflections on the utility of this ‘syndrome’ to South African women who kill their abusers” (2005) *SACJ* 259 at 260.

¹⁴⁶ Reddi (2005) *SACJ supra* note 145-259 at 260.

¹⁴⁷ Ludsin and Vetten (2005) *supra* note 16 at 12.

¹⁴⁸ Walker (1979) *supra* note 19 at XV.

¹⁴⁹ Moore, D “Battered Women” (1979) at 8.

Moore correctly states that recognition should also be given to the psychological damage which one person can do to another by using fear, guilt or other forms of psychological abuse.¹⁵⁰

Dershowitz provides a more liberal and constitutionally sound definition of “Battered person’s syndrome” and states:¹⁵¹

“This condition is a modified version of the battered woman syndrome, expanded to include male victims of long-term physical or sexual abuse, that was first articulated by psychologist Lenore Walker in her book *The Battered Woman*.”

According to Dershowitz the battered person’s syndrome originates from the cycle of abuse that individuals are subjected to in abusive contexts at the hand of their spouses.¹⁵²

The continuous and unpredictable nature of this abuse eventually results in the individual developing a condition known as “learned helplessness.”¹⁵³ The latter makes the abused person feel that he or she is not in control of the situation and accordingly powerless.¹⁵⁴

Dershowitz also states:¹⁵⁵

“Misdiagnosing this important psychological problem to fit into a political agenda will delay its proper treatment and cure. The problems of spousal

¹⁵⁰ Moore (1979) *supra* note 149 at 8. Moore also correctly observes that the terms “battered women”, “battered wives”, “battered spouses” and “battered partners” could also be used interchangeably. This approach also applies to this study. Emphasis will mainly be placed on most battered women as the area with the most controversy.

¹⁵¹ Dershowitz, AM “The Abuse Excuse – and other cop-outs, Sob stories and evasions of Responsibility” (1994) at 322.

¹⁵² Dershowitz (1994) *supra* note 151 at 322.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

¹⁵⁵ Dershowitz (1994) *supra* note 151 at 313.

abuse and violence are far too serious to be turned into divisive ‘we versus them’ political or gender issues.”

The Oxford Dictionary of Law defines battered woman syndrome as follows:¹⁵⁶

“A psychological syndrome suffered by a person (typically a woman) as a result of prolonged and extreme physical and emotional abuse by her partner.”

The Britannica Concise Encyclopaedia describes battered woman syndrome as a psychological and behavioral pattern displayed by female victims.¹⁵⁷

The medical dictionary defines battered woman syndrome slightly differently:¹⁵⁸

“A pattern of signs and symptoms, such as fear and a perceived inability to escape, appearing in women who are physically and mentally abused over an extended period by a husband or other dominant individual.”

Schuller and Vidmar state that the term battered woman syndrome is descriptive in the sense that it refers to a pattern of responses and perceptions typical to women who have been subjected to abuse by their partner.¹⁵⁹

Reddi states that battered woman syndrome refers to a pattern of psychological and behavioural symptoms evident in women living in abusive relationships.¹⁶⁰

¹⁵⁶ Oxford Dictionary of Law (2006) 6th ed at 53 where “battery” is defined in the Oxford Dictionary as: “the intentional or reckless application of physical force to another person.”

¹⁵⁷ Britannica Concise Encyclopaedia (2007) <http://www.encyclopedia.com/doc/1B1-356756.html> [accessed on 2008/07/16].

¹⁵⁸ As defined on <http://www.answers.com/topic/battered-woman-syndrome-cat=health> [accessed on 2008/07/16].

¹⁵⁹ Schuller, R and Widmar, N “Battered Woman Syndrome Evidence in the Courtroom – A Review at the Literature” (1992) *Law and Human Behavior* vol 16 no 3 273 at 274.

¹⁶⁰ Reddi (2005) *SACJ supra* note 145 at 260. Reddi takes the view that “battered woman syndrome” is merely a legal defence strategy that is implemented to account for battered women’s experiences. See also *S v Engelbrecht* 2005 (2) SACR 41 (W); *S v Ferreira* 2004 (2) SACR 454 (SCA); Burchell and Milton (2005) *supra* note 75 at 451-454. The battered woman syndrome will be extensively discussed in chapter 2 *infra*.

For purposes of this study “battered woman syndrome” will mean a pattern of signs and symptoms displayed by a woman as a result of physical or psychological abuse by a husband or partner over an extended or prolonged period of time.

2.3 Pathological criminal incapacity

“Do you imagine that Orestes grew mad after the parricide, and was not distracted and haunted by execrable furies before he warmed the pointed dagger in his mother’s blood? Nay, from the time that you supposed him out of his senses, he really did nothing that you can blame.”¹⁶¹

Pathological criminal incapacity relates to the situation where a person’s incapacity to appreciate the wrongfulness of his or her actions, or to act in accordance with such an appreciation is caused by “mental illness” or “mental defect” as envisaged in section 77–78 of the Criminal Procedure Act.¹⁶²

Pathological criminal incapacity is also more commonly referred to as the “insanity” defence.

Snyman defines pathological criminal incapacity as follows:¹⁶³

“The defence of mental illness is limited to situations where X suffered from a pathological disturbance of his mental abilities. ‘Pathological’ means ‘emanating from a disease’.”

Burchell and Milton state the following:¹⁶⁴

¹⁶¹ Horace as quoted in Roche, P “The Criminal mind ... A study of communication between the Criminal Law and Psychiatry” (1958) at 82.

¹⁶² 51 of 1977. Snyman (2008) *supra* note 1 at 170. See also Van der Merwe, FW “Nie-Patologiese Ontoerekeningsvatbaarheid as Verweer in die Suid-Afrikaanse Strafreë” (1996) - Unpublished LLM dissertation Unisa at 134.

¹⁶³ Snyman (2008) *supra* note 1 at 162.

¹⁶⁴ Burchell and Milton (2005) *supra* note 73 at 370.

“Mental disease or defect may deprive persons of the capacity to appreciate the wrongfulness of their conduct. It may also deprive them of the capacity to control their conduct. A person who suffers from a mental condition that has such effect is said to be insane.”

Burchell and Milton explain that the requirement which entails that the illness should be pathological means that any mental disorders which are the result of a disease will qualify as a mental illness as envisaged in section 78.¹⁶⁵

At this stage there is no formal definition of mental illness. In *S v Stellmacher* Mouton J held that “mental illness” denotes:¹⁶⁶

“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.”

In *S v Laubscher*¹⁶⁷ Joubert J A referred to pathological criminal incapacity as:

“... statutêre, ontoerekeningsvatbaarheid ...”

Louw notes the following:¹⁶⁸

“Pathological incapacity is due to an intrinsic brain disorder, such as mental illness or mental handicap.”

Van Oosten states the following:¹⁶⁹

¹⁶⁵ Burchell and Milton (2005) *supra* note 73 at 375.

¹⁶⁶ *S v Stellmacher* 1983 (2) SA 181 (SWA) at 187 H; Burchell and Milton (2005) *supra* note 73 at 375; Visser and Mare (1990) *supra* note 77 at 327. See also Strauss (1991) *supra* note 48 at 127–134.

¹⁶⁷ *S v Laubscher* 1988 (1) SA 163 (A) at 167 E–I.

¹⁶⁸ Louw in Kaliski (ed) (2006) *supra* note 2 at 38.

¹⁶⁹ Van Oosten, FFW “The insanity defence: its place and role in the criminal law” (1990) SACJ at 1.

“Section 78(1)’s first defence relates to a disturbance of the accused’s cognitive and the second to a disturbance of his conative functions. Together they constitute a mixed test of criminal incapacity that consists of a combination of the psychiatric and psychological tests and requires both mental illness or defect and the impairment of the accused’s mental faculties in the manner described by the two defences.”

In *S v Eadie*¹⁷⁰, Navsa J A made the following remark:¹⁷¹

“In our law, criminal incapacity due to mental illness is classified as pathological incapacity.”

For purposes of this study pathological criminal incapacity is defined as the incapacity to appreciate the wrongfulness of an act or omission, or the incapacity to act in accordance with such an appreciation as a result of a pathological disturbance of the mental faculties due to a mental illness or mental defect.

2.4 Diminished criminal capacity

Section 78(7) of the Criminal Procedure Act reads as follows:¹⁷²

“If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act but that his capacity to appreciate the wrongfulness of the act or to act in accordance with an appreciation of the wrongfulness of the act was diminished by reason of mental illness or mental defect, the court may take the fact of such diminished responsibility into account when sentencing the accused.”

The Rumpff report notes that diminished responsibility exists when it is established that a normal accused person committed an act under circumstances which renders the act less reprehensible for example in a situation of provocation or

¹⁷⁰ *S v Eadie* 2002 (1) SACR 663 (SCA).

¹⁷¹ At 673 J.

¹⁷² 51 of 1977.

temptation.¹⁷³ The doctrine of diminished criminal incapacity accordingly entails that where it is established that an accused's criminal capacity was diminished or impaired, such diminished capacity will be taken into account in the mitigation of punishment.

The Rumpff report notes:¹⁷⁴

“In such cases no problems arise as to the nature of the punishment or treatment because one is really dealing here with grounds for mitigation of punishment in respect of a person who is otherwise held to be completely responsible.”

Du Toit *et al* note that diminished responsibility is closer related to punishment than to criminal responsibility.¹⁷⁵

According to Snyman section 78(7) reaffirms that the dividing line between criminal capacity and criminal incapacity is not absolute but rather denotes a question of degree.¹⁷⁶ A person may thus be suffering from a specific mental illness or mental defect, yet still retain the capacity to appreciate the wrongfulness of his conduct and be able to act in accordance with such appreciation.¹⁷⁷ Snyman correctly describes the situation as follows:¹⁷⁸

“If it appears that, despite his criminal capacity, he finds it more difficult than a normal person to act in accordance with his appreciation of right and

¹⁷³ Rumpff Report *supra* note 59 at paragraph 8.3.

¹⁷⁴ Rumpff Report *supra* note 59 at paragraph 8.3.

¹⁷⁵ Du Toit, E, De Jager, F, Paizes, A, Skeen, A and Van der Merwe, S “Commentary on the Criminal Procedure Act” (2007) (hereafter “Du Toit *et al*”) at 13–23. See also *S v Mnyanda* 1976 (2) SA 751 (A) at 766–7.

¹⁷⁶ Snyman (2008) *supra* note 1 at 176–177. The Rumpff Report *supra* note 59 at paragraph 8.1 also states: “Practical experience also teaches however – and psychology and psychiatry confirm this – that there are gradations of normality and that it is difficult in some cases to draw a dividing line between normality and abnormality for the purposes of the law.” See also Burchell and Milton (2005) *supra* note 73 at 400 where it is stated that there are varying degrees of mental abnormality and accordingly the borderline between mental illness which is sufficient to satisfy the requirements for reliance on the insanity defence and that which does not, is not clear.

¹⁷⁷ Snyman (2008) *supra* note 1 at 176-177.

¹⁷⁸ *Ibid.*

wrong, because his ability to resist temptation is less than that of a normal person, he must be convicted of the crime (assuming that the other requirements for liability are also met) but these psychological factors may be taken into account and may then warrant the imposition of a less severe punishment.”

LAWSA defines diminished criminal responsibility as follows:¹⁷⁹

“Diminished responsibility is determined with reference to the mental ability of the accused. If, for example, the court finds that at the time of the commission of an act the accused was criminally responsible for the act but that the accused’s capacity to appreciate its wrongfulness or to act in accordance with an appreciation of its wrongfulness was diminished by reason of mental illness or mental defect, he or she is said to have diminished responsibility.”

Section 78(7) in its current form only provides for diminished criminal capacity if an accused’s mental faculties were diminished by reason of mental illness or mental defect.

In *S v Laubscher*¹⁸⁰ Joubert J A held the following:¹⁸¹

“Die Wetgewer hou in art 78(7) ook rekening met verminderde toerekeningsvatbaarheid waar ‘n dader bevind word om ten tyde van die pleeg van die misdaad wel strafregtelik toerekeningsvatbaar te wees maar sy onderskeidingsvermoë of weerstandskrag (wilsbeheervermoë) was

¹⁷⁹ LAWSA (2004) *supra* note 75 at 63. See also *S v Mnyanda* 1976 (2) SA 751 A at 766 F; *S v Lehnberg* 1975 (4) SA 553 (A). See also the more recent judgment in *S v Mnisi* 2009 (2) SACR 227 (SCA) at 231 A-B where Boruchowitz AJA held: “The appellant does not seek to rely upon the defence of temporary non-pathological criminal incapacity but rather upon diminished responsibility which is not a defence but is relevant to the question of sentence. The former relates to a lack of criminal capacity arising from a non-pathological cause which is of a temporary nature whereas the latter presupposes criminal capacity but reduces culpability”. The latter judgment will be discussed in more detail in chapter 2 *infra*. See also Carstens, PA “Criminal liability and sentencing for murder committed with diminished criminal capacity due to provocation” (2010) *De Jure* 388-394.

¹⁸⁰ *S v Laubscher* 1988 (1) SA 163 (A).

¹⁸¹ At 167 J – 168 B.

vanweë 'n patologiese versteuring verminder. Dit speel geen rol by die strafregtelike aanspreeklikheid nie maar dit kan wel by vonnisoplegging in aanmerking geneem word. ... Want dit is ook moontlik om *nie-patologiese verminderde toerekeningsvatbaarheid te kry wat weens 'n nie-patologiese toestand die dader se onderskeidings-vermoë of weerstandskrag (wilsbeheervermoë) ten tyde van die pleeg van die misdaad verminder het.*¹⁸²

It is submitted that diminished criminal capacity should also apply to cases of criminal incapacity attributable to non-pathological causes. In the light of the current controversy surrounding the defence of non-pathological criminal incapacity, this could possibly provide a more clinical and judicially sound approach to cases of non-pathological criminal incapacity as the diminished criminal capacity will only have a bearing on punishment and will not result in a finding of criminal non-responsibility.

Burchell and Hunt state that where provocation or emotional stress are unsuccessfully invoked as defences by an accused, the existence of some form of provocation or emotional stress at the time of the commission of the crime or before may constitute a factor which diminishes the accused's responsibility and which could accordingly result in a reduction in sentence or punishment.¹⁸³

Van der Merwe states that the doctrine of diminished criminal capacity can be divided into three sub-components, namely:¹⁸⁴

- (a) Diminished criminal capacity in its narrow sense relating to the current section 78 (7) where the diminished criminal capacity is due to a mental illness or mental defect;

¹⁸² Emphasis added.

¹⁸³ Burchell and Hunt (1997) *supra* note 130 at 219. See also *S v Shapiro* 1994 (1) SACR 112 (A) at 120 E-G and *S v Di Blasi* 1996 (1) SACR 1 (A). As will be indicated in chapter 2 below, the doctrine of diminished criminal capacity could also be utilised productively within the "battered woman syndrome" context.

¹⁸⁴ Van der Merwe, DP "Die begrip verminderde toerekeningsvatbaarheid en die implementering daarvan" (1983) *TRW* at 175–176.

- (b) Diminished criminal capacity in a broader sense in which even a non-pathological state can also lead to diminished criminal capacity for example youth, intoxication, provocation, anger or fear;
- (c) Diminished culpability (“strafbaarheid”) as a result of other factors.

Once it is established that an accused person possessed the necessary criminal capacity and all of the other requirements for criminal liability are present, the accused has to be convicted. A court can, however, find that despite the presence of criminal capacity, the accused’s criminal capacity was diminished. Diminished criminal capacity will accordingly not affect the criminal liability of the accused, but will play a role in the sentencing process.¹⁸⁵ Diminished criminal capacity will accordingly serve as an extenuating circumstance in imposing a lesser sentence.¹⁸⁶

In *R v Hugo Schreiner J* stated the following:¹⁸⁷

“...A mind which, though not diseased so as to provide evidence of insanity in the legal sense, may be subject to delusion, or to some erroneous belief or some defect, in circumstances which would make a crime committed under its influence less reprehensible or diabolical than it would be in the sense of a mind of normal condition. Such a delusion, erroneous belief, or defect, would appear to us to be a fact which may in proper cases be held to provide an extenuating circumstance.”

Strauss notes that although section 78 (7) deals essentially with diminished responsibility as a result of mental illness or mental defect, a finding of extenuating

¹⁸⁵ See Nel (2008) *supra* note 97 at 17.

¹⁸⁶ *R v Biyana* 1938 (EDLD) at 310. See also Fradella, HF “From insanity to Diminished Capacity” (2007) where it is stated at 59 that diminished capacity is not a defense but rather relates to the admissibility of evidence pertaining to the accused’s mental state. Diminished responsibility allows either a jury or a judge to mitigate the punishment of a mentally disabled but sane offender in any case where the jury believes that the defendant is less culpable than his normal counterpart who commits the same criminal act.

¹⁸⁷ *R v Hugo* 1940 (WLD) 285 at 288. See also Nel (2008) *supra* note 97 at 17.

circumstances may be made by a court even in cases where it has not been established that the accused was mentally ill or defective.¹⁸⁸

2.5 Automatism

The primary requirement for criminal liability is that there must be “conduct” on the part of an accused.¹⁸⁹ The term “conduct” refers to an act or omission.¹⁹⁰ Snyman notes that the word “act” is frequently used in a wide sense to refer to both an act and omission since punishment for omissions very seldom occurs.¹⁹¹ The requirement of an act forms the basis of criminal liability. One of the core requirements of an act is that it should be voluntary as only voluntary human conduct is punishable.¹⁹²

With regards to voluntariness, Snyman notes:¹⁹³

“conduct is voluntary if X is capable of subjecting her bodily movements to her will or intellect.”

The term voluntariness should further be clearly distinguished from the term “willingly”, as the latter term merely indicates the accused’s wishes to conduct herself in a particular manner.

Burchell and Milton state:¹⁹⁴

“This principle is expressed by the requirement that for purposes of the criminal law, a human act must be voluntary in the sense that it is subject to the accused’s conscious will. Where for some reason or another the person

¹⁸⁸ Strauss (1991) *supra* note 48 at 134; *S v M* 1985 (1) SA, (A). See also Tredoux *et al* (2005) *supra* note 35 at 417.

¹⁸⁹ Snyman (2008) *supra* note 1 at 51; Burchell and Milton (2005) *supra* note 73 at 178. See also generally *S v Cunningham* 1996 (1) SACR 631 (A); *S v Trickett* 1973 (3) SA 526 (T).

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² *Ibid.* See also *S v Johnson* 1969 (1) SA 201 (A) at 204; *S v Kok* 1998 (1) SACR 532 (N) at 545 D-E; *S v Henry* 1999 (1) SACR 13 (SCA) at 19.

¹⁹³ Snyman (2008) *supra* note 1 at 54. See also Tredoux *et al* (2005) *supra* note 35 at 413.

¹⁹⁴ Burchell and Milton (2005) *supra* note 73 at 179.

is deprived of the freedom of his will, his actions are “involuntary” and he cannot be held criminally liable for them.”

Conduct is generally deemed to be involuntary if it occurs during a state of automatism.¹⁹⁵ Automatism generally refers to the situation where a person’s conduct is involuntary in that he or she acts in a mechanical fashion. Examples of such mechanical behaviour are sneezing fits, somnambulism, sleepwalking and epileptic fits.¹⁹⁶

Snyman describes automatism as follows:¹⁹⁷

“... the muscular movements are more reminiscent of the mechanical behaviour of an automaton than of the responsible conduct of a human being whose bodily movements are subject to the control of her will. It really does not matter much in what terms the conduct is described; the question is simply whether it was voluntary, in other words, whether the person concerned was capable of subjecting her bodily movements of her behaviour to the control of her will.”

The Oxford Concise Medical Dictionary describes automatism as follows:¹⁹⁸

“Behaviour that may be associated with epilepsy, in which the patient performs well-organised movements or tasks while unaware of doing so. The movements may be simple and repetitive, such as hand clapping, or they may be so complex as to mimic a person’s normal conscious activities.”

Fenwick provides an all-encompassing definition of automatism by stating:¹⁹⁹

¹⁹⁵ Burchell and Milton (2005) *supra* note 73 at 180.

¹⁹⁶ Snyman (2008) *supra* note 1 at 55. See also *S v Dhlamini* 1995 (1) SA 120 (T); *S v Mkize* 1959 (2) SA 260 (N); *R v Schoonwinkel* 1953 (3) SA 136 (C); *S v Majola* 2001 (1) SACR 337 (N).

¹⁹⁷ Snyman (2008) *supra* note 1 at 56.

¹⁹⁸ Oxford Concise Medical Dictionary 5th ed. (1998).

“An automatism is an involuntary piece of behaviour over which the individual has no control. The behaviour itself is usually inappropriate to the circumstances, and may be out of character for the individual. It can be complex, coordinated and apparently purposeful and directed, though lacking in judgment. Afterwards the individual may have no recollection, or only partial and confused memory, for his actions. In organic automatisms there must be some disturbance of brain functions, sufficient to give rise to the above features. In psychogenic automatisms, the behaviour is complex, coordinated and appropriate to some aspect of the patient’s psychopathology. The sensorium is usually clear, but there will be severe or complete amnesia for the episode.”

In *R v Zulch*²⁰⁰, Maritz J summarized the defence of automatism as follows:²⁰¹

“Now, according to Dr Vermooten, the form of mental disorder from which the accused suffered when he killed his child was hysterical automatism, which may be described as an automatic condition which is uncontrolled, which has no volition.”

Bluglas and Bowden define automatism as follows:²⁰²

“Any act which is done by the muscles without any control of the mind, such as a spasm, reflex or convulsion, or an act by a person who is unconscious because he is asleep.”

Automatism is accordingly the term generally used to refer to involuntary conduct as a result of some form of impaired consciousness.

¹⁹⁹ Fenwick, P “Brain, mind and behaviour” *British journal of psychiatry* (1993) at 163. See also Vorster, M “An analysis of the Amnesias with specific reference to ‘Non-Pathological Sane Automatism’” (2002) - Unpublished PhD thesis University of Witwatersrand at 33.

²⁰⁰ *R v Zulch* 1937 (TPD) 400.

²⁰¹ At 403. See also Nel (2008) *supra* note 97 at 21.

²⁰² Bluglas, R and Bowden, P “Principles and Practice of forensic Psychiatry” (1990) at 72. See also McSherry, B “Criminal responsibility, fleeting states of mental impairment, and the power of self-control” (2004) *International Journal of Law and Psychiatry* at 449.

In *Bratty v Attorney-General for Northern Ireland* automatism was conceptualized as:²⁰³

“connoting the state of a person who, though capable of action, is not conscious of what he is doing ... It means unconscious involuntary action, and it is a defence because the mind does not go with what is being done.”

The World Book Medical Encyclopaedia defines automatism as follows:²⁰⁴

“Automatism is a condition in which a person performs acts without conscious knowledge or later memory of what he or she is doing. Although the person appears to be functioning normally, he or she does not manifest personality, and behaviour may be abnormal. The condition normally represents a hysterical trance. It may also follow some severe trauma or an attack of certain forms of epilepsy. Sleep-walking is one example of automatisms.”

It is thus clear that the requirement that an act should be voluntary is essential in every criminal trial. There can be no question of criminal liability in the absence of a voluntary human act. The necessity for a discussion of the defence of automatism in the course of this study flows from confusion that often exists as to the distinction between automatism and criminal incapacity as will be illustrated in chapter 2 of this study. It is from the outset of utmost importance to note that the defences of automatism and criminal incapacity relate to different requirements of criminal liability and as such are two distinct defences that should clearly be separated.

There are various classifications of the different forms of automatisms.²⁰⁵ For purposes of this study, however, only the distinction between sane and insane automatism will be illustrated.

²⁰³ *Bratty v Attorney-General for Northern Ireland* (1961) 3 All E.R 523. See notes 192 and 196 *supra* for South African case law pertaining to automatism.

²⁰⁴ World Book Medical Encyclopaedia 7th ed (1997).

2.5.1 Sane automatism

Sane automatism generally occurs when a person acts involuntarily as a result of external factors. The involuntariness of the conduct does not have a pathological foundation coupled with some biological cause. As a result of these external factors the person is incapable of controlling his or her actions and accordingly the act which is performed is not regarded by law as a voluntary act.

Schapp states the following.²⁰⁶

“At first glance, it appears that sane automatism differs from insane automatism in that the latter is caused by a disease of the mind, whereas the former is the product of a temporary impairment from external physical factors.”

Snyman notes that the term sane automatism generally refers to the situation where a person who is mentally sane, acts involuntarily as a result of for example an epileptic fit.²⁰⁷ Snyman states that the use of the terminology of “sane” and “insane” automatism is confusing and that automatism should be limited to involuntary conduct not attributable to any form of mental illness.²⁰⁸ In cases of

²⁰⁵ For a comprehensive classification see Vorster (2002) *supra* note 199 at 33. Vorster differentiates between “organic automatisms” and “non-organic automatisms”. Examples of the latter are:

- Organic automatisms – epilepsy, somnambulism (“sleepwalking”), hypoglycaemia, alcohol and drugs, transient global amnesia.
- Non-organic automatisms – this form of automatism most frequently results from emotional stress and is also referred to as “hysterical dissociation”. Another example is psychogenic automatism.

²⁰⁶ Schapp, RF “Automatism, insanity and the psychology of criminal responsibility: A philosophical enquiry” (1991) at 79. See also Tredoux *et al* (2005) *supra* note 35 at 425 where sane automatism is defined as: “The state of acting involuntarily due to non-pathological factors.”

²⁰⁷ Snyman (2008) *supra* note 1 at 56.

²⁰⁸ Snyman (2008) *supra* note 1 at 56. In *S v Kok* 2001 (2) SACR 106 (SCA) 109 at 110 D-E it was noted that the term “sane automatism” is not a psychiatric term but rather used to refer to automatism arising from causes other than mental illness.

sane automatism the onus of proof is on the state to prove that the act was voluntary.²⁰⁹ If the defence is successful the accused goes free.

Strauss notes that the defence of automatism is approached by courts with great caution.²¹⁰ Strauss states the following in this regard:²¹¹

“To raise a defence of sane automatism there must be evidence strong enough to create doubt as to the voluntary nature of the alleged *actus reus* (unlawful act).”

In *S v Trickett* Marais J noted:²¹²

“This defence is commonly recognised as being ‘automatism’, which however according to the Courts may be either of a sane or of an insane nature.”

LAWSA notes the following:²¹³

“If a sane person who is in a state of automatism commits an act which would otherwise be criminal, he or she has a complete defence and is entitled to an acquittal. ... A defence of sane automatism will be successful only if there is sufficiently cogent evidence to raise a reasonable doubt about the voluntary nature of the *actus reus*, and if there is medical or other expert evidence to show that the involuntary or unconscious nature of the

²⁰⁹ Snyman (2008) *supra* note 1 at 56. See also *S v Cunningham* 1996 (1) SACR 631 (A) at 635; *S v Henry* 1999(1) SACR 13 (SCA) at 19 I-J. See also *S v Trickett* 1973 (3) SA 526 (TPD) where Marais J states (at 530 C–D): “On the other hand, if the defence calls into question the voluntary nature of the act constituting the offences without relying in any way upon a pathological mental condition to “explain” or “prove” the absence of a free exercise of will, or even to render acceptable the bona fides of the accused in raising such a defence, it would seem that the onus of proving the presence of a voluntary misdeed would be upon the prosecution.”

²¹⁰ Strauss (1991) *supra* note 48 at 130.

²¹¹ Strauss (1991) *supra* note 48 at 130. See also LAWSA (2004) *supra* note 75 at 68.

²¹² *S v Trickett supra* at 532 E–F. See also Kaliski (2006) *supra* note 2 at 107.

²¹³ LAWSA (2004) *supra* note 75 at 68. See also Tredoux *et al* (2005) *supra* note 35 at 404. See also Lambrechts, H “n Ondersoek na nie-patologiese ontoerekeningsvatbaarheid en die regverdiging vir die voortbestaan van gesonde outomatisme en aanverwante verwerre in die Suid-Afrikaanse Strafreg” (2005) - Unpublished LLD thesis University of the Free State at 39.

actus reus is quite possible due to causes other than mental illness or mental defect.”

For purposes of this study sane automatism will be defined as the temporary inability to act voluntarily where the cause of such inability cannot be ascribed to pathological causes or a mental illness.

2.5.2 Insane automatism

Insane automatism generally occurs when a person acts involuntarily and the involuntariness of conduct is brought about by an internal factor such as a mental illness.

Snyman notes that in the case of insane automatism a person’s unconscious conduct is attributable to some form of mental pathology.²¹⁴

Burchell and Milton describe insane automatism as follows:²¹⁵

“A condition of insane automatism results from a pathological mental condition which requires the accused under both the common and statute law to prove this pathological condition on a balance of probabilities.”

Tredoux defines insane automatism as follows:²¹⁶

“The state of acting involuntarily due to pathological factors, such as mental illness or brain disorder.”

In case of insane automatism or involuntary conduct attributable to mental illness, the onus is on the accused to prove on a balance of probabilities that he or she

²¹⁴ Snyman (2008) *supra* note 1 at 56.

²¹⁵ Burchell and Milton (2005) *supra* note 73 at 139. See also Strauss (1991) *supra* note 48 at 130.

²¹⁶ Tredoux *et al* (2005) *supra* note 35 at 419.

suffered from a mental illness at the time of the alleged crime.²¹⁷ The finding in the case of a successful defence of insane automatism will also differ from the finding in cases of sane automatism. Where the involuntary behaviour was attributable to pathological causes, the accused will be dealt with in terms of section 78(6) of the Criminal Procedure Act which states that the accused should be found not guilty and that a court then retains a discretion to remand the accused to a psychiatric institution.²¹⁸ A special verdict in terms of section 78(6) will be ordered.²¹⁹

For purposes of this study insane automatism is defined as the inability to act voluntarily where such involuntariness is caused by some form of pathology or mental illness.

2.6 Expert evidence

Expert evidence, as indicated above, is a form of opinion evidence which is generally inadmissible unless the subject enquiry and the facts in dispute are of such a nature that the court is in need of assistance from experts in the relevant field in order to derive at an informed judgment. The question as to the admissibility of such evidence depends upon the relevance of such opinion.²²⁰

As early as 1554 Saunders described the importance of expert evidence as follows:²²¹

“If matters arise in our law which concern other sciences or faculties we commonly apply for the aid of the science or faculty which it concerns. This is a commendable thing in our law. For thereby it appears that we do not

²¹⁷ Snyman (2008) *supra* note 1 at 57.

²¹⁸ *Ibid.*

²¹⁹ See *S v Mahlinza* 1967 (1) SA 408 (A). See also Schapp (1991) *supra* note 204 at 75–76; Snyman (2008) *supra* note 1 at 57 and LAWSA (2004) *supra* note 75 at 68.

²²⁰ Schwikkard and Van der Merwe (2009) *supra* note 60 at 83; Zeffert and Paizes (2009) *supra* note 60 at 289.

²²¹ As quoted in Banks, NK “Trials and Tribulations: Social Science Evidence, Expert Witnesses, The Voice of Authority and the Discourse of Ideology in the Courts” (1999) *Murdoch University Electronic Journal of Law* vol 6 at 1.

dismiss all other sciences, but our own, but we approve of them and encourage them as things worthy of commendation.”

The general rule of common law was that the opinions, beliefs and inferences of a particular witness were inadmissible to prove the truth of an issue believed or inferred if such matters were relevant to facts in issue of a particular case.²²²

In South Africa the general rule is that any opinion expressed on an issue which the court can decide upon without hearing such an opinion is in principle inadmissible due to the irrelevance of such opinion.²²³ One of the motivations behind the opinion-rule is sometimes regarded as the protection of the function of the tribunal of fact and that a witness should not be permitted to express opinions on ultimate issues which only a court may decide upon.²²⁴ The latter is also often referred to as the “ultimate issue” principle.

According to Dennis, the rule against opinion evidence is based on three main principles:²²⁵

- Witness’s opinions are unnecessary and superfluous;
- The reception of opinions raises collateral issues which could result in confusion of the fact-finder. These issues include the qualifications of the witness, the basis for delivering an opinion and so forth;
- There is an inherent danger that the witness delivering an opinion will usurp the function of the court.

In *R v Vilbro* Fagan CJ stated the following pertaining to the opinion-rule:²²⁶

“It simply endeavours to save time and avoid confusing testimony by telling the witness: ‘The tribunal is on this subject in possession of the same

²²² Murphy, P “Murphy on Evidence” (2008) at 361.

²²³ Schwikkard and Van der Merwe (2009) *supra* note 60 at 83.

²²⁴ Schwikkard and Van der Merwe (2009) *supra* note 60 at 84. See also Zeffert and Paizes (2009) *supra* note 60 at 309.

²²⁵ Dennis, I “The Law of Evidence” (2007) 3rd ed at 847.

²²⁶ *R v Vilbro* 1957 (3) SA 223 (A.D.) at 228.

materials of information as yourself, thus, as you can add nothing to our materials for judgment, your further testimony is unnecessary and merely cumpers the proceedings’.”

According to Zeffert *et al* opinion evidence is accepted if it is established to be relevant, and rejected if irrelevant.

There are, however, two exceptions to the general rule against the admission of opinion evidence:

- Opinion evidence is desirable and admissible where it consists of inferences to be drawn pertaining to issues where specialized skill or knowledge is required which falls outside the experience and skill of the trier of fact;²²⁷
- In cases of “lay” opinion or “non expert” opinion where it is not feasible for the witness to separate the observed facts from the inferences that the witness drew from such facts.²²⁸

For purposes of this discussion and study, the emphasis will fall on expert evidence.

Kenny states the following with regard to expert evidence:²²⁹

“Expert evidence differs from ordinary evidence on matters of fact in that it is not based on the use of untutored senses or on the observation of the average man, but on specialized training, experience out of the common and or theoretical information of a recondite kind.”

Zeffert *et al* describe expert evidence as follows:²³⁰

²²⁷ Dennis (2007) *supra* note 225 at 847; Murphy (2008) *supra* note 222 at 361–362.

²²⁸ Dennis (2007) *supra* note 225 at 847; Zeffert and Paizes (2009) *supra* note 60 at 309-311.

²²⁹ Kenny, A “The Psychiatric expert in court” (1984) *Psychological Medicine* at 293 as quoted in Meintjes–Van der Walt, L “Expert Evidence in the Criminal Justice Process: A comparative Approach” (2001) at 63.

²³⁰ Zeffert and Paizes (2009) *supra* note 60 at 309-312.

“The opinion of expert witnesses is admissible whenever, by reason of their special knowledge and skill, they are better qualified to draw inferences than the judicial officer. There are some subjects upon which the court is usually quite incapable of forming an opinion unassisted, and others upon which it could come to some sort of independent conclusion, but the help of an expert would be useful.”

Murphy provides the following description as to expert evidence.²³¹

“It is an ancient rule of the common law that on a subject requiring special knowledge and competence, evidence is admissible from witnesses who have acquired, by study or practice, the necessary expertise on the subject. Such witnesses are known as “experts”. The evidence is justified by the fact that the court would be unable, unaided, to draw proper inferences and form proper opinions from such specialised facts as might be proved, and even perhaps to judge what facts have been satisfactorily proved.”

Meintjes-Van der Walt states that expert witnesses are permitted to testify if they have specialized knowledge, skill, training or experience which will enable them to provide information and express opinions that are generally not available to the average person.²³²

Slovenko correctly notes that expert testimony is admissible due to the fact that special skill and experience are needed in order to understand certain matters.²³³ In many cases a court will have difficulty to reach an informed decision due to the difficulty of a particular issue and accordingly the opinion of those skilled in the subject at issue may be required to render assistance.²³⁴

²³¹ Murphy (2008) *supra* note 222 at 364. See also Schwikkard and Van der Merwe (2009) *supra* note 60 at 90-103; *Ruto Flour Mills Ltd v Adelson* (1) 1958 (4) SA 235 T; *S v Gouws* 1967 (4) SA 527 (E).

²³² Meintjes-Van der Walt (2001) *supra* note 229 at 64.

²³³ Slovenko (2002) *supra* note 7 at 11–12.

²³⁴ Slovenko (2002) *supra* note 7 at 12.

A party seeking to present the opinion of a witness as an expert opinion must satisfy the court that the witness not only possesses specialist knowledge, training, skill and experience, but also that the expert witness can assist the court in deciding the core issues.²³⁵

In *Coopers (SA) (Pty) Ltd v Deutsche Gesellschaft for Schädlingsbekämpfung Mbh* the following was stated:²³⁶

“(T)here are, however, cases where the court is by reason of lack of special knowledge and skill, not sufficiently informed to enable it to undertake the task of drawing properly reasoned inferences from the facts established by the evidence. In such cases, the evidence of expert witnesses may be received because, by reason of their special knowledge and skill, they are better qualified to draw inferences than the trier of fact.”

Sales and Shuman indicate that experts can be used to provide facts and opinion that will be necessary to aid in resolving a disputed factual issue in a case.²³⁷ Expert witnesses can also be used to educate judges as to scientific or other technical or specialized information that is unlikely to be within the knowledge and experience of judges, but will aid in deciding a case more fairly.²³⁸

Within the domain of the defence of criminal incapacity, expert evidence of psychiatrists and psychologists and more specifically forensic psychiatrists and psychologists is essential in the assessment of the validity and merits of the defence. It is submitted that issues pertaining to criminal incapacity will in most cases not fall within the knowledge and experience of the judicial authority due to

²³⁵ Schwikkard and Van der Merwe (2009) *supra* note 60 at 92-96. In *Menday v Protea Assurance Co Ltd* 1976 (1) SA 565 (E) at 569 it was stated: “It is not the mere opinion of the witness which is decisive but his ability to satisfy the Court that, because of his special skill, training or experience, the reasons for the opinion which he expresses are acceptable ... The expert must either himself have knowledge or experience in the special field on which he testifies (whatever general knowledge he may also have in pure theory) or he must rely on knowledge or experience of others who themselves are shown to be acceptable experts in that field.”

²³⁶ *Coopers (SA) (Pty) Ltd v Deutsche Gesellschaft for Schädlingsbekämpfung Mbh* 1976 (3) SA 352 (A) at 370 F–H.

²³⁷ Sales and Shuman (2005) *supra* note 64 at 5.

²³⁸ *Ibid.*

the scientific entity thereof which results in the necessity of psychiatrists and psychologists in this regard.

Mental health expert witnesses are defined by Meintjes-Van der Walt and Allan as follows:²³⁹

“Mental health expert witnesses, who for example, can be psychiatrists, psychologists, social workers or occupational therapists, can be defined as specialists who are specifically instructed to undertake evaluations of people, form opinions based on their findings, write reports and, if required, give evidence during which they express opinions and provide the facts on which their opinions are based. As such they are consultants the court uses when it needs information and opinions about the mental functioning of a person that is beyond the knowledge of the court. Their function is to help the court, and not to further the cause of a particular side in the case.”

Sales and Shuman provide the following dramatic statement pertaining to forensic assessment:²⁴⁰

“... whereas diagnosis in clinical settings is an evolving phenomenon that the clinician can modify as therapy proceeds, forensic assessment, in most instances, is a snapshot described on the witness stand. Finally, although the questions sought to be answered in clinical settings are defined by the clinician and patient, the questions raised in the forensic setting are defined by the law without regard to their grounding in constructs that respond to clinical or scientific knowledge.”

For purposes of this study expert evidence is defined as evidence of opinion supplied by an individual who by means of specialised knowledge, skill or

²³⁹ Allan, A and Meintjes-Van der Walt, L “Expert Evidence” in Kaliski (ed) (2006) *supra* note 2 at 343. Social workers and occupational therapists are excluded. In terms of the Mental Health Care Act 17 of 2002 a “mental health care practitioner” means a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.

²⁴⁰ Sales and Shuman (2005) *supra* note 64 at 9.

experience can assist the trier of fact in determining the factual issue of criminal capacity.

2.7 Psychiatry

“Psychiatry, more than any other branch of medicine, forces its practitioners to wrestle with the nature of evidence, the validity of introspection, problems in communication, and other long-standing philosophical issues.”²⁴¹

The term psychiatry was coined by Johann Christian Reil in 1808 and derives from the Greek word “psyche” which means “soul” or “mind” and “*iatros*” which means “healer” or “doctor”.²⁴²

Psychiatry is a field of medicine focused specifically on the human mind, aiming to study, prevent and treat mental disorders in humans.

The Wikipedia encyclopaedia defines the practice of psychiatry as follows.²⁴³

“Psychiatry is a medical specialty which exists to study, prevent, and treat mental disorders in humans. Psychiatric assessment typically involves a mental status examination and taking a case history, and psychological tests may be administered. Physical examinations may be conducted and occasionally neuro-images or other neurophysiologic measurements taken. Diagnostic procedures vary but official criteria are listed in manuals, the most common being the ICD from the World Health Organization and the DSM from the American Psychiatric Association. Psychiatric medication is a central treatment option which is largely unique to psychiatry along with rarer procedures such as Electroconvulsive therapy. Psychotherapy is also

²⁴¹ Guze, SB “Why Psychiatry is a Branch of Medicine” (1992) at 4.

²⁴² Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/Psychiatry> [accessed on 2008/08/26]. The word “psyche” derives from the ancient Greek for “soul” and “butterfly”. It is interesting to note that the butterfly features on the coat of arms of the Royal College of Psychiatrists. See also James, FE “Psyche” *Psychiatric Bulletin* (1991) at 429–431.

²⁴³ Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/Psychiatry> [accessed on 2008/08/26].

a major treatment option in psychiatry, although it is also the speciality of other mental health professionals.”

The practice of psychiatry is one branch of medicine that is both complex and very controversial.²⁴⁴ The practice of psychiatry in South Africa is mainly regulated by legislation in the form of the Mental Health Care Act.²⁴⁵

Kaliski states the following pertaining to the practice of psychiatry:²⁴⁶

“Psychiatry is a medical specialty. After completing the medical undergraduate degree (usually MB Ch.B/MB B. Ch.) the aspiring psychiatrist has to complete a one year internship in a general hospital. After at least two years of further general practice (including one year of community service) the doctor enters into a four-year registrar training programme under the auspices of an academic department of psychiatry, while working full time in a state psychiatric hospital. Throughout the four years the registrar will work in six-month rotations in various specialised areas, such as acute and emergency psychiatry, child and adolescent psychiatry, old age psychiatry, neuropsychiatry, psychotherapy units, liaison and consultation for the medically ill that require psychiatric care etc. Ultimately, the registrar has to write examinations that are administered in two parts, one for basic neurosciences and psychology, and two for neurology and clinical psychiatry. The universities offer a degree (a M. Med) and the College of Psychiatry a fellowship (PC Psych (SA)) to successful candidates. Either is sufficient for registration with the Health Professions Council (HPC) as a specialist psychiatrist.”

²⁴⁴ See Carstens and Pearmain (2007) *supra* note 33 at 745. See also *R v Von Zell* 1953 (3) SA 301 (A) at 311A-B where Van den Heever JA referred to psychiatry as an “empirical and speculative science with rather elastic notation and terminology, which is usually wise after the event.” See also Carstens, PA “Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid” (1996) - Unpublished LLD thesis University of Pretoria at 522.

²⁴⁵ 17 of 2002 which commenced on 15 Dec ember 2004. See also Carstens and Pearmain (2007) *supra* note 33 at 745.

²⁴⁶ Kaliski (2006) *supra* note 2 at 377 “Appendix: Mental Health Practitioners”.

In the course of this study the pivotal importance of psychiatrists will be illustrated with reference to the defence of criminal incapacity. As the defence of criminal incapacity becomes more popular, there is a growing awareness of the fundamental need for psychiatrists to evaluate persons raising this defence in order to assess the merits of such defence.

Madalo describes psychiatry as follows:²⁴⁷

“Modern psychiatry applies knowledge from the biological and social sciences to the care and treatment of patients suffering from disorders of mental activity and behaviour”

Mandalo in addition notes that psychiatry is faced with a novel challenge in the sense that it can define for the law those mental functions which need to be assessed to ensure a meaningful and sophisticated understanding of the mechanics of the human mind.²⁴⁸

Bazon made a very striking remark by stating:²⁴⁹

“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 psychiatrists would open up their reservoirs of knowledge in the courtroom.”

In terms of the Mental Health Care Act a psychiatrist is a “Mental Health care practitioner” who has been trained to provide mental health care, treatment and

²⁴⁷ Madalo (2000) *supra* note 39 at 8.

²⁴⁸ *Ibid* at 10.

²⁴⁹ As quoted in Greenspan, EL “The Role of the psychiatrist in the Criminal Justice System” (1978) *Am Psychiatry Assoc. J* vol 23 p 137 at 138–139.

rehabilitation services and is accordingly registered as such in terms of the Health Professions Act 54 of 1974.²⁵⁰

Kaliski defines a psychiatrist as follows:²⁵¹

“Psychiatrists are primarily orientated to assess and treat mental disorders (as described in the DSM-IV), and in the first instance should be consulted to exclude the presence of these disorders, or comment on treatment strategies. Often the psychiatrist will be able to comment on so-called normal behaviour in various contexts, especially as it pertains to the disorders under discussion. Generally psychiatrists use the same methods of examination as other medical specialists (including blood tests, brain scans, cerebro-spinal fluid tests, EEG’s etc. and prefer to use biological treatments (together with psychotherapy). Many psychiatrists have additional expertise in the various psychotherapies (such as psychoanalysis, cognitive behavioural therapy etc.), or in sub-specialties such as child psychiatry. *It is always crucial to ascertain each psychiatrist’s actual area of expertise.*”²⁵²

Freckelton and Selby state that a psychiatrist is a qualified medical practitioner specialising in the diagnosis, treatment and prevention of mental illness and related disorders.²⁵³

According to Kisker, the psychiatrist as a physician is qualified to diagnose and assess the more serious mental illnesses as well as those organic in origin.²⁵⁴ As such the psychiatrist’s main priorities will lie either in the physical aspects of

²⁵⁰ See S1 of the Mental Health Care Act. See also Carstens and Pearmain (2007) *supra* note 33 at 745.

²⁵¹ Kaliski (2006) *supra* note 2 at 377; Carstens and Pearmain (2007) *supra* note 33 at 745-746.

²⁵² Emphasis added. One of the main arguments of this study will entail the view that the area of specialization of a particular psychiatrist plays a pivotal role in the assessment of the probative value of the expert evidence presented by such practitioner.

²⁵³ Freckelton, I and Selby, H “Expert evidence in Criminal Law” (1999) at 572.

²⁵⁴ Kisker, SW “The Disorganised Personality” (1964) at 20 as quoted in Carstens and Pearmain (2007) *supra* note 33 at 746–747. See also Tredoux *et al* (2005) *supra* note 35 at 424 where a psychiatrist is defined as: “A medical specialist who treats mental and psychological disorders or illnesses.”

mental disease or in the psychological phenomena associated with such conditions.²⁵⁵ The psychiatrist is ultimately responsible for assessing and interviewing hospitalised patients and stating the most appropriate treatment they should receive and as soon as the most appropriate treatment has been decided upon, the psychiatrist is in charge of supervising the treatment.²⁵⁶ Kisker in addition notes:²⁵⁷

“The psychiatrist also is likely to be involved in research studies, functions, hospital and clinic administration and community relations. ... A psychiatrist ordinarily is consulted when the personality breakdown is severe, when it is suspected that the condition has an organic cause, when the disorder is so serious that hospital care is needed, and when court commitment to a hospital is involved.”

There are various sub-specialties to the practice of psychiatry, for example child and adolescent psychiatry, biological psychiatry etc.²⁵⁸ For purposes of this study emphasis will be placed mainly on the practice of forensic psychiatry.

2.8 Forensic psychiatry

Forensic psychiatry is a subspeciality of psychiatry. It encompasses and deals with the interaction between law and psychiatry.²⁵⁹ Within the domain of the defence of criminal incapacity, forensic psychiatrists will be involved mainly in the assessment of an individual's competency or fitness to stand trial, the evaluation and assessment of the existence of a mental illness or mental defect and also with regard to sentencing recommendations.²⁶⁰

²⁵⁵ *Ibid.*

²⁵⁶ *Ibid.*

²⁵⁷ *Ibid.*

²⁵⁸ See Kermani, E “Handbook of Psychiatry and the Law” (1989); Carstens and Pearmain (2007) *supra* note 33 at 746.

²⁵⁹ Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/Forensic-psychiatry> [accessed on 2008/07/15]. See also generally Brakel, SJ and Brooks, AL “Law and psychiatry in the Criminal Justice System” (2001); Power, DJ, Curran, P and Hughes, JM “Criminal Law and Forensic Psychiatry” (1996). See also Lacoursiere, RB “Forensic Psychiatry: Less Typical Applications” (1999) *Washburn Law Journal* at 29-40.

²⁶⁰ See chapter 3 below.

Faulk defines forensic psychiatry as follows:²⁶¹

“Forensic means pertaining to, connected with, or used in courts of law. A forensic psychiatrist’s work may be said to start with the preparation of psychiatric reports for the court on the mental state of offenders suspected of having a mental abnormality.”

The principal difference between a psychiatrist and a forensic psychiatrist entails that a psychiatrist is a medical doctor who has completed several years of additional training in the analysis, diagnosis, and treatment of mental disorders, whereas a forensic psychiatrist is a psychiatrist who has additional training and/or experience related to the various interfaces of mental health with law.²⁶²

Levy states the following pertaining to forensic psychiatry:²⁶³

“Forensic psychiatry is the application of psychiatric clinical knowledge and research to the practice of law where the criminal defendant’s mental status is at issue. The forensic psychiatrist is an expert at making diagnostic and prognostic judgments that are informed by scientific research and clinical experience about whether a plaintiff’s subjectively experienced emotional distress and/or functional impairment can be plausibly related to the alleged accident, injury or tort.”

Gunn and Taylor list the following forensic psychiatry skills:²⁶⁴

- The assessment of behavioural abnormalities.
- The writing of reports for courts and lawyers.
- The giving of evidence in court.

²⁶¹ Faulk, M “Basic Forensic psychiatry” (1994) at 1.

²⁶² Reid Psychiatry <http://www.reidpsychiatry.com/reidfaq.html> as [accessed on 2008/07/15].

²⁶³ Levy, M “Shrink in the courtroom: Forensic Psychiatry and Law” published in San Francisco Attorney Magazine December 2000–January 2001.

²⁶⁴ Gunn, J and Taylor, PJ “Forensic Psychiatry-Clinical, Legal and Ethical issues” (1993) at 3 (hereafter “Gunn and Taylor”).

- Understanding and using security as a means of treatment.
- The treatment of chronic disorders especially those which exhibit behavioural problems such as severe psychoses and personality disorders.
- Knowledge of mental health law.
- Skill in the psychological treatments of behaviour disorders.

Within the context of the defence of criminal incapacity the forensic psychiatrist will mainly be consulted and utilised for purposes of conducting a psycholegal assessment of the accused in order to ascertain the mental stage of the accused. The forensic psychiatrist will also be required to write a report and give evidence in court.

Gunn and Taylor accordingly define forensic psychiatry as follows.²⁶⁵

“Forensic psychiatry is the prevention, amelioration and treatment of victimization which is associated with mental disease.”

2.9 Clinical psychology

Clinical psychology can be described as the scientific study and application of psychology with the aim of understanding, preventing and relieving psychologically-based distress or dysfunction in order to promote subjective well-being and personal development.²⁶⁶ Although clinical psychologists are mainly involved in psychological assessments and the practice of psychotherapy, they also engage in research, teaching, consultation and forensic testimony.

The field of clinical psychology is often confused with the field of psychiatry. These two professions generally have similar goals, for example the alleviation of mental distress, but they are distinct in the sense that psychiatrists are physicians with the appropriate medical degrees.²⁶⁷ Psychiatrists focus on medication-based

²⁶⁵ Gunn and Taylor (1993) *supra* note 264 at 2.

²⁶⁶ Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/Clinical-psychology> [accessed on 2008/09/05].

²⁶⁷ Wikipedia Encyclopaedia *supra* note 259 at 1.

solutions whereas clinical psychologists are trained in psychological assessment by means of various assessment tools.²⁶⁸

As psychiatrists are physicians they tend to use the medical model to assess psychological problems and some rely on psychotropic medications as the chief method of addressing these problems. Clinical psychologists, on the other hand, do not prescribe medication.

In South Africa the practise of psychology is regulated by a Professional Board established in terms of the Health Professions Act.²⁶⁹

In terms of the Health Professions Act the following “psychological acts” may only be performed by registered psychologists:²⁷⁰

- (a) The evaluation of behaviour or mental processes of personality adjustments of individuals or of groups of persons, through the interpretation of tests for the determination of intellectual abilities, aptitude, interests, personality make-up or personality functioning, and the diagnosis of personality and emotional functions and mental functioning deficiencies according to a recognised scientific system for the classification of mental deficiencies;
- (b) The use of any method or practice aimed at aiding persons or groups of persons in the adjustment of personality, emotional or behavioural problems or at the promotion of positive personality change, growth and development, and the identification and evaluation of personality dynamics and personality functioning according to psychological scientific methods;

²⁶⁸ Wikipedia Encyclopaedia *supra* note 259 at 4. These measures generally fall within one of several categories, including:

- Intelligence and achievement tests
- Personality tests – these tests of personality aim to describe patterns of behaviour, thoughts and feelings.
- Neuropsychological tests
- Clinical observation – such assessment investigates certain core areas such as general appearance and behaviour, mood and affect, perception, comprehension, orientation, insight, memory and content of communication.

²⁶⁹ Act 54 of 1974. See also Tredoux *et al* (2005) *supra* note 35 at 13.

²⁷⁰ See section 37(2)(a)–(h). See also Tredoux *et al* (2005) *supra* note 35 at 13.

- (c) The evaluation of emotional, behavioural and cognitive processes or adjustment of personality of individuals or groups of persons by the usage and interpretation of questionnaires, tests, projections or other techniques or any apparatus, whether of South African origin or imported, for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psycho-physiological functioning or psychopathology;
- (d) The exercising of control over prescribed questionnaires or tests or prescribed techniques, apparatus or instruments for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psycho-physiological functioning or psychopathology;
- (e) The development of and control over the development of questionnaires, tests, techniques, apparatus or instruments for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psycho-physiological functioning or psychopathology;
- (f) The use of any psychotherapeutic method, technique or procedure to rectify, relieve or change personality, emotional, behavioural or adjustment problems or mental deficiencies of individuals or groups of people;
- (g) The use of hypnosis and hypnotherapy;
- (h) The use of any psychological method or counselling to prevent personality, emotional, cognitive, behavioural and adjustment problems or mental illnesses of individuals or groups of people.

The Professional Board for psychology deals with the administration and regulation of Psychology as a profession and is regulated by a larger body, namely the Health Professions Council of South Africa (HPCSA).²⁷¹

²⁷¹ Tredoux *et al* (2005) *supra* note 35 at 10.

Table 1: Central areas of academic psychology²⁷²

Area	Focus	Proponents/ theorists
Developmental psychology	The development of human cognition and emotion from gestation to adulthood	Jean Piaget Anna Freud
Social psychology	Social and group processes underlying such phenomena as conformity, obedience, ethno-centrism/racism, crowd violence	Stanley Milgram Henri Tajfel
Physiological/biological psychology	Biological and bodily processes (especially those of the brain and nervous systems) that are implicated in, and influence human behaviour	Frank Borchers Karl Pribram Aleksandr Luria
Cognitive psychology/cognitive science	Human processing, storage and retrieval of information (e.g. memory, perception, problem-solving, decision-making)	Ulric Neisser Jerry Fodor Ann Treisman
Clinical psychology	The study, assessment and treatment of psychological problems, distress and illness	Sigmund Freud Karen Horney
Health psychology	The promotion and maintenance of physical health, as well as the prevention of illness, through psychological means	Joseph Matarazzo Aaron Antonovsky
Industrial psychology	The study and practice of business and organisational matters from a psychological perspective. Particularly focused on the recruitment, training and assessment of work personnel	Frederick Taylor Hugo Münsterberg Douglas McGregor
Educational psychology	The application of psychology to education; the study of learning as a phenomenon, and the enhancement of different kinds of learning and teaching strategies	B F Skinner Lev Vygotsky

The areas of psychology referred to in the table above often reflect the differences in approach and underlying philosophy. For instance, it is not unusual to find developmental psychologists who disagree about how the cognitive development

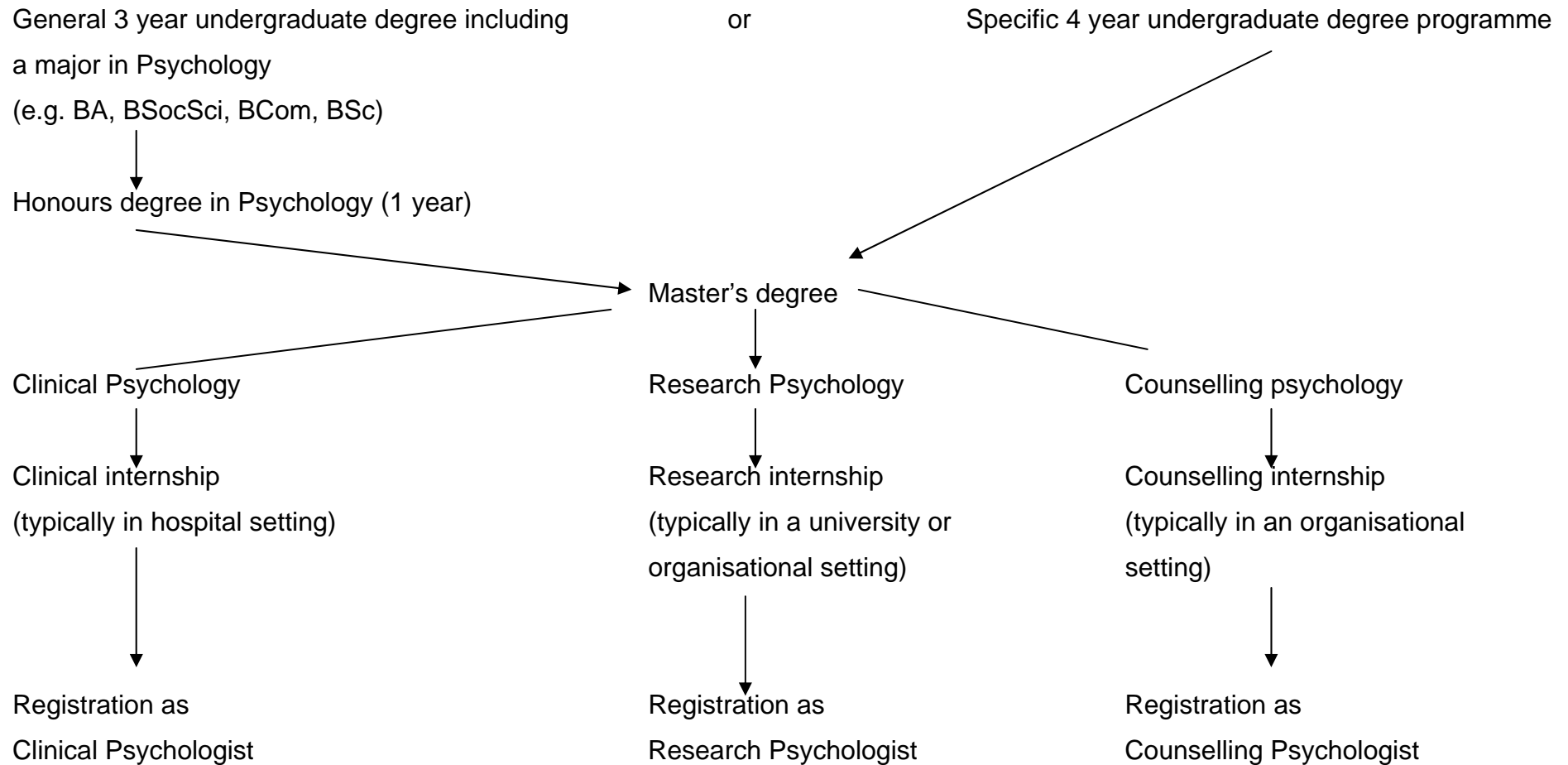
²⁷² Tredoux *et al* (2005) *supra* note 35 at 7.

of children should be researched, or what is ultimately “true” (rather than socially constructed) about the development of children.

There are various subspecialties of psychology of which clinical psychology is one example.²⁷³

²⁷³ See Table 1 as extracted from Tredoux *et al* (2005) *supra* note 35 at 7.

Table 2: Some common routes to registration as a psychologist²⁷⁴



²⁷⁴ See Table 2 as extracted from Tredoux *et al* (2005) *supra* note 35 at 12.

With regards to the educational background of a clinical psychologist, Lay²⁷⁵ explains that in South Africa, in order to qualify as a psychologist, a person is required to complete a university undergraduate degree in social sciences in conjunction with a three-year major in Psychology.²⁷⁶ Thereafter, they will be required to complete a one-year Honours, followed by a Masters Degree in Psychology.²⁷⁷ Students at the Honours level will start to specialise in specific fields such as Clinical, Counselling, Educational, or Industrial psychology.²⁷⁸ The Masters course usually takes two years during which the first year is an academic year during which potential clinical and counselling psychologists will receive specialised training in the psychodynamic understanding of human functioning.²⁷⁹ The latter will include topics such as developmental psychology, personality theory, psychopathology, psychological assessment, psychotherapy, counselling, and neuro-psychology.²⁸⁰ The second year will involve a one-year practical internship at a designated institution such as a psychiatric hospital or counselling centre and as part of their Masters they are also required to complete a short thesis or dissertation. A recent requirement is a one-year community placement before the individual can practise as fully qualified psychologists. Thereafter, the individual is required to register with the HPCSA.²⁸¹

Lay notes that psychologists are more concerned with the emotional and psychological factors that contribute to mental states.²⁸² Lay also states that psychological assessments generally proceed with interviews that correspond to those conducted by psychiatrists with similar conclusions.²⁸³

Lay states the following with regard to the expertise of a clinical psychologist:²⁸⁴

²⁷⁵ Lay, S in Kaliski (2006) *supra* note 2 at 378-379 "Appendix: Mental Health Practitioners". See also Table 2 by Tredoux *et al* (2005) *supra* note 35 at 12.

²⁷⁶ *Ibid.*

²⁷⁷ *Ibid.*

²⁷⁸ *Ibid.*

²⁷⁹ *Ibid.*

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

²⁸² *Ibid.*

²⁸³ *Ibid.*

²⁸⁴ *Ibid.*

Psychologists have additional expertise in being able to administer and interpret psychometric tests. These consist of predetermined items that are conducted in an objective and standardised fashion. Psychometric tests generally comprise of three categories:

- *Intellectual assessment.* The most well-known are IQ tests. But there are many other tests that attempt to overcome biases that culture and education cause, which is a critical issue in assessment in this country.
- *Personality assessment.* These comprise of either objective tests in which the examinee answers questions on a questionnaire that is scored, or projective tests, an unstructured test in which the examinee is shown pictures or inkblots (Rorschach test) and asked to construct narratives about these.
- *Neuropsychological tests:* These are batteries of tests designed to detect changes in the brain, mostly of a cognitive, volitional and emotional nature. These are very specialised tests and should only be administered and interpreted by a psychologist who has received additional training in neuropsychology.

Within the context of the defence of criminal incapacity, the Criminal Procedure Act²⁸⁵ currently provides for the presentation of expert evidence by a clinical psychologist in the event of a criminal incapacity enquiry. During the course of this study the role of the clinical psychologist within the context of the psycholegal assessment process will be evaluated as well as the probative value of expert evidence presented by a clinical psychologist in support of a defence of criminal incapacity.

2.10 Forensic psychology

Another sub-speciality of psychology that will be addressed during the course of this study is the field of forensic psychology and its impact on the defence of criminal incapacity. The motivation for including the practice of forensic psychology

²⁸⁵ See section 79(1) of the Criminal Procedure Act 51 of 1977.

in this study lies mainly in the distinction between a forensic and a therapeutic evaluation.

Melton *et al* indicate that the various dimensions distinguishing a therapeutic from a forensic assessment are the following:²⁸⁶

- *Scope.* Rather than the broad set of issues a psychologist addresses in a clinical setting, a forensic psychologist addresses a narrowly defined set of events or interactions of a non-clinical nature.
- *Importance of client's perspective.* A clinician places primary importance on understanding the client's unique point of view, while the forensic psychologist is interested in accuracy, and the client's viewpoint is secondary.
- *Voluntariness.* Usually in a clinical setting a psychologist is dealing with a voluntary client. A forensic psychologist evaluates clients by order of a judge or at the behest of an attorney.
- *Autonomy.* Voluntary clients have more latitude and autonomy regarding the assessment's objectives. Any assessment usually takes their concerns into account. The objectives of a forensic examination are confined by the applicable statutes or common law elements that pertain to the legal issue in question.
- *Threats to validity.* While the client and therapist are working toward a common goal, although unconscious distortion may occur, in the forensic context there is a substantially greater likelihood of intentional and conscious distortion.
- *Relationship and dynamics.* Therapeutic interactions work toward developing a trusting, emphatic therapeutic alliance; a forensic psychologist may not ethically nurture the client or act in a "helping" role, as the forensic evaluator has divided loyalties and there are substantial limits on

²⁸⁶ Melton *et al* (2007) *supra* note 49 at 44. See also Shapiro, DL "Forensic Psychological Assessment – An Integrative Approach" (1991) at 1-4; Nicholson, RA and Norwood, S "The Quality of Forensic Psychological Assessments, Reports and Testimony: Acknowledging the Gap between promise and Practice" (2000) *Law and Human Behaviour* at 9; Barlow, DH and Durand, UM "Abnormal Psychology – An Integrative Approach" (1995) at 77-116.

confidentiality he can guarantee the client. A forensic evaluator must always be aware of manipulation in the adversary context of a legal setting. These concerns mandate an emotional distance that is unlike a therapeutic interaction.

- *Pace and setting.* Unlike therapeutic interactions which may be guided by many factors, the forensic setting with its court schedules, limited resources, and other external factors, place great time constraints on the evaluation without opportunities for re-evaluation. The forensic examiner focuses on the importance of accuracy and the finality of legal dispositions.

Forensic psychology can be defined as the interface between psychology and the legal system. It is a subspeciality of applied psychology concerned with the collection, examination and presentation of psychological evidence for judicial purposes.²⁸⁷ The practice of forensic psychology comprises the understanding of applicable law in order to conduct legal evaluations and interact appropriately with judges, attorneys and other legal professionals. A very important aspect of forensic psychology is the ability to testify in court and reformulating psychological findings into legal language of the court in order to provide information in such a way that it can be understood.²⁸⁸ A forensic psychologist can be trained in clinical, social, organizational or any other branch of psychology.

Forensic psychologists are frequently appointed by the court to assess an accused's competency or fitness to stand trial as well as the accused's state of mind at the time of the offence. Forensic psychologists also provide sentencing recommendations, treatment recommendations as well as any additional information the judge requests including information pertaining to mitigating factors and the assessment of future risk.²⁸⁹

²⁸⁷ Wikipedia Encyclopaedia <http://en.wikipedia.org/wiki/Forensic/psychology> [accessed on 2008/07/15].

²⁸⁸ *Ibid.*

²⁸⁹ See also Tredoux *et al* (2005) *supra* note 35 at 63–86.

A forensic psychologist is thus any psychologist who by virtue of training or experience may assist a court or a trier of fact in arriving at a just and fair decision.²⁹⁰

Davies, Hollin and Bull elaborate further on the definition of forensic psychology by stating:²⁹¹

“It is often said that forensic psychology is a broad church embracing a variety of studies at the interface of psychology and the law. However, to pursue the analogy a little further, it is a church with two main aisles: *legal psychology* covering the application of psychological knowledge and methods to the process of law and *criminological psychology* dealing with the application of psychological theory and method to the understanding (and reduction) of criminal behaviour. In a nutshell, legal psychology deals with evidence, witnesses and the courts while criminological psychology focuses on crime and criminals.”

Other terms used to refer to forensic psychology are “psychology and law” and “legal psychology”.

Gudjonsson and Haward define forensic psychology as:²⁹²

“... that branch of applied psychology which is concerned with the collection, examination and presentation of evidence for judicial purposes.”

Arrigo and Shipley state the following pertaining to the practice of forensic psychology and its role and place:²⁹³

“The expanse of the field is rooted in its sundry models of instruction and practice. Clinical practitioners emphasize the assessment, diagnosis, and

²⁹⁰ See <http://www.geocities.com/Athens/7429/forensicpsychprep.html> [accessed on 2008/07/15].

²⁹¹ Davies, G, Hollin, C and Bull, R “Forensic Psychology” (2008) at xi.

²⁹² Gudjonsson, GH and Haward, LRC “Forensic Psychology: A guide to Practice” (1998) at 1.

²⁹³ Arrigo, BA and Shipley, SL “Introduction to Forensic Psychology: Issues and Controversies in Law, Law Enforcement and Corrections” (2005) at xvii.

treatment of different civil and criminal forensic populations. Law/psychology practitioners emphasize the development of the legally trained specialist whose overlapping skills in courtroom processes and human behaviour make for a formidable expert in the treatment and policy arenas. Law-psychology-justice practitioners emphasize the development of a cross-trained specialist whose integrative knowledge base in psychology, criminology, organizational analysis, policy studies, and law readies the person for the increasing demands of a multifaceted profession. If appropriately prepared, this specialist moves skilfully among those in the psychotherapeutic, management, and advocacy communities.”

According to Arrigo and Shipley forensic psychologists are primarily concerned with crime and justice.²⁹⁴

Howitt provides the following definition of forensic psychology.²⁹⁵

“Forensic psychology literally is psychology to do with the courts of law. The term *forensic* and *forum* have the same Latin origins. A forum is merely a room for public debate, hence the word forensic. Criminal psychology is mainly to do with psychological aspects of criminal behaviour and includes issues such as origins of criminality.”

Reference to criminal psychology is specifically included in this section as this concept will also be addressed during the course of this study.

It is important to note that a forensic psychologist views an accused from a different point of view than the traditional clinical psychologist as indicated above. Traditional psychological tests and interview procedures are not always sufficient when applied in a forensic setting. Unlike the more traditional applications of

²⁹⁴ Arrigo and Shipley (2005) *supra* note 293 at xviii.

²⁹⁵ Howitt, D “Introduction to forensic and Criminal Psychology” (2006) at 2.

clinical psychology informed consent is not required when the assessment is ordered by the court.²⁹⁶

Kaliski and Zabow state the following:²⁹⁷

“Forensic evaluations do not usually occur within fiduciary relationships, and may be best characterised as ‘examiner-examinee’ relationships. ... Unlike the usual doctor-patient relationship, in which there has to be concern that the individual’s autonomy is respected, care taken that no harm befalls him or that his best interests are served, the psycholegal relationship may be beholden to the greater needs of the community.”

3 Problem statement and hypotheses

During the course of an extensive literature study pertaining to “the role of expert evidence in support of the defence of criminal incapacity” certain controversial and problematic questions were identified which will form the cornerstone and foundational framework of the present study. These problematic hypotheses can be formulated as follows:

- What is the precise role and place of expert evidence within the framework of the defence of criminal incapacity?
- What role does psychiatry and psychology play in the assessment and evaluation of the defence of non-pathological criminal incapacity?
- What is the precise role and value of psychiatry and psychology during the assessment of battered woman syndrome evidence?
- What is the current status of a battered woman/spouse who kills her/his abusive partner? Can the defence of criminal incapacity be invoked, and if

²⁹⁶ Wikipedia Encyclopaedia *supra* n 217.

²⁹⁷ Zabow, T and Kaliski, SZ “Ethical Considerations” in Kaliski (ed) (2006) *supra* note 2 at 359.

so, should the defence be one of non-pathological or pathological criminal incapacity?

- What influence does the South African Constitution have on the defence of criminal incapacity? What is the Constitutional relevance of the burden of proof in relation to the defence of pathological criminal incapacity?
- How do psychological and psychiatric sciences contribute towards proving the defence of criminal incapacity?
- What are the probative value, reliability and validity of forensic assessments in the judicial process?
- What is the role of forensic psychiatry and psychology in support of the defence of criminal incapacity?
- Who is qualified to provide expert testimony in support of a defence of criminal incapacity?
- What ethical considerations should apply during a psycholegal assessment?
- What is the current standard in respect of the concept of “mental illness” and “mental defect” and how does this impact on the sustainability and merits of the defence of pathological criminal incapacity?
- Should the Criminal Procedure Act, in its current form, be amended with reference to specific problem areas, in order to provide more clarity and legal certainty in respect of the defence of criminal incapacity?
- What should the mental health expert witness expect in the court and what impact could his or her testimony have?

4 Central theoretical statement

During the course of this study the author will attempt to verify the following central theoretical statement:

Mental health experts, and more specifically, forensic mental health experts, play a pivotal and essentially crucial role in the assessment and proof of the merits and validity of the defence of criminal incapacity. There is a fundamental need for carefully trained specialists with a proper understanding of the mechanics of law, the sciences of psychology and psychiatry respectively, and the complexities of human behaviour to assist the court in cases where the defence of criminal incapacity is raised. The role of the mental health expert in support of the defence of criminal incapacity is dual functional in the sense that it is in the first place pivotal to have the assistance of such an expert and in the second place it is important that the expert be adequately trained and experienced in the particular field of mental health concerned.

5 Methodology

This study will entail a theoretical and investigative exposition of the role of expert evidence in support of the defence of criminal incapacity.

In order to address the abovementioned hypotheses, the present study will be conducted as follows:

Chapter 2

This chapter will critically address the role of expert evidence in respect of the defence of non-pathological criminal incapacity. This chapter will deal extensively with the defence of non-pathological criminal incapacity with a discussion pertaining to the origin, development, recent controversies pertaining to this defence with an assessment of the role that expert evidence has played in support of this defence as well as the future role of expert evidence in support of this

defence. This chapter will also evaluate the plight of the battered woman within the current legal system with recommendations on how the battered woman could possibly be accommodated within the ambit of the defence of non-pathological criminal incapacity.

Chapter 3

This chapter will critically address the defence of pathological criminal incapacity as well as address the role of expert evidence in respect of this defence better known as the defence of mental illness or “insanity”. This chapter will also address the problem areas specifically with reference to the definition of “mental illness” and “mental defect” and the lack of clarity as to the precise meaning that should be attached to these words. The impact of the Diagnostic and Statistical Manual of Mental Disorders (“DSM IV”) on the definition of “mental illness” and “mental defect” will also be evaluated. It is further clear that the definition of “mental illness” and “mental defect” ascribed by psychiatrists differ markedly from the meaning ascribed to these terms in section 77–79 of the Criminal Procedure Act 51 of 1977. This “gap” will also be discussed critically.

Chapter 4

This chapter will discuss the rules of the Law of Evidence relating to expert evidence within the ambit of the “opinion rule”. The evidentiary principles relating to scientific evidence will also be discussed in this chapter. This chapter will also discuss the role of the psychiatrist and the psychologist within the context of the defence of criminal incapacity as these two experts will be the main role players during the presentation of expert evidence in support of this defence with reference to section 77–79 of the Criminal Procedure Act 51 of 1977. This chapter will also address the sustainability of the “ultimate issue” principle pertaining to expert evidence in the light of our current Constitution of the Republic of South Africa, 1996. The various ethical dilemmas encountered within the forensic assessment process will also be assessed critically.

Chapter 5

In this chapter a comparative perspective will be provided pertaining to a *capita selecta* of principles of expert evidence in the United States of America. The ethical codes of the practices of forensic psychiatry and psychology in the United States of America will also be assessed.

Chapter 6

This chapter will contain a summary of the research conducted and valuable recommendations flowing from the research will be presented.

“More and more we lawyers are awaking to a perception of the truth that what divides and distracts us in the solution of a legal problem is not so much uncertainty about the law as uncertainty about the facts – the facts which generate the law. Let the facts be known as they are, and the law will sprout from the seed and turn its branches toward the light.”²⁹⁸

²⁹⁸ Benjamin Nathan Cordozo “What medicine can do for Law”. Address before the New York Academy of Medicine, November 1, 1928 as quoted in Allen, RC, Ferster, EZ and Rubin, JG “Readings in Law and Psychiatry” (1968) at 1.

CHAPTER 2

THE DEFENCE OF NON-PATHOLOGICAL CRIMINAL INCAPACITY: ASSESSING THE FUNDAMENTAL NEED FOR EXPERT EVIDENCE AND LEGAL CERTAINTY

“One is tempted to define man as a rational animal who always loses his temper when he is called upon to act in accordance with the dictates of reason.” (Oscar Wilde [1854–1900] in “The Critic as Artist” [1891])

1 Introduction

Over the past two to three decades, South African criminal law has viewed the emergence of a defence currently labelled as non-pathological criminal incapacity.¹

¹ Snyman, CR “Criminal Law” (2008) 5th ed at 162-169; Snyman, CR “Strafreg” (2006) 5th ed at 161-167; Snyman, CR “Criminal Law” (2002) 4th ed at 163-167; Burchell, J and Milton, J “Principles of Criminal Law” (2005) 3rd ed at 358-369, 403-454; Kaliski, SZ “Psycholegal Assessment in South Africa” (2006) at 34-57; Tredoux, C, Foster, D, Allan, A, Cohen, A and Wassenaar, D “Psychology and Law” (2005) at 400-407 (hereafter referred to as “Tredoux *et al*”); Ludsin, H and Vetten, L “Spiral of Entrapment – Abused women in conflict with the Law” (2005) at 155-167; Strauss, SA “Doctor, patient and the law – A selection of practical issues” (1991) at 134-135; Pistorius, M “Fatal Females” (2004) at 15-58; Strauss, SA “Nie-Patologiese Ontoerekeningsvatbaarheid as verweer in die Strafreg: ‘n Nuwe uitdaging vir Deskundige, mediese getuies” (1995) *SAPM* at 14-15/34; Snyman, CR “Die Verweer van nie-patologiese Ontoerekeningsvatbaarheid in die Strafreg” (1989) *TRW* at 1-15; Van Oosten, FFW “Non-pathological criminal incapacity versus pathological criminal incapacity” (1993) *SACJ* at 127-147; Louw, PF “Die Algemene Toerekeningsvatbaarheidsmaatstaf” (1987) *SACJ* at 362-370; Bergenthuin, JG “Die algemene toerekeningsvatbaarheidsmaatstaf” (1985) *De Jure* at 275-282; Burchell, EM and Hunt, PMA “South African Criminal Law and Procedure – General Principles of Criminal Law” (1997) at 35-36, 153-161, 201-219; Du Toit, E, De Jager, FJ, Paizes, A, Skeen, A ST Q and Van der Merwe, S “Commentary on the Criminal Procedure Act” (2007) at 13-17 – 13-19 (hereafter “Du Toit *et al*”); Burchell, J and Milton, J “Cases and Materials on Criminal Law” (2007) at 336-437; Kriegler, J and Kruger, A “Hiemstra – Suid-Afrikaanse Strafproses” (2008) 6th ed at 13-14 – 13-24; Bergenthuin, JG “Provokasie as Verweer in die Suid-Afrikaanse Strafreg” (1985) Unpublished LLD thesis University of Pretoria; Bergenthuin, JG “Provokasie in die Suid-Afrikaanse Strafreg” (1986) at 98-109; Carstens, PA and Le Roux, J “The defence of non-pathological incapacity with reference to the battered wife who kills her abusive husband” (2000) *SACJ* at 180-189; Joubert, W A and Faris, JA “The Law of South Africa” (2004) vol 6 2nd ed (hereafter *LAWSA*) at 70-72; S v Chretien 1981 (1) SA 1097 (A); S v Van Vuuren 1983 (1) SA 12 (A); S v Arnold 1985 (3) SA 256 (C); S v Adams 1986 (4) SA 882 (A); S v Campher 1987 (1) SA 940 (A); S v Wiid 1990 (1) SACR 561 (A); S v Potgieter 1994 (1) SACR 61 (A); S v Kalogoropoulos 1993 (1) SACR 12 (A); S v Kensley 1995 (1) SACR 646 (A); S v Nursingh 1995 (2) SACR 331 (D); S v Di Blasi 1996 (1) SACR 1 (A); S v Cunningham 1996 (1) SACR 631 (A); S v Francis 1999 (1) SACR 650 (SCA); S v Henry (1999), All SA 290 (SCA), 1999 (1) SACR 13 (SCA); S v Kok 2001 (2) SACR 106 (SCA); S v Eadie 2002 (3) SA 719 (SCA), 2002 (1) SACR 663 (SCA); S v Moses 1996 (1) SACR 701 (C); S v Gesualdo 1997 (2) SACR 68 (W); S v Smith 1990 (1) SACR 130 (A); S v Rittman 1992 (2) SACR 110 (NMHC); S v Calitz 1990 (1) SACR 119 (A); S

This ubiquitous defence has not only given rise to much controversy and debate, but has also resulted in a head-on conflict between the fields of behavioural sciences, on the one hand, and the law, on the other. The heart of this conflict could be traced to the fundamental recognition and understanding of the merits and nature of the defence of non-pathological criminal incapacity. The probative value of expert evidence in support of a defence of non-pathological criminal incapacity is currently a highly controversial issue.

Whenever the defence of pathological criminal incapacity is raised, expert psychiatric and psychological evidence is statutorily provided for within the context of the accused being sent for observation.²

The latter observation can be conducted either if it appears to a court that the accused is not capable of understanding the proceedings in order to make a proper defence, or if it appears that the accused's mental state at the time of the commission of the alleged crime is questionable.

v Engelbrecht 2005 (2) SACR 41 (WLD); S v Ferreira 2004 (2) SACR 454 (SCA); S v Kensley 1995 (1) SACR 646 (A); S v Laubscher 1988 (1) SA 163 (A); S v Leaner 1996 (2) SACR 247 (C); S v Nursingh 1995 (2) SACR 331 (D); S v Scholtz 2006 (1) SACR 442 (EPD); S v Volkman 2005 (2) SACR 402 (CPD); Boister, N "Case discussions, Liability – Non-pathological Criminal Incapacity" (1995) SACJ vol 8 at 367; Burchell, J "Non-pathological incapacity: Evaluation of psychiatric testimony" (1995) SACJ vol 8 at 37; De Vos, P "Criminal capacity, provocation and HIV" (1996) SACJ vol 9 at 354; Hoctor, S "Road Rage and reasoning about Responsibility" (2001) SACJ vol 14 at 195; Le Roux, J "Strafregtelike aanspreeklikheid en die verweer van tydelike nie-patologiese ontoerekeningsvatbaarheid – verlies van konatiewe Geestesfunksie onderskei van blote verlies van Humeur – S v Eadie (1) 2001 (1) SACR 172 THRHR 2002 vol 65 at 478; Le Roux, J "Strafregtelike aanspreeklikheid en die verweer van nie-patologiese oftewel gesonde outomatisme" *De Jure* (2000) vol 33 (1) at 190; Louw, R "S v Eadie: Road Rage, Incapacity and Legal confusion" (2001) SACJ vol 14 at 206; Louw, R "S v Eadie: The end of the road for the defence of provocation?" (2003) SACJ vol 16 at 200; Meintjes-Van der Walt, L "Making a muddle into a mess? The amendment of section 78 of the Criminal Procedure Act" (2002) SACJ vol 15 at 242; Rumpff, F "Feite of Woorde" (1990) *Consultus* vol 3 (1) at 19; Snyman, CR "Is there such a defence in our Criminal Law as "Emotional Stress?" (1985) *SALJ* at 240; Snyman, CR "The tension between legal theory and policy considerations in the general principles of Criminal Law" (2003) *Acta Juridica* at 1; De Wet, JC and Swanepoel, HL "Strafreg" (1975) at 105-135.

² See Section 77-79 of the Criminal Procedure Act, 51 of 1977 (hereafter "The Criminal Procedure Act"). These sections pertaining to pathological criminal incapacity will be discussed extensively in chapter 3 below.

If, however, the defence is one of non-pathological criminal incapacity, expert evidence is not a prerequisite in order to rely on the defence and does not fulfil an indispensable function.³

In *S v Volkman* Hockey AJ remarked as follows:⁴

“Clearly, the legislature made a distinction between allegations of criminal incapacity based on mental illness or mental defect, on the one hand, and such incapacity based on ‘any other reason’ on the other. Where there is an allegation or appearance of mental illness or mental defect, the court is obliged (“the court shall”) to direct that, the accused is referred for observation in terms of section 79 of the Act. If, however, there is an allegation of lack of criminal responsibility for any other reason, other than mental illness or mental defect, the court has a discretion whether to refer the accused for observation or not. Non-pathological incapacity falls within the latter category. Entrusting the court with discretion in cases of non-pathological incapacity is not surprising.”

In terms of section 78(2) of the Criminal Procedure Act, a court retains a discretionary power to refer an accused for observation whenever the defence of non-pathological criminal incapacity is the defence in question. This referral can be made upon a request by either the accused, the State or the court. The problematic issue pertaining to expert evidence in support of the defence of non-pathological criminal incapacity, lies not so intensely with the referral of an accused for observation but rather with the expert mental health professionals conducting the observation. It is a known fact that the facilities for purposes of a forensic evaluation in State hospitals are limited and accordingly not every accused can be referred randomly.⁵ The problem with the defence of non-pathological criminal incapacity is that psychiatrists are generally sceptical and

³ Snyder, CR “Criminal Law” (2002), 4th ed at 166; *S v Calitz supra* note 1 at 119-121; *S v Laubscher supra* note 1 at 166-167; *S v Lesch supra* note 1; *S v Kalogoropoulos supra* note 1 at 21i; *S v Van der Sandt* 1998 (2) SACR 627 (W) at 636 G.

⁴ *S v Volkman* 2004 (4) All SA 697 (C) at 699.

⁵ Statistics obtained on 24 November 2008 during an interview with Dr P de Wet, a psychiatrist at Weskoppies Hospital of Weskoppies Mental Institution revealed that even though approximately 46 beds are available, only approximately 38 can be allocated to accused persons due to a lack of staff at the particular institution.

non-responsive to this defence due to the fact that the causes of non-pathological criminal incapacity are external factors and not a known mental illness or mental defect or some form of pathology, in which psychiatrists are trained, as clearly explained in the previous chapter.

Accordingly, when conducting a forensic assessment, a psychiatrist will examine an accused in order to establish whether the accused suffers, or suffered at the time of the commission of the crime in question, from a known mental illness or mental defect or some pathological disturbance that rendered the accused incapable of appreciating the wrongfulness of his or her actions or acting in accordance with such appreciation. In almost all cases of non-pathological criminal incapacity, the latter will be absent which results in this particular portion of expert evidence not adding probative value in support of this defence or even disproving the defence if the referral was requested by the State.

Strauss correctly states:⁶

“In die praktyk kan dit vir ‘n deskundige uiters moeilik wees om met ‘n eenvoudige ‘ja’ of ‘nee’ te antwoord. Daar moet in gedagte gehou word dat ons in dié gevalle juis nie ‘n handboek-diagnose van geestespatologie het waarby die geskiedenis van die beskuldigde of die identifisering van bepaalde sindrome aanduidend kan wees van bepaalde bevindinge oor sy vermoëns nie.”

This type of expert evidence will most probably not survive cross examination by the State to disprove the defence and also, if the referral was requested by the State, it could be attacked by the defence on grounds relating to reliability and validity.

The problem in respect of expert evidence pertaining to the defence of non-pathological criminal incapacity is further exacerbated by the fact that mental health professionals do not, generally, draw a distinction between the defence of

⁶ Strauss (1995) *SAPM supra* note 1 at 15.

sane automatism or involuntariness of conduct, on the one hand, and “lack of self-control” that relates to the second leg of the test for criminal capacity,⁷ on the other. From a medical point of view “lack of self-control” and automatism are one and the same defence. From a legal perspective, automatism or involuntariness of conduct and “lack of self-control” are two distinct and separate defences relating to different requirements for criminal liability.⁸

Louw correctly states:⁹

“It is at this point that law and psychology appear to part ways. Lack of self-control appears to be a legal contraction not readily amenable to psychological analysis.”

Accordingly, the precise demarcation and distinction between the defences of sane automatism and non-pathological criminal incapacity has given rise to much debate which inadvertently affects the probative value of expert evidence in support of these defences respectively. In the light of the fact that the Courts have not been consistent in their approach towards the proper weight attached to expert evidence and the rules regulating the admission of such evidence in cases of non-pathological criminal incapacity, very little guidance is provided towards a proper standard for admitting such evidence in cases where the defence is one of non-pathological criminal incapacity.

In the midst of the war between law and medicine pertaining to the defence of non-pathological criminal incapacity, stands the battered woman.¹⁰ Non-pathological criminal incapacity is one of the defences available to the battered woman who

⁷ See *S v Moses supra* note 1 at 711C-D where Dr Jedaar, the State psychiatrist, stated: “A person can never lose control except in a state of automatism, or other pathological states. Even in a state of rage or extreme anger I am still of the same belief that you will have the cognitive ability to weight the expression of that rage.”

⁸ Snyman (2008) *supra* note 1 at 51, 162; Burchell and Milton (2005) *supra* note 1 at 139; Le Roux (2008) *THRHR supra* note 1 at 478

⁹ Louw “Principles of Criminal Law: Pathological and Non-Pathological Criminal Incapacity” in Kaliski (ed)(2006) *supra* note 1 at 52.

¹⁰ For purposes of this chapter reference will be made to battered women and the battered woman syndrome. This should, however, be construed to also refer to the “battered spouse” or “battered partner” and is not intended to be portrayed as being gender specific.

kills her abusive spouse or partner and has been raised successfully in the past.¹¹ The heated debate between law and medicine as to the merits and existence of the defence of non-pathological criminal incapacity, to some extent casts doubt on the availability of this defence to a battered woman. The question that arises is whether psychologists, and more specifically forensic psychologists, are not in a better position to provide expert evidence in cases where battered woman syndrome evidence is presented in the light of the fact that psychiatrists do not welcome the defence of non-pathological criminal incapacity. Should the defence of non-pathological criminal incapacity not be based on a different form of expert evidence as opposed to pathological criminal incapacity?

One of the most controversial decisions in the history of the defence of non-pathological criminal incapacity is the decision in *S v Eadie*.¹² This decision casts doubt on the future existence and place of the defence of non-pathological criminal incapacity. The decision also did not provide clarity as to the role of expert evidence pertaining to this defence. This decision and its impact on the defence of non-pathological criminal incapacity will be assessed in detail in this chapter.

In this chapter the author will examine the defence of non-pathological criminal incapacity with specific reference to the origin, development and future place of this defence. The Constitutional aspects pertaining to this defence will also be discussed. The role of mental health professionals in the assessment of this defence will be dealt with extensively. The presentation of battered woman syndrome evidence in support of this defence will also be evaluated within the context of the battered woman who kills her abusive partner or spouse with possible recommendations for reform.

¹¹ Snyman (2008) *supra* note 1 at 165; *S v Wiid supra* note 1 at 561.

¹² *S v Eadie supra* note 1 at 663; *S v Eadie supra* note 1 at 719; Louw, (2001) *supra* note 1 at 206; Louw, (2003) *SACJ supra* note 1 at 200; Le Roux (2002) *THRHR supra* note 1 at 478; Hoctor (2001) *SACJ supra* note 1 at 195; Snyman (2008) *supra* note 1 at 164-169; Snyman "Strafreg" (2006) 5th ed at 163-167; Burchell and Milton 2005 *supra* note 1 at 427-451; Joubert, WA and Faris, JA "The Law of South Africa" (2004) vol 6 2nd ed 70-72 (hereafter "LAWSA"); Burchell and Milton (2007) *supra* note 1 at 381-402, Du Toit *et al*, (2007) *supra* note 1 at 13-17 - 13-19.

2 Mode of discussion

The primary objective of this chapter is to provide an analysis of the current role and place of expert evidence in support of the defence of non-pathological criminal incapacity with a careful dissemination of the critical issues in respect of this defence. The first part of this chapter will focus on the origin and development of the defence of non-pathological criminal incapacity with a discussion of the most important case law pertaining to this defence. The probative value of expert evidence in these cases will be carefully scrutinised. Only a *capita selecta* of origins of non-pathological criminal incapacity will receive attention in this chapter. The specific origins of non-pathological criminal incapacity that will be discussed and assessed against the backdrop of the role of expert evidence in support of this defence are provocation, emotional stress and intoxication as these are the reasons most commonly encountered in practice for raising the defence of non-pathological criminal incapacity. For purposes of this chapter youthfulness will not be discussed. The second part of this chapter will be devoted to a discussion of the “battered woman” and the presentation of battered woman syndrome evidence in support of a defence of non-pathological criminal incapacity. The researcher acknowledges that the current chapter will be exposed to criticism levelled towards the length, and possibly, the layout of the chapter. The following reasons are, however, advanced as justification for the length and layout of the chapter:

- The defence of non-pathological criminal incapacity is largely uncodified and as such almost exclusively founded in case law.
- In order to adequately assess the proper role and place of expert evidence in support of the defence of non-pathological criminal incapacity, an in depth analysis and dissemination of decisions dealing with the latter defence was inescapable in order to address the role and probative value of expert evidence in support of this defence.
- Between the defences of pathological- and non-pathological criminal incapacity, the defence of non-pathological criminal incapacity is by far the defence which is most controversial and clouded with numerous anomalies with specific reference to the need for expert evidence as well as the debate relating to the continued existence of this defence within our

current criminal justice system. The latter inadvertently exacerbates the need for an in depth analysis.

- The specific causes of non-pathological criminal incapacity addressed in this chapter, are addressed within the context of the defence of non-pathological criminal incapacity and more specifically, within the context of the role, place of, and the need for expert evidence in support of the defence of non-pathological criminal incapacity. Accordingly, these causes of non-pathological criminal incapacity are addressed in this chapter and not in separate, independent chapters as the main theme of the study entails the role and place of expert evidence in support of the defence of criminal incapacity and not the causes of criminal incapacity and more specifically, non-pathological criminal incapacity.
- Academic opinions advanced in respect of the various decisions pertaining to the defence of non-pathological criminal incapacity will be encapsulated subsequent to the discussion of each decision. In this manner the latter will serve to integrate the various views held in all the decided case law.

3 Constitutional foundation

“The sacred rights of mankind are not to be rummaged for, among old parchments, or musty records. They are written, as with sun beam in the whole volume of human nature, by the hand of divinity itself; and can never be erased or obscured by mortal power.” (Alexander Hamilton [1775])

3.1 Introductory remarks

On 8 May 1996 the Constitutional Assembly adopted the current Constitution of the Republic of South Africa, which commenced on 4 February 1997.¹³ Within a

¹³ Constitution of the Republic of South Africa, 1996. See also De Waal, J, Currie, I, Erasmus, G “The Bill of Rights Handbook” (2005) 5th ed at 6; Cheadle, MH, Davis, DM and Haysom, NRL “South African Constitutional Law: The Bill of Rights” (2002) at 20 and also Devenish, GE “The South African Constitution” (2005) at 1 where in the preface it is stated: “Equal and exact justice to all men, of whatever state or persuasion, religious or political, peace, commerce, and honest friendship with all nations ... Freedom of religion, freedom of the press, and freedom of person under the protection of the *habeas corpus* ... These

new constitutional dispensation South Africa has come a long way in facing various constitutional challenges. An assessment of the role of expert evidence in support of the defence of criminal incapacity will have limited value if not addressed against the backdrop of our current Constitution. Accordingly, before embarking on a discussion of the role and place of expert evidence in support of the defence of non-pathological criminal incapacity, the author will first discuss the Constitutional foundation of the topic.

The Constitution is currently the Supreme law of South Africa.¹⁴ A Constitution, in short, can be conceptualized as a formal written instrument or “social contract” representative of the people of the country and “accorded public assent through ratification by means of a special procedure”.¹⁵

principles form the bright constellation which has gone before us, and guided our steps through the age of revolution and reformation.”

See also Devenish, GE “A Commentary on The South African Constitution” (1998) at 3-10; Steytler, N “Constitutional Criminal Procedure – A commentary on the Constitution of the Republic of South Africa, 1996” (1998).

¹⁴ Section 1 of the Constitution states:

“1. The Republic of South Africa is one, sovereign, democratic state founded on the following values:

- (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.
- (b) Non-racialism and non-sexism.
- (c) Supremacy of the Constitution.
- (d) ...”

Section 2 of the Constitution states:

“2. This Constitution is the Supreme law of the Republic, law or conduct inconsistent with it is invalid, and the obligation imposed by it must be fulfilled.” See also Carstens, PA and Pearmain, D “Foundational Principles of South African Medical Law” (2007) at 21.

In *S v Makwanyane* 1995 (3) SA 391 (CC) 487 Mahomed J observed:

“In some countries the Constitution only formalises, in a legal instrument, a historical consensus of values and aspirations evolved incrementally from a stable and unbroken past to accommodate the needs of the future. The South African Constitution is different: it retains from the past only what is defensible and represents a decisive break from, and a ringing rejection of, that part of the past which is disgracefully racist, authoritarian, insular, and repressive, and a vigorous identification of and commitment to a democratic, universalistic, caring and aspirationally egalitarian ethos expressly articulated in the Constitution. The contrast between the past which it repudiates and the future to which it seeks to commit the nation is stark and dramatic.” See also at 498 where it is stated: “The Constitution makes it particularly imperative for courts to develop the entrenched fundamental rights in terms of a cohesive set of values, ideal to an open and democratic society. To this end common values of human rights protection the world over and foreign precedent may be instructive.” See also Carstens and Pearmain (2007) *supra* at 21-22. See also Devenish, GE “The South African Constitution” (2005) at 31-34.

¹⁵ Devenish, (2005) *supra* note 13 at 1. The Shorter Oxford English Dictionary (1992) 408 defines the term “Constitution” as: “the system or body of fundamental principles according to which a nation, state, or body politic is constituted or governed.”

In *Attorney-General v Dow* 1994 (6), (Bot) 7B-C, Amisshah JP stated:

“(a) written constitution is the legislation or compact which establishes the State itself. It paints in broad strokes on a large canvass the institutions of that State, allocating powers,

Chapter 2 of the Constitution contains the Bill of Rights. It protects the negative and positive rights of all people against the government of South Africa, including its executive, legislative and judicial branches.¹⁶

Cheadle, Davis and Haysom state the following in respect of a Bill of Rights:¹⁷

“A bill of rights is a particular feature of modern democratic constitutions. Its function is not only to ensure the perpetuation of democratic governance, but also to articulate the fundamental values that must animate the three branches of government in the realisation of the kind of society contemplated by that government. A bill of rights limits the exercise of power by defining the limits of legislative freedom. It engages in a particular way with the legal system – a bill of rights is really no more than a set of rules that govern the content of other rules.”

Section 7 of the Constitution reads as follows:

“7(1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.

(2) The state must respect, protect, promote, and fulfil the rights in the Bill of Rights.

(3) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.”

The German Constitution played a huge role in the origin and development of section 7 (1) of the Constitution.¹⁸ Subsection (1) contains the basic principles of

defining relationships between the institutions and the people within the jurisdiction of the State, and between the people themselves.”

¹⁶ Section 8(1) states:

“The Bill of Rights applies to all law and binds the legislature, the executive, the judiciary and all organs of State.”

¹⁷ Cheadle, Davis, and Haysom, (2002) *supra* note 13 at 2. In *Carmichele v Minister of Safety and Security and Another* 2001 (10) 995 (CC) Ackermann and Goldstone JJ stated at para 54:“Our Constitution is not merely a formal document regulating public power. It also embodies, like the German Constitution, an objective, normative value system.”

the Bill of Rights and confirms the democratic values of human dignity, equality and freedom.

The State is obliged to “respect, protect and fulfil these rights.”¹⁹ In *S v Makwanyane and Another*²⁰ it was stated that “Respect for life and dignity, which are at the heart of section 11 (2) (of the interim Constitution) are values of the highest order under our Constitution”. Sub-section (1) accordingly reaffirms the basic principles enunciated in section (1) of the Constitution namely that South Africa is one sovereign democratic state founded on the values of human dignity, the achievement of equality and advancement of human rights and freedoms, non racialism and non sexism.²¹

Sub-section (2) imposes duties on the State to give content to the rights in the Bill of Rights.²²

In the light of the fact that the Bill of Rights is the cornerstone of democracy in South Africa and the values of human dignity, equality and freedom being of paramount importance, it is necessary to reflect on the specific fundamental rights

¹⁸ Devenish (2005) *supra* note 13 at 44-46; Cheadle, Davis and Haysom (2005) *supra* note 13 at 13-18; Davis, D, Cheadle, H and Haysom, N “Fundamental Rights in the Constitution – Commentary and Cases” (1997) at 27-28.

¹⁹ Section 7(2). See also Devenish (2005) *supra* note 13 at 45. In *Rail Commuter Action Group v Transnet Ltd t/a Metrorail* (2002) 3A11 SA 741 at par 20 Nugent JA stated: “(t)he State is obliged by the terms of section 7 of the 1996 Constitution not only to respect but also to ‘protect, promote and fulfil the rights in the Bill of Rights’ and section 2 demands that the obligations imposed by the Constitution must be fulfilled.”

²⁰ *S v Makwanyane and Another* 1995 (6) BCLR 665 (CC) at par 111. See also Cheadle, Davis, and Haysom, (2002) *supra* note 13 at 14. See also *Ferreira v Levin NO and Others* and *Vryenhoek and Others v Powell NO and Others* 1996 (1) BCLR 1 (CC); *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 (12) BCLR 1517. In *S v Jordan* (Sex Workers Education and Advocacy Task force as Amici Curiae) 2002 (6) SA 642 (CC) the Court, at 670 stated: “The Constitution itself makes plain that the law must further the values of the Constitution. It is no answer then to a constitutional complaint to say that the constitutional problem lies not in the law but in social values when the law serves to foster those values. The law must be conscientiously developed to foster values consistent with our Constitution. Where, although neutral on its face, its substantive effect is to undermine the values of the Constitution, it will be susceptible to constitutional challenge.”

²¹ Cheadle, Davis and Haysom, (2002) *supra* note 13 at 16.

²² See *Strydom v Minister of Correctional Services and Others* 1999 (3) 342 (W); *Carmichele v Minister of Safety and Security and Another* 2001 (10) BCLR 995 (CC).

contained in the Bill of Rights that could possibly play a role in respect of the defence of non-pathological criminal incapacity.²³

Section 8 of the Constitution reads as follows:²⁴

“8(1) The Bill of Right applies to all law, and binds the legislature, the executive, the judiciary and all organs of State.

(2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.

(3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of Subsection (2), a court –

(a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right, and

(b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36 (1).

(4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person.”

Section 8 of the Constitution plays a pivotal role in respect of the defence of non-pathological criminal incapacity. The defence of non-pathological criminal incapacity is to a large extent a common law defence, except for limited statutory reference to this defence.²⁵ During the course of this chapter it will be indicated that there are numerous controversies and huge uncertainty pertaining to the defence of non-pathological criminal incapacity and the future of this defence is dubious. The exact role and place of expert evidence in support of this defence is also uncertain.

²³ See also Carstens and Pearmain, (2007) *supra* note 14 at 7; De Waal, Currie, Erasmus (2005) *supra* note 13 at 31-49; Tredoux *et al* (2005) *supra* note 1 at 41, Kaliski (2006) *supra* note 1 at 14; Burchell, J “Criminal Justice at the Crossroads” (2002) SALJ 579 at 590-591. See also Burchell and Milton (2005) *supra* note 1 at 113.

²⁴ Cheadle, Davis and Haysom (2002) *supra* note 13 at 19; Davis, Cheadle and Haysom (1997) *supra* note 18 at 29; De Waal, Currie and Erasmus (2005) *supra* note 13 at 31; Devenish, GE “The South African Constitution” (2005) at 44-46.

²⁵ See section 78 (2) of the Criminal Procedure Act 51 of 1977.

The question that inevitably arises is whether this defence is not in need of development. Has the time not arrived for the common law to be developed to the extent that legislation does not give effect to various rights in the Bill of Rights in respect of this defence?

It is accordingly important to briefly discuss aspects pertaining to section 8 of the Bill of Rights. In terms of section 8 all law is subject to the provisions of the Bill of Rights. It binds the State and also natural and juristic persons.²⁶

The Bill of Rights regulates the relationship between an individual and the State and also the relationship between individuals or private persons. The latter is also referred to as the so-called vertical and horizontal application of the Bill of Rights.²⁷ The most prominent feature of a Constitution is to restrain the State in respect of laws that are enacted. Accordingly the constitutionality of a particular law enacted by the legislative sphere of the State can be challenged on the basis that it conflicts with the Bill of Rights.²⁸ The relation between the citizen and the State is referred to as a “vertical” relation whereas the relation between private persons is referred to as a “horizontal” relation.²⁹ For purposes of this study the vertical application of the Bill of Rights is of more importance as it concerns the State as opposed to the accused.

In terms of section 8 (1) the Bill of Rights “applies to all law”. The latter entails that any legal norm, irrespective of whether it is a statutory provision or a rule in terms

²⁶ Cheadle, Davis and Haysom (2002) *supra* note 13 at 19; Davis, Cheadle and Haysom (1997) *supra* note 18 at 30-33. See also *Du Plessis and Others v De Klerk and Another* 1996 (5) BCLR 658 (CC); *Carmichele v Minister of Safety and Security and Another* 2001 (10) BCLR 995 CC; *Mandela v Falati* 1994 (4) BCLR 1 (W). See also De Waal, Currie and Erasmus (2001) *supra* note 13 at 45.

²⁷ De Waal, Currie and Erasmus (2005) *supra* note 13 at 43-44; Cheadle, Davis and Haysom (2002) *supra* note 13 at 20-26; *Du Plessis and Others v De Klerk and Another* 1996 (5) BCLR 658 (CC).

²⁸ Cheadle, Davis and Haysom (2002) *supra* note 13 at 21.

²⁹ See Cheadle, Davis and Haysom (2002) *supra* note 13 at 21 where it is stated that both the interim and final Constitutions were primarily vertical in nature. See also Davis, Cheadle and Haysom (1997) *supra* note 18 at 43. See *Du Plessis & Others v De Klerk and Another* 1996 (3) SA 850 (CC) where Mahomed DP stated: “I am not persuaded that there is, in the modern State, any right which exists which is not ultimately sourced in some law, even if it be no more than an unarticulated premise of the common law and even if that common law is constitutionally immunised from legislative invasion ...” (para 7a). See also Devenish “The South African Constitution” (2005) at 46.

of the common law or customary law, may be challenged once it is established that it infringes a right in the Bill of Rights.³⁰

Accordingly, the impact of section 8 (1) can be summarised as follows:

- Legislation – if any legislation does not adhere or conform to the Bill of Rights, it must be declared invalid. For purposes of this study, it is necessary to evaluate the provisions in the Criminal Procedure Act pertaining to the defence of criminal incapacity in order to assess the constitutionality or unconstitutionality thereof. Before making a finding of invalidity, a court should attempt to reconcile the particular legislation with the Bill of Rights.³¹
- Common Law – if a particular common law rule infringes a right in the Bill of Rights, a court must declare it invalid. The High Courts, Supreme Court of Appeal and the Constitutional Court have inherent powers to develop the common law in order to bring it in line with the Constitution.³²

Section 8 (1) further binds all organs of State in all spheres of government to comply with the provisions of the Bill of Rights.³³

Section 8 (1) binds the legislature in each sphere of State to the Bill of Rights. Accordingly, Parliament, the provincial legislatures and the municipal councils are,

³⁰ Cheadle, Davis and Haysom (2002) *supra* note 13 at 32; Davis, Cheadle and Haysom (1997) *supra* note 18 at 44-45. In terms of section 172 of the Constitution a court has the power to declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency.”

³¹ Cheadle, Davis and Haysom (2002) *supra* note 13 at 32-33; *De Lange v Smuts NO* 1998 (7) BCLR 658 (CC) at paragraph 85; *Swanepoel v Transnet* 2000 (2) SA 191 (T).

³² Cheadle, Davis and Haysom (2002) *supra* note 13 at 33 – this power to develop the common law is derived from either section 8 (3) or 39 (2) of the Constitution.

³³ De Waal, Currie and Erasmus (2005) *supra* note 13 at 43-54; Cheadle, Davis and Haysom (2002) *supra* note 13 at 34-36. In terms of section 239 of the Constitution an “Organ of State” is defined as:

- (a) any department of State or administration in the national, provincial or local sphere of government, or
- (b) any other functionary or institution –
 - (i) exercising a power or performing a function in terms of the Constitution or a provincial Constitution, or
 - (ii) exercising a public power or performing a public function in terms of any legislation, but does not include a court or a judicial officer.”

within their legislative capacities, bound by the Bill of Rights.³⁴ The legislatures are bound in both their legislative and non-legislative functions.³⁵

Section 8 (1) further binds executives in all spheres of government – national, provincial and municipal.

Section 8 (2) provides for the application of the Bill of Rights to the exercise of private power. Private persons will accordingly be bound to the extent that the rights are applicable to them having regard to the nature of the right and the duty imposed by it.³⁶

The section that is of particular importance for this study is section 8 (3). This section imposes an obligation on a court, once it has been established that a provision of the Bill of Rights applies to a natural person, to apply or develop the common law to the extent that legislation does not give effect to that right and that a court may also develop rules of the common law to limit the right, provided that it is done in accordance with the limitation clause.³⁷

In the light of the fact that the defence of non-pathological criminal incapacity is mainly a common law defence with limited statutory recognition, the question that falls to be answered is whether the common law in this respect should not be developed in terms of section 8 (3)?

³⁴ Cheadle, Davis and Haysom (2002) *supra* note 13 at 34-35. See also *S v Thebus* 2003 (6) SA 505 (CC).

³⁵ Cheadle, Davis and Haysom (2002) *supra* note 13 at 34. See also *Speaker of the National Assembly v De Lille and Another* 1999 (11) BCLR 1339 (SCA) where the non-legislative conduct of the National Assembly came under the spotlight. The Cape High Court held that the National Assembly was subject to the Constitution and bound by the Bill of Rights. See also *De Lille v Speaker of the National Assembly* 1998 (3) SA 430 (C) where the High Court held: “The National Assembly is subject to the Supremacy of the Constitution. It is an organ of State and therefore it is bound by the Bill of Rights. All its decisions and acts are subject to the Constitution and the Bill of Rights Parliament can no longer claim supreme power subject to limitations imposed by the Constitution. It is subject in all respects to the provisions of our Constitution” (paragraph 25). See also De Waal, Currie and Erasmus “The Bill of Rights Handbook” 4th ed (2001) at 47.

³⁶ Cheadle, Davis and Haysom (2002) *supra* note 13 at 36; De Waal, Currie and Erasmus (2005) *supra* note 13 at 20-23.

³⁷ Section 36, Currie, De Waal and Erasmus (2005) *supra* note 13 at 50-54; Devenish (2005) *supra* note 13 at 46-47; Davis, Cheadle and Haysom “Fundamental Rights in the Constitution – Commentary and Cases” (1997) at 45.

De Waal, Currie and Erasmus indicate that there are three ways in which the Bill of Rights can apply in a legal dispute:³⁸

- The Bill of Rights may operate as a yardstick against which ordinary law is tested.
- The Provisions of the Bill of Rights may also be beacons that must guide the interpretation and application of the ordinary law and legal reform.
- The Bill of Rights may govern legal disputes directly.

De Waal, Currie and Erasmus distinguish between the direct and indirect application of the Bill of Rights:³⁹

“Direct application. The reach of Bill of Rights (beneficiaries, duties and time) demarcates the types of legal disputes to which the Bill of Rights applies as directly applicable law. Within this demarcated area, the Bill of Rights overrides ordinary law and any conduct that is inconsistent with the Bill of Rights and, subject to considerations relating to justiciability and constitutional jurisdiction, it generates its own set of remedies. This form of application is termed the direct application of the Bill of Rights.

Indirect application. At the same time, the Bill of Rights contains a set of values that must be respected whenever ordinary law is interpreted, developed or applied. This form of application is termed the indirect application of the Bill of Rights. When indirectly applied, the Bill of Rights does not override ordinary law or generate its own remedies. The special rules contained in the Constitution that deal with the procedural issues of standing and the jurisdiction of the courts are also irrelevant. Rather, the Bill of Rights respects the procedural rules and remedies of ordinary law, but demands furtherance of the values of the Bill of Rights through the operation of ordinary law.”

³⁸ De Waal, Currie and Erasmus (2005) *supra* note 13 at 32-35.

³⁹ Currie, De Waal and Erasmus (2001) *supra* note 13 at 35-37. See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 32. See also *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) at paragraph 56.

It should also be borne in mind that in practice the indirect application of the Bill of Rights to the law must always be determined before its direct application to law or conduct.⁴⁰

Section 39 (2) of the Bill of Rights states the following:

“39(2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.”

Section 39 (2) pertains to the indirect application of the Bill of Rights.

In *S v Thebus*,⁴¹ Moseneke J stated the following:⁴²

“Since the advent of constitutional democracy, all law must conform to the command of the supreme law, the Constitution, from which all law derives its legitimacy, force and validity. Thus, any law which precedes the coming into force of the Constitution remains binding and valid only to the extent of its constitutional consistency. The Bill of Rights enshrines fundamental rights which are to be enjoyed by all people in our country. Subject to the limitations envisaged in s36, the State must respect, protect, promote and fulfil the rights in the Bill of Rights. The protected rights therein apply to all law and bind all organs of State including the judiciary.”

Moseneke J also distinguished two instances that could give rise to a need for the development of the common law:⁴³

“It seems to me that the need to develop the common law under S39 (2) could arise in at least two instances. The first would be when a rule of the common law is inconsistent with a constitutional provision. Repugnancy of this kind would compel an adaptation of the common law to resolve the

⁴⁰ *Ibid.*

⁴¹ *S v Thebus* 2003 (6) SA 505 (CC), 2003 (2) SACR 319 (CC).

⁴² Paragraph 24.

⁴³ Paragraph 28. See also Burchell and Milton (2005) *supra* note 1 at 114-115.

inconsistency. The second possibility arises even when a rule of the common law is not inconsistent with a specific constitutional provision but may fall short of its spirit, purport and objects. Then, the common law must be adapted so it grows in harmony with the ‘objective normative valve system’ found in the Constitution.”⁴⁴

In the *Pharmaceutical Manufacturers* case, Chaskalson P stated that:⁴⁵

“The common law supplements the provisions of the written Constitution but derives its force from it. It must be developed to fulfil the purposes of the Constitution and the legal order that it proclaims – thus, the command that law be developed and interpreted by the courts to promote the ‘spirit, purport and objects of the Bill of Rights.’ This ensures that the common law will evolve within the framework of the Constitution consistently with the basic norms of the legal order it establishes. There is, however, only one system of law and within that system the Constitution is the supreme law with which all other law must comply.”

The question that falls to be answered is whether the defence and the law relating to the defence of non-pathological criminal incapacity is in need of development. The second question to be answered is how this development should be implemented? Can the law pertaining to the defence of non-pathological criminal incapacity be developed by means of a direct application of the Bill of Rights in terms of section 8 (3) or by means of an indirect application in terms of section 39 (2), in order to harmonise the law pertaining to this defence with the spirit, purport and objects of the Bill of Rights?

During the course of this chapter, the author will indicate that the application of the defence of non-pathological criminal incapacity and the role of expert evidence in support of this defence have not been consistent. The future role and place of this

⁴⁴ See also *Shabalala and Others v Attorney-General of Transvaal and Another* 1996 (1) SA 725 (CC), 1995 (2) SACR 761 (CC), 1995 (12) BCLR 1593 (CC); *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* 2000 (2) SA 1 (CC).

⁴⁵ *Pharmaceutical Manufacturers Association of SA and Another, In re Ex parte President of Republic of South Africa and Others* 2000 (2) SA 674 (CC). See also *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) specifically paragraph 27–29.

defence is currently a highly controversial and problematic issue. The need accordingly arises for the development of the law relating to this defence in order to create clarity and legal certainty in this regard.

The defence of non-pathological criminal incapacity is mainly a common-law defence. The only vague reference to such a defence is found in section 78 (2) of the Criminal Procedure Act where reference is made to “.. in any other case” for purposes of referral for observation in terms of section 79 where the criminal responsibility of an accused is in issue.⁴⁶

The fact that the law relating to the defence of non-pathological criminal incapacity is founded mainly in the common-law, coupled with the controversy surrounding this defence as well as the uncertain role and place of expert evidence in support of this defence, clearly indicates that change is needed.

3.2 Development of the common law in terms of the indirect application of the Bill of Rights: section 39(2)

Before a court may resort to direct application of the Bill of Rights, it must first consider the indirect application of the Bill of Rights.⁴⁷ In terms of section 39 (2) there is a general obligation on every court, tribunal or forum to promote the spirit, purport and objects of the Bill of Rights when interpreting any legislation.⁴⁸ When interpreting any statutory provision, the Bill of Rights has to be positively enhanced with specific reference to the values enshrined in S1.⁴⁹ In terms of statutory law, indirect application of the Bill of Rights will entail that a court must attempt to

⁴⁶ See S78 (2) – this section will be discussed in more detail below.

⁴⁷ Currie, De Waal and Erasmus (2005) *supra* note 13 at 64. See also *S v Mhlungu* 1995 (3) SA 867 (CC) where Kentridge AJ held: (paragraph 59)

“I would lay it down as a general principle that where it is possible to decide any case, civil or criminal, without reaching a constitutional issue, that is the course which should be followed.” See *Zantsi v Council of State, Ciskei* 1995 (4) SA 615 (CC) at paragraph 8.

⁴⁸ *Ibid.*

⁴⁹ This was also provided for in the Interim Constitution Act 200 of 1993 where section 35 (3) stated: “(3) In the interpretation of any law and the application and development of the common law and customary law, a court shall have due regard to the spirit, purport and objects of this Chapter.”

interpret legislation in conformity with the Bill of Rights before declaring the particular legislation in conflict with the Bill of Rights and accordingly invalid.⁵⁰

In terms of the common law the principle of developing the common law in conformity with the Bill of Rights is affirmed.⁵¹

Cheadle, Davis and Haysom state that section 39 (2) is applicable in at least two ways.⁵²

“It firstly mandates that all legislation must be interpreted to be congruent with the Constitution. Where this proves to be impossible, the legislation stands to be set aside as being unconstitutional. ... A second, albeit related, purpose is that a constitutionally orientated approach to legislative interpretation is now mandated. In some cases a literal approach to interpretation may well provide a result which is in harmony with the spirit, purport and objects of the Constitution.”

When interpreting the Criminal Procedure Act and the provisions pertaining to the defence of non-pathological criminal incapacity, a court or forum must promote the spirit, purport and objects of the Bill of Rights. This obligation also exists when developing the common law.

In *Govender v Minister of Safety and Security*⁵³, the Supreme Court of Appeal held the following pertaining to constitutional challenges to legislation:⁵⁴

- (a) to examine the objects and purport of the Act or the section under consideration;
- (b) to examine the ambit and meaning of the rights protected by the Constitution;

⁵⁰ Currie, De Waal and Erasmus (2005) *supra* note 13 at 64; Cheadle, Davis and Haysom (2002) *supra* note 15 at 743-746.

⁵¹ *Idem*.

⁵² Cheadle, Davis and Haysom (2002) *supra* note 13 at 746.

⁵³ *Govender v Minister of Safety and Security* 2001 (4) SA 273 (SCA). See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 65.

⁵⁴ Paragraph 11.

- (c) to ascertain whether it is reasonably possible to interpret the Act or section under consideration in such a manner that it conforms with the Constitution, i.e. by protecting the rights therein protected;
- (d) if such interpretation is possible, to give effect to it, and
- (e) if it is not possible, to initiate steps leading to a declaration of constitutional invalidity.

As was stated above, the defence of non-pathological criminal incapacity has very little statutory reference and recognition. It could be argued that section 78(2) does not adequately give effect to an accused's right to "adduce and challenge evidence"⁵⁵ in terms of section 35(3)(i) of the Bill of Rights because of the fact that there is no obligation on a court to refer an accused for observation in terms of section 79 of the Criminal Procedure Act when reliance is placed on this defence. Accordingly, when interpreting section 78(2) of the Criminal Procedure Act, this particular section currently does not promote the spirit, purport and objects of the Bill of Rights as the role of expert evidence in support of this defence is dubious and vague.

In the light of the fact that the defence of non-pathological criminal incapacity and the role of expert evidence in support thereof is mainly common-law based, the focus should be placed on attempting to develop the common-law rules pertaining to this defence in order to harmonise it with the spirit, purport and objects of the Bill of Rights.

In *S v Thebus*, Moseneke J stated:⁵⁶

"The superior courts have always had an inherent power to refashion and develop the common law in order to reflect the changing social, moral and economic make-up of society. That power is now constitutionally authorised and must be exercised within the prescripts and ethos of the Constitution."

⁵⁵ Section 35 (3) (i) of the Constitution. This right will form one of the cornerstones of this study.

⁵⁶ *S v Thebus supra* note 41 above paragraph 31. Currie, De Waal and Erasmus (2005) *supra* note 13 at 67.

As were stated above, Moseneke J distinguished two instances when development in terms of section 39 (2) is called for:⁵⁷

- (a) when a rule of the common law is inconsistent with a constitutional provision,
- (b) when a rule of the common law is not inconsistent with a specific constitutional provision but may fall short of its spirit, purport and objects.

It is accordingly submitted that the existing principles of the common law relating to the defence of non-pathological criminal incapacity are in need of change in order for the law to give better effect to the Bill of Rights. Currie, De Waal and Erasmus note that when the common law is developed, it should be done on a case-by-case basis.⁵⁸

It is also important to note that section 173 of the Constitution reads as follows:

“173. The Constitutional Court, Supreme Court of Appeal and High Courts have the inherent power to protect and regulate their own process, and to develop the common law, taking into account the interests of justice.”

One of the landmark decisions pertaining to the development of the common law, is the decision of *Carmichele v Minister of Safety and Security*.⁵⁹ It is necessary to briefly focus on this case for purposes of the present discussion.

The facts of this decision were as follows. The applicant, Alix Jean Carmichele (the applicant), was viciously attacked and injured by one Francois Coetzee. The attack took place at the home of one Julie Gosling at Noetzie just outside Knysna.

The applicant brought a delictual action in the High Court for damages against the Minister for Safety and Security and the Minister of Justice and Constitutional

⁵⁷ See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 67; *Ex parte Minister of Safety and Security and Others: In re S v Walters and Another* 2002 (4) SA 613 (CC).

⁵⁸ Currie, De Waal and Erasmus (2005) *supra* note 13 at 69. See also *Du Plessis v De Klerk* 1996 (3) SA 850 (CC) at paragraph 63; *Shabalala v Attorney-General Transvaal* 1996 (1) SA 725 (CC).

⁵⁹ *Carmichele v Minister of Safety and Security* 2002 (1) SACR 79 (CC); See also *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC), 2001 (1) SA 481 (SCA).

Development. She claimed that members of the South African Police Service and the public prosecutors at Knysna had negligently failed to comply with a legal duty they owed to her to take steps to prevent Coetzee from causing her harm.

The High Court held that there was no evidence upon which a court could reasonably find that the said duty had existed and that the police or public prosecutors had acted wrongfully. Accordingly, absolution from the instance was ordered. The applicant appealed to the Supreme Court of Appeal, but the Appeal was dismissed. The applicant then launched an application for leave to appeal to the Constitutional Court. Before the Constitutional Court the applicant contended that the police and prosecutors had owed her a duty to safeguard her constitutional rights to life, the respect for and protection of her dignity, freedom and security and privacy⁶⁰.

It was also contended that the police and prosecution services were among the primary agencies of the State responsible for the discharge of its constitutional duty to protect the public in general and women in particular against violent crime, and that, on the facts of the instant case, the applicant was entitled to damages in delict for their failure to do so⁶¹.

The applicant also submitted that the High Court and the Supreme Court of Appeal had erred in not applying the relevant provisions of the (interim) Constitution⁶² in determining whether the police and prosecutors had been obliged to protect her. Counsel for the applicant relied in particular on the constitutional obligation to develop the common law with due regard to the spirit, purport and objects of the Bill of Rights as stated in section 35 (3) of the Interim Constitution and section 39 (2) of the Constitution of the Republic of South Africa.⁶³

In delivering judgment, the Constitutional Court made important findings pertaining to section 39 (2) of the Constitution and the duty of courts to develop the common law that is of importance for the present discussion. The relevant portions of the

⁶⁰ At paragraph 25.

⁶¹ At paragraph 30.

⁶² Act 200 of 1995 ("Interim Constitution").

⁶³ Act 108 of 1996 at paragraph 28.

judgment could also apply to an argument in favour of the development of the common law principles pertaining to the defence of non-pathological criminal incapacity.

With regards to the development of the common law, Ackermann and Goldstone JJ held the following:⁶⁴

“It needs to be stressed that the obligation of courts to develop the common law, in the context of the S 39(2) objectives, is not purely discretionary. On the contrary, it is implicit in S 39(2) read with S 173 that where the common law as it stands is deficient in promoting the S 39(2) objectives, the courts are under a general obligation to develop it appropriately. We say a ‘general obligation’ because we do not mean to suggest that a court must, in each and every case where the common law is involved, embark on an independent exercise as to whether the common law is in need of development and, if so, how it is to be developed under S 39(2). At the same time there might be circumstances where a court is obliged to raise the matter on its own and require full argument from the parties.

It was implicit in the applicant’s case that the common law had to be developed beyond existing precedent. In such a situation there are two stages to the inquiry a court is obliged to undertake. They cannot be hermetically separated from one another. The first stage is to consider whether the existing common law, having regard to the S 39(2) objectives, requires development in accordance with these objectives. This inquiry requires a reconsideration of the common law in the light of S 39(2). If this inquiry leads to a positive answer, the second stage concerns itself with how such development is to take place in order to meet the S 39(2) objectives. Possibly because of the way the case was argued before them, neither the High Court nor the SCA embarked on either stage of the above inquiry.”

And further:⁶⁵

⁶⁴ Paragraph 39-40.

“The influence of the fundamental constitutional values on the common law is mandated by S 39(2) of the Constitution. It is within the matrix of this objective normative value system that the common law must be developed.”

Ackermann and Goldstone JJ also held that the proper development of the common law in terms of section 39(2) is dependent on proper interaction between, on the one hand, the High Courts and the Supreme Court of Appeal which have particular expertise and experience in this area of the law and, on the other hand, the Constitutional Court.⁶⁶

Ackermann and Goldstone JJ accordingly referred the case back to the High Court in order for the trial to continue⁶⁷.

The *Carmichele* decision is a landmark decision in the sense that it opens the door for development of existing common law that may fall short of the spirit, purport and objects of the Bill of Rights. Even though the court in *Carmichele* did not expressly lay down a set formula for such development to take place, it nevertheless confirmed the importance of the development of the common law in order to harmonise it with the Bill of Rights.

Currently the defence of non-pathological criminal incapacity is clouded with controversy and confusion. The approach towards expert evidence in support of this defence, as will be indicated, has not been consistent.⁶⁸ Due to the vagueness, uncertainty and confusion, it could be argued that the common law principles pertaining to this defence fall short of the spirit, purport and objects of the Bill of Rights. It is accordingly submitted, against the backdrop of the

⁶⁵ Paragraph 54. See also *Amod v Multilateral Motor Vehicle Accidents Fund* 1998 (4) SA 753 (CC) paragraph 33 where it was stated: “The Supreme Court of Appeal has jurisdiction to develop the common law in all matters including constitutional matters. Because of the breadth of its jurisdiction and its expertise in the common law, its views as to whether the common law should or should not be developed in a ‘constitutional manner’ are of particular importance.” See also *Christian Education South Africa v Minister of Education* 1999 (2) SA 83 (CC) at paragraph 8.

⁶⁶ Paragraph 55.

⁶⁷ Paragraph 84.

⁶⁸ See *S v Laubscher supra* note 1 and *S v Calitz supra* note 1 which will be discussed comprehensively below.

Carmichele decision, that the law relating to the defence of non-pathological criminal incapacity is in desperate need of development.

3.3 Development of the common law in terms of the direct application of the Bill of Rights: section 8(3)

Section 8(3) of the Constitution imposes a duty on a court when applying a provision of the Bill of Rights to a natural or juristic person, to apply, and if necessary, develop the common law to the extent that legislation does not give effect to that right and also grants a court a discretionary function to develop rules of the common law to limit such right provided it is effected in accordance with the limitation clause contained in section 36.⁶⁹

It is accordingly necessary to evaluate the application of this section in relation to the development of the defence of non-pathological criminal incapacity as a defence.

Section 9 of the Constitution reads as follows:

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

(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.

⁶⁹ Cheadle, Davis and Haysom (2002) *supra* note 13 at 19; Currie, De Waal and Erasmus (2005) *supra* note 13 at 31; Devenish “The South African Constitution” (2005) at 46; Davis, Cheadle and Haysom (1997) *supra* note 18 at 29.

(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.”

Section 35(3)(i) of the Constitution states:⁷⁰

⁷⁰ Section 35(3)(i) is of pivotal importance to the current study. Section 35, however, reads as follows:

Arrested, detained and accused persons

35. (1) Everyone who is arrested for allegedly committing an offence has the right –

- (a) to remain silent;
 - (b) to be informed promptly –
 - (i) of the right to remain silent; and
 - (ii) of the consequences of not remaining silent;
 - (c) not to be compelled to make any confession or admission that could be used in evidence against that person;
 - (d) to be brought before a court as soon as reasonably possible, but not later than –
 - (i) 48 hours after the arrest; or
 - (ii) the end of the first court day after the expiry of the 48 hours, if the 48 hours expire outside ordinary court hours or on a day which is not an ordinary court day;
 - (e) at the first court appearance after being arrested, to be charged or to be informed of the reason for the detention to continue, or to be released; and
 - (f) to be released from detention if the interests of justice permit, subject to reasonable conditions.
- (2) Everyone who is detained, including every sentenced prisoner, has the right –
- (a) to be informed promptly of the reason for being detained;
 - (b) to choose, and to consult with, a legal practitioner, and to be informed of this right promptly;
 - (c) to have a legal practitioner assigned to the detained person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
 - (d) to challenge the lawfulness of the detention in person before a court and, if the detention is unlawful, to be released;
 - (e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and
 - (f) to communicate with, and be visited by, that person's -
 - (i) spouse or partner;
 - (ii) next of kin;
 - (iii) chosen religious counsellor; and
 - (iv) chosen medical practitioner.
- (3) Every accused person has a right to a fair trial, which includes the right -
- (a) to be informed of the charge with sufficient detail to answer it;
 - (b) to have adequate time and facilities to prepare a defence;
 - (c) to a public trial before an ordinary court;
 - (d) to have their trial begin and conclude without reasonable delay;
 - (e) to be present when being tried;
 - (f) to choose, and be represented by, a legal practitioner, and to be informed of his right promptly;
 - (g) to have a legal practitioner assigned to the accused person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
 - (h) to be presumed innocent, to remain silent, and not to testify during the proceedings;
 - (i) to adduce and challenge evidence;
 - (j) not to be compelled to give self-incriminating evidence;

“(3) Every accused person has a right to a fair trial, which includes the right
-
(i) to adduce and challenge evidence.”

It could be argued that an accused person raising the defence of non-pathological criminal incapacity does not enjoy equal benefit and protection of the law due to the vagueness and uncertainty pertaining to this defence. It can further be argued that, as a result of the fact that expert evidence is not a prerequisite in order to rely on this defence, an accused’s right to a fair trial and more specifically, the right to adduce and challenge evidence, is prejudiced.

Accordingly, when applying these rights to an accused person, the question that falls to be answered is whether the common law should not be developed to the extent that legislation does not give effect to these rights.

It should also be borne in mind that section 8(3) also provides for the development of the common law to limit such rights. Expert evidence could, for example, be statutorily provided for in support of the defence of non-pathological criminal incapacity, but it could be limited by requiring an accused to establish a sufficient basis for such defence.

-
- (k) to be tried in a language that the accused person understands or, if that is not practicable, to have the proceedings interpreted in that language;
 - (l) not to be convicted for an act or omission that was not an offence under either national or international law at the time it was committed or omitted;
 - (m) not to be tried for an offence in respect of an act or omission for which that person has previously been either acquitted or convicted;
 - (n) to the benefit of the least severe of the prescribed punishments if the prescribed punishment for the offence has been changed between the time that the offence was committed and the time of sentencing; and
 - (o) of appeal to, or review by, a higher court.
- (4) Whenever this section requires information to be given to a person, that information must be given in a language that the person understands.
- (5) Evidence obtained in a manner that violates any right in the Bill of Rights must be excluded if the admission of that evidence would render the trial unfair or otherwise be detrimental to the administration of justice.
- See also Cheadle, Davis and Haysom (2002) *supra* note 13 at 630 and specifically 661, Currie, De Waal and Erasmus (2005) *supra* note 13 at 644.

Cheadle, Davis and Haysom provide the following reasons underlying the peremptory instruction that courts must develop the common law to give effect to particular rights:⁷¹

- The harmonisation of the common law with the rights in the Constitution promotes and ensures the integrity and coherence of the legal system as a whole and of the common law in particular.
- The provision ensures a rule-based response to conduct infringing constitutional rights.
- As soon as a common law rule is established, any further conduct in breach of the rule does not give rise to constitutional litigation. Any further disputes will be governed by the newly developed common-law rule.
- The “piecemeal” development of the common-law is what courts have done since the establishment of the courts in South Africa and is what they do well.

The precise manner in which the common law is to be developed remains questionable. The appropriate way would be by means of legislation or in the case of non-pathological criminal incapacity, the amendment of Sections 77-79.

In the *Carmichele*-case, Ackermann and Goldstone JJ stated:⁷²

“In exercising their powers to develop the common law, Judges should be mindful of the fact that the major engine for law reform should be the legislature and not the Judiciary.

.....

We would add, too, that this duty upon Judges arises in respect both of the civil and criminal law, whether or not the parties in any particular case request the Court to develop the common law under section 39(2).”

⁷¹ Cheadle, Davis and Haysom (2002) *supra* note 13 at 42.

⁷² *Carmichele v Minister of Safety and Security supra* note 57 at paragraph 36. See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 74.

3.4 Other rights in the Bill of Rights relevant to the defence of non-pathological criminal incapacity

3.4.1 Human dignity

Section 10 of the Constitution states:

“Everyone has inherent dignity and the right to have their dignity respected and protected.”

The right to human dignity is a cornerstone value of the Bill of Rights and accordingly all the individual rights are founded on this value.⁷³

Haysom states the following in respect of the right to dignity:⁷⁴

“It serves to reinforce other rights and to underwrite their importance. It is, also, a critical tool in interpreting or giving purpose and meaning to those other fundamental rights, a tool of which the Constitutional Court has made frequent use.”

Haysom also notes that the right to dignity is useful in resolving conflict between different rights and aids in harmonising the competing claims of freedom, equality and democracy.⁷⁵

In *S v Makwanyane*⁷⁶ it was held by O’Regan J:

“The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern.”

⁷³ Cheadle, Davis and Haysom (2002) *supra* note 13 at 123.

⁷⁴ Haysom in Cheadle, Davis and Haysom (2002) *supra* note 13 at 123.

⁷⁵ *Ibid.*

⁷⁶ *S v Makwanyane supra* note 13 at 451. See also Carstens and Pearmain (2007) *supra* note 14 at 29 and Devenish (2005) *supra* note 13 at 62.

Devenish also notes that human dignity is the most important right in the Constitution and that it accordingly enjoys vertical and horizontal application.⁷⁷

The respect for human dignity requires that the exercise of any power, specifically the power of government, must be in line with and based on the inherent worth of human beings. The legality of any official conduct is required to be assessed according to whether human dignity was violated in any way.⁷⁸

In the light of the fact that the right to dignity is recognised as a foundational right as well as a core value in human rights jurisprudence, it goes without saying that any law pertaining to the defence of non-pathological criminal incapacity should be considered and applied and also enacted with respect for the inherent dignity of both the accused person and also the victim. The right to dignity will particularly feature in respect of the battered woman who kills her abusive husband or partner. Haysom states that dignity implies respect for a sphere of autonomy for every human being, to be protected from unlawful invasions of a person's autonomy to make choices. The latter is one of the problematic aspects with reference to the battered woman who kills her abusive spouse or partner as prolonged abuse is clearly a direct infringement of the most core and foundational right of every human being.

3.4.2 Freedom and Security of the Person

Section 12(1) of the Constitution states:

“12. (1) Everyone has the right to freedom and security of the person, which includes the right –

- (a) not to be deprived of freedom arbitrarily or without just cause;
- (b) not to be detained without trial;

⁷⁷ Devenish (2005) *supra* note 13 at 61.

⁷⁸ Devenish (2005) *supra* note 13 at 63. See also *S v Williams* 1995 (7) BCLR 861 (CC) at paragraphs 35-37.

- (c) to be free from all forms of violence from either public or private sources;
- (d) not to be tortured in any way, and
- (e) not to be treated or punished in a cruel, inhuman or degrading way.”

In *Bernstein and Others v Bester NO and Others* O'Regan J described the concept of freedom and liberty as follows:⁷⁹

“The conception of freedom underlying the Constitution must embrace that interdependence without denying the value of individual autonomy. It must recognise the important role that the State, and others, will play in seeking to enhance individual autonomy and dignity and the enjoyment of rights and freedoms.”

Section 12(1)(c) contains the right to be free from all forms of violence. This right specifically relates to battered women who kill their abusive spouses. Prolonged and incidental abuse negates this right to a particular battered woman.

Section 12(1)(d) seeks to protect persons from seven different modes of conduct: torture, cruel treatment, cruel punishment, inhuman treatment, inhuman punishment, degrading treatment as well as degrading punishment.⁸⁰ This section is also important when hearing battered woman syndrome evidence in the sense that a battered woman who was abused over a prolonged period, was subjected to serious human rights violations. The latter can especially play a role during sentencing.

It is interesting to note that Haysom refers to the case of *Denmark v Greece* where it was held that inhuman treatment deals with such treatment that causes severe

⁷⁹ *Bernstein and Others v Bester NO and Others* 1996 (4) BCLR 449 (CC) at paragraph 150. See also Cheadle, Davis and Haysom (2002) *supra* note 13 at 155; *Ferreira v Levin NO and Others and Vryenhoek and Others v Powell NO and Others* 1996 (1) BCLR 1 (CC). See also Devenish (2005) *supra* note 13 at 70-77.

⁸⁰ Cheadle, Davis and Haysom (2002) *supra* note 13 at 162. See also *S v Williams and Others* 1995 (7) BCLR 861 (CC) at 869.

mental or physical suffering that is unjustifiable.⁸¹ The particular treatment must attain the minimal level or degree of severity if it is to be classified as “inhuman”.⁸² Accordingly, the evaluation of this minimum is relative and dependent on all circumstances of the case such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.⁸³ The latter findings can be of assistance in the assessment of inhuman treatment in the scenario of the battered woman.

3.4.3 Privacy

Section 14 of the Constitution states:

- “14. Everyone has the right to privacy, which includes the right not to have -
- (a) their person or home searched;
 - (b) their property searched;
 - (c) their possessions seized, or
 - (d) the privacy of their communications infringed.”

Section 14(d) is of particular importance to the defence of non-pathological criminal incapacity. The problematic issue is to what extent communications between an accused and a mental health practitioner is privileged and whether statements by an accused during such assessment can be used in a subsequent trial to determine the accused’s mental state at the time of the alleged crime.⁸⁴

The common law acknowledges the right to privacy as an independent personality right that forms part of the “dignitas”.⁸⁵

In *Bernstein v Bester*,⁸⁶ Ackermann J mentioned examples of breach of privacy that included entry into a private residence, the reading of private documents,

⁸¹ *Denmark v Greece* (3321-3/67;3344/67 YB 12 bis) as discussed by Haysom in Cheadle, Davis and Haysom (2002) *supra* note 13 at 166.

⁸² *Ibid.*

⁸³ *Ibid.* See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 248.

⁸⁴ See the conflicting opinions in *S v Leaner* 1996 (2) SACR 347 (C) and *S v Kok* 1998 (1) SACR 532 (NPD) as discussed in paragraph 12 *infra*.

⁸⁵ Currie, De Waal and Erasmus (2005) *supra* note 13 at 316.

listening in to private conversations and the disclosure of private facts in breach of a relationship of confidentiality.

The extent to which communications between an accused and a mental health practitioner are protected and the question as to whether statements made by an accused are privileged will be assessed in this chapter with reference to the defence of non-pathological criminal incapacity.

3.4.4 Access to information

Section 32(1) reads as follows:

“32. (1) Everyone has the right of access to:
(a) any information held by the State, and
(b) any information that is held by another person and that is required for the exercise or protection of any rights.”

The right to freedom of information is founded on the idea that people are entitled to have access to information in the possession of the State that has an impact on them.⁸⁷ Currently, the Promotion of Access to Information Act serves to give effect to Section 32(1) of the Constitution.⁸⁸

⁸⁶ *Bernstein v Bester* NO 1996 (2) SA 751 (CC) at paragraph 68; Currie, De Waal and Erasmus (2005) *supra* note 13 at 316. See also *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 (12) 1517 (CC) where the Constitutional Court stated at paragraph 32: “Privacy recognises that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community.” See also Cheadle, Davis and Haysom (2002) *supra* note 13 at 185.

⁸⁷ Currie, De Waal and Erasmus (2005) *supra* note 13 at 684. See also Davis in Cheadle, Davis and Haysom (2002) *supra* note 13 at 575.

⁸⁸ The Promotion of Access to Information Act, Act 2 of 2000. See also Cheadle, Davis and Haysom (2002) *supra* n13 583-584. In *Shabalala and Others v Attorney-General of the Transvaal and Another* 1995 (12) BCLR 1593 (CC), the Constitutional Court had to consider whether the common-law privilege in respect of police dockets, as laid down in *R v Steyn* 1954 (1) SA 324 (AD) was in line with the Constitution and also whether the common-law rule which prohibits an accused or his or her legal representative from consulting with a State witness in the absence of permission of a prosecuting agency is in line with the Constitution. Mohomen, DP held the following: (paragraph 55)
(a) It is difficult to conceive of any circumstances in which the prosecution can justify withholding from the accused access to any statement or document in the police docket which favours the accused or is exculpatory.

This right could find application when an accused person raising the defence of non-pathological criminal incapacity requires certain information held by the State in order to conduct the defence of non-pathological criminal incapacity.

3.4.5 Right to a fair trial

Section 35(3)(i) states that every accused person has a right to a fair trial, which includes the right to adduce and challenge evidence.⁸⁹ This section is pivotal to

(b) The unilateral claim of the prosecution in its justification of a refusal to allow access on the grounds that such access might defeat the objects of the protection in items 3 and 4 of paragraph 40 above cannot be sufficient in itself.

(c) Sufficient evidence or circumstances ought to be placed before the judicial officer to enable the Court to apply its own mind in assessing the legitimacy of the claim. It is for the Court to decide what evidence would be sufficient in a particular case and what weight must be attached thereto.

(d) Inherently there might be some element of uncertainty as to whether the disclosure of the relevant documents might or might not lead to the identification of informers or to the intimidation of witnesses or the impediment of the proper ends of justice. The judgment of the prosecuting and investigating authorities in regard to the assessment of such risks might be a very potent factor in the adjudication process ... What the prosecution must therefore be obliged to do (by a proper disclosure of as much of the evidence and material as it is able) is to establish that it has reasonable grounds for its belief that the disclosure of the information sought carries with it a reasonable risk that it might lead to the identity of informers or the intimidation of witnesses or the impediment of the proper ends of justice.

(e) If the State is unable to justify its opposition to the disclosure of the relevant information on these grounds, its claim that a refusal of access to the relevant documents is justified, should fail.

(f) If, in the special circumstances of a particular case, the Court needs access to disputed documents concerned in order to make a proper assessment of the legitimacy of the prosecution's claim and any insight in that document might reasonably defeat the object of the protection which the prosecution is anxious to assert, the Court would be entitled to examine such a document for this purpose without affording to the accused an opportunity of any knowledge of its contents but making proper allowance for that factor in the ultimate act of adjudication.

(g) Even where the State has satisfied the Court that there is a reasonable risk that the disclosure of the statements or documents sought might impair the protection and the concerns referred to ...or in any way impede the proper ends of justice, it does not follow that access to such statements in such circumstances must necessarily be denied to the accused. The Court still retains a discretion. There may be circumstances where the non-disclosure of such statements might carry a reasonable risk that the accused may not receive a fair trial and might even wrongly be convicted. The Court should exercise a proper discretion in such cases by balancing the degree of risk involved in attracting the consequences sought to be avoided by the prosecution (if access is permitted) against the degree of the risk that a fair trial might not ensue (if such access is denied.)

See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 688.

⁸⁹ The complete section 35 has already been cited in note 63 above. See also Currie, De Waal and Erasmus (2005) *supra* note 13 at 782. It has been held that there rests an obligation on a presiding officer to assist an unrepresented accused in respect of his or her right to adduce and challenge evidence. See generally *S v Simxadi* 1997 (1) SACR 169 (C); *S v Sishi* (2000) 2 All SA 56 (N); *S v Dyani* 2004 (2) SACR 365 (E). See also Cheadle, Davis and Haysom (2002) *supra* n13 661; Devenish (2005) *supra* note 13 at 173-177.

this chapter. In the light of the fact that expert evidence is not a prerequisite in order to rely on the defence of non-pathological criminal incapacity, it could be argued that an accused relying on this defence is prejudiced, particularly if expert evidence which is crucial, is not advanced on behalf of the accused. Expert evidence, if submitted, advanced by the accused as well as the State will provide more clarity pertaining to the factual issues before the court and will also give recognition to the fundamental right of an accused to adduce and challenge evidence.

Section 35(3)(h) states:

“Every accused person has a right to a fair trial, which includes the right –
(h) to be presumed innocent, to remain silent, and not to testify during the proceedings, ...”

Section 35(3)(h) in effect refers to three rights: the right to be presumed innocent, the right to remain silent and the right not to testify.⁹⁰

Schwikkard states that the presumption of innocence is used to refer to two different factors:⁹¹

- a rule regulating the standard of proof;
- a policy directive that the subject of a criminal investigation should be regarded as innocent throughout the trial regardless of the possible outcome.

These rights are aimed at reaffirming the State’s onus to prove the liability of an accused beyond reasonable doubt. The right to be presumed innocent is

⁹⁰ Steytler (1998) *supra* note 13 at 317.

⁹¹ Schwikkard, PJ in Currie, De Waal and Erasmus (2005) *supra* note 13 at 748. In *Ferreira v Levin NO: Vryenhoek v Powell NO* 1996 1 BCLR 1 (CC) at paragraph 246 Sachs J states: “the right to silence, the right not to be a compellable witness against oneself, the right to be presumed innocent until proven guilty and the refusal to permit evidence of admissions that were made freely and voluntarily, are all composite and mutually re-enforcing parts of the adversarial system of criminal justice that is deeply implanted in our country and resolutely affirmed by the Constitution.”

regarded as one of the essential rights in any criminal justice system.⁹² With reference to the defence of non-pathological criminal incapacity the application of the presumption of innocence becomes relevant in determining the burden of proof. The question whether the reverse onus provision applicable to the defence of pathological criminal incapacity should also apply to non-pathological criminal incapacity will also be addressed below.

The presumption of innocence is infringed whenever an accused is required by a statutory or common law presumption to prove or disprove on a balance of probabilities either an element of or a defence to an offence.⁹³ The latter currently applies to the defence of pathological criminal incapacity but not to non-pathological criminal incapacity.

It is submitted that the burden of proof should be the same in respect of both these defences. It is further submitted that the reverse onus provision should also apply to the defence of non-pathological criminal incapacity. Steytler notes that the relation between the reverse onus and the purpose it serves is very important – it should be rational.⁹⁴ It could be argued that the reverse onus provision is necessary to curb abuse of the defence of criminal incapacity and that there are no other less restrictive means to achieve this goal. Unfortunately reverse onuses have been unsuccessful largely due to the fact that the State could not indicate that less restrictive means could be employed to achieve the purpose.⁹⁵

Schwikkard correctly notes that the normative value accorded to the presumption of innocence as a fundamental right has been emphasised by the court's insistence that any justification for infringing the presumption of innocence would have to be "clear, convincing and compelling."⁹⁶

⁹² Steytler (1998) *supra* note 13 at 320.

⁹³ Steytler (1998) *supra* note 13 at 322; *S v Bhulwana*; *S v Gwadiso* 1995 (12) *BCLR* 1579 (CC); *S v Coetzee* 1997 (4) *BCLR* 437 (CC) at paragraph 226.

⁹⁴ Steytler (1998) *supra* note 13 at 324.

⁹⁵ Steytler (1998) *supra* note 13 at 325; *S v Pineiro* 1993 (2) *SACR* 412 (Nm).

⁹⁶ Schwikkard in Currie, De Waal and Erasmus (2005) *supra* note 13 at 751; *S v Mbatha* 1996 (2) *SA* 464 (CC) at paragraph 14.

For purposes of this discussion the right to remain silent and the right not to testify will not be discussed.

3.4.6 Limitation of rights

Constitutional rights and freedoms are not absolute and can accordingly be restricted.⁹⁷ Section 36 contains the set criteria to determine when a particular right in the Bill of Rights can be restricted or limited.

Section 36 reads as follows:

“36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –

- (a) the nature of the right;
- (b) the importance of the purpose of the limitation;
- (c) the nature and extent of the limitation;
- (d) the relation between the limitation and its purpose, and
- (e) less restrictive means to achieve the purpose.

(2) Except as provided in Subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.”

A particular law may accordingly limit a right contained in the Bill of Rights if it is a law of general application that is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.⁹⁸ It is thus necessary, when applying or relying on any particular right in the Bill of Rights, to bear in mind that such right is not absolute and can be curbed in terms of Section 36.

⁹⁷ Currie, De Waal and Erasmus (2005) *supra* note 13 at 168; Devenish (2005) *supra* note 13 at 179. See also Cheadle in Cheadle, Davis and Haysom (2002) *supra* note 13 at 695 where it is stated:

“An express limitation clause also provides a matrix for assessing the justifiability of a limitation.”

⁹⁸ Currie, De Waal and Erasmus (2005) *supra* note 13 at 168.

Cheadle states that a limitation clause “provides a template not only for the courts but, more importantly, for the legislature, and it provides a common platform for dialogue between the courts and the legislature.”⁹⁹

4 Reflections on the history and development of the defence of non-pathological criminal incapacity

4.1 Position before *S v Chretien*¹⁰⁰

Up to 1981, it was generally accepted that criminal capacity could be excluded or diminished if the cause of the incapacity was mental illness, youthfulness, intoxication and provocation.¹⁰¹ Snyman submits that before 1981, intoxication and provocation were only regarded as partial defences.¹⁰²

4.2 Position after *S v Chretien*

The legal standing in respect of the defence of criminal incapacity was dramatically changed by the decision laid down by Rumpff CJ in *S v Chretien*.

The facts of the decision were briefly that the accused had attended a party at which there was a good deal of drinking which eventually broke up in circumstances of some discontent. While under the influence of alcohol, the accused had driven his car into a crowd of people who had been at the party and

⁹⁹ Cheadle in Cheadle, Davis and Haysom (2002) *supra* note 13 at 695. See also generally Van der Schyff, G “Limitation of Rights – A Study of the European Convention and the South African Bill of Rights” (2005) for a comparison between the limitation of Fundamental rights in the Constitution of South Africa with European Convention. See also *S v Walters* 2002 (4) SA 613 (CC); *S v Makwanyane* 1995 (3) SA 391 (CC).

¹⁰⁰ 1981 (1) SA 1097 (A).

¹⁰¹ Snyman, CR “Criminal Law” (2002) 4th ed at 164; Snyman, (2008) *supra* note 1 at 164; Burchell and Milton, (2005) *supra* note 1 at 404-407; Tredoux *et al* (2005) *supra* note 1 at 400-403; Kaliski, (2006) *supra* note 1 at 105; Du Toit *et al* (2007) *supra* note 1 at 13-17; Strauss, (1995) SAPM *supra* note 1 at 14-15/34.

¹⁰² Snyman (1989) TRW *supra* note 1 at 1-15. See also Van Oosten (1993) SACJ *supra* note 1 at 127 where he states: “However, the development, in recent times, of intoxication and provocation as fully fledged defences which may, *inter alia*, negative criminal capacity has drastically changed the picture for better and for worse. Suddenly there were four criminal incapacity defences instead of two and the possibility of more in the offing.” See also Bergenthuin (1986) *De Jure supra* note 1 at 98.

who were standing in the street. One person was killed and five were injured. On charges of murder and attempted murder, the trial court found the accused guilty of culpable homicide but acquitted him of attempted murder and even common assault.

The following question of law was reserved for decision by the Appellate division:¹⁰³

“Whether on the facts found proven by the court the learned judge was correct in law in holding that the accused on a charge of attempted murder could not be convicted of common assault where the necessary intention for the offence charged had been influenced by the voluntary consumption of alcohol.”

The most important findings pertaining to criminal incapacity were the following where Rumpff CJ state:¹⁰⁴

“Na my mening is dit verkiesliker om te aanvaar dat indien dit uit die getuienis blyk dat ‘n beskuldigde werklik so besope was dat hy inderdaad nie besef het wat hy gedoen het nie, die publieke beleid (die regsdoelstelling van die gemeenskap) nie vereis dat van die suiwer regs-wetenskaplike benadering afgesien moet word nie en dat die beskuldigde ‘n straf moet ondergaan bloot omdat hy vrywillig ‘n toestand bereik het waarin hy juridies nie kan handel nie of ontoerekeningsvatbaar is.”

Rumpff CJ also states that when a person is so intoxicated that he or she does not appreciate the unlawfulness of his or her actions or when his or her inhibitions were crushed, he or she will be deemed to have lacked criminal capacity and if

¹⁰³ At 1102 C-D. See also Burchell and Milton (2007) *supra* note 1 at 362-368.

¹⁰⁴ At 1105 F-G. See also *S v Johnson* 1969(1) SA 201 (A) at 211; *R v Bourke* 1916 TPD 303 at 307; Van der Merwe, DP Toerekeningsvatbaarheid v ‘Specific Intent’ – die Chretien-beslissings” (1981) *Obiter* at 142; Burchell, EM “Provocation and Intoxication” (1959) SACJ at 385, Nel, PW “Toerekeningsvatbaarheid in die Suid-Afrikaanse Strafbereg” (2007) Unpublished LLM thesis University of Pretoria at 48.

there is reasonable doubt, the accused should be afforded the benefit of the doubt.¹⁰⁵

Rumpff CJ also observes:¹⁰⁶

“Na my mening is iemand wat papdrunk is en wat onbewus is van wat hy doen, nie aanspreeklik nie omdat ‘n spierbeweging in die toestand gedoen nie ‘n strafregtelike handeling is nie. Indien iemand ‘n handeling verrig (meer as ‘n onwillekeurige spierbeweging) maar so besope is dat hy nie besef wat hy doen nie of dat hy die ongeoorlooftheid van sy handeling nie besef nie, is hy nie toerekeningsvatbaar nie maar ek wil herhaal dat ‘n hof alleen op grond van getuienis wat dit regverdig tot die konklusie, of redelike twyfel, sal kom dat wanneer iemand inderdaad ‘n handeling (of omissie) begaan het wat ‘n misdad is, hy dermate besope was dat hy nie toerekeningsvatbaar is nie.”

The question of law which was reserved, was answered in the affirmative.

The practical importance of the decision in *Chretien* for purposes of this study, is that it opened the door for the defence currently labelled non-pathological criminal incapacity. Although this decision did not lay down any principles pertaining to the role of expert evidence in support of this defence, it nevertheless established a foundation for a defence, later to be coined non-pathological criminal incapacity.¹⁰⁷

The practical implications of this decision were that a person who is so intoxicated that his/her muscular movements are involuntary, there is no act and accordingly no criminal liability.¹⁰⁸ In exceptional circumstances a person can be so drunk that he/she lacks criminal capacity in which event such a person will also escape criminal liability. A court will, however, not lightly infer that an accused as a result of intoxication acted involuntarily or lacked criminal capacity or lacked intention. A different approach may lead to the administration of justice being discredited.¹⁰⁹

¹⁰⁵ At 1106 B.

¹⁰⁶ At 1106 E-G.

¹⁰⁷ See *S v Laubscher supra* note 1 at 166 F-G; Snyman (2002) *supra* note 1 at 158.

¹⁰⁸ Snyman, CR “Criminal Law Casebook” (2003) 3rd ed at 126.

¹⁰⁹ *Ibid.*

After the *Chretien*-decision the question accordingly arose as to whether, apart from defences such as youthfulness or mental illness, there could perhaps be a general defence of criminal incapacity. A number of subsequent decisions have answered this question affirmatively.¹¹⁰

5 Reflections on a general defence of criminal incapacity: description of cause of mental inability irrelevant

The defence of criminal incapacity is currently divided into two categories, namely pathological and non-pathological criminal incapacity.

A court will always first attempt to establish whether the defence is one of pathological criminal incapacity, in other words, whether the accused at the time of the commission of the crime was suffering from some known pathology in the form of a mental illness, or not. This will determine whether the court is statutorily obliged to send an accused for observation in terms of section 79 of the Criminal Procedure Act. If, according to the court, an accused was not suffering from a mental illness or mental defect and the defence is not one of pathological criminal incapacity, a court retains a discretion whether to refer an accused for observation.¹¹¹

The need for expert assistance and evidence is accordingly determined not by the criminal incapacity itself, but by the cause of the incapacity.

The question that inevitably arises is whether the time has not arrived to establish a general defence of criminal incapacity with mental illness as one factor which could have an influence on criminal capacity. It is submitted that a general defence of criminal incapacity will not only create legal certainty, but will provide a

¹¹⁰ *S v Arnold supra* note 1; *S v Campher supra* note 1; *S v Laubscher supra* note 1. These decisions will be discussed comprehensively in this chapter with the emphasis on the role of expert evidence. See also Snyman TRW (1989) *supra* note 1 at 1. See also *S v Shivute* 1991 (1) SACR 656 (Nm) at 660; *S v Ingram* 1995 (1) SACR, (A) at 4 h-i; *S v Van der Sandt* 1998 (2) SACR 627 (W) at 636a; Van Oosten (1993) SACJ *supra* note 1 at 146.

¹¹¹ See section 78(2) of the Criminal Procedure Act. See also Van Oosten SACJ (1993) *supra* note 1 at 146-147.

more judicially sound approach to the application of the defence of criminal incapacity.

Bergenthuin correctly states that one of the main reasons why criminal capacity has not yet attained complete recognition as a requirement for criminal liability, is because a general criteria for the establishment of criminal capacity has not been formulated.¹¹²

With the recognition of criminal capacity as a prerequisite for criminal liability, be it as a distinct and separate element of a crime or as a requirement for culpability, a person who lacks criminal capacity will not be held liable due to the recognition of criminal capacity as an element or prerequisite for a crime.¹¹³

Bergenthuin summarises the problem with regards to a lack of a general defence of criminal incapacity as follows:¹¹⁴

“Die gebrek aan ‘n algemene toerekeningsvatbaarheidskriterium wat die toepassing van pragmatiese reëls binne alle begrensing van kasuïstiek noodsaak, skep egter juis die gevaar dat ‘n ontoerekeningsvatbare persoon wel strafregtelik aanspreeklik mag staan, omdat die feitestel waarvolgens sy geval beoordeel word nie binne ‘n bekende presedent tuishoort nie.”

Bergenthuin correctly observes that upon close scrutiny of the *Chretien*-decision,¹¹⁵ there is no indication that intoxication, for example, should be singled

¹¹² Bergenthuin, JG “Die algemene toerekeningsvatbaarheidsmaatstaf” *De Jure* (1985) at 273, Bergenthuin, (1985) *supra* note 1 at 577.

¹¹³ Bergenthuin (1985) *supra* note 1 at 274.

¹¹⁴ *Ibid.* Bergenthuin takes the view that the root of the problem pertaining to the lack of a proper general criteria for the assessment of criminal capacity, lies in the application of the psychological theory of culpability which focuses on the subjective state of mind of the accused as opposed to the normative theory which is aimed at the evaluation of the convictions of the community. Bergenthuin submits that the acceptance of the normative theory of culpability will provide more clarity as to the position of criminal capacity (at 277). See also generally *S v Bailey* 1982 (3) SA 772 (A).

¹¹⁵ *S v Chretien supra* note 1.

out as a ground for criminal incapacity. Accordingly other grounds can also exclude criminal capacity.¹¹⁶

In *S v Campher*,¹¹⁷ Viljoen AJ stated:¹¹⁸

“Die beginsels van ontoerekeningsvatbaarheid behoort te geld of die geestesversteuring of gemoedsomwenteling ookal deur drank of ‘n heftige emosie veroorsaak is. Die verskillende geestestoestande behoort nie gekompartementaliseer te word nie; die beginsel moet slegs nagekom word deur kriteria vir ontoerekeningsvatbaarheid toe te pas afgesien van die vraag of die beskuldigde se aberrase tydelik of permanent van aard was.”

In the same decision, Boshoff AJA states:¹¹⁹

“Die afwesigheid van toerekeningsvatbaarheid is nie beperk tot gevalle waar die dader aan ‘n geesteskrankheid ly nie. Dit is ook denkbaar en bestaanbaar by gevalle van tydelike verstandelike beneweling.”

It is submitted that the views of Viljoen AJ and Boshoff AJ (acting) are correct. Although this is a relatively older decision, the need for change and development pertaining to the defence of non-pathological criminal incapacity, has not changed. It is submitted that there is a need for the development of a general defence of criminal incapacity where the reliance placed on this defence will not be determined by the alleged cause of incapacity, but rather on the lack of criminal capacity itself. Any factor which causes a person to lack the ability to appreciate the wrongfulness of his or her actions or to act in accordance with an appreciation of wrongfulness, will be relevant in determining the existence or lack of criminal capacity.

¹¹⁶ See *S v Van Vuuren* 1983 (1) SA 12 (A), where severe emotional stress was acknowledged as a ground for exclusion of criminal capacity. See also Bergenthuin (1985) *supra* note 1 at 281.

¹¹⁷ *S v Campher* 1987 (1) SA 940 (A).

¹¹⁸ At 955 A-C.

¹¹⁹ At 965 H.

Louw advances the following arguments in favour of a general defence of criminal incapacity:¹²⁰

- From a juridical point of view, such development is “pure”. It is “pure” in the sense that it is in line with the nature of fault as well as the role of fault and criminal capacity in relation to the definition of crime. Louw submits that it is a logical development and scientifically accountable also taking into account the convictions of society.
- The development of such defence will provide a new defence to accused persons who are mentally sound.
- “Sane” criminal incapacity also differs from voluntary intoxication in that “sane” incapacity cannot be deemed a manifestation of the accused’s will. The accused did not desire the particular state and in cases of provocation it is usually the victim who induced or caused the situation.

Louw also advances the following arguments against the development of a general defence of criminal incapacity:¹²¹

- It is not the primary role of the law to serve science and logic. As Louw correctly states, this view is positivistic and it reduces the law to a set of rules. It should further be borne in mind that when interpreting legislation or developing the common law, a court is obliged to promote the spirit, purport and objects of the Bill of Rights.¹²²
- It is expected of a normal person to curb his or her emotions and urges. Accordingly, the defence will be open to abuse. It is, however, true, as Louw correctly states, that each person’s level of tolerance in respect of anger and emotional resistance is different and it is in any event difficult to establish whether an accused at a given moment, lost control of him/herself.
- The recognition of a general defence of criminal incapacity will result in punishment losing its reformatory and preventative functions in that an

¹²⁰ Louw, PF “Die algemene Toerekeningsvatbaarheidsmaatstaf” *SACJ* (1987) at 368.

¹²¹ Louw (1987) *SACJ supra* note 120 at 369.

¹²² Section 39(2) of the Constitution as discussed above.

emotionally unstable accused will not be taught to keep his or her emotions intact.

By developing a general defence of criminal incapacity the aim is to provide legal certainty and a clear set of rules and norms to be applied in each case where this defence is raised. The development of such defence presupposes the additional establishment of strict rules and requirements when relying on this defence. By requiring an accused to establish a solid foundation for the defence, abuse of this defence will be curbed. It is also at this point where expert evidence plays a pivotal and vital role. Due to the biological-psychological nature of the test for criminal incapacity and the intrinsic nature of this defence, the *ipse dixit* of an accused that he or she lacked criminal capacity, should never be sufficient. Expert evidence should be a prerequisite to support such an averment. In order to attain a more balanced and just view, it should be required that both defence and State retain their own experts. By establishing a general defence of criminal incapacity, the emphasis will accordingly not fall so severely on the cause of the incapacity, but rather on the lack of criminal capacity itself. Such development will also be more in line with our Constitutional values. The further development and implementation of the concept of diminished criminal capacity will further guarantee a just and fair outcome where criminal incapacity is raised.¹²³

In order to rely on the defence of non-pathological criminal incapacity it is not necessary to prove that the accused's inability was the result of any specific cause or pathological state.¹²⁴ The only requirement that needs to be satisfied is that the court should be convinced on the evidence as a whole that, at the time of the act, the accused was incapable of appreciating the wrongfulness of his or her act or of acting in accordance with such an appreciation, irrespective of the cause of the inability.¹²⁵

The cause of the inability may be "emotional collapse", "emotional stress", "total disintegration of the personality" or various other causes such as shock, fear,

¹²³ This concept is discussed in more detail below.

¹²⁴ Snyman (2002) *supra* note 1 at 164-165.

¹²⁵ *Ibid.*

tension or provocation. The cause could also be as a result of provocation by somebody else, and the provocation could also be linked to physical or mental exhaustion as a result of insulting behaviour over a long period of time, which increasingly strained the accused's powers of self-restraint, until these powers eventually snapped.¹²⁶

Snyman states:¹²⁷

“Different psychiatrists or judges may use different expressions to describe the cause of X's incapacity, but the exact description of the cause of the condition is not important. What is important is not the cause of the inability or the description of this cause, but the inability itself.”

6 Lack of criminal capacity to be distinguished from sane automatism

It is from the outset of utmost importance to distinguish clearly between conduct that is involuntary, on the one hand, and the lack of criminal capacity, with specific reference to the lack of the ability to act in accordance with an appreciation of the wrongfulness of the conduct (the conative mental ability), on the other. Even though these two inquiries relate to different requirements of criminal liability, they have vicariously been conflated by courts as well as mental health practitioners.¹²⁸

Criminal conduct must be voluntary. Conduct is voluntary if the accused's muscular movements are controlled by the accused's conscious will or intellect.¹²⁹

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸ Burchell and Milton (2005) *supra* note 1 at 436-437; *S v Eadie supra* note 1 at paragraph 57. See also comments by Dr Kaliski in *S v Eadie supra* note 1 paragraph 43; *S v Francis* 1999 (1) SACR 650 (SCA) at 652G-H.

¹²⁹ Burchell and Milton (2005) *supra* note 1 at 139; Snyman, (2008) *supra* note 1 at 51; 162. See also *S v Chretien supra* note 1 where Rumpff CJ at 1106 E-G stated:

“Na my mening is iemand wat papdrunk is en wat onbewus is van wat hy doen, nie aanspreeklik nie omdat 'n spierbeweging in dié toestand gedoen nie 'n strafregtelike handeling is nie. Indien iemand 'n handeling verrig (meer as 'n onwillekeurige spierbeweging) maar so besope is dat hy nie besef wat hy doen nie of dat hy die ongeoorlooftheid van sy handeling nie besef nie, is hy nie toerekeningsvatbaar nie.” This quotation also serves to clearly illustrate the differentiation between the defences of automatism and criminal incapacity.

The requirement of conduct in the form of an *commissio* or *omissio* is the first basic element of liability.¹³⁰

Snyman also notes that the concept of an act performs two important roles in the construction of liability:

- it forms the basis of liability
- it serves to limit the scope of liability.¹³¹

As the basic element in the establishment of criminal liability, all the other elements or requirements for liability are qualified by the act.¹³² An investigation into the element of unlawfulness is accordingly premature if it has not yet been established whether there has been an act which corresponds with the definitional elements of a crime.¹³³

In respect of the second role fulfilled by the act, the act must be formulated in such a way that it excludes from the inquiry conduct or events which are irrelevant.¹³⁴

Automatism is the defence which is raised when it is alleged that an accused's behaviour was not voluntary.¹³⁵ Involuntary conduct refers to the inability of a person to subject his muscular movements to his will or intellect and accordingly relates to the question of whether a person has committed an act in the criminal law sense of the word.¹³⁶ According to Snyman the crucial aspect here is whether a person is capable of controlling his physical movements through his will.¹³⁷ If a sane person commits an act in a state of automatism which act would otherwise

¹³⁰ Snyman (2008) *supra* note 1 at 51.

¹³¹ Snyman (2008) *supra* note 1 at 52.

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ *Ibid.*

¹³⁵ Snyman (2008) *supra* note 1 at 55; Burchell and Milton (2005) *supra* note 1 at 139; Tredoux *et al* (2005) *supra* note 1 at 404-405.

¹³⁶ Snyman (2008) *supra* note 1 at 162. See also *S v Mkize* 1959 (2) SA 260 (N) at 266; *S v Ngang* 1960 (3) SA 363 (T) 366; *S v Stellmacher* 1983 (2) SA 181 (SWA) 185 A – B; Burchell and Milton (2005) *supra* note 1 at 179 - 180.

¹³⁷ *Ibid.*

be criminal, he or she will have a complete defence and will as such be entitled to an acquittal.¹³⁸

Such acquittal will be founded on the rule that only a voluntary human act in the form of a commission or omission can lead to criminal liability.¹³⁹

In order for the defence of sane automatism to succeed, there has to be sufficiently cogent evidence in order to raise reasonable doubt as to the voluntary nature of the *actus reus* and also medical or expert evidence to indicate that the involuntary nature of the *actus reus* is due to a cause other than a mental illness or mental defect.¹⁴⁰

Where the defence of sane automatism is raised, the onus falls on the State to prove beyond reasonable doubt that the act was committed voluntarily.¹⁴¹ In discharging the onus, the State is assisted by the natural inference that in the absence of exceptional circumstances, a sane person who engages in conduct which would ordinarily give rise to criminal liability does so consciously and voluntarily.¹⁴²

In *S v Henry Scott* JA noted:¹⁴³

“It is trite law that a cognitive or voluntary act is an essential element of criminal responsibility. It is also well established that where the commission of such an act is put in issue on the ground that the absence of voluntariness was attributable to a cause other than mental pathology, the onus is on the State to establish this element beyond reasonable doubt.”

¹³⁸ LAWSA (2004) *supra* note 12 at 68. See also *R v Dhlamini* 1955 (1) SA 120 (T) at 121; *S v Nursing* 1995 (2) SACR 331 (D).

¹³⁹ LAWSA (2004) *supra* note 12 at 68. See also *Du Toit et al*, (2007) *supra* note 1 at 13-15. See also *S v Viljoen* 1992 (1) SACR 601 (T); Louw, in *Kaliski* (2006) *supra* note 1 at 37.

¹⁴⁰ LAWSA (2004) *supra* note 12 at 68 ; *Du Toit et al* (2007) *supra* note 1 at 13-15.

¹⁴¹ LAWSA (2004) *supra* note 1 at 68. See also *S v Cunningham* *supra* note 1 at 635J-636G.

¹⁴² As expressed by Scott JA in *S v Cunningham* *supra* note 1 at 635 j-636 g. See also *S v Eadie* 2002 (1) SACR 663 (SCA) 681 F-H.

¹⁴³ *S v Henry* 1991 (1) SACR 13 (SCA) at 19 I-J; *S v Kalogoropoulos* 1993 (1) SACR 12 (A); *S v Kensley* 1995 (1) SACR 646 (A) at 658I-J; *S v Trickett* 1973 (3) SA 526 (T) at 532; Schmidt, CWH “Laying the foundation for a defence of Sane Automatism” *SALJ* (1973) vol 90 at 329.

When the defence of sane automatism is raised, a proper foundation has to be established. Expert evidence may be necessary to lay the factual foundation for this defence but ultimately the decision rests with the court, taking into account the medical evidence as well as all the facts of the case.¹⁴⁴

It is also necessary to take note of the fact that automatism can take two forms, namely sane and insane automatism.¹⁴⁵ Insane automatism relates to involuntary behaviour attributable to a mental illness or mental defect. Accordingly, in the latter event, the principles applicable to criminal incapacity due to mental illness or mental defect must be applied.¹⁴⁶

The inability of a person to subject his muscular movements according to his or her will or intellect should not be confused with the inability to act in accordance with an appreciation of the wrongfulness of the act, or better known, as the absence of the conative component of the capacity inquiry.¹⁴⁷ If a person is unable to subject his muscular movements according to his will or intellect, it means that the requirement of an act or conduct was absent.¹⁴⁸ The defence in the latter will be automatism as discussed above.

If, on the other hand, a person is unable to act in accordance with an appreciation of the wrongfulness of the act, he or she does have the power of subjecting his or her bodily movements to his or her will, but is incapable of resisting the commission of a crime.¹⁴⁹ The appropriate defence in this instance will be lack of criminal capacity due to the absence of the conative component of the capacity inquiry.

¹⁴⁴ LAWSA (2004) *supra* note 1 at 68. See also *S v Di Blasi supra* note 1 at 7B-D where the court held that the accused is required to establish a factual foundation for the contention that non-pathological factors induced a state of diminished criminal capacity.

¹⁴⁵ LAWSA (2004) *supra* note 12 at 68; Burchell and Milton (2005) *supra* note 1 at 139; Louw, in Kaliski (ed)(2006) *supra* note 1 at 38.

¹⁴⁶ LAWSA (2004) *supra* note 1 at 68; Snyman (2008) *supra* note 1 at 56. For a detailed distinction between the concepts of “sane” and “insane” automatism, see chapter 1 above.

¹⁴⁷ Snyman (2008) *supra* note 1 at 162.

¹⁴⁸ Snyman (2008) *supra* note 1 at 162; Van Oosten (1993) SACJ *supra* note 1 at 126.

¹⁴⁹ *Ibid.*

It is of pivotal importance that these two defences be retained as two distinct defences pertaining to different requirements of criminal liability. An inquiry into an accused's criminal capacity will only be conducted once it has been established that the accused acted voluntarily and unlawfully. The distinction between these two defences is not always welcomed by the medical profession. The consequence of this is that the expert evidence advanced in support of, for example, criminal incapacity, will inadvertently lack probative value, if the defence is not understood and entertained by the mental health professional testifying in support of it.

In *S v Eadie*, Navsa JA stated the following:¹⁵⁰

“I agree with Ronald Louw that there is no distinction between sane automatism and non-pathological incapacity due to emotional stress and provocation ... It appears logical that when it has been shown that an accused has the ability to appreciate the difference between right and wrong, in order to escape liability, he would have to successfully raise involuntariness as a defence. However, the result is the same if an accused's verified defence is that his psyche had disintegrated to such an extent that he was unable to exercise control over his movements and that he acted as an automaton – his acts would then have been unconscious and involuntary.”

The abovementioned statement is unfortunate. Not only does it create confusion, but it also dismisses trite legal principles that have long been applied.

Le Roux also correctly submits that sane automatism excludes the conduct element of a crime due to the fact that it excludes voluntariness.¹⁵¹ On the other hand, a person can lack criminal capacity either due to a lack of appreciation of

¹⁵⁰ *S v Eadie* 2002 (1) SACR 663 (SCA) at 689 B-C. Navsa JA refers to an article by Louw, R “*S v Eadie: Road Rage, Incapacity and Legal Confusion*” (2001) SACJ at 206. See also Louw, R “*S v Eadie: The end of the road for the defence of provocation?*” SACJ (2003) vol 16 at 200; Snyman, CR “The tension between legal theory and policy considerations in the general principles of Criminal Law” (2003) *Acta Juridica* at 1-22. These articles will be discussed later in this chapter when the decision in *S v Eadie supra* is analysed.

¹⁵¹ Le Roux (2002) *THRHR supra* note 1 at 478-481.

the wrongfulness of an act or due to the inability of acting in accordance with an appreciation of the wrongfulness of an act.

In various decisions the courts have consistently distinguished clearly between sane automatism and non-pathological criminal incapacity¹⁵².

In *S v Stellmacher*¹⁵³ the accused had been on a strict diet for a period of several weeks. On the particular day in question he had eaten nothing and had performed strenuous physical labour. He went to the local hotel at six o'clock in the afternoon and consumed at least half a bottle of brandy. There was, in the bar, a strong reflection in his eyes of the setting sun through an empty bottle. As a result of the latter, he lapsed into an automatic state during which he fired at persons in the bar, killing one person. The expert evidence relating to the accused's condition was that the automatism was attributable to hypoglycaemia and/or epilepsy of a relatively short duration and that the accused's fasting and drinking may have precipitated these conditions.¹⁵⁴ Mouton J, however, held that the evidence indicated that the accused lacked criminal capacity when he committed the act that constituted the crime.¹⁵⁵ The question which accordingly arose was whether the accused had suffered from a mental illness as contemplated by section 78 of the Criminal Procedure Act.

Mouton J, citing Hiemstra, held that a mental illness or mental defect related to a pathological disturbance of the accused's mental faculties and not a mere temporary aberration of the accused's mental capacity not attributable to a mental illness.¹⁵⁶

The court accordingly held that the State had not proved, beyond reasonable doubt, that the accused's behaviour was indicative of a pathological disturbance of his mental faculties not attributable to a temporary aberration of the mental capacity which was not due to a mental illness.

¹⁵² See *S v Moses supra* note 1 at 713 B.

¹⁵³ *S v Stellmacher* 1983 (2) SA 181 (SWA). See also Burchell and Milton (2007) *supra* note 1 at 355; Snyman (2008) *supra* note 1 at 171-172; Louw in Kaliski (ed)(2006) *supra* note 1 at 37.

¹⁵⁴ See the evidence of Drs Van Rensburg, Gouse and Grove at 183 B-G.

¹⁵⁵ At 187 A.

¹⁵⁶ At 187 H.

Accordingly, the court held that a foundation had been established for a defence of criminal incapacity not induced or caused by mental illness.¹⁵⁷ The accused was acquitted.

The relevance and importance of this decision lies in the fact that the court, irrespective of the expert evidence indicating a state of automatism, held that the evidence revealed a state of non-pathological criminal incapacity although the latter terminology was not used by the court.

In *S v Arnold*¹⁵⁸ the facts were briefly as follows. The accused had an unstable childhood and, in the course of his adult life, more than one unsuccessful relationship with women. He was later divorced from his first wife and then married the deceased. He had two sons from his first marriage, aged 16 and 11 years. The younger one had a serious disability – he was hard of hearing. The accused had a very deep love for his boy probably as a result of his disability. The accused was also infatuated with the deceased. Some witnesses also described it as him being besotted with her. Shortly after the marriage the deceased's mother came to stay with them. She was a divorcée, who was receiving treatment for a hysterical condition. There was an unusually close relationship between the deceased and her mother. A psychiatrist also described it as pathological¹⁵⁹. The deceased developed a hostile attitude towards her husband's disabled son. As a result the accused had to arrange for the child to be placed in what the court referred to as "a home for committed" children¹⁶⁰. This step distressed the accused deeply. The relationship between the accused and the deceased became strained, yet he still loved her very much. The facts reveal that the deceased was a beautiful woman, well aware of the fact that she was most attractive to men, whose attentions she enjoyed. She had a pleasant but immature personality with histrionic tendencies. The accused himself was highly

¹⁵⁷ At 188 A-B.

¹⁵⁸ 1985 (3) SA 256 CPD; Snyman (1985) *SALJ supra* note 1 at 240; Visser PJ, Maré MC "Visser & Vorster's General Principles of Criminal law Through the cases" 3rd ed (1990) at 400-404; Ellis J "Emotional Stress" – 'n Nuwe Handelingsuitsluitingsgrond?' *De Jure* 1986 vol 1 (19) at 340.

¹⁵⁹ At 258 D.

¹⁶⁰ At 1258 E-F.

emotional and, according to the court “experience[d] the most intense feelings, far more than is normal”¹⁶¹. On the day the deceased was killed, the accused took his son to the home for committed children. Earlier the same day he had argued with the deceased. The accused always carried a gun with him. On this particular day the accused had his gun with him. It was practice entering the house to put the gun down in a secure place and on this occasion he had the gun in his hand but because of the position taken up by the deceased he was unable to put it down. During the verbal exchanges that ensued, he held the gun in his hand, hitting it against the couch to emphasize points made by him. During the conversation the gun went off, the bullet going in the opposite direction from where the accused was standing, but missing the deceased. The conversation continued. The deceased told the accused that she wanted to return to singing, dancing and cabaret. By cabaret she meant strip dancing. While she was discussing the strip dancing she intended to do after leaving the house, the deceased bent forward displaying her bare breasts. This was described by the court as “obviously an act of provocation”¹⁶². The deceased was then shot and fell to the ground. The accused testified that he did not remember aiming the gun and pulling the trigger. The accused was upset, took the deceased in his arms and called the police.

It is now important to focus on the expert evidence presented in this case.

On behalf of the defence, Dr Gittelson, a psychiatrist, gave expert evidence. The state did not call any psychiatrist nor contest the opinions expressed by Dr Gittelson. His evidence was based upon very thorough investigation. He saw the accused the day after the fateful event and in all had interviewed him for a period of 19 hours. He also investigated the background of the deceased and the mother-in-law. In this he had valuable information from prior reports by psychologists on the two people. All of the information the accused provided Dr Gittelson with, indicated that he was truthful in all that he said to him including that he could not remember certain vital events. When asked whether the accused could appreciate the wrongfulness of his act, he replied that normally the accused was not deficient in this respect, but that at the relevant time the last thing in his

¹⁶¹ At 259 B-C.
¹⁶² At 261 G-H.

mind was the question as to whether what he did was right or wrong¹⁶³. His conscious mind was so “flooded” by emotions that it interfered with his capacity to appreciate what was right or wrong and, because of his emotional state, he may have lost the capacity to exercise control over his actions¹⁶⁴.

Dr Gittelsohn also said that it may be that the accused had acted subconsciously at the crucial time because of the emotional storm and hence that he did not know what he was doing but that the severity of the storm was a question of degree and that he could not say whether in fact the accused was conscious of what he was doing or not. The legal questions the court had to decide upon were:

- (a) Did the accused perform an act in the legal sense?
- (b) If he did perform a legal act, did he have the necessary criminal capacity at the time of the act?
- (c) If he did have the necessary criminal capacity, did he have the requisite intention?

The court found the accused not guilty as it could not find beyond reasonable doubt that when the accused killed the deceased he was acting consciously and not subconsciously.

It is also of interest to note that the court also recognised that not only youthfulness, mental disorder and intoxication could give rise to criminal incapacity, but also other factors, such as extreme emotional stress.¹⁶⁵

What is of importance for this study is the pivotal role that the testimony of Dr Gittelsohn played in this area. Upon a careful investigation of the case report it becomes apparent that the evaluation of the accused by Dr Gittelsohn played a crucial role in the outcome of the case. It is true that this judgment has been

¹⁶³ At 263 B-D.

¹⁶⁴ *Ibid.*

¹⁶⁵ At 264 C-D.

criticized.¹⁶⁶ This case serves as an illustration of the indispensable role that the psychiatrist plays in proving criminal capacity or incapacity, as the case may be.

This case further serves as authority for the argument in favour of a clear distinction between the defences of sane automatism and non-pathological criminal incapacity. In this case Burger J dealt with each of the questions of law mentioned above separately and distinctly, again reaffirming the essential need for distinguishing between these two defences.¹⁶⁷

In *S v McDonald*¹⁶⁸ the appellant was convicted of murder and attempted murder in a regional court and was sentenced to fifteen and five years' imprisonment respectively. This case mainly dealt with sane automatism as a defence. The charges arose from a shooting incident that occurred involving the appellant's ex-wife's new partner (the deceased) and his ex-wife's brother-in-law as a result of a quarrel as to the appellant's visitation of his two sons as stated in their divorce agreement. The facts revealed that on the day of the shooting the appellant was supposed to collect his two sons for visitation whereupon he was told that one of the two was still at the cinema.

The appellant admitted firing the shots which killed the deceased but denied that he had fired consciously and deliberately and denied that, at the time of so firing, he was capable of forming the intention to kill or that he had the necessary intention. He contended that the shooting had occurred at a time when he was "experiencing a dissociative episode or state of mind (sane automatism)¹⁶⁹". The appellant made a statement in terms of section 115(2) of the Criminal Procedure Act which was amended before his evidence to state that he had acted "in a state of episodic behavioural dyscontrol" (which equated to the legal defence of temporary non-pathological criminal incapacity)¹⁷⁰.

¹⁶⁶ See Snyman (1985) *SALJ supra* note 1 at 244-251.

¹⁶⁷ See in particular 263 G – 264 H. See also *S v Els* 1993 (1) *SACR* 723 (O) at 735 B where the court clearly differentiated between the defences of automatism and non-pathological criminal incapacity. This decision will be discussed in more detail below. See also generally *S v Kok* 1998 (1) *SACR* 532 (N).

¹⁶⁸ 2000 (2) *SACR* 493 (N).

¹⁶⁹ At 495 B-C.

¹⁷⁰ At 499 E-F.

The facts of this decision will not be elaborated upon as it is more the findings of the court pertaining to expert evidence of psychologists that are of significance to the present discussion.

In this case the defence called a psychologist, Mr Neville Alexander Hodgson. He formed the opinion that, at the time of the shooting, the appellant was probably in a dissociative state. The appellant was consequently unaware of his actions at the critical time and would not have remembered that he had shot the deceased and the complainant. Professor Lourens Schlebusch, a lecturer and clinical psychologist, also testified for the defence.

The state, in rebuttal, called the evidence of Ms Brenda Ann Bosch, a registered clinical psychologist. She formed the view that the appellant, probably on account of the trauma surrounding the shooting incident, suffered from a state of retrograde dissociative amnesia, which entails lacking the ability to recall matters after the event¹⁷¹. According to her assessment, the appellant was aware of his actions at the relevant time but probably did not recollect it subsequently.

The experts were unanimous in their conclusion that the appellant's condition at the relevant time was not attributable to any pathological factors.

In delivering judgment, Naidu AJ noted the following:¹⁷²

“Our law now accepts that extreme emotional distress can lead to a state of criminal incapacity which means that a person in this state is unable to appreciate the wrongfulness of his actions and to act accordingly.”

Pertaining to the required foundation to be established by the person or accused raising the defence Naidu AJ opined as follows:¹⁷³

¹⁷¹ At 499 h-i.

¹⁷² At 500 B.

¹⁷³ At 500 I-J-501 A.

“It seems logical therefore that in an endeavour to ‘lay the foundation’ in cases of non-pathological criminal incapacity, some medical evidence of an expert nature will be necessary. The court, however, is the final arbiter regarding the voluntariness or otherwise of the act complained of and a person’s responsibility for his actions. In its deliberations the court will have to take cognizance of not only the medical evidence but also of all the facts of the case, more particularly the nature of the accused’s actions during the relevant period.”

Naidu AJ continued to state¹⁷⁴ that, in his view, although the evidence of the psychologists in cases of this nature might elucidate a useful analysis of the state of mind of the accused person, it should not displace the court’s function which entails assessing, in the light of all the evidence and probabilities, whether a sufficient foundation has been established for a finding that the accused at the relevant time lacked the requisite criminal capacity.

All of the experts in this case agreed that for sane automatism to avail a person, there had to be a “trigger” of extraordinary significance.¹⁷⁵ Naidu AJ held that in this case the identifiable trigger mechanism required for the defence of automatism or episodic behaviour dyscontrol was absent and accordingly held that the evidence revealed conscious behaviour on the part of the appellant¹⁷⁶. The appeal was therefore dismissed.

The *McDonald* decision also illustrates the difference between the defences of sane automatism and non-pathological criminal incapacity as the plea explanation of the accused was pertinently amended from a defence of sane automatism to one of non-pathological criminal incapacity.

¹⁷⁴ At 501 I-J where the court also refers to the case of *S v Kok* 1998 (1) SACR 532 (N) at 545 I-J where Combrink J held: “... where the defence of sane automatism was raised, it was not the court’s function to find which of two opposing psychiatric opinions was to be preferred. However, psychiatric evidence was not of such vital importance in such a case, because at the end of the day it was for the court to decide on the evidence whether the defence had been made out.”

¹⁷⁵ At 502 L.

¹⁷⁶ At 507 C-E.

It is true that there are points of similarity between these two defences. These relate to the foundation that has to be established, the fact that the defence is subject to close scrutiny by the courts as well as the need for expert evidence in support of both defences. They are nevertheless separate and distinct defences relating to different requirements for liability.

7 Burden of proof

One of the most fundamental distinctions between the defences of pathological and non-pathological criminal incapacity, lies in the burden of proof for the specific defence.

In the case of non-pathological criminal incapacity, the onus of proof falls on the State to prove beyond reasonable doubt that the accused had criminal capacity at the time of the commission of the crime.¹⁷⁷ This is in line with the rule that, for a conviction, the State must prove all the requirements for liability beyond reasonable doubt.

The legal position pertaining to the burden of proof in cases of non-pathological criminal incapacity can be captured as follows:

- Whenever an accused person relies on the defence of temporary non-pathological criminal incapacity, the State bears the onus of proving that the accused had the required criminal capacity at the relevant time.¹⁷⁸
- In discharging the onus, the State is assisted by the natural inference that, in the absence of exceptional circumstances, a sane person who engages in conduct which would ordinarily result in criminal liability, does so consciously and voluntarily.¹⁷⁹

¹⁷⁷ Snyman (2002) *supra* note 1 at 165; *S v Calitz supra* note 1 at 126H – 127C; *S v Wiid supra* note 1 at 564 B-G; *S v Francis* 1999 (1) SACR 650 (SCA) at 652 C-H.

¹⁷⁸ Snyman (2002) *supra* note 1 at 165; *S v Eadie supra* note 1 at 666 a-d; *S v Scholtz supra* note 1 at 445 C-E; *S v Rittman* 1992 (2) SACR (Nm) 117 D-E; Strauss (1995) *SAPM supra* note 1 at 15; Carstens and Le Roux (2000) *SACJ supra* note 1 at 180; “Hiemstra” (2007) *supra* note 1 at 224; Meintjes Van der Walt (2002) *SACJ* at 244-245; *S v Moses* 1996 (1) SACR 701 (C).

¹⁷⁹ *S v Eadie supra* note 1 at 666 A-D; See *S v Cunningham supra* note 1 at 635 G-J.

- An accused person who raises the defence of non-pathological criminal incapacity, is required to lay a factual foundation for it, sufficient at least to create a reasonable doubt as to whether the accused had criminal capacity.¹⁸⁰
- Evidence in support of such defence should be carefully scrutinised. In *S v Gesualdo*¹⁸¹, Borchers J noted:¹⁸²
“It goes without saying that a defence of this nature must be carefully scrutinised by the court, and that a court would be unlikely to find that such state may have existed only by virtue of the accused’s *ipissima verba*.”
- It is for the court to decide the question of the accused’s criminal capacity, having regard to the expert evidence and all the facts of the case, including the nature of the accused’s actions during the relevant period.¹⁸³

Snyman also notes that it must appear from an accused’s own evidence or that of witnesses called by him, by his or her plea explanation at the beginning of the trial or from questions posed by him or her or his or her legal representative, that the defence relied upon is one of non-pathological criminal incapacity.¹⁸⁴

¹⁸⁰ *S v Trickett supra* note 1 at 537 D-E where it was held that in order to rely on the defence of automatism the following requirements need to be satisfied:

(1) there must be evidence sufficiently cogent to raise a reasonable doubt as to the voluntary nature of the *actus reus* alleged in the indictment, and,

(2) there must, in addition, be medical or other expert evidence to show that the involuntary or unconscious nature of the *actus reus* was quite possibly due to causes other than mental illness or disorder. This evidence would then rebut the presumption of voluntariness and accordingly the issue will be decided solely on the facts and if there is doubt as to whether the act was voluntary or involuntary, the doubt must redound to the benefit of the accused. Although this defence was one of automatism, it is submitted that the rules pertaining to the foundation that has to be established, is in principle the same or similar. See also Schmidt 1973 SALJ 330, *S v Shivute* 1991 (1) SACR 656 (NM) at 660 C-H.

¹⁸¹ *S v Gesualdo* 1997 (2) SACR 68 (WLD).

¹⁸² At 74 F-H. See also Snyman (2002) *supra* note 1 at 166; *S v Potgieter supra* note 1 at 72-73; *S v Di Blasi supra* note 1 at 7C.

¹⁸³ *S v Eadie supra* note 1 at 666 A-B; *S v Scholtz supra* note 1 at 445 C-E.

¹⁸⁴ Snyman (2002) *supra* note 1 at 160. See also *S v Di Blasi supra* note 1 at 7B-C where Vivier AJ states:

“It is for an accused person to lay a factual foundation for his defence that non-pathological causes resulted in diminished criminal responsibility, and the issue is for the court to decide.”

In cases where the defence of pathological criminal incapacity is raised, the onus rests on the accused to prove on a balance of probabilities that he or she suffered from a mental illness at the time of the commission of the crime.¹⁸⁵

The position pertaining to the burden of proof in cases of pathological criminal incapacity thus differs markedly from the onus of proof in cases of non-pathological criminal incapacity. The question that inevitably falls to be answered is whether this distinction is compatible with the Constitution? It is submitted that uniformity is needed in respect of the onus of proof where the defence of criminal incapacity is raised, regardless of the cause of the alleged incapacity.

In 1998, section 78 of the Criminal Procedure Act was amended and section 78 (1B) was inserted, which reads as follows:

“Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the burden of proof with reference to the criminal responsibility of the accused shall be on the party who raises the issue.”

¹⁸⁵ Snyman (2008) *supra* note 1 at 175; Burchell and Milton (2005) *supra* note 1 at 394-395. This is also in line with section 78 (1A) of the Criminal Procedure Act which states: “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.” See also *S v Cunningham* *supra* note 1 at 635G, where Scott JA stated: “Criminal responsibility presupposes a voluntary act (or omission) on the part of the wrongdoer. Automatism therefor necessarily precludes criminal responsibility. As far as the onus of proof is concerned, a distinction is drawn between automatism attributable to a morbid or pathological disturbance of the mental faculties, whether temporary or permanent, and so-called ‘sane’ automatism which is to some non-pathological cause and which is of a temporary nature. In accordance with the presumption of sanity the onus in the case of the former is upon the accused and is to be discharged on a balance of probabilities. Where it is sought to place reliance on the latter, the onus remains on the State to establish voluntariness of the act beyond reasonable doubt ... In discharging the onus upon it the State, however, is assisted by the natural inference that in the absence of exceptional circumstances a sane person who engages in conduct which would ordinarily give rise to criminal liability does so consciously and voluntarily. Common sense dictates that before this inference will be disturbed a proper basis must be laid which is sufficiently cogent and compelling to raise a reasonable doubt as to the voluntary nature of the alleged *actus reus* and, if involuntary, that this was attributable to some cause other than mental pathology. It follows that in most if not all cases, medical evidence of an expert nature will be necessary to lay a factual foundation for the defence and to displace the inference just mentioned. But ultimately it is for the court to decide the issue of the voluntary nature or otherwise of the alleged act and indeed the accused’s criminal responsibility for his actions. In doing so it will have regard not only to the expert evidence but to all the facts of the case, including the nature of the accused’s actions during the relevant period.”

Following a liberal construction of section 78 (1B), the logical inference to be drawn is that in all cases where the defence is one of criminal incapacity, the onus of proof will fall on the accused.

Burchell and Milton, however, submit that such conclusion is not what the legislature intended.¹⁸⁶

According to Burchell and Milton the amended legislation is aimed at regulating matters pertaining to pathological criminal incapacity and not non-pathological criminal incapacity.¹⁸⁷ Du Toit *et al* also hold the view that section 78 (1B) does not relieve the State of its burden of proof where the accused relies on the defence of non-pathological criminal incapacity.¹⁸⁸ Schwikkard correctly notes that there are various ways in which the problematic issue pertaining to the burden of proof in cases of pathological as opposed to non-pathological criminal incapacity can be resolved.¹⁸⁹ The latter can be effected by either eliminating the reverse onus in respect of these two defences or applying it to both.

Milton notes, with reference to the Criminal Matters Amendment Act of 1998, that the reverse onus in respect of the defence of criminal incapacity “involves a form of unconstitutional discrimination in that the onus is reversed only in the case of insanity and not where the defence is one of non-pathological criminal incapacity.”¹⁹⁰

The question that arises is whether the reverse onus should not apply to both the defences of pathological and non-pathological criminal incapacity. The earlier discussion of a general defence of criminal incapacity could also apply with reference to the burden of proof. With the establishment of a general defence of criminal incapacity there will also be one set of rules pertaining to the burden of

¹⁸⁶ Burchell and Milton (2005) *supra* note 1 at 390-391.

¹⁸⁷ *Ibid.*

¹⁸⁸ Du Toit *et al* (2007) *supra* note 1 at 13-20.

¹⁸⁹ Schwikkard, PJ “Insanity: The tenacious reverse onus” in *The exemplary Scholar-Essays in honour of John Milton* (2007) at 80. See also Meintjes-Van der Walt (2002) *SACJ* at 242.

¹⁹⁰ Milton, J “Law reform: The Criminal Matters Amendment Act 1998 brings some sanity (but only some) to the defence of Sanity” (1999) *SACJ* 12 at 46. See also Schwikkard (2007) *supra* note 189 at 87.

proof as a distinction will not be made based on the cause of incapacity, but rather focus on the incapacity itself with one particular burden of proof to satisfy.

In *S v Campher Viljoen* AJ noted the following:¹⁹¹

“... die onus is in die geval van gewone dronkenskap, anders as by ‘insanity’, op die Staat geplaas. ... Net so onrealisties as die onderskeiding tussen tydelike aberrasie vanweë drankiname en ‘n geestessiekte as gevolg van drank is die onderskeid tussen sieklike outomatisme en gesonde outomatisme waarvolgens die uitsprakereg die bewyslas in eersgenoemde geval op die beskuldigde rus en in laasgenoemde geval op die Staat. Dit egter net terloops.”

In *S v Adams Viljoen* JA stated:¹⁹²

“Had the Rumpff commission been consistent it would, I suggest with respect, have come to the conclusion that in all cases in which a defence of lack of criminal capacity is raised the onus is on the accused. ..., correctly in my opinion, that in all cases in which criminal responsibility, whether it be by reason of insanity or any other cause such as intoxication, of an accused is an issue, the onus ought to be the same.”

In *S v Kok* Scott JA remarked *obiter* that it is doubtful whether the anomaly pertaining to the distinction between pathological and non-pathological criminal incapacity in respect of the burden of proof, can be upheld in our modern law with the enactment of the new Constitution.¹⁹³

It is submitted that the burden of proof in cases of pathological and non-pathological criminal incapacity should be the same.

¹⁹¹ *S v Campher* *supra* note 1 at 954H – 955A. See also De Villiers, DS “Evidence Through the Cases” (2007) 3rd ed at 451.

¹⁹² *S van Adams* 1986 (4) SA 822 (A) at 897-902. The latter case dealt with the possession of dangerous weapons.

¹⁹³ *S v Kok* 2001 (2) SACR 106 (SCA) at 110H – 111A.

Schwikkard states, and it is submitted that this view is correct, that in the light of the fact that the legislature in section 78(2) clearly refers to both pathological and non-pathological criminal incapacity, it would be more appropriate to interpret section 78 (1B) as referring to both pathological and non-pathological criminal incapacity.¹⁹⁴

Snyman takes the view that an accused person, in cases where non-pathological criminal incapacity is raised, should also bear the burden of proof.¹⁹⁵ According to Snyman, the following arguments could be advanced in favour of such burden falling on the accused:

- There is a general presumption that all persons are sane. Accordingly, if a person raises the defence of criminal incapacity, regardless of the cause, he or she should carry the burden of proving such criminal incapacity.
- By placing the burden of proof on the accused, the abuse of this defence will be curbed.
- Of all the people present during the trial, the accused is in the best position to convey his or her mental state at the time of the act.

It remains an undeniable fact that a reverse onus provision will *prima facie* infringe upon section 35(3)(h)¹⁹⁶ of the Constitution which contains the presumption of innocence. It is, however, submitted that given the fact that this defence of non-pathological criminal incapacity could easily be abused, a reverse onus will ensure that a proper factual basis is established in order to rely on this defence. It is submitted that a reverse onus also applying to the defence of non-pathological criminal incapacity will constitute a reasonable and justifiable limitation in terms of the limitation clause contained in section 36 of the Constitution, in respect of the right to be presumed innocent. The importance of the purpose of the limitation, which is to curb potential abuse of this defence, is extremely important.

¹⁹⁴ Schwikkard (2007) *supra* note 189 at 88-90.

¹⁹⁵ Snyman (1989) TRW *supra* note 1 at 1-15. See also Van der Merwe, FW "Nie-patologiese ontoerekeningsvatbaarheid as verweer in die Suid-Afrikaanse Strafreë" (1996) unpublished LLM dissertation (Unisa) at 34.

¹⁹⁶ Section 35(3)(h) reads as follows:

"35. (3) Every accused person has a right to a fair trial, which includes the right - ...
(b) to be presumed innocent, to remain silent, and not to testify during the proceedings."

It should also be borne in mind that if the defence of non-pathological criminal incapacity is successfully raised, it will result in the acquittal of an accused. Whether the alleged criminal incapacity was caused by provocation, emotional stress or whatever factor, the accused will walk out of the courtroom a free person. Accordingly, the purpose of such burden and thus the limitation of this fundamental right in the Constitution is to ensure that this defence is subjected to stringent measures in order to prevent abuse of this defence. An accused will thus have to prove his or her criminal incapacity on a balance of probabilities. In order to discharge this onus, the accused has to lay a proper foundation for his or her defence.

Although expert evidence of a psychiatric or psychological nature is not required in order to establish such foundation, it is doubtful whether this defence will succeed in the absence thereof.¹⁹⁷

8 Defence of non-pathological criminal incapacity ought not to succeed easily

Due to fears that this defence can easily be abused, a court will generally approach this defence of non-pathological criminal incapacity with great care and also scrutinize the evidence in support of such a defence with great caution.¹⁹⁸

In *S v Kensley*, Van den Heever JA held the following:¹⁹⁹

- The *ipse dixit* of an accused that in a given situation, he was unable to control himself, will not lead to an acquittal.
- Evidence upon which a defence of “sane criminal incapacity due to intense emotion” is founded, will be treated with circumspection.

¹⁹⁷ Snyman (1989) *TRW supra* note 1 at 15.

¹⁹⁸ Snyman (2002) *supra* note 1 at 166; Carstens and Le Roux *SACJ* (2000) *supra* note 1 at 101-102; *S v Potgieter supra* note 1 at 72-73; *S v Di Blasi supra* note 1 at 7; *S v Henry supra* note 1 at 20C.

¹⁹⁹ *S v Kensley* 1995 (1) SACR 646 (A) at 658 G-J; *S v Gesualdo supra* note 1 at 74 G-H; *S v Eadie supra* note 1 at 666 A-D; *S v Scholtz* 2006 (1) SACR 442 (EPD) at 445 B-I; LAWSA *supra* note 12 at 71.

Snyman submits that it is unlikely for an accused to succeed with the defence of non-pathological criminal incapacity if he or she was emotionally disturbed for only a brief period before and during the act.²⁰⁰ Snyman notes that in many of the cases where this defence succeeded, the accused's conduct was preceded by a prolonged period of severe emotional stress.²⁰¹

It is thus clear that the courts approach this defence with caution and circumspection.

9 Expert evidence

The central cornerstone and foundation of this chapter and the present study, is the role of expert evidence in support of the defence of criminal incapacity. It is therefore necessary to take a closer look at the current role and place of expert evidence in support of the defence of non-pathological criminal incapacity.

9.1 Traditional approach in respect of expert evidence

The traditional approach in respect of expert evidence in support of the defence of non-pathological criminal incapacity, is that it does not fulfil an indispensable function and that the defence can succeed in the absence of such evidence.²⁰² It is, however, doubtful whether this defence will ever be successfully established in the absence of expert evidence.

Snyman correctly submits that it is very important for an accused who relies on the defence of non-pathological criminal incapacity to adduce expert evidence in order to corroborate his or her alleged incapacity at the time of the commission of the act as it is difficult for a court to determine an accused's mental abilities at the time of

²⁰⁰ Snyman (2002) *supra* note 1 at 166.

²⁰¹ *Ibid.*

²⁰² Snyman (2002) *supra* note 1 at 166; Snyman (1989) TRW *supra* note 1 at 14-15; Van Oosten (1993) SACJ *supra* note 1 at 141; Du Toit *et al* (2007) *supra* note 1 at 13-17. See also S v *Volkman* 2005 (2) SACR 402 (CPD).

the commission of the act in the absence of such evidence.²⁰³ Expert evidence in this regard will form part of the foundation that an accused has to establish in support of such defence.

According to the traditional approach, the court is in a position to decide on its own, taking into account the medical evidence and all the facts of the case, the issue of the accused's alleged criminal incapacity.²⁰⁴

According to the traditional approach expert evidence is thus not a prerequisite for a successful reliance on this defence.

In *R v Harris*²⁰⁵ it was held:²⁰⁶

“... it must be borne in mind that ...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.”

In a few decisions it was held that expert evidence does not fulfil an indispensable function and is not essential in support of the defence of non-pathological criminal incapacity²⁰⁷. The decisions in *Laubscher*, *Calitz* and *Lesch* all illustrate this traditional approach to expert evidence and will briefly be discussed. In *S v Laubscher*²⁰⁸ the appellant was a 23-year old medical student. He was highly intelligent and emotionally very sensitive. He embarked on a relationship with one C, who later became pregnant whereafter they married. The appellant's parents-

²⁰³ Snyman (2002) *supra* note 1 at 166.

²⁰⁴ Du Toit *et al* (2007) *supra* note 1 at 17-17. See also Hiemstra (2007) *supra* note 1 at 222.

²⁰⁵ *R v Harris* 1965 (2) SA 340 (A).

²⁰⁶ At 365 B-C.

²⁰⁷ See *S v Calitz supra* note 1; *S v Lesch supra* note 1. These decisions will be extensively assessed below.

²⁰⁸ 1988 (1) SA 163 (AD).

in-law did not accept him and were cold and aloof towards him. On the day the fatal shooting occurred the appellant had arranged to collect C and their child. When he went to fetch C, however, she told him that she no longer wished to go with him and he was told to leave the house. He left the house but later returned demanding that he be given the child. He fired into various rooms of the house with his pistol and killed C's father.

At his trial for murder and attempted murder, it was contended on behalf of the appellant that he had suffered a total psychological breakdown or disintegration of his personality of a temporary nature and that he acted involuntarily. The court, per Joubert JA, held that although the appellant's actions had been irrational, he had acted voluntarily in that he had the powers of discernment and restraint so that he had not been criminally unaccountable, but rather suffered diminished responsibility. With regard to diminished responsibility the court noted:²⁰⁹

“Want dit is ook moontlik om nie-patologiese verminderde toerekeningsvatbaarheid te kry wat weens nie-patologiese toestand die dader se onderskeidingsvermoë of weerstandkrag ten tye van die pleeg van die misdaad verminder het.”

With reference to the expert evidence the following can be noted:

The expert witnesses who testified were Dr Zabow who testified on behalf of the State and Dr Zabow and Prof Weyers for the defence. The one expert, Dr Zabow, was of the opinion that the accused did not lack capacity but had diminished capacity. Prof Weyers could not state with certainty that a total disintegration of personality did in fact occur. Dr Marais testified that the accused lacked criminal capacity.

The court per Joubert JA²¹⁰ noted the following with respect to expert evidence:

²⁰⁹ At 168 B-C.

²¹⁰ At 171J-172F.

“Dit moet in gedagte gehou word dat psigiatriese getuienis oor ‘n beskuldigde se ongesteldheid of geestesgebrek in die vorm van ‘n patologiese versteuring ten tyde van die pleeg van die misdaad waar dit handel oor sy statutêre ontoerekeningsvatbaarheid ‘n onmisbare funksie vervul om ‘n hof behulpsaam te wees met sy beslissing waar ‘n paneel psigiaters ‘n ondersoek ingevolge art 79(4)(d) uitgebring het. Artikel 78(3) magtig die hof waar sodanige bevinding eenparig is en nie bestry word nie om die aangeleentheid aan die hand van ‘n verslag sonder die aanhoor van verdere getuienis te beslis. In so ‘n geval laat die hof hom lei deur die eenparige bevinding van die paneel psigiaters..... Aangesien dit hier oor ‘n nie-patologiese toestand van die appellant ten tyde van die pleeg van die beweerde misdade handel het die psigiatriese getuienis nie so ‘n onmisbare funksie vervul nie omdat die verhoorhof aan die hand van die aanvaarde feite self in staat was om die omskrywing van die begrip ‘totale persoonlikheidsdisintegrasië’ daarop toe te pas en dan tot ‘n bevinding te raak of die appellant nie-patologies ontoerekeningsvatbaar of slegs nie-patologies verminderd toerekeningsvatbaar was.”

The court in this case was thus reluctant to place too much reliance on the role of expert evidence.

In *S v Calitz*²¹¹ the appellant was a sergeant of the South-West Africa Police Service. The facts were briefly that the appellant paid a visit to the “kraal” of the deceased to ascertain whether there were any terrorists in the nearby vicinity. The appellant had during the course of arriving at the “kraal”, drove over three poles that had a ritual symbolism for the deceased. An argument arose between the appellant and the deceased whereafter the appellant assaulted the deceased, resulting in the deceased’s death. The appellant relied on the defence of non-pathological criminal incapacity. It was contended on behalf of the appellant that he suffered from temporary mental incapacity as a result of being in a state of raging anger at the time of the commission of the assault.

²¹¹ *S v Calitz* 1990 (1) SACR 119 (A).

In support of his defence of criminal incapacity, counsel for the appellant relied on the expert opinion and testimony of two expert psychiatrists, Dr AH Potgieter as well as Dr AJ Plomp. Both experts were of the opinion that appellant suffered from temporary mental incapacity. Dr Potgieter described the mental state of the appellant as “tydelike bewussynsvernouing of beneweling” with a total loss of self-control²¹². Dr Potgieter also confirmed that in the event of the appellant being able to provide a detailed recollection of the events, his opinion would fall away. Dr Plomp described the memories as “afleidings”²¹³. Dr Plomp described temporary mental incapacity as “n toestand waarin oorweldigende emosie so prominent is dat dit die rasonale denke, oordeel en geheue heeltemal oorskadu”²¹⁴. Some of the appellant’s versions of the events are described by Dr Plomp as “growwe detail”²¹⁵.

The appellant was in fact able to recall quite a lot of detail relating to the assault which was not consistent with the defence of temporary mental incapacity²¹⁶.

Dr J Fourie testified for the State. His opinion was that the appellant was able to distinguish between right and wrong and was able to act in accordance with such appreciation²¹⁷. Dr Fourie conducted a consultation with the appellant and stated that the appellant’s acts were voluntary and goal directed acts. He also stated that usually, when someone gets angry and acts with rage, he will not be able to recall or remember all the details of his actions.

The court per Eksteen JA stated:²¹⁸

“Waar die hof met twee botsende psigiatriese menings te make het, kan dit kwalik verwag word om die een bo die ander te verkies. Op stuk van sake is die hof ‘n leek op die gebied van psigiatrie, en kan hom dus nie gesaghebbend uitspreek oor botsende psigiatriese teorieë nie.”

²¹² At 125 B-C.

²¹³ At 125 D-E.

²¹⁴ At 125 C-D.

²¹⁵ At 125 F-H.

²¹⁶ The role of amnesia in the defence of non-pathological criminal incapacity will be discussed extensively in paragraph 16 below.

²¹⁷ At 125 I-J.

²¹⁸ At 126 I-J.

The court also referred to the *dictum* in the *Harris* case and with reference to the *Laubscher* case held that expert evidence did not play an indispensable function in this case²¹⁹. The court rejected the evidence of Dr Potgieter and Dr Plomp with regard to describing the appellant's recollection of the events as "afleidings". The court held that someone suffering from temporary mental incapacity will not be able to give such a detailed description of the events²²⁰. Accordingly, the defence of non-pathological criminal incapacity was rejected.

In *S v Lesch*²²¹ the accused's defence was based upon a lack of capacity to act in accordance with the appreciation of the unlawfulness of his conduct. From the facts it appeared that the accused had been telephoned at work by his daughter, who told him that their neighbour, who had in the past adopted a threatening and aggressive attitude, had uttered certain threats directed at both her and the accused. The accused went home shortly thereafter, where he discussed the matter briefly with his daughter. He then proceeded to fetch a revolver, which he concealed in his pocket. He then, despite his daughter's admonitions, left the house with the revolver in order to confront his neighbour. The confrontation took place in his neighbour's garden. The evidence was that his neighbour addressed certain remarks at the accused, whereupon the accused repeatedly shot and killed his neighbour. Thereafter the accused, *inter alia*, approached an acquaintance (one J) with the request that, since he was not in a fit state to drive, he should take him to the police. According to J the accused was in a state of shock. According to the police, to whom the accused made a statement, he was, however, calm and tranquil.²²² In his statement to the police he did not refer to any loss of self-control. It was common cause that the accused did not suffer from any mental disease or defect at the time of the commission of the offence. The crux of his defence was that the conduct attributed to him could not be imputed to him as he, as a consequence of a rage reaction, did not have the capacity to act in accordance with his admitted awareness of the unlawfulness of his conduct.²²³ The psychiatric

²¹⁹ At 126 D-127B.

²²⁰ At 127 G.

²²¹ 1983 (1) SA 814 (O).

²²² Visser & Maré (1991) *supra* note 158 at 404.

²²³ At 816 C-D.

evidence by Dr Wolf was to the effect that the accused's emotions had, at the time of the commission of the offence, attained an "orgasmic climax", so that there was no self-control, although he realised what he was doing and what the consequences of his act would be²²⁴.

Dr Wolf, a psychiatrist in private practice, was called to testify on behalf of the accused. He based his expert opinion upon statements obtained from witnesses, a summary of the facts supplied by the State, the post-mortem report and facts pertaining to the accused's background. According to the case report Dr Wolf was not present when the accused testified.²²⁵

Dr Wolf conducted various consultations with the accused. During these interviews the accused was serious, he gave a clear version of the events and his memory and concentration were not impaired. Dr Wolf, however, came to the conclusion that the accused was unable to control himself.²²⁶

The accused's behaviour is described in the report as follows:

"Toe hy die oorledene fisies sien, het dit alles daartoe bygedra dat hy, om die getuie se woorde te gebruik, 'n orgastiese hoogtepunt bereik het, sodat daar geen selfbeheer meer was nie, alhoewel beskuldigde se geestesvermoëns sodanig was dat hy besef het wat hy gedoen het en wat die gevolge van sy handeling was. Volgens hierdie getuie was die beskuldigde in dieselfde posisie as 'n persoon wat in 'n motor sonder remme op 'n afdraend aan die loop gaan."²²⁷

Dr Wolf testified that the accused's lack of self-control was as a result of his emotions at the relevant time. He also testified that a person's cognitive, conative and affective functions formed an integrated part of a person's personality.²²⁸ During cross-examination Dr Wolf concurred with the view that his opinion is

²²⁴ At 822 A-B.

²²⁵ At 821 F.

²²⁶ At 821 H.

²²⁷ At 822 A-B.

²²⁸ At 822 C-D.

based on the presupposition that the accused's version of the events is truthful. When asked whether the accused had the capacity to act in accordance with the appreciation of the wrongfulness of his act, Dr Wolf answered in the affirmative.²²⁹ The very same question was later again put to Dr Wolf, but only in different terminology. Dr Wolf was asked whether the accused could control himself upon which he answered in the negative.²³⁰

The crux of Dr Wolf's testimony was to the effect that the accused lacked self-control as a result of an emotional storm.²³¹

It was also held by the Court that the evidence pertaining to the events giving rise to the emotional storm, the accused's behaviour before, during and after the act as well as evidence pertaining to the accused's memory of the events during the commission of the crime were all pivotal in determining whether the accused did experience an emotional storm at the relevant time.²³² The accused, however, never testified that he lacked self-control.

As to the argument that the accused lacked self-control, the court per Hatting AJ held, taking into consideration the facts of the case, that the accused did beyond reasonable doubt, have the capacity to realise that his actions were wrongful and he had the capacity to act in accordance with his appreciation.²³³ The court also held that provocation did not exclude intention to murder, but rather contributed to the formation of this intention. The accused was accordingly convicted of murder.

In both the *Laubscher* and *Calitz* decisions it was held that expert evidence does not play a vital role in support of the defence of non-pathological criminal

²²⁹ At 822 F-G.

²³⁰ At 823 A-B. The court also affirms that the State bears the onus of proving the accused's guilt beyond reasonable doubt and also that criminal capacity is a prerequisite to incur criminal liability.

²³¹ At 824 B-C.

²³² At 824 D-E. See also *R v Kennedy* 1951 (4) SA 431 (A) at 434 H as well as 435 A where the court stated per Hatting AJ: "It appears from the evidence and is in fact generally accepted that there is at present no known method by which a medical expert, by examination of a person who has been found to be of psychopathic personality, can ascertain whether at the critical period he was suffering from such an emotional storm. This can only be decided of the events which are said to have led up including his own evidence as to his recollection of what happened in the commission of the act and thereafter."

²³³ At 825 C-E.

incapacity. The latter approach accords with the traditional view in respect of expert evidence where this defence is raised. It is submitted that the traditional approach is outdated and inconsistent with section 35(3)(1) of the Constitution which guarantees an accused person the right to a fair trial which includes the right to adduce and challenge evidence.

The decision in *Lesch* clearly illustrates the basic principle that the expert merely serves to assist the court in its finding. One cannot help but note that Dr Wolf's testimony in this case did not carry as much weight as the surrounding circumstances of the case. In this case the evidence of the expert merely assisted the court, but the facts of the case were, however, such that the court could make a decision on its own. It is, however, still important to put the expert in the witness box as the expert's opinion is necessary and pivotal in order to ascertain the accused's state of mind at the time of the commission of the crime.

It is also submitted that arguments in favour of expert evidence in cases of this nature are not directed towards a possible acquittal for an accused but merely serves as a tool by which courts can properly determine the facts before them. The issues in cases where non-pathological criminal incapacity is raised as a defence are often very complex and thus beyond the understanding of the court. In order for justice to prevail it is necessary to obtain expert psychiatric evidence.

9.2 Essential need for expert evidence in support of the defence of non-pathological criminal incapacity

It is submitted that there is an essential and fundamental need for expert evidence when the defence of non-pathological criminal incapacity is raised. In the light of the fact that this defence is approached by the courts with great caution and scrutiny, the presentation of expert evidence in support of this defence becomes crucial.²³⁴

²³⁴ Carstens and Le Roux (2000) *SACJ supra* note 1 at 182; Strauss (1995) *SAPM supra* note 1 at 15; Hiemstra (2007) *supra* note 1 at 222.

Strauss submits that the defence of non-pathological criminal incapacity presents a challenge to psychiatrists and mental health professionals.²³⁵

Strauss correctly states the following:²³⁶

“Daar moet in gedagte gehou word dat ons in dié gevalle juis nie ‘n handboek-diagnose van geestespatologie het waarby die geskiedenis van die beskuldigde of die identifisering van bepaalde sindrome aanduidend kan wees van bepaalde bevindinge oor sy vermoëns nie.”

It is accordingly necessary to illustrate the pivotal need for expert evidence in support of the defence of non-pathological criminal incapacity as enunciated in case law.

In *S v Campher*²³⁷ the facts were briefly as follows. The appellant was charged with and convicted of the murder of her husband. She appealed against the conviction. The facts disclosed that the deceased and the appellant had a very unhappy marriage. The deceased had a very violent personality and became angry very easily. The deceased had on various occasions assaulted the appellant and also caused her severe emotional stress. On the day the shooting occurred, the appellant and the deceased had various arguments. The deceased thereafter went out to see to his doves which he kept in a cage outside the house. While outside the deceased called the appellant to join him outside in order to render assistance in the cage. She abided by this command. He then demanded that she hold a lock while he drills a hole with his electric drill. In order to drill the hole properly, she had to lie in a very awkward and difficult position in order to avoid the lock from shifting. As a result of this the hole turned out to be skew. The deceased then screamed at the appellant and threatened her. She then ran to the house with him following. She removed the firearm which she kept in her bedside table drawer. He forced her back to the cage and ordered her to pray for it to become straight. She then shot him. In the court *a quo* three defences were

²³⁵ Strauss (1995) SAPM *supra* note 1 at 15.

²³⁶ *Ibid.*

²³⁷ *S v Campher* 1987 (1) SA 940 (A). See also Snyman (1989) TRW *supra* note 1 at 8-9; Rumpff (1990) *Consultus supra* note 1 at 19-22.

raised, namely that the appellant acted as a result of provocation, the second related to the fact that she lost self-control and the third was that she acted in self-defence. The second and third defences were rejected by the trial court.

On appeal Viljoen AJ held that the appellant's behaviour was not indicative of provocation, but rather that the behaviour of the deceased towards the appellant and the children as well as the physical strain she had to endure all caused a total breakdown in the appellant. Her behaviour was indicative of desperation and helplessness. The defence of non-pathological criminal incapacity was, however, never explicitly raised in this case and no expert medical evidence in this regard was presented in support of such defence.

Viljoen AJ also held that the criteria set forth in section 78(1) of the Criminal Procedure Act can also apply to cases where the incapacity was the result of causes other than mental illness or mental defect.²³⁸

In the court *a quo* the appellant was convicted of murder and the court accordingly held that the State had proved beyond reasonable doubt that the appellant had the necessary intention to kill the deceased and that her subjective state of mind, although subjected to severe provocation, was to kill the deceased.

On appeal Viljoen AJ held that the question was not whether the appellant had the necessary intention to kill the deceased, but rather whether she had the capacity to appreciate the wrongfulness of her conduct, and if so, whether she also had the capacity to act in accordance with such appreciation.²³⁹ Viljoen AJ also noted the absence of psychiatric evidence in this case.²⁴⁰

²³⁸ At 954 F-G where it is stated by Viljoen AJ: "Dat die gelding van art 78 van Wet 51 van 1977 so ingekort is, beteken egter nie dat die kriteria wat in ons reg ontwikkel het en nou in die artikel vasgelê is, nie op tydelike aantasting van die geestesvermoëns toegepas kan word nie."

²³⁹ At 955 I-J.

²⁴⁰ At 956 B-C where it is stated by Viljoen AJ: "In hierdie saak is daar soos ek alreeds opgemerk het, geen deskundige psigiatriese getuienis gelei nie ... As leek op hierdie gebied meen ek egter dat die feit dat die appellante na die tyd besef het dat sy die oorledene geskiet het, die Hof nie verhinder om tot die bevinding te gemaak dat die appellante se emosies so breekpunt bereik het en haar so oorweldig het dat sy nie op die kritieke oomblik kon weerstand bied nie." This statement is clearly indicative of the need for expert evidence in this case.

Viljoen AJ held that the State had not proved beyond reasonable doubt that the appellant had the necessary criminal capacity and that the conviction should be set aside. This was held despite the absence of psychiatric evidence.²⁴¹

Jacobs AJ on the other hand, held that the appellant was correctly convicted and accordingly dismissed the appeal as far as the conviction was concerned. The appeal succeeded with regard to sentence.

Jacobs AJ also held that the defence of criminal incapacity, specifically pertaining to the second leg of the test, whether the appellant had the capacity to act in accordance with the appreciation of the wrongfulness of the act, will only be suggested if such incapacity was as a result of a mental illness or mental defect.²⁴²

With regard to expert evidence Jacobs AJ held:²⁴³

“Die feit dat mnr Van Oosten wat namens die appellante by die verhoor verskyn het geen psigiatriese getuienis aangebied het nie en self blykbaar nie appellante se getuienis vertolk het as sou dit daarop neerkom dat sy weens ‘n onweerstaanbare drang (‘irresistible impulse’) verhinder was om haar optrede te beheer nie, maak dit vir hierdie Hof uiters moeilik, en wat myself betref onmoontlik, om ‘n afleiding te maak dat die appellante weens enige skielik opvlammende impulsiewe drang wat onweerstaanbaar was nie in staat was om haar handeling in te rig of te kontroleer ooreenkomstig haar insigte nie.”

²⁴¹ See also Snyman (1989) *TRW supra* note 1 at 8.

²⁴² This defence was previously referred to as the “irresistible impulse” defence. Jacobs AJ at 960 states: “Ek is in elk geval van mening dat die sogenaamde onweerstaanbare drang maatstaf wat in ons reg voor 1977 erken en toegepas is, heeltemal deur artikel 78(1)(b) van die Strafproseswet 51 van 1977 vervang is en dat, net soos voor die inwerkingtreding van die voormelde artikel van die Wet, ‘n persoon wat oor die vermoë beskik om die ongeoorlooftheid van sy handeling te besef moor nie oor die vermoë beskik om ooreenkomstig ‘n besef van die ongeoorlooftheid van sy handeling op te tree nie, slegs dan strafregtelik nie toerekenbaar is vir so ‘n handeling nie indien sy onvermoë om sy handeling ooreenkomstig sy besef in te rig die gevolg is van geestesongesteldheid of gebrek.” See also Burchell and Hunt (1997) *supra* note 1 at 206.

²⁴³ At 960 D-E.

Boshoff AJ agreed with Jacobs AJ and held that the appellant was correctly convicted and also dismissed the appeal with regard to the conviction. Boshoff AJ was, however, of the opinion that the defence of criminal incapacity is not limited to cases where the accused suffered from a mental illness or mental defect.²⁴⁴

Boshoff AJ also held²⁴⁵ that when the cause of the criminal incapacity is attributable to a mental disturbance not caused by a mental illness, the subsequent finding by the court should be in favour of the accused if reasonable doubt exists regarding the existence or not of criminal capacity.

With regards to expert evidence Boshoff AJ held:²⁴⁶

“Daar is ook geen psigiatriese of klinies-sielkundige getuienis wat enigszins kan aantoon dat die appellante wel ‘n geestesversteuring gehad het wat die gevolg kon gehad het om die ongeoorloofdheid van haar handeling te besef nie of om ooreenkomstig ‘n besef van die ongeoorloofdheid van haar handeling op te tree nie. maar volgens my beskeie mening is ‘n Hof nie sonder die hulp van psigiatriese of klinies-sielkundige getuienis in die vermoë om te kan oordeel of sy op enige stadium aan ‘n geestesversteuring gely het wat die vereiste gevolge vir ontoerekeningsvatbaarheid gehad het nie.”

This decision is a clear example of the need for expert psychiatric evidence in cases where non-pathological criminal incapacity is raised. In the first instance, the appellant’s defence which was nothing other than a lack of criminal capacity as a result of lack of self-control due to severe emotional and physical abuse was never properly canvassed. Secondly, no expert evidence pertaining to the appellant’s conduct at the time of the shooting or as an explanation for her behaviour was ever put before the court. Upon close scrutiny of the facts of the

²⁴⁴ At 955 H “Die afwesigheid van toerekeningsvatbaarheid is nie beperk tot gevalle waar die dader aan ‘n geesteskrankheid ly nie. Dit is ook denkbaar en bestaanbaar by gevalle van tydelik verstandelike beneweling.”

²⁴⁵ At 966 H-I.

²⁴⁶ At 966 J- 967 A-C.

decision certain portions of evidence by the appellant indicates a need for a proper psychiatric evaluation.²⁴⁷

This case serves as an example of the consequences that follow if proper expert psychiatric or psychological evidence is absent. All three of the judges on appeal recognized the intense need for expert psychiatric evidence to be placed before the court. This will enable the court to draw informed inferences from all of the objective facts of the case in order to render an objective, informed decision. Psychiatric testimony would have put the court in a better position as to the appellant's behaviour. The absence of expert evidence in this case was thus a substantial flaw. It is not to say, however, that the eventual verdict of the court would have been different, but with a proper defence of non-pathological criminal incapacity together with a solid foundation established by expert psychiatric evidence, the court would have been in a better position to determine the factual issues before it.

Rumpff²⁴⁸ in his commentary on the *Campher*-decision also emphasises the need for psychiatric evidence:

“Die reg het respek vir die psigiatriese wetenskap en ‘n hof sal die bevindings van daardie wetenskap aanvaar indien bevind word dat die feite van die saak wel ‘n psigiatriese opinie regverdig. Daar is dus gevalle waar die psigiatriese opinie aanvaar sal word en gevalle waar die opinie nie aanvaar sal word nie. Dit doen geen afbreuk aan die feit nie dat ‘n hof wat moet besluit of ‘n beskuldigde se geestestoestand hom ontoerekeningsvatbaar maak altyd in ‘n moordsaak psigiatriese getuienis sal wil aanhoor.”

²⁴⁷ At 946 C where the statement of the appellant is quoted: “Maar hier binnekant my was besig ‘n storm om los te kom. Ek kan net nie meer nie, want ek het gevoel dat hy besig was om my af te takel. Ek was vir hom ‘n vloerlap. Hy het op my getrap net omdat hy lus kry ... Ek kan dit nie verwerk het nie. Ek kon dit glad nie verwerk het nie.” And further at 947 C-D: “Ek het op my knieë gestaan. Ek het gehuil en al wat ek weet, dit was ‘n krisistyd in my lewe. Een van die dinge ..., ek was emosioneel af. Ek het gevoel hoe gaan ek af en af. Dis of ek in ‘n sluik ingaan in ‘n diep, donker put. Ek het gevoel of ek kan flou word, en ek as kind van God het gefeil daar ... En vir my was hy soos ‘n monster voor my, en al wat ek weet, is nadat ek uit die hok uit is, het ek besef ek het hom geskiet.” These words could also possibly be indicative of depression within the accused at the time of the act. With proper expert evidence, this could have been established.

²⁴⁸ Rumpff, F “Feite of Woorde” *Consultus* (1990) 3 19-22 at 21.

In the *Campher*-decision the majority of the Appellate division (Viljoen AJ²⁴⁹ and Boshoff AAJ²⁵⁰) had, in respect of expert evidence, thus confirmed the principle that proof that an accused suffered from a mental illness or defect is not a prerequisite for the successful reliance on the defence of absence of criminal capacity.²⁵¹

In *S v Wiid*²⁵² the appellant was charged with murder of her husband and accordingly convicted. In her plea explanation at the outset of the trial, her defence was canvassed as follows:²⁵³

- “2. Op 3 Desember 1987 het my verhouding met die oorledene ‘n breekpunt bereik en was ek in ‘n hoogs gespanne toestand.
3. Kort voor gemelde voorval het oorledene my ernstig aangerand.
4. Oorledene het ook gedreig om my te vermoor.
5. Alhoewel ek erken dat ek my man doodgeskiet het, kan ek dit nie onthou nie.
6. Toe ek oorledene geskiet het, het ek as gevolg van verskeie faktore waarskynlik onbewustelik opgetree en nie besef dat my handeling wederregtelik is nie.
7. Ek was ook nie in staat om enige beheer oor my gemelde handeling uit te oefen nie. Derhalwe was my handeling nie strafregtelik toerekenbaar nie.
8. My ontorekeningsvatbaarheid was tydelik van aard en is nie aan enige permanente of tydelike geestesongesteldheid of gebreke (soos in artikel 78 van die Strafproseswet bedoel) toe te skryf nie.”

The appellant thus relied on the defence of non-pathological criminal incapacity. The judgment contains important *ratio decidendi* pertaining to the defence of non-pathological criminal incapacity.²⁵⁴

²⁴⁹ At 954-955.

²⁵⁰ At 965 G-J. This ‘majority’ does not refer to the ‘majority’ confirming the Appellant’s conviction. The majority in the latter respect was Jacobs JA and Boshoff AJA.

²⁵¹ See also Burchell and Hunt (1997) *supra* note 1 at 206.

²⁵² *S v Wiid* 1990 (1) SACR 561 (A).

²⁵³ In accordance with section 115 of the Criminal Procedure Act referred to at 563 B-E of the judgment.

The facts disclosed that the appellant and the deceased were married for 32 years and had a daughter and a son. The appellant loved the deceased. The deceased had, during the course of their marriage, various extra-marital relations. This caused the appellant severe emotional stress. The deceased also abused the appellant frequently. The deceased had a violent personality.

On the day of the shooting, the appellant suspected that the deceased was visiting one Ms Bets Bekker, with whom he had an affair, but convinced the appellant three days before that he had ended it. The appellant phoned her friend, Ms Harmse, with a request to pay her a visit. When the deceased returned later the evening an altercation broke out between him and the appellant. The deceased wanted to record their altercation on tape but the deceased assaulted the appellant as a result of which the tape recorder fell on the floor. The appellant sustained a broken nose and front tooth. Her ear was also swollen and blue. Her glasses were also broken during the assault and her mouth and nose bled extensively. The deceased then went to the bedroom. The appellant then shot the deceased. When questioned by the police, the appellant had a very vague recollection of the events. In the trial court the two expert witnesses testified on behalf of the appellant.

Mr Gillmer, a psychologist, testified that the appellant absolutely adored the deceased. He stated the following:²⁵⁵

²⁵⁴ At 564 A-G. At C-D the court quotes *S v Mahlinza* 1967 (1) SA 408 (A): “Indien die vraag ontstaan of die ontoerekeningsvatbaarheid van ‘n beskuldigde die gevolg is van geesteskrankheid of van ‘n geestesversteuring wat nie deur geesteskrankheid veroorsaak is nie, en indien daar ‘n grondslag gelê word in die getuienis vir ‘n beroep op ontoerekeningsvatbaarheid nie deur geesteskrankheid veroorsaak nie, moet uitsluitel gegee word ten gunste van die beskuldigde indien daar ‘n redelike twyfel oor die oorsaak van sy ontoerekeningsvatbaarheid bestaan.” And at E-F: “Hoewel by gesonde outomatisme die bewyslas op die staat rus, moet die beskuldigde eers die fondament vir die verweer lê. Daar moet getuienis van die kant van die beskuldigde wees wat sterk genoeg is om twyfel te laat ontstaan oor die vrywilligheid van die beweerde daad of versuim. Dit moet gerugsteun word deur geneeskundige of ander deskundige getuienis wat aantoon dat die onwillekeurige gedraging heel moontlik te wyte was aan oorsake anders as geestesongesteldheid of geestesgebrek. As aan die einde van die verhoor daar twyfel bestaan of die gedraging willekeurig was of nie, moet die beskuldigde die voordeel van die twyfel geniet.”

²⁵⁵ At 567 D-E.

“Subject to the neuropsychological findings, it would certainly seem feasible that this personality, in the circumstances described by the accused, could have had an impairment of psychological functioning such as to render her temporarily unable to bring proper judgment to bear upon the situation in which she found herself at the time of the shooting.”

A second psychologist, Dr R P Plunkett, also testified on behalf of the appellant. In this testimony he referred to the following factors:²⁵⁶

- “1) The intake of sedatives and alcohol as well as the fact that the appellant didn’t eat.
- 2) The severe assault on the appellant by the deceased, especially the blows to the head.
- 3) The threats by the deceased that he would kill the appellant.”

According to Dr Plunkett, the combination of these factors, as well as the general state of anxiety which the appellant experienced, resulted in the appellant being in “a state of ... complete lack of responsibility at that time”. He also expressed the opinion that the appellant was not able to distinguish between right and wrong.

The trial court, not having much regard of the expert evidence, held that the appellant killed the deceased intentionally. The trial court rejected the evidence by the appellant as to her version of the events.²⁵⁷ The trial court held that the appellant had the capacity to appreciate the wrongfulness of her conduct and that she had the capacity to act in accordance with such appreciation.

On appeal, Goldstone JA took a different approach. In his judgment, Goldstone JA took into account the evidence of Mr Gillmer and Dr Plunkett and found that there was a reasonable possibility that the appellant was not acting consciously when she shot the deceased. It was found that there was reasonable doubt as to whether she shot the deceased intentionally in a goal directed manner. According to the court such behaviour was in dire contrast to the personality and character of

²⁵⁶ At 567 F-G.

²⁵⁷ See 568 A-J and 569 A.

the appellant. The fact that she fired seven shots was indicative of uncontrolled behaviour. The court held that there was reasonable doubt as to the appellant's criminal capacity at the relevant time and that she should be afforded the benefit of the doubt. The appellant was accordingly acquitted.

It is striking from this judgment that the approach followed with regard to expert evidence in the trial court stands in dire contrast to the view of the Appellate division in this respect. This decision is important as it illustrates the need for expert evidence and that such evidence fulfils an indispensable function when ascertaining an accused's behaviour at the time the alleged crime was committed.

This decision also illuminates the prejudicial effect if expert evidence is not properly assessed and evaluated.

10 Referral in terms of section 78(2) and 79 of the Criminal Procedure Act where the defence of non-pathological criminal incapacity is raised

Before 2002, the Criminal Procedure Act did not provide for a referral in terms of section 79 if the defence of non-pathological criminal incapacity was raised.²⁵⁸

The Criminal Matters Amendment Act²⁵⁹, however, changed matters in respect of the defence of non-pathological criminal incapacity.

Section 78(2) was amended and currently reads as follows:

"If it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall in the case of an allegation or appearance of mental illness or

²⁵⁸ See *S v Volkman* 2005 (2) SACR 402 (CPD) at 405I – 406G.

²⁵⁹ Section 78(2) was introduced by section 5(C) of the Criminal Matters Amendment Act 68 of 1998 which came into operation on 28 February 2002.

mental defect, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.”

Certain phrases of the abovementioned section require closer scrutiny:

- “... any other reason ...” – this is a clear reference to non-pathological causes of criminal incapacity – these could include provocation, emotional stress, shock, intoxication etcetera. It is submitted that this phrase should be interpreted in its wide sense.
- “... shall ...” – there is a clear obligation on a court to refer an accused for observation if the defence of pathological criminal incapacity is raised.
- “... may ...” – this word has the effect of affording a discretion to a court when the defence of non-pathological criminal incapacity is raised, to decide whether or not to refer an accused for observation. The question could be asked as to whether this word has any function. Should a referral not be compulsory in both cases of pathological and non-pathological criminal incapacity? The term “shall” should then be used to refer to criminal incapacity due to a mental illness or mental defect and criminal incapacity as a result of “any other reason.”²⁶⁰

If an accused is referred for observation, such referral will be conducted and reported on in accordance with section 79 of the Criminal Procedure Act. It should be noted that such referral could be effected at the request of the accused, the State as well as the court.

Section 79 reads as follows:

“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

²⁶⁰ See *S v Volkman supra* note 258 at 405 F-G.

- 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 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
 - (iv) by a clinical psychologist where the court so directs.
- (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.
- (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.”²⁶¹

In *S v Volkman*²⁶² the court had to interpret and apply section 78 (2). The facts of the case were as follows. The accused, Ernest Heinrich Volkman, was charged with murder. He subsequently indicated that he intended raising the defence of non-pathological criminal incapacity as a defence. The State then applied for the accused to be observed for reasons other than pathological causes. The defence did not object to this request but requested the court that the observation takes place at daytime.

The court, per Hockey AJ, ordered the referral of the accused to Valkenberg Psychiatric Hospital for the purposes of conducting an enquiry and for a report to be prepared in accordance with section 79. Such report had to specifically include a finding as to whether the capacity of the accused to appreciate the wrongfulness of the act for which he was charged, or to act in accordance with an appreciation of the wrongfulness of the act, was, at the time of the commission thereof, affected by a non-pathological condition or by any other cause. The accused's bail conditions were also amended to make provision for the accused to report to the Medical Superintendent every Monday to Friday from 08h30 to 17h00. The State then brought another application to the extent that the accused be admitted for observation on a full-time basis as opposed to observation during daytime hours only.

²⁶¹ Section 79 will be discussed comprehensively in Chapter 3 below. Section 79(1) was amended by the new Sexual Offences Act 32 of 2007 which commenced on 16 December 2007. Only the portions relevant to the defence of non-pathological criminal incapacity are discussed here.

²⁶² *S v Volkman supra* note 258.

In respect of the distinction between non-pathological and pathological criminal incapacity, Hockey AJ held:²⁶³

“Clearly, the legislature made a distinction between allegations of criminal incapacity based on mental illness or mental defect, on the one hand, and such incapacity based on ‘any other reason’ on the other. Where there is an allegation or appearance of mental illness, or mental defect, the court is obliged (‘the court shall’) to direct that the accused be referred for observation in terms of S79 of the Act. If, however, there is an allegation of lack of criminal responsibility for any reason other than mental illness or mental defect, the court has a discretion whether to refer the accused for observation or not. Non-pathological incapacity falls within the latter category. Entrusting the court with discretion in cases of non-pathological incapacity is not surprising.”

Hockey AJ also notes that psychiatric evidence is not indispensable, but that the court should be mindful of the helpful role of such evidence.²⁶⁴

Professor Kaliski, who gave evidence on behalf of the State, stated that the conditions at Valkenberg Psychiatric Hospital to which the accused would be subjected if he was to be referred for observation, were appalling and abject. Professor Kaliski accordingly stated that these conditions were undignified and in violation of basic human rights of patients.²⁶⁵

The main consideration in this case was whether it would have been in the interest of justice to order that the accused be referred for observation in terms of section 78 (2) for a period of 30 days as requested by the State considered against the backdrop of the inhumane conditions at Valkenberg Psychiatric Hospital.

²⁶³ At 405 F-G (paragraph 8).

²⁶⁴ At 406 F-H (paragraph 13). See also *S v Henry supra* note 1 at 20 F-G.

²⁶⁵ At 408 C (paragraph 23).

Hockey AJ held that the granting of an order for referral would infringe the accused's rights to human dignity and freedom and also the rights to be detained under conditions that are consistent with human dignity, including adequate accommodation as afforded by section 35 (2) (e) of the Constitution.²⁶⁶

Hockey AJ accordingly held that in the light of the fact that psychiatric evidence is not a prerequisite to counter the defence of non-pathological criminal incapacity and having regard to the extremely unpleasant and degrading conditions that the accused would have been subjected to if the order is granted, that it would not be appropriate to grant the order as requested by the State.²⁶⁷

Hockey AJ also referred to the evidence by Dr Panieri Peter that was given during the first application, stating that it may be possible to compile a report in terms of section 79 of the Criminal Procedure Act if the accused was seen only in daytime. Hockey AJ held that in the light of the wide discretion the court has under section 78 (2) and 79 (2) as well as the appalling conditions at Valkenberg Psychiatric Hospital, that the first order, although unusual, was justified in that it afforded the State the opportunity to have a report compiled by a panel constituted in terms of section 79 (1) (b) of the Criminal Procedure Act, whilst at the same time “mitigating the inroad that this process would have on the human rights of the accused.”²⁶⁸ Hockey AJ noted that such an order would, to a certain extent, solve the problems of over-crowding at State psychiatric hospitals. The application to have the accused admitted in terms of section 78 (2) was accordingly dismissed.

This decision reaffirms the existence in our current criminal justice system of the defence of non-pathological criminal incapacity. Even though the court to a certain extent adhered to the traditional approach in respect of expert evidence, it still opened the door for a referral for observation to take place in cases of non-pathological criminal incapacity – even providing for alternative times during which such observation can be conducted.

²⁶⁶ At 408 H-I (paragraph 26).

²⁶⁷ At 409 D-E (paragraph 30).

²⁶⁸ At 410 B-C (paragraph 37).

If a general defence of criminal incapacity should be followed, no distinction will be drawn between an accused being referred as a result of an alleged mental illness or mental defect being present and an accused who lacked criminal capacity as a result of non-pathological causes. The focus will fall on the alleged lack of criminal capacity which has to be determined. This will possibly have the effect that alternative arrangements pertaining to time-schedules will not be possible as espoused in the *Volkman*-decision.

In the alternative, the current distinction between a referral for observation as a result of an alleged mental illness or mental defect, on the one hand, and for “... any other reason ...” should be adhered to. In both cases, however, referral should be made compulsory. In cases where the alleged cause of incapacity was due to non-pathological causes, it could be argued that due to the fact that such accused will in some cases not pose a threat to the safety of the community or society, different time-schedules could perhaps be imposed. This will aid in preventing overcrowded hospitals.

Meintjes-Van der Walt also states that section 78 (2) of the Criminal Procedure Act provides for those pleading sane automatism or non-pathological criminal incapacity, to also be sent for observation.²⁶⁹ The report in terms of this observation is drawn up by a team of court-appointed experts.²⁷⁰

Meintjes-Van der Walt states the following advantages of court-appointed experts:

- crystallising the issues in dispute;
- reducing the length of hearings;
- saving money for the parties and the court system;
- levelling the playing fields between parties of unequal resources.

It is submitted that if a referral for observation is compulsory for both the defences of non-pathological and pathological criminal incapacity, it will be to the advantage of both the State as well as the accused. Compulsory referral will be to the benefit

²⁶⁹ Meintjes-Van der Walt (2002) *SACJ supra* note 1 at 247.

²⁷⁰ *Ibid.*

of the State in the sense that it will be easier to obtain a referral in order to ascertain the accused's alleged lack of criminal capacity. It will also be to the advantage of the accused and his or her constitutional right in terms of section 35 (3) (1) to adduce and challenge evidence – expert evidence will then be compulsory. Section 79 also provides for a team of court-appointed experts to conduct the evaluation.

In the Law Commission Report that preceded the amendment of section 78 (2) it was agreed that the basis which an accused person has to lay in respect of non-pathological criminal incapacity, should consist of psychological or psychiatric evidence.²⁷¹

It was also stated that the State is confronted with the following dilemmas:

- there is no presumption which comes to its rescue;
- the accused only has to raise a reasonable possibility of criminal incapacity;
- there is no provision in the Criminal Procedure Act which comes to the rescue of the State in order to counter the plea of non-pathological criminal incapacity;
- although it was stated repeatedly by the Rumpff Commission that the normal person should control his urges, an ability which the normal mentally healthy person is capable of, the courts have sometimes successfully recognised this defence.²⁷²

The Law Commission report stated the following advantages if an accused is indeed referred for observation.²⁷³

²⁷¹ South African Law Commission "The Declaration and Detention of Persons as State Patients under the Criminal Procedure Act, Act 51 of 1977, and the Discharge of such persons under the Mental Health Act, Act 18 of 1973, Including the Burden of Proof with regard to the Mental State of an Accused or Convicted Person" Project 89 (1995) 116 (hereafter "Law Commission (1995)").

²⁷² Law Commission (1995) *supra* note 271 paragraph 7.165.

²⁷³ Law Commission (1995) *supra* note 271 paragraph 7.167.

- such observation is conducted under ideal circumstances and all relevant additional information can be collected,
- the court procedure does not have to be delayed for days with evidence and questions which are only of importance to the psychiatrist, which adds greatly to the costs both for the State and the accused;
- the interests of the community are served due to the fact that the best evidence pertaining to the defence can be put before the court only by means of such observation.

It was also submitted in the report that the defence of criminal incapacity refers in particular to the mental abilities of the accused and that the psychiatrist not only has a role to play, but is also accountable to the community.²⁷⁴ It was stated, and it is submitted that this view is correct, that psychiatric evidence is indispensable and that the psychiatrists themselves wish to fulfil their roles with the necessary responsibility, but that there is no adequate provision for this in the present Criminal Procedure Act. This was, however, to a certain extent relieved by the current Section 78 (2). It was also submitted that the State is at a disadvantage if the plea of non-pathological criminal incapacity is raised if the experts of the State have not assessed the accused²⁷⁵.

The abovementioned argument in favour of compulsory referral for observation has merit. The problematic issues in respect of expert evidence in support of the defence of non-pathological criminal incapacity could be relieved by the mere deletion of the word “may” and substituting it with the word “shall”.

The latter approach will be more in line with our current constitutional dispensation and provide legal certainty in respect of the role of expert evidence in support of the defence of non-pathological criminal incapacity.

²⁷⁴ Law Commission (1995) *supra* note 271 paragraph 7.168.

²⁷⁵ *Ibid.*

11 Principles of expert evidence through the cases

The defence of non-pathological criminal incapacity is mainly a common law defence finding its roots in case law. In the light of the fact that there are no clear-cut rules pertaining to the role and probative value of expert evidence in support of the defence of non-pathological criminal incapacity, an in-depth look at the approaches followed in respect of expert evidence in the various cases dealing with this defence, is needed. The following discussion will be devoted to an in-depth analysis of principles that became clear in case law relating to the role of expert evidence. The methodology that will be applied will include a discussion of the particular case, the views espoused by the various expert witnesses followed by a brief analysis of the particular case.

11.1 Expert evidence should consist of scientific and specialized knowledge

In *S v Kalogoropoulos*²⁷⁶ the facts were briefly as follows. This Greek tragedy, as aptly referred to by the court, involved a number of people, namely Athanasios Kalogoropoulos, the appellant, Dafni, his wife, Dimitra, his 13-year old daughter, Macheras, the appellant's business partner and friend, Charitomeni, the wife of Macheras, Dora, the housemaid in the appellant's home, Julia, Dora's cousin, Stefanos, husband of Dafni's sister and Stergiou, husband of the appellant's sister.

On the day of the fateful events, the appellant drove past his home and saw Macheras's car parked in the yard. He thought at that stage that Macheras was visiting Dafni with improper intentions. When he confronted them about it he became more suspicious. The appellant then went to his house and questioned Dora, the housemaid, about visitors. Dora insisted that no one had visited the home earlier that day. The appellant, however, still suspected that a love affair existed between his wife and Macheras and was overcome with jealousy and despair. He then consumed half a bottle of vodka and went back to his shop. He also carried a revolver with him. He had a habit of always carrying a revolver with him. At the shop the appellant also consumed whisky. He then took out his

²⁷⁶ *S v Kalogoropoulos* 1993 (1) SACR 12 (A).

revolver and accused Dafni and Macheras who had in the meantime returned to the shop, of having had sexual relations that afternoon. They denied it. A heated altercation then arose in the course of which Dafni and the appellant swore at each other. The appellant threatened to shoot Dafni. Macheras then moved towards the appellant but was pushed back onto his chair. Charitomeni then entered and the appellant waved his revolver to and fro, pointing it between Dafni and Macheras. A shot then went off, hitting Dafni and wounding her. Charitomeni then shouted “You have killed her!”²⁷⁷

Further shots were fired in rapid succession. Two of them struck Macheras in the chest, killing him. Another shot hit and wounded Charitomeni. The appellant then left the building and drove home. He went inside, opened the safe where the firearms were kept and armed himself with a pistol. He asked Dimitra, his daughter, where Dora was and was informed that she was in her room. The appellant then went into the yard, where he shot the family dog, firing two shots. He then went into Dora’s room and fired two shots, killing her.

The appellant was charged in the court *a quo* as follows:²⁷⁸

- Count 1: Murder – the killing of Macheras.
- Count 2: Murder – the killing of Dora.
- Count 3: Attempted murder – the wounding of Dafni.
- Count 4: Attempted murder – the wounding of Charitomeni.

He was convicted and sentenced as follows:²⁷⁹

- Count 1: Culpable homicide – 5 years’ imprisonment, to run concurrently with sentence on count 2.
- Count 2: Murder – 8 years’ imprisonment.
- Count 3: Common assault – 2 years’ imprisonment, to run concurrently with sentence on count 1.

²⁷⁷ At 14G.

²⁷⁸ At 15 D-F.

²⁷⁹ At 15 E-F.

Count 4: Common assault – 2 years' imprisonment, to run concurrently with sentence on count 1.²⁸⁰

The appellant appealed against the convictions on counts 1, 2 and 4 and against the sentences on all counts. The statement of the appellant that was put before the trial court explaining his behaviour on the day of the fateful events included, amongst other submissions, the following:

- (a) The accused suffered from retrograde amnesia and that he was informed at the hospital and thereafter that he had committed the acts which resulted in the charges against him.
- (b) The events were a culmination of numerous other provocative acts by the accused's wife who habitually and derisively referred to the 21 years difference in their ages, rejected him both publicly and privately, spurned, ridiculed and taunted him with increasing intensity, and, knowing that he was jealous and deeply in love with her, fanned his jealousy by her conduct.
- (c) The accused contented that as a result of liquor which he had consumed in a short period of time, more particularly having regard to the provocation referred to above, he was unable:
 - (i) to form the required intention to commit the alleged crimes; and
 - (ii) to appreciate the wrongfulness of his actions or act in accordance with such appreciation; and
 - (iii) to engage in any purposeful behaviour.²⁸¹

The appellant's defence was thus one of non-pathological criminal incapacity. On appeal the court had to consider whether the appellant's defence of criminal incapacity should succeed or whether the evidence before the trial court warranted the rejection of the appellant's defence of lack of criminal capacity.

In regard to this defence the trial court heard the evidence of two psychiatrists, Dr B Jeppe, called by the appellant, and Dr M Vorster, called by the State.

²⁸⁰ At 15 C-F. A detailed exposition of the facts is provided as the facts of the case are complex and many people were involved.

²⁸¹ At 15 H-I and 16 A-D.

Dr Jeppe and Dr Vorster agreed that the appellant experienced genuine amnesia as from the moment when the first shot was fired. Dr Jeppe was of the view that as from that moment the appellant was “totally unable to exert proper control over his actions” and that this condition subsisted when he shot Dora.

Dr Vorster, however, differentiated between the shooting in the office and the shooting of Dora. Her view was that in the office, more or less from the time the first shot was fired, the appellant was unable to act in accordance with an appreciation of the wrongfulness of what he was doing, but that when he left the office, he was once again “in control”, and that he was not experiencing a “loss of control” when he shot Dora.

Expert evidence was also received regarding the appellant’s blood alcohol level both at the time of the shooting in the office and at the time of shooting Dora, which proved to be about 0.24 gram per 100 ml²⁸².

The evidence of the two psychiatrists was carefully scrutinized by Botha JA on appeal and for purposes of this discussion it is important to discuss the court’s approach thereto.²⁸³

The doctors agreed that the appellant did not suffer from any mental illness or mental defect. Psychologically he was perceived as a normal individual with normal intelligence and sound judgment. Dr Jeppe stated²⁸⁴ the following about the appellant’s personality:

“..... (he is) rather a timid individual, especially in regard to his relationship with ... his wife, by whom he appeared to feel emasculated, although he appeared to be desperately attached to her.”

²⁸² At 20 H-I.

²⁸³ At 20 I-J Jacobs JA states: “In this regard we are not hampered, nor assisted, by findings of credibility or reliability on the part of the trial judge. It is common cause that both the psychiatrists were well qualified to give expert evidence in their field, and that they did so in good faith, honestly and without bias. We are in a good position to assess the evidence on its merits as was the court *a quo*”.

²⁸⁴ At 21 A-B.

Dr Vorster stated:²⁸⁵

“..... in his personality he feels a little inadequate”; “he was able to assert himself, but in terms of his relationship with his wife, his feeling of inadequacy made that assertion more difficult.”

The doctors were also unanimous that the appellant genuinely suffered from amnesia as claimed by him. According to them the appellant had what is generally known as an alcoholic blackout. It differs vitally from automatism. Dr Vorster stated that in automatism there is no conscious thought, but as to a blackout she said:²⁸⁶

“A blackout or a blank out, as Dr Jeppe used the term, occurs in people who are either heavy drinkers or alcoholics, where they act quite normally and they are quite normal, but afterwards have no memory for what they have done. So, during the time that they are performing the actions, they are conscious, they are voluntary. They perform any kind of actions, but the only difference is that afterwards they cannot remember what they have done. So during the time that they have performed those actions, they are liable for everything they are doing, because there is conscious thought.”

And further:

“ ... The salient point about blank out is that the person is quite normal. They are simply not laying down memory banks. So, they could be doing any kind of work, any kind of task.”

Dr Vorster, when cross-examined about the appellant’s alleged lack of control at the time when he shot Dora, repeatedly refuted the notion that the appellant’s blackout had anything to do with the question of control. She stressed that it merely explains the memory loss and that it was not a factor to be taken into

²⁸⁵ At 21 B-C.
²⁸⁶ At 21 D-E.

account in regard to the question of control at all. Consequently, according to the expert evidence in this case, the appellant's amnesia had no direct bearing at all on the issue of his criminal capacity.

Botha JA states²⁸⁷ that eventhough psychiatric evidence in cases of non-pathological criminal incapacity is not as indispensable as in cases where criminal incapacity is attributed to pathological cases, an accused person is required to establish a foundation sufficient at least to create reasonable doubt as to the existence or not of criminal capacity. Ultimately it is for the court to assess the accused's criminal responsibility taking into account the expert evidence and all other relevant facts including the accused's actions during the relevant period²⁸⁸.

It is important to also take note of the court's view as to the value of the psychiatric evidence tendered.

Botha JA held that both Dr Jeppe and Dr Vorster, in expressing their views as to the appellant's mental state at the relevant time, focused attention mainly on the appellant's loss of control and that the evidence on the record indicated that the opinions expressed pertaining the appellant's control over his actions did not purport to rest on the exercise of any specialised scientific or technical procedures or expertise. Botha JA held²⁸⁹ the expression 'loss of control' was not put as a term of art peculiar to the discipline of psychiatry or perhaps psychology. It was not suggested that the views expressed were derived from arcane knowledge of the workings of the human mind to which psychiatrists alone have access by virtue of their training or experience. Instead, what the doctors presented in their evidence was to take the facts deposed to in the trial and to draw inferences therefrom as to the appellant's control over his actions, or the lack of it. Botha JA held that drawing inferences as to the mental state of a person's mind from objective facts relating to his/her conduct was an exercise which was not unique to

²⁸⁷ At 21H-22A.

²⁸⁸ *Ibid.*

²⁸⁹ *Ibid.*

the psychiatric or psychological professions²⁹⁰. Botha JA in addition held²⁹¹ that courts of law perform the exercise daily, and in addition stated:

“In the circumstances of the case I perceive no cause for this court to have any hesitancy in considering the opinions of the psychiatrists on their merits, in accordance with our own experience of, and insight into, human behaviour, and deciding itself upon the inferences that are to be drawn from the objective facts relating to the appellant’s actions.”

As illustrated in the discussion of the facts above, it can be seen that the facts of this case can be divided into two stages – that is the shooting at the office and the shooting that took place at the appellant’s home afterwards when the appellant shot Dora and the dog.

The two psychiatrists were divided in opinion as to whether the appellant lacked self-control at the time when he shot Dora. Dr Jeppe was of the opinion that the appellant was not fully aware of the occurring events and that he could not fully control his behaviour.²⁹² Dr Vorster contended that these subsequent actions were not actions of a person who lacked self-control.²⁹³ The court agreed with the views and conclusion of Dr Vorster, but noted that it would have rejected Dr Jeppe’s evidence even if Dr Vorster had not given voice to her disagreement.²⁹⁴

The court accordingly held that all of the appellant’s actions after he left the office, and the whole of his outward conduct then, proclaim that he was well aware of what he was doing and that he was well in control of himself. The court found that there was no foundation of fact for the notion that the appellant, when he shot

²⁹⁰ *Ibid.*

²⁹¹ *Ibid.*

²⁹² At 22 H-I.

²⁹³ At 23 B-F. It is interesting to take note of Dr Vorster’s answers to certain questions posed to him by the court at 23 E: “Would that not indicate that there was this, this loss of control that was present at the office, continued right up to the time of the shooting at the dog and the shooting of the late Dora Seleke? - No, it is not the time period that impresses me. It is his activities during that time. Had he had a continued loss of control, in fact one would have expected random shootings of everybody he met. Not intentional actions as have been described over the past few days” and further by Dr Vorster: “I am not saying Mr Kalogoropoulos was not angry at that point. What I am saying was that he had not lost control.”

²⁹⁴ At 23 I-J.

Dora, was unable to control his actions and thus that he was unable to act in accordance with his appreciation of the wrongfulness of his conduct.

It is now important to focus on the approach followed in respect of the evidence of the psychiatrists pertaining to the shooting at the office.

Dr Jeppe stated the following:²⁹⁵

“It is my opinion that as a result of emotional stress, extending over many months, intensified by the excessive use of alcohol and brought to a climax by a tremendous emotional blow, the accused was precipitated into a state of dissociation in which he had a diminished awareness of what was going on and he became totally unable to exert proper control over his actions on the evening of Tuesday, 16 February 1988, which eventuated in the death of George Macheras and Dora Seleke and the injuries to Dafni Kalogoropoulos and Charitomeni Macheras.”

A huge obstacle in Dr Jeppe’s evidence was that he made mention of “diminished awareness.”²⁹⁶ It is clear that this statement is not an indication of either an inability to appreciate wrongfulness, or an inability to act in accordance with such appreciation.

Dr Vorster testified the following:²⁹⁷

“I think we have a build-up of anger here. We have a build-up of alcohol and therefore we have a gradual build-up of loss of control. While he was

²⁹⁵ At 24 D.

²⁹⁶ He also later testified at 24 F: “He was shattered psychologically, my lord, by what he thought had happened, that he had killed his wife, because he had heard the shout, you have killed her. And of course the effect of the alcohol blurred his control in any event. I believe that the combination of the two, my lord, made it, diminished his ability to be fully aware of what was happening and certainly his ability to control his behaviour.”

²⁹⁷ At 25 B-F. With reference to Charitomeni’s shout: “I think he had his finger on the trigger at that stage. It was at that point where he lost control and that is exactly why he carried on shooting and did not stop. If he had been controlled, he would have then stopped. ... He was no longer able to act in accordance with his appreciation of wrongfulness. ... As to the anger, the extreme anger, as I see it at the office, was with all the shouting and swearing and the arguing, jealousy, all combined, to make him lose control.”

pointing the firearm between two of the victims, there we still see that the accused is in control.”

The court stated the only two facts gleaned from Dr Vorster’s evidence, differentiating the shooting at the office from the shooting of Dora, were that the appellant kept on shooting and the fact that there were shouting, swearing and arguing.

The court, however, rejected Dr Vorster’s opinion in this regard. It was held that immediately before the shooting at the office the appellant was in control of himself and immediately thereafter he was again in control of himself. Thus on the face of his conduct before and after, the court found that it is inconceivable that in the brief interval in between he was deprived of self-control. The firing at the office stopped when the revolver was empty but was resumed when the appellant fetched a replacement and found his next victim. It was found that the appellant shot Dora (and the dog) because he was angry and emotionally upset, but while in a frame of mind where he could exert self-control. The court held that there was no foundation in fact for differentiating between the appellant’s state of mind during the couple of seconds that it took him to fire the shots in the office, and his state of mind before and after that episode. The defence of criminal incapacity was accordingly rejected.

- Reflections on the *Kalogoropoulos*-decision

This case deserves careful scrutiny as the court’s approach to the evidence presented by the two psychiatrists is of importance. It is clear that the court did not attach too much weight to the expert evidence. The reason for this could perhaps be found in the fact that they only drew inferences from the facts which the court itself, without the assistance of the experts, could have done. Experts in cases of this nature should thus try not to merely draw inferences only, but should also “astonish” the court with experience, skill, specialized techniques and expertise in order to better assist the court in reaching its conclusion on the facts. Expert evidence should accordingly be scientifically reliable in order to carry sufficient weight.

11.2 Value of expert evidence dependent on the cogency and truthfulness of the accused's version of the events

A case that also cast a spotlight on the pivotal importance of expert psychiatric evidence is the case of *S v Potgieter*²⁹⁸. The facts of this case are as follows:

The appellant, a 36-year old woman, stood trial in the South Eastern Cape Local Division of the Supreme Court on a charge of murder. The State alleged that she had intentionally and unlawfully killed the deceased, Badian Stow Bosch, hereafter “the deceased”, with whom she was living as her husband. Her defence was that when she shot him she did so in a state of “sane automatism”, or impelled by an irresistible impulse and that she therefore lacked the legal capacity to commit a criminal act. This defence was rejected as false in the court *a quo* and the appellant was found guilty as charged.

The appellant was married to Jan Potgieter. They had three children, a boy, Brandon, and two daughters, Cyndee and Shannon. She eventually met the deceased which led to her subsequent divorce, terminating the marriage with Jan Potgieter which had not been a happy one. She later moved in with the deceased. She had been awarded custody of the three children. The deceased said that he did not want them in the way and they were placed in a boarding school. The deceased was unpleasant towards the children. He drank excessively, was foul mouthed and often assaulted the appellant by hitting her. She remained with him because she continued to love him despite his conduct, was materially dependent on him and hoped that his repeated promises to behave decently would be kept. The appellant later gave birth to a boy, Tyrone. On the particular Sunday the appellant and the deceased again had words after which he assaulted her. She phoned her sister-in-law as well as a friend telling them that the deceased assaulted her. The appellant's friend offered her accommodation, but she declined the offer.

²⁹⁸ *S v Potgieter* 1994 (1) SACR 61 (A). See also Burchell (1995) SACJ *supra* note 1 at 837.

She then telephoned a locksmith and explained to him that she needed money and a gun from a locked safe for a journey she proposed taking on the Monday morning. Mr Britz arrived and opened the safe and, according to the appellant, handed the pistol and ammunition to her. She removed the pistol from its holster and placed one of the magazines in it and put the gun in her handbag. According to the evidence of the locksmith, she did not tell him about the pistol and he did not see her remove the weapon from the safe. He was at no stage involved in removing the pistol and did not see her do so. She then went to the police station to lay a charge of assault and to seek police protection. At the police station she was informed that, because a detective was not on duty on a Sunday, she should return the next day to make a statement. She then returned to her home.

The appellant's version of the events that took place that evening was the following. She went upstairs to put the baby to bed. After putting him to bed, she took the pistol in its holster from the handbag and left the handbag in the child's room with the spare magazine containing live cartridges still in it. She put the pistol, still in its holster, on the vanity slab.

She woke up at some stage during the night with the baby crying. She heard loud music downstairs. Without turning on any lights upstairs she went downstairs to see what was going on and to prepare another bottle for the baby. She found the deceased in a lounge chair looking at the static pattern on the television screen. The loud music came from the television set. She asked him to turn the music down but he ignored her. She went back upstairs to the baby's room and gave him his bottle and settled him. As she reached her room, the deceased arrived at the doorway at more or less the same time. She asked him please to turn down the music. He grabbed her by the upper arms and threw her against the wall between the bedroom and bathroom. Her last recollection of the incident was of him shouting something at her as she saw his blurred image moving away from her towards the bedroom window. She remembered nothing further until she heard a "loud bang" and she realised that she had shot her husband²⁹⁹.

²⁹⁹ At 69 E-F.

The detective on duty drew a series of sketches depicting the possible positions of the deceased when the shot was fired. He was trained to undertake such a task and had the necessary experience. The injuries, taken in conjunction with certain other undisputed evidence, proved beyond any doubt that the deceased at the time he was shot, was lying in bed.

In her plea explanation, the appellant's defence was canvassed as automatism, alternatively lack of criminal capacity.³⁰⁰

The court, per Kumleben JA, noted that the reliability and truthfulness of the alleged offender is in the nature of the defence a crucial factor in laying a proper foundation.³⁰¹

The court also quoted the dictum from *R v H*³⁰² in which the following was held:

“Defences such as automatism and amnesia require to be carefully scrutinised. That they are supported by medical evidence, although of great assistance to the court, will not necessarily relieve the court from its duty of careful scrutiny for, in the nature of things, such medical evidence must often be based upon the hypothesis that the accused is giving a truthful account of the events in question.”

Kumleben JA also held that the *ipsi dixit* of an accused person that the act was involuntary and unconsciously committed, based on evidence tendered in support of such assertion, will generally be accepted unless it can be proved that such evidence “cannot reasonably be true”³⁰³.

³⁰⁰ At 72 D-H. “3. ... the accused pleads that at the time of the alleged crime she acted involuntarily in that she acted without being able to appreciate the wrongfulness of her act and therefore acted in a state of automatism; alternatively she acted whilst suffering from, and subject to, an irresistible impulse and whilst unable to act in accordance with an appreciation of the wrongfulness of her act. The accused therefore pleads that she is not criminally accountable or responsible for the said act. 4. The unaccountability set out in para 3 above was non-pathological of nature, was of a temporary nature and was not due to any permanent or temporary mental illness or defect as envisaged by Act 51 of 1977.”

³⁰¹ The court also referred to the judgments of *Kalogoropoulos supra* note 1; *Laubscher supra* note ;, *Calitz supra* note 1 and *Wiid supra* note 1 as discussed *supra*.

³⁰² 1962 (1) SA 197 (A) at 208 A-C.

³⁰³ At 73 E.

The judgment also cited Hiemstra:³⁰⁴

“Daar moet getuienis van die kant van die beskuldigde wees wat sterk genoeg is om twyfel te laat ontstaan oor die vrywilligheid van die beweerde daad of versuim. Dit moet gerugsteun word deur geneeskundige of ander deskundige getuienis wat aantoon dat die onwillekeurige gedraging heel moontlik te wyte was aan oorsake anders as geestesongesteldheid of geestesgebrek. As aan die einde van die verhoor daar twyfel bestaan of die gedraging willekeurig was of nie, moet die beskuldigde die voordeel van die twyfel geniet.”

Kumleben JA also stated:³⁰⁵

“The need for careful scrutiny of such evidence is rightly stressed. Facts which can be relied upon as indicating that a person was acting in a state of automatism are often consistent with, in fact the reason for, the commission of a deliberate, unlawful act. Thus – as one knows – stress, frustration, fatigue and provocation, for instance, may diminish self-control to the extent that, colloquially put, a person ‘snaps’ and a conscious act amounting to a crime results. Similarly, subsequent manifestations of certain emotions, such as fear, panic, guilt and shame, may be present after either a deliberate or an involuntary act has been committed. The facts – particularly those summarised thus far – must therefore be closely examined to determine where the truth lies.”

Kumleben JA found that the appellant was not a truthful witness in many respects. Kumleben JA accordingly held, on an appraisal of all the evidence, the following:³⁰⁶

³⁰⁴ See 73 G-H of the judgment.

³⁰⁵ At 73 J-74 B.

³⁰⁶ At 80 J-81 H.

- The appellant was in many respects an untruthful witness. This finding was based on improbabilities and contradictions in her own evidence, and on the discrepancies between her testimony and that of the locksmith, Britz, whose evidence was not challenged and whose veracity was beyond question.
- It may be accepted that the appellant was assaulted by the deceased that Sunday. Whether such assaults took place at times in the manner described by the appellant was questionable.
- The pistol was not taken from the safe because she was leaving for Durban the next morning and it was not removed openly in the presence of Britz.
- The pistol when it was used that night was not taken from the vanity slab.
- The deceased was asleep at the time the shot was fired or, if not asleep, had not assaulted the appellant as described by her seconds before lying down.

It was held that the appellant's account of what took place over the pertinent period could not reasonably have been true. It was found that the factual foundation on which to consider the validity of the defences that were raised, namely automatism and irresistible impulse, had been absent.³⁰⁷ Dr Potgieter, who testified on behalf of the appellant, testified and based his opinion on the assumption that the appellant's evidence was truthful in all material respects. He readily conceded that if his opinion was to be rejected by the court his opinion no longer held.³⁰⁸

It is also pointed out that Dr Potgieter accepted the appellant's account virtually without qualification or reservation. As the court notes initially, after consulting with the appellant and reflecting on the matter, Dr Potgieter concluded that automatism was the probable explanation of her conduct. After attending the trial and listening to the evidence in court, he became more certain of his diagnosis: he altered his conclusion of "waarskynlik" to "heel waarskynlik" in the light of her testimony³⁰⁹. He was asked on what grounds he had any reservation at all – why he could not express his final conclusion as a certainty. His reply to this was that it was only the appellant's contradiction about where she had put the storeroom key

³⁰⁷ At 81 E.

³⁰⁸ At 81 E-F.

³⁰⁹ At 81 F-H.

that had cast doubt in his mind as to her honesty and reliability. Kumleben JA, however, held that it was not only in this one respect that the appellant's evidence had been defective. It is important to take note of Kumleben JA's comments as to the expert evidence put forward in this case.³¹⁰

Dr Potgieter, who as already mentioned testified on behalf of the appellant, testified that from his research on the subject of automatism and his study of the authorities on the subject, he extracted certain criteria which, if satisfied, pointed to or established automatism³¹¹.

Dr Kaliski was of the view, based on his observations of the appellant's behaviour at Valkenberg Psychiatric Hospital and her evidence in court, that she was "a lot tougher than what we give her credit for" and that within limits she was capable of standing up for herself³¹². Her own evidence of what she had endured at the hands of the deceased over a long period of time tended to confirm this.

Amongst the criteria relied upon by Dr Potgieter were the facts that the appellant had no past history of acts of violence and that the killing was not planned beforehand during the course of the Sunday. He also referred to her subsequent reaction and emotional condition when she realised that she had killed the deceased.

Dr Kaliski, with some scepticism and reservations, accepted that these facts were consistent with automatism but stressed that they are as consistent with one being provoked or driven to act violently and consciously and thereafter becoming distraught, even hysterical, in the realisation of what had happened and its implications³¹³.

³¹⁰ At 82 B Kumleben JA held: "In the light of my conclusion that the necessary factual basis is wanting, it is strictly speaking unnecessary to comment on the psychiatric evidence. I do, however, propose to do so and review it on the supposition that the evidence of the appellant is acceptable as regards to the pertinent period: more particularly, on the assumption that the pistol was on the vanity slab and that the position of the deceased when shot can be reconciled with her story." See 82 C-J and 83 A-J of the judgment.

³¹¹ At 82 C.

³¹² At E-F.

³¹³ At 82 H-J. Dr Kaliski in addition observed the following: "Some people when they snap, they smash up a place, some people when they snap, they assault other people. When under provocation, having given a long background of say stress, whatever, when under provocation

The state of amnesia was a further factor referred to by Dr Potgieter and Dr Kaliski pointed out that in respect to amnesia, “when a person acts in a state of automatism, there must be an amnesia”, but that the opposite was not always true. According to Dr Kaliski, psychogenic amnesia, which he described as “forgetting the disagreeable” after the event, is relatively common in a situation similar to that with which the appellant was confronted.³¹⁴

It was also noted that the fact or assumption of amnesia depended upon the appellant being truthful when she said that she remembered nothing. The latter is not a condition which is easily capable of objective proof. The next question that required expert evidence was whether there had been any simulation on the part of the appellant.

Dr Potgieter stated³¹⁵:

“Ek gaan net opsommend sê dat my opinie nadat ek die konsekwentheid opmerk van wat sy vir my ten tye van ons aanvanklike konsultasies gegee het en wat ek hier in die Hof in gehoor het laat by my geen twyfel dat ten opsigte van die gebeure van daardie spesifieke oomblik van die outomatisme absoluut konsekwent weergegee is volgens alle inligting tans tot my beskikking.”

But later he remarked³¹⁶:

“... simulاسie kan nooit totaal uitgeskakel word nie. Uiters onwaarskynlik.”

And further³¹⁷:

a person snaps and smashes up things and then afterwards says: ‘I don’t know what came over me, that is just not me, I don’t even remember doing it’ we are quite happy to say that person had just lost his temper. When the same person goes through the same sequence, but instead of destroying items in the environment, he assaults (fatally) somebody, we somehow feel compelled to give it a different name, we want to call it dissociative state or something else.”

³¹⁴ At 83 A-B.

³¹⁵ At 83 C-D.

³¹⁶ At 83 D-E.

“... Ek kan nie glo dat die beskuldigde psigiatries so gesofistikeerd is dat sy sulke tipiese fenomene soos terugflitse kan simuleer nie.”

The above conclusion was in part based on Dr Potgieter’s general conclusion that the appellant was truthful in all respects.

Dr Kaliski, on the other hand, apart from the assessment of the truthfulness of the appellant as a witness, did not accept her description of the final scene as consistent with automatic behaviour. He pointed out that in her account to him, she said that the deceased “shoved her against the wall, the back of her head hit the wall, he was saying things, he then went down on the bed and she heard an explosion, she had not left the room, she cannot remember fetching the gun. She remembers running down the steps to get her ex-husband”³¹⁸. Dr Kaliski, focusing his attention on the final episode, disputed the conclusion of Dr Potgieter that the appellant acted involuntarily³¹⁹.

Dr Kaliski also pointed out at various stages during his evidence that the actions of the appellant, from the time she was pushed against the wall, were not of a routine or automatic nature. They involved a number of relatively complicated and “goal-directed” steps resulting in a single lethal shot being discharged. She had to locate the pistol at a place where it was not normally kept, that is, on the vanity slab. She had to remove it from the holster, she had to cock the pistol and release the safety catch and thereafter in relative darkness she had to aim at the target on the bed.³²⁰

³¹⁷ *Ibid.*

³¹⁸ At 83 G-H.

³¹⁹ At 83 H-84 B. Dr Kaliski states the following: “If I may proceed to the actual automatism or automatic behaviour, you know you can get lost and lost in definitions M’ Lord, but the central point to be made about an automatism, the behaviour has to be automatic. And this is where we, this is the actual crux of it. ... That yes, behaviour can be complex but it is apparently purposeful. I think the word used in Afrikaans was ‘klaarblyklik’. And in this article by Prof Henning who is the author in London, in his introduction to the concepts of defining automatism, he says that the first thing to go in automatism is a person’s higher order functions which he described as the higher order function of reasoning, judgment and intelligence. What this means is the person’s ability to meaningfully interact with his environment, his awareness of what he is doing, and to actually act in a very precise goal – directed fashion in the environment, must be diminished.”

³²⁰ At 84 B-C.

Kumleben JA accordingly held:

“I must confess to difficulty in accepting that all this could have been done automatically and on this issue, if it were necessary, I would accept Dr Kaliski’s conclusion in preference to that of Dr Potgieter. In expressing this view, I take into account Dr Potgieter’s over-sanguine view, as I see it, of the appellant’s honesty and the comments made in regard to his criteria which, again as I see it, places them in a perspective which reduces their cogency to a material extent. During the hearing of the appeal, I should mention, no separate argument was advanced in respect of the alternative defence of irresistible impulse. It was correctly accepted that should the appellant’s evidence be rejected, this defence would also fail. In the result I consider that the conviction must stand ...”³²¹

The Appellate Division exercised mercy in setting aside the sentence of seven years’ imprisonment. The court held that the trial court had erred in imposing what it regarded as an exemplary sentence in the light of the increased prevalence of this sort of offence: in doing so the court had overstressed the retributive element. The case was accordingly remitted to the trial court to sentence the appellant afresh after due compliance with the provisions of section 276A(1)(a) of the Criminal Procedure Act.

- Reflections on the *Potgieter*-decision

The decision in the *Potgieter*-case is interesting in many respects. The importance of expert psychiatric evidence is once again emphasised. It is further important to take note of the divergent opinions capable of being advanced within a factual situation similar to the *Potgieter*-case.

³²¹ At 84 D-F.

Burchell³²² also correctly submits that the important message conveyed in *Potgieter's* case is that the defence of non-pathological incapacity will be very carefully scrutinised by courts and, if the version of the facts presented by the accused is found to be unreliable or untruthful, the psychiatric evidence based on the supposed truthfulness of the accused's version of the facts must also fall away.

One of the major obstacles that arise in the psychiatric evaluation of any person, whether that person has raised the defence of pathological incapacity (insanity) or non-pathological incapacity, is that the psychiatric evaluation takes place before the full evidence has been heard in court.³²³ Burchell correctly asserts that in the interests of the pursuit of truth, it would be better to allow the psychiatrist who has given evidence of the mental state of the accused an opportunity to re-assess his opinion after hearing all the other evidence.³²⁴

Burchell³²⁵ correctly suggests two practical solutions that could be of assistance to courts that are called upon to consider the defence of non-pathological criminal incapacity:

- (a) A judge hearing a matter involving the defence of non-pathological incapacity based on provocation and emotional stress would be entitled and, in fact, strongly encouraged, to require the State to lead psychiatric or psychological evidence in order to test evidence on the question of capacity led by the defence against evidence of capacity led by the State.

In the *Potgieter*-case the abovementioned suggestion becomes evident in the court's evaluation of Dr Kaliski's evidence weighed against the evidence of Dr Potgieter. On a scale of probabilities it was evident that the court attached more weight to the evidence of Dr Kaliski, appointed by the prosecution in rebuttal, than to Dr Potgieter's evidence presented in support of the appellant's defence of automatism.

³²² Burchell (1995) *SACJ supra* note 1 at 38-39.

³²³ Burchell (1995) *SACJ supra* note 1 at 39.

³²⁴ *Ibid.*

³²⁵ Burchell (1995) *SACJ supra* note 1 at 41-42.

A court in such a case is under no obligation to accept either the psychiatric evidence adduced by the defence or the State, but access to a balanced view is preferable to access to a one-sided perspective only.³²⁶

- (b) The evidence referred to in (a) above should, if possible, be heard after the factual issues of the case, particularly with regard to the credibility of the accused's story, have been canvassed. Burchell also submits that despite the difficulties in separating the issues of credibility and capacity, it would be wise to entrench the procedure in all cases involving psychiatric evidence in criminal trials or, at least, to offer the expert witnesses an opportunity to re-evaluate their evidence, if necessary, at the end of the fact-gathering stage of the trial.

As indicated by Kumleben JA in the *Potgieter*-case, the weight attached to psychiatric evidence depends on the cogency of the accused's version of what happened, and accordingly the hearing of the psychiatric evidence should be postponed until after the accused's version has been tested in cross-examination and also in the presence of the particular psychiatrists.³²⁷

This case also illustrates the importance of both the State and the accused presenting expert evidence.

11.3 Expert evidence well established

In *S v Nursingh*³²⁸ the accused was charged with three counts of murder. The charges followed upon him shooting and killing his mother and maternal grandparents with whom he had been living. On the day of the killings, the accused, at that stage, a university student, and his friend, Aman Soni, cut down a

³²⁶ *Ibid.*

³²⁷ *Ibid.*

³²⁸ *S v Nursingh* 1995 (2) SACR 331 (D). See also Coetzee, LC "Criminal Capacity – sane automatism – evidence of prolonged sexual abuse of accused by his mother – accused having personality profile which predisposed him to violent emotional reaction wherein he would not be able to distinguish right from wrong – *S v Nursingh* 1995 (2) SACR 331 (D)" *Codicillus* (1996) at 96-98.

mango tree and removed the branches. As a reward for this chore, the accused obtained permission from his mother to go to a concert he had wished to attend. The reason attendance of this concert was so important to the accused was due to the fact that this was the first time in his life he had asked a girl to accompany him on a date.

That same evening, Aman Soni was at the house of the accused and his family. The accused had invited Soni to go out with him that evening. Soni waited upstairs in the accused's room while the accused went down to ask his mother's permission to go out. Soni heard the sound of voices in argument at first and then the mother's voice raised to a screaming pitch and then the sound of shots followed. (It later appeared that three shots had struck the accused's mother and grandfather and four shots struck the accused's grandmother). Soni ran downstairs, taking a knife of the accused that was lying about, in case he thought he should be in any danger. There he found the accused standing in the doorway and the mother of the accused on the floor. He touched the accused on the shoulder. The accused reacted by jumping, as though startled. According to Soni, the accused first looked dazed and not quite aware of what was going on and then started crying. Soni went to the body of the grandfather, felt the grandfather's chest to see whether he was still alive and then in a state of panic told the accused "let's get out of here"³²⁹. Soni ran to get the keys to the family motorcar and, while looking for them, the accused joined him, "babbling and not saying anything sensible."³³⁰ The two of them then drove to the vicinity of the University. When Soni asked the accused what they were going to do, the accused just continued crying. Soni testified during the trial that he was not sure whether his question had even been heard. They discarded the pistol alongside the road, where it was later found.

The defence put forward on behalf of the accused was that, by reason of his peculiar family circumstances and upbringing, he had a personality make-up which predisposed him to a violent emotional reaction in the event of other events occurring that would push that predisposition into a state of eruption. Put

³²⁹ At 337 F-G.

³³⁰ At 332 G.

differently it would mean that at the moment and when those circumstances occurred to trigger off this disruption of his mind, it would become so clouded by an emotional storm that he would not have the mental ability to distinguish between right and wrong and act in accordance with that insight.³³¹ The defence of the accused was thus one of non-pathological criminal incapacity.

The peculiar circumstances which were relied on were those relating to the accused's upbringing. It was submitted that these led to his condition prior to the shooting, and that they consisted of a prolonged, continuous and at times severe physical, psychological and sexual abuse, mainly at the hands of his mother. This fashioned and produced a personality replete with inner conflicts, mainly centred on a fear of separation and abandonment. This made him, on the one hand, intensely dependent on his mother but with, on the other hand, a latent anger and resentment at that dependence.³³² He feared separation from her and the home that he knew, but would also feel trapped by conflicting inclinations to be close at some times and to be distant at other times, compliant or rebellious, wanting to exercise some independence but afraid to do so because withdrawal from that situation would mean isolation.

Turning to expert evidence, the case was put forward on the basis of expert evidence from a psychiatrist and a psychologist, one of whom had actual experience in dealing with this nature of occurrence, and the other experience in dealing with cases of sane automatism. Both these witnesses had qualified themselves by examination of the accused and consideration of the known circumstances of the case, and were of the conclusion that what happened on the evening in question was a singular combination of circumstances that faced the accused, with his vulnerability of make-up, with a sudden and immediate threat to him of devastating proportions.³³³ Within the context of the previous history of abuse, it triggered off his state of altered consciousness, which manifests itself in a

³³¹ At 332 G-H.

³³² At 332 I-J.

³³³ At 333 B-C.

markedly reduced or even a wholly incomplete, awareness of normality, with accompanying loss of judgment and self-control³³⁴.

The psychiatrist identified the resulting mental state as a separation of intellect and emotion, with temporary destruction of the intellect, a state in which, although the individual's actions may be goal directed, he would be using no more intellect than a dog biting in a moment of response to provocation. According to the psychiatrist, it was a syndrome and a profile that was well-known and documented in contemporary psychiatric literature and research.³³⁵

The psychologist described the accused's state as "an acute cataclysmic crisis"³³⁶. According to the psychologist it is a known and identified mental trauma that occurs in the context of a particular relationship of people like husband and wife or parent and child. It occurs in people with a particular emotional vulnerability. According to the psychologist, when such a person has that vulnerability incited by some stimulus, it results in an overwhelming of the normal psychic equilibrium by an all-consuming rage, resulting in the disruption and the displacement of logical thinking. It accordingly manifests itself in an explosion of aggressiveness that frequently leads to homicide.

According to Squires J both these experts meant to state the same thing, which is conflict in a particular relationship, which leads to an unbearable tension, which is released in this violent way by some trigger event. Both experts were of the view that such an occurrence was not a pathological one. It is a non-recurring event, particularly if the cause of it is removed. It is further characterised by an inability to remember what happened, although that particular aspect is the result of the fact that the cognitive reading ability of the mind is not registering during the relevant period and therefore there are no recollections.

During the course of the judgment Squires J noted³³⁷ that where an accused person relies on non-pathological causes in support of a defence of criminal

³³⁴ At 333 C-D.

³³⁵ At 333 D-E.

³³⁶ At 333 E-F.

³³⁷ At 334 B-C.

incapacity, he or she is required to establish a factual foundation for it in evidence, sufficient at least to create a reasonable doubt on the issue as to whether he had the requisite mental capacity. At the end of the day, it is for the court to decide the issue an individual's criminal responsibility for his or her actions, taking into account the expert evidence, and all the facts of the case, including the accused's actions before, during and after the relevant phase.

The state did not call any expert evidence in behavioural science or psychiatric medicine to dispute or challenge the existence of the phenomenon described by the expert witnesses for the defence.

Squires J found that the most serious aspect in this case had been the sexual abuse. The evidence established the existence of a bed for the accused in his mother's bedroom, in a house where there had been ample space for each occupant to have his or her own room. The accused also experience sexual aversion. Squires J noted as to the latter.³³⁸

“The psychiatric rationalisation of this in the light of the accused's evidence was not only unchallenged but seems to us to be cogent and compelling. That is, that one cannot be averse to something, unless it has been previously experienced and associated with negative, repulsive feelings.”

Squires J also states.³³⁹

“It is also reinforced by the need to carefully scrutinise defences of this sort because of the ease with which they can be raised and the potential for mischief if they are upheld without sufficient and proper cause.”

After having regard to the evidence of Aman Soni, whom the court found to be a truthful witness, the court held that the accused's startled reaction at Soni's touch, his dazed appearance, babbling, incoherent talking, increasing panic at the realisation of what had happened, and the desire to distance himself from

³³⁸ At 335 l.

³³⁹ At 336 l.

knowledge and acceptance of it, were all part of the profile established by temporary inability of control explained by both the psychiatrist and psychologist.³⁴⁰

The court considered it impossible that a normally meek, obedient, loving, dutiful child would suddenly go berserk and slaughter his whole family, thereby bringing upon himself the very thing he feared most – separation from them – unless some unimaginable pressure pushed him to do so.

With regard to the expert evidence, Squires J noted³⁴¹ that the court was very impressed by the expert evidence. It explained in sensible, intelligible terms a phenomenon which lawyers, and probably most laymen, suspect. The experts accepted that they could be misled by the accused or anyone in that particular situation, but they were aware of that possibility and took steps to guard against it. By reason of comparing what the accused said and testing it against the surrounding circumstances they found his explanation to be supported and they were satisfied and even convinced that the accused was truthful and that this tragedy had occurred for the reasons which they explained.

Accordingly, the court held that a sufficient factual foundation had been laid which at least established a reasonable doubt as to the accused's criminal capacity at the time of the shooting. The accused was acquitted on all counts.

- Reflections on the *Nursingh* decision

It is abundantly clear by the statements by Squires J that much weight was attached to the expert evidence by the psychiatrist and psychologist in this case. It not only emphasises the intense need for expert evidence in cases of this

³⁴⁰ At 338 B-C.

³⁴¹ At 338 I-J-339 A. See also 339 A-C where Squires J held:

“In our law a man is responsible only for wrongful acts that he knows he is committing. Before he can be convicted of an offence, he must have the intellectual or mental capacity to commit it. That means an ability to distinguish between right and wrong and act in accordance with that appreciation. If that is lacking then obviously it follows he does not have the necessary capacity and it is for the prosecution to prove that he knew what he was doing.”

nature, but also indicates the importance of such evidence being led by both the prosecution as well as the defence. In this case the State did not lead any evidence of an expert nature, such as evidence of behavioural scientists, psychiatrists or psychologists to rebut the case of the accused. One would expect the prosecution to at least call one expert, whether it is a psychiatrist or psychologist to also conduct an examination and evaluation of the accused. The latter will either confirm or deny aspects pertaining to the truthfulness, credibility and consistency of evidence presented by the accused. The *Potgieter*-decision serves as an illustration of the importance of expert evidence being presented by both prosecution and defence.

According to Louw³⁴², the court in the *Nursingh*-judgment conflated the capacity test with intention as well as automatism. He refers to the following statement by the court:³⁴³

“The primary issue in the matter is whether, at the time and in the circumstances, in which he fired those ten shots, he had the mental ability or capacity to know what he was doing and whether what he was doing was wrongful. If he did, then a second issue fails to be considered, which is whether he could have formed the necessary level of intention to constitute the offence of murder.”

According to Louw, the court is incorrect in its formulation of the capacity test in referring to the capacity of the accused to know what he was doing and the capacity to know what he was doing was wrongful. The test for capacity is thus not defined correctly. Louw also refers to other references by the court where the court confuses intention and capacity.³⁴⁴

And also states:³⁴⁵

³⁴² Louw R “*S v Eadie: Road Rage, Incapacity and Legal Confusion*” (2001) *SACJ* vol 14 no 2 206-216 at 208.

³⁴³ At 332 E-F.

³⁴⁴ At 339 A-B. See note 341 *supra*.

³⁴⁵ At 339 D.

“That explosion (the shooting of the three deceased) was not the result of a functioning mind, so all its consequences can be regarded as unintentional.”

It should be borne in mind that the capacity enquiry precedes the intention enquiry and that if capacity is absent the enquiry ends and no further investigation as to intention is undertaken. Accordingly, intention and capacity should not be conflated as they are two distinct concepts. Capacity is also not an element of a crime whereas intention is an element of a crime.

11.4 Personality and character of the accused irrelevant when assessing the merit of the defence of non-pathological criminal incapacity

In *S v Kensley*³⁴⁶ the appellant stood trial in the Cape Provincial Division of the Supreme Court on two counts of murder, three of attempted murder, and a contravention of section 39(1)(m) of the Arms and Ammunition Act 75 of 1969, that is, handling a firearm while under the influence of liquor³⁴⁷. He initially pleaded not guilty to all of these offences, claiming to have suffered from amnesia, alternatively that he had temporarily lacked criminal capacity at the relevant time. The latter was not as a result of any mental illness or mental defect as contemplated by section 78(1) of the Criminal Procedure Act, but was attributable to non-pathological factors, namely a combination of severe emotional stress and intoxication. He was convicted of culpable homicide, murder, two counts of attempted murder as well as the charge under the Arms and Ammunition Act. The facts can be summarised as follows:

Adelaide de Sousa, then 18 years old, regarded Yolanda Jallahrs, then 16, as her best friend. Yolanda had been friends with two transvestites, usually called Brooke and Adele. Their actual names were Deon Brown and Adiel Bekko. They, however, dressed and disguised themselves as women and admitted to being homosexual. These four left for the Westridge City nightclub in the early hours of the morning of Saturday 20 May 1989. The four cadged a lift and arrived there

³⁴⁶ *S v Kensley* 1995 (1) SACR 646 (A). See also Boister, N “General principles of liability – case discussions – Non-pathological Criminal Incapacity” (1995) SACJ vol 8(3) at 367-368.

³⁴⁷ This Act has since be repealed by the Firearms Control Act 6 of 2000.

before closing time. Adelaide then saw an acquaintance, Randall Adams, and asked for transport home. He was there on his motorcycle, so he went to his friend, the appellant, who had arrived earlier by car, and asked him to oblige. It also appeared from the facts that the appellant and the woman, Celeste, with whom the appellant had a relationship and by whom he had a child, were experiencing problems that evening. The appellant agreed to provide a lift. The group moved off to Yolanda's home in Mitchells Plain, the appellant in his car with Shaun, his other friend, and the two genuine and two ostensible females, Randall following them on his motorcycle. The appellant and Yolanda went off on Randall's motorcycle to go and get appellant's tape recorder to provide music in the car. Two further car trips were undertaken, once to buy something to eat and later on to get another bottle of rum. On that particular occasion Shaun drove the appellant's car. The appellant was in the back seat petting Yolanda who had quite a lot to drink by then. The appellant suggested that they should go to the beach. He transferred his amorous attentions to Brooke, and on arrival at the beach, the pair of them left the car and disappeared into the bushes. Randall took a long swim. At about seven in the morning, they decided to return to Yolanda's home.

On the way to Yolanda's home, an argument arose among those seated in the back of the car about the fact that the transvestites were men, not women. It became progressively heated. When the car came to a halt the appellant and the two transvestites disembarked. The appellant was angered by the fact not only that they were men, but that his friends, Shaun and Randall, had kept him in the dark about this fact. Randall walked with Brooke and Adele intending to take Adelaide into the house when he heard a shot go off. He saw the appellant standing in the street at the car with the pistol in his hand. Then the appellant pointed the firearm at them. They scattered towards the house, Randall went over the garden wall and received a glancing wound in the back. Brooke, by then trying to gain entry to the house, turned and was shot in the stomach. Shaun came into the premises via the gate and knelt behind the wall. Adele heard him plead with the appellant not to shoot, but did not see the actual execution. Randall, as he lay wounded in the garden, saw the appellant follow Shaun in, repeatedly demanding to know why he had not been told that the two "girls" were men. He was extremely

angry, spoke in disjointed phrases, pointed the pistol at Shaun's head and despite Randall's shouted protest, fired.

Yolanda's death was the subject of the first count of murder, Shaun's of the second. The wounding of Randall and Brooke led to a conviction on two of the three counts of attempted murder. On the third count, based on the evidence of only Adele, who admitted to have been very drunk, the appellant was acquitted.

An order was made in terms of section 79 of the Criminal Procedure Act. The ensuing unanimous report in terms of section 79(4)(b), (c) and (d) was to the effect that the appellant was not mentally ill, nor certifiable in terms of the Mental Health Act and fit to stand trial in terms of section 77(1)³⁴⁸. It is accordingly important to closely scrutinize the expert evidence led in this case.

Dr Greenberg, leader of the panel of experts who had contributed to the assessment of the appellant after the period of observation conducted earlier at the Valkenberg Psychiatric Hospital, was called to testify for the state. Dr Greenberg was called as an expert witness in relation to the defence raised by appellant of non-pathological criminal incapacity at the time of the offences charged. The main thrust of Dr Greenberg's work and experience is forensic psychiatry. He made it clear that he was familiar with the content of the term "criminal capacity" but that this term as well as the word "automatism" in relation to persons not suffering from any pathology was legal terms and not psychiatric ones.³⁴⁹ He further explained that psychiatrists do recognise as pathology which could exclude "criminal capacity" as defined in law, outside factors such as a blow to the head, which would not render the recipient certifiable in terms of the Mental Health Act.

He was satisfied that, at the time of the events in question, the appellant suffered from no pathology recognised in psychiatry, he knew what he was doing and was capable of controlling his actions. Though his judgment had been impaired by the consumption of alcohol, his criminal responsibility was still intact. Dr Greenberg

³⁴⁸ At 652 E.

³⁴⁹ At 652 I.

provided reasons for doubting – though not excluding the possibility – that the appellant had developed amnesia subsequent to the events of the morning. He was of the opinion that poor recollection of the events that occurred could have been due to alcohol, to involuntary suppression of the memory, a defence mechanism precipitated by extreme stressful events, or to malingering. He explained that in the appellant’s case it was not due to any pathology, whether as understood by lawyers or by psychiatrists. There was no history of any loss of memory on previous occasions when the appellant had consumed alcohol, or at all. He explained³⁵⁰ that, had the appellant told someone that he had dreamed that he walked along the beach with a woman who turned out to be a man:

“... this could be explained in terms of a subjective recall of his experience, that is that he ...subjectively perceives the events as a dreamlike state because he was intoxicated and because he was emotionally laden ... but ... this is in fact memory recall of events which took place in ... circumstances of alcohol intoxication and related stress factors.”

Dr Greenberg regarded any subsequent amnesia irrelevant to the crucial issue as to whether the appellant at the time of the shootings was capable of appreciating the difference between right and wrong, and of acting in accordance with that appreciation. He stated that alcohol does not cause a person to behave in a particular way, it merely disinhibits him and lessens his concern with the consequences of his behaviour. In the same way factors such as anger or sexual arousal may motivate behaviour or explain how such behaviour could happen, so that the person might have certain impulses, which he would be able to control but choose not to control. He further stated that the liquor the appellant had consumed as well as his rage described by the witnesses, would not have robbed him of his freedom of choice but would have impaired his judgment, probably severely, as to the social consequences of his actions. The appellant’s comments during and immediately after the crucial events and his actions were all consistent with complex goal directed behaviour showing that the higher functions of the brain were involved.

³⁵⁰ At 653 D.

Under cross-examination Dr Greenberg³⁵¹ testified:

“There were factors which were important in the eventual behaviour of the accused ... These factors were the alcohol, the sexual disinhibition or ... probable sexual arousal, the anger of being deceived, the stress in the (appellant’s) personal life at the time surrounding these alleged offences, both financial and personal. I think these factors are all relevant in terms of the (appellant’s) mental state. However, in terms of his criminal responsibility, or his capacity to be responsible or appreciate his actions and act accordingly ... (this) was still intact.”

He also testified that for total loss of control due to intoxication, the intoxicated person would be so far gone that he would lack the ability to indulge in goal directed activity. When Dr Greenberg was asked as to the fact that the appellant’s conduct had been contrary to what was regarded as being his normal personality, Dr Greenberg said that little could be deduced from that. He concluded by saying that the situation in which the appellant had found himself that morning, was in itself not normal. With regards to the appellant’s allegation of amnesia, no direct evidence was presented by the defence to counter that of the State as to the events on which the charges were based.³⁵²

The main defence witness was Dr AF Teggin, a psychiatrist in private practice who assessed the appellant psychiatrically. Ms Park, a clinical psychologist in private practice, also performed an assessment on the appellant. The appellant was referred to Ms Park by Dr Teggin for a personality assessment. She spent between three and a half and four hours with the appellant in the course of two consultations. Her description of the appellant was as follows:³⁵³

“.....an emotionally restricted person who could tend to conform to the needs and expectations of others rather than experience ease in expression of his

³⁵¹ At 653 H-J.

³⁵² At 656 F.

³⁵³ At 657 D-E.

own feelings and emotional life; ... who used ... alcohol as a coping situation to cope with emotional stresses in any better way ...

His lifelong emotional suppression generated an escalation of unexpressed anger and resentments, which under normal situations remained within strong conscious control.”

The appellant’s conduct was described by the State witnesses to be in complete contradiction to this personality profile.

During cross-examination, Ms Park conceded that she had not consulted any collateral sources of information but relied on what the appellant himself had told her, that the team at Valkenberg Psychiatric Hospital had had better opportunities of assessing than she had and that her impression was that, though able at the time of the events in question to distinguish between right and wrong, the appellant “actually experienced quite a considerable degree ... (of) loss of control.”³⁵⁴ She expressed the possibility that the loss of control might have been total.

Dr Teggin met the appellant on three separate occasions, the duration of such sessions being approximately three to four hours. He had perused Ms Park’s report as well as that of Dr Greenberg. He submitted that the question of amnesia was a totally separate issue from that of criminal capacity and that the alleged dream to which the appellant testified was probably a partial memory.³⁵⁵

The major discrepancy between his and Dr Greenberg’s evidence, lies in the fact that in Dr Teggin’s view a person may consume alcohol to a point where even though aware of his surrounding circumstances, he loses self-control without necessarily being stuporose or comatose. Due to the fact that the appellant’s conduct had been quite out of character, he was of the view³⁵⁶ that the disinhibitory effect of alcohol brought this to the fore:

³⁵⁴ At 657 F.

³⁵⁵ At 657 G.

³⁵⁶ At 657 I.

“... a lot of emotional reactions which are not related in any way to the events of that evening but had in fact been bottled up over months, if not years.”

He further accepted the possibility in theory that in a situation of extreme anger an individual might be aware of what he is doing and that it is wrong, but in the same time lose all ability to control his actions.³⁵⁷ In Dr Teggin’s view, the appellant was probably aware of what he was doing but lacked control. Such loss of control may range from partial to total. Although it was for the court to determine where the appellant’s loss lay within that range, Dr Teggin was of the view that:

“... on the probabilities ... the accused was not able to stop himself.”³⁵⁸

In the course of the judgment Van den Heever JA noted³⁵⁹ that the onus in cases where criminal capacity falls to be assessed burdens the State to prove beyond reasonable doubt that an accused could not only distinguish between right and wrong but also that he or she was capable of acting in accordance with that distinction and those decisions cannot be construed in such a manner that the *ipse dixit* of an accused that in the given situation he or she was unable to control himself must lead to an acquittal.

Van den Heever in addition held³⁶⁰:

“Criminal law for purposes of conviction – sentence may well be a different matter – constitutes a set of norms applicable to sane adult members of society in general, not different norms depending on the personality of the offender. Then virtue would be punished and indiscipline rewarded: the

³⁵⁷ When Dr Teggin was asked as to why he refers to that as a theoretical possibility he stated: “Where I see that in its commonest situation is men who beat up their wives, usually in a situation of alcohol intoxication coupled with feelings of jealousy which may be morbid jealousy. And I have often had this described to me by such men who are extremely remorseful thereafter and will describe how they were carried away in rage and were beating their wife in a goal-directed way, inflicting damage to her, but completely unable to stop themselves.”

³⁵⁸ At 658 D.

³⁵⁹ At 658 F-J.

³⁶⁰ *Ibid.*

short tempered man absolved for the lack of self-control required of his more restrained brother. As a matter of self-preservation society expects its members, even when under the influence of alcohol, to keep their emotions sufficiently in check to avoid harming others and the requirement is a realistic one since experience teaches that people normally do ...

It follows that the evidence, on which a defence of sane criminal incapacity due to intense emotion is based, should be viewed with circumspection.”

Van den Heever JA held that from the evidence it was clear that the appellant was very angry. It was also held that the evidence painted a picture of goal-directed behaviour which was sufficiently complicated as was also pointed out by Dr Greenberg and which required conscious intellectual effort. It was further found that Dr Teggin’s evidence that the appellant’s goal-directed behaviour showed impaired control rather than total loss of control was founded primarily on the fact that the appellant’s conduct was completely out of what he perceived to be the appellant’s character.³⁶¹ It was held that one cannot state what his “normal” reaction should be in a totally abnormal situation.

The court accordingly held that in the circumstances the State had discharged its onus and the appellant had been correctly convicted. The court held further that the trial court had not erred in imposing the sentence or in holding that a non-custodial sentence would not take adequate account of the appellant’s misconduct or satisfy the natural indignation of society at such conduct. The appeal was dismissed.

- Reflections on the *Kensley*-decision

This decision serves as a confirmation that the *ipse dixit* of an accused is not sufficient for a successful reliance on the defence of non-pathological criminal incapacity. A proper foundation has to be established. It goes without saying that

³⁶¹ At 659 G.

in order to establish a sound factual foundation, expert psychiatric evidence is of pivotal importance.

Another important aspect of the *Kensley*-decision is that Van den Heever JA noted that the expert called on behalf of the appellant, Dr Teggin, based his opinion to a great extent on what he perceived to be the character of the appellant. Dr Teggin also stated that the appellant's conduct on the day of the shooting had been atypical in that he had never reacted this way. It is clear from the report that this evidence was hardly convincing. The court favoured the evidence of Dr Greenberg. Van den Heever JA, as mentioned above, also noted that Criminal Law cannot set different norms depending on the personality of the offender.

Boister³⁶² submits that what Van den Heever JA appears to have been saying in the *Kensley*-decision is that an offender's personality defects will not be operative in establishing a defence of non-pathological criminal incapacity. Instead, his lack of self-control in difficult situations is tested against the assumed capacity of the rest of the members of society to control themselves in such situations – his subjective inability is measured against a normative standard. The question that could be asked is whether the subjective enquiry into criminal capacity should pave a way for a normative evaluation – that is where the conduct of the accused is measured against a standard of reasonableness – thus how a reasonable person would have acted under the same emotional stress.

11.5 Sane automatism distinguished from non-pathological criminal incapacity – expert evidence should pertain to the particular defence raised

In *S v Moses*³⁶³ the important role of expert evidence was again emphasised. This case provides an excellent example of the weight attached to expert evidence as well as the principle of the court properly weighing the expert evidence of the

³⁶² Boister (1995) *SACJ supra* note 346 at 368.

³⁶³ *S v Moses* 1996 (1) *SACR* 701 (C).

defence to that of the State in reaching an informed decision. The facts were the following:

The accused, Mr Christopher Ralph Moses, aged 24, was indicted on two charges, namely murder and robbery. He pleaded not guilty to both. His plea statement in terms of section 115 of the Criminal Procedure Act was handed to the court. In his plea he admitted that he killed Gerhard Pretorius, the deceased, on 27 January 1995. He stated that he was extremely provoked by the deceased who told him that he (the deceased) had Aids just after they had unprotected anal intercourse. He was provoked to an extent that he lost control over his actions. He thus raised provocation and more specifically non-pathological criminal incapacity as a defence. The accused was acquitted on the robbery charge as there was insufficient evidence in that regard.

The deceased was killed by the accused on Friday 27 January 1995 at his flat in Sea Point. His body was discovered by Mr Hawtey, the caretaker at Selbourne Flats, Rocklands Road, Sea Point on Tuesday 31 January 1995. The following facts were common cause:

- (a) That the deceased and the accused were homosexual lovers;
- (b) that the deceased was HIV positive even though there was no evidence that he had full blown Aids;
- (c) that the post-mortem examination on the corpse of the deceased was performed by Professor Knobel on 1 February 1995;
- (d) that the deceased suffered no further injuries subsequent to the infliction of the wounds until such time as an autopsy was performed on the deceased; and
- (e) that the deceased died as a consequence of an incised wound of the throat through the larynx and an extensive head injury and the consequences thereof.³⁶⁴

³⁶⁴ At 702 F-H.

The accused was one of seven children. After he matriculated he obtained a bursary to study law and also obtained entrance at the University of the Western Cape. He could not complete his studies due to the fact that both of his sisters fell pregnant and consequently he had to support his family.

The accused was sexually abused by his father as a child. He also testified that when he was young he was “daddy’s little boy”, his favourite in the family³⁶⁵. He did not, however, reveal this abuse to his mother because he feared that his father would assault his mother as he did on previous occasions. The accused was also a child prostitute for a long period. When his father passed away, the accused was overcome by feelings of anger and betrayal towards his father. It was also common cause that the accused was homosexual. When he divulged this to his mother at the age of 21, she was very upset about it and told him to leave the common home and never return again. The accused was very angry about this as he felt that he had sacrificed his future for his family. Thereafter he went into a rage and literally smashed his mother’s house. He also tried to cut his wrists as he did not feel like living anymore and he felt that his family had not appreciated what he had done for them. The accused also at one stage smashed his car. The result was that the car was a write-off. After he had been kicked out, the accused was practically homeless. Sometimes he would sleep in the streets and at one stage he also stayed in a shack³⁶⁶.

The accused met the deceased at the beginning of November 1994. They developed a relationship. It was physical to a point, but there was no physical penetration. The deceased showed love and concern and the accused saw the deceased as an escape route from his past. The deceased indicated to the accused that he wanted to go overseas at the end of 1995 or beginning of 1996. The accused then proposed to buy a car from the deceased, but the accused had no money at that stage. The deceased was willing to sell the car to the accused if the accused would sleep with him. The accused and the deceased signed an agreement of sale in terms of which the car was sold to the accused for R12 000.

³⁶⁵ At 702 I-J.

³⁶⁶ At 703 I-J.

On the night in question both the accused and the deceased went to the deceased's flat. The accused went to the deceased's flat in order to provide the deceased with his part of the deal, which was sexual intercourse. The deceased consumed liquor and the accused only a soft drink. They kissed and hugged whereafter they proceeded to the bedroom. The deceased anally penetrated the accused. This was a very painful experience to the accused to the extent that he pushed the deceased off. The deceased then suddenly blurted out that he had Aids. Thereafter the accused became very angry as he thought that he would die a horrible death. He testified that he was not sure of everything that went through his mind but he was angry and he felt much betrayed as he had loved the deceased. He then reached for an ornament next to the door. As he picked it up the ornament broke and he let it go. He was angry at that time because he hated the deceased for abusing his trust and not confiding in him that he had Aids. The experience of that night reminded him of how he was sexually abused by his father in the past. He then ran to the lounge and picked up a black cat ornament. He went back to the deceased in the bedroom. At that time the deceased was motioning backwards towards the bed as the accused moved in. The accused hit him on the head with the cat. As he hit the deceased the thoughts were still flooding his mind. He was thinking of how he was going to die a horrible death and that his future had come to an end. He even thought of not living anymore. He did not feel in control of things at that stage. He testified that he could see what he was doing, but that he could not control himself³⁶⁷. The accused struck the deceased twice with the black cat ornament. The accused then ran to the kitchen and got hold of a small knife. He ran back to the deceased's bedroom. The deceased at that time was in the process of getting up. The accused stabbed the deceased in his side while the latter attempted to get up. The deceased moved his hand as if to strike him. The accused then ran back to the kitchen and got hold of a big knife. Thereafter he ran back to the deceased's bedroom and cut the deceased's throat and wrists.

The accused testified that when he cut the deceased's throat and wrists, he could see what he was doing but he could not stop himself³⁶⁸. The accused also

³⁶⁷ At 705 G-H.
³⁶⁸ *Ibid.*

testified that after seeing that the deceased was dead he was shocked at what he did. After a while he got into the car and drove off. As he drove towards Hout Bay, he picked up a hitchhiker near Camps Bay, Mr Laubscher. He asked Mr Laubscher whether or not he was willing to engage in oral sex with him. Mr Laubscher refused and the accused dropped him off and drove home.

With regards to the credibility of the accused, the court per Hlope J was satisfied that he made a favourable impression and that his evidence was favourable, reliable and truthful.³⁶⁹

In support of the defence of non-pathological criminal incapacity flowing from extreme provocation, the defence led two expert witnesses, namely Mr Yodaiken, a clinical psychologist and Dr Gittleson, a psychiatrist. It is necessary to first discuss Mr Yodaiken's evidence.³⁷⁰

Mr Yodaiken testified that he is a practising clinical psychologist who has been practising as such for 20 years. He is used to forensic work and has appeared in custody matters, murder trials and fraud cases. He testified that he had conducted various interviews with the accused, Mr Moses, amounting to at least ten hours of quality time³⁷¹. He also told the court that three psychometric tests were conducted with the accused. These were Thematic Apperception Tests, which was administered by Ms DC Hargovan (also a clinical psychologist), the Milton Clinical Multi-axial Inventory-II as well as the Rorschach Ink Blot Test. The psychometric results revealed that the accused derived from a dysfunctional family background characterised by violence, sexual abuse, absence of boundaries and insufficient parental controls. The accused displayed a rage from a very early age when he was about two or three. He also testified that the accused suffered from a borderline personality disorder. Mr Yodaiken further observed that the accused's relationships were characterised by a strong need for affection with a fear of rejection. As soon as he believes that he is being rejected, he reacts with rage.

³⁶⁹ At 708 B-F.

³⁷⁰ At 708 H-J and 709 A-I.

³⁷¹ At 708 G-J.

Mr Yodaiken further testified that the accused is extremely impulsive and has difficulty in controlling his impulses³⁷². He was clearly a disturbed personality who suffered due to his background. When provoked his controls do break down and he discharges in a raged and uncontrolled manner. As a result of his personality structure, the accused would be easily provoked particularly when he himself is vulnerable as a result of stress, anxiety, depression or when he is affectionately attached to another. Mr Yodaiken stated that the difference between a normal personality and the accused lies in the vulnerability to the stimulus and the emotional and impulse controls³⁷³. In the accused's case he was likely, if and when extremely provoked, to have known what he was doing but would have been unable to stop himself.

Mr Yodaiken told the court that the accused had formed an attachment with the deceased during the two months in which they had known each other³⁷⁴. The deceased was kind, considerate and caring. He provided the accused with many of the experiences which he had longed for and the accused attached affectionately to him. In this attachment, which is characteristic of his personality, he had come to idealise the deceased who he perceived to be the ideal person. When the deceased accordingly told him that he had Aids, this would have completely destroyed the image and trust that the accused had built up of the deceased and, in the light of the accused's personality, the impact of this was in all likelihood so devastating that it collapsed his controls.

Mr Yodaiken did not contend that the accused was acting in a state of automatism during the killing. When asked to comment on the different weapons used to inflict injuries on the deceased, he stated that to him the two acts, that is hitting the deceased with a blunt object and the stabbing, were in fact one³⁷⁵.

³⁷² At 709 B-C.

³⁷³ At 709 C-E.

³⁷⁴ At 709 E-F.

³⁷⁵ At 709 H-I.

It is now important to take a look at Dr Gittleson's evidence.³⁷⁶ Dr Gittleson compiled a comprehensive report. His evidence corroborated that of Mr Yodaiken in material respects. Dr Gittleson told the court that immediately prior to the killing the accused was feeling sad. Dr Gittleson testified that he believed that the accused knew what he was doing at the time of the killing. He would have had the capacity to foresee that the deceased would be killed. However, his capacity to exert the normal degree of control over his actions and also to consider his behaviour in the light of what was wrong was significantly impaired at the time of the killing.

Dr Gittleson further testified that the accused was in a state of rage and the reason for the rage was that he felt devastated by what the deceased had told him. He was also extremely hurt by the manner in which the deceased had made love to him. It left him in pain, abused and not loved by the deceased. He also testified that less consciously the accused was reacting not just with a sense of rage at what the deceased had done, but the deceased's conduct also triggered feelings that belonged to his relationship with his father. Dr Gittleson stressed that it was a combination of the factors alluded to above together with the "extraordinary stimulus", namely being told by the deceased that he had Aids, which led to a state of rage reaction.

Dr Gittleson described the extraordinary stimulus as follows:³⁷⁷

"It was not a trigger that would be part of a normal living. I don't know how many people have experienced the situation where they have been first of all made to feel bad about a sexual experience they have just had. He felt abused. He felt that he was not gentle, not caring, unloving and then to be told by his partner that the partner has Aids. I mean I find that extraordinary. I don't think that many people have ever been in such a situation. ... I think everybody would react with varying degrees of anger, and just how much anger depends on that individual person."

³⁷⁶ At 709 J and 710 A-J.

³⁷⁷ At 710 G.

Dr Gittleson testified further that when a person is in a state of rage one's capacity to retain control is definitely impaired³⁷⁸. With specific reference to the accused, it was possible for a state of rage to have continued to such a degree that loss of control or partial loss of control, lasted throughout the time that the killing took place. During the killing the accused's capacity to stop himself and to control his behaviour in accordance with what he knew was right and wrong, was impaired. Dr Gittleson also stated that a rage episode would rarely last for longer than minutes and that once that episode of minutes is over, a person can quite quickly revert to a relatively normal level of functioning.

Against the evidence of Mr Yodaiken and Dr Gittleson, was the evidence of Dr Jedaar, the state psychiatrist attached to the forensic unit at Valkenberg Psychiatric Hospital. After the defence led expert evidence, the State applied to reopen its case in order to lead expert evidence in rebuttal in which event Dr Jedaar testified. Dr Jedaar's evidence was the following:³⁷⁹

He testified that a person can never lose control except in a state of automatism, or other pathological states. He testified that the ability to appreciate the wrongfulness of an act is a cognitive function. Conduct in a state of automatism is automatic, involuntary, reflexive, uncontrolled, unconscious and not goal-directed or motor-controlled where the person is in a dissociative state. A state of automatism also requires a trigger event which unleashes an overwhelming response and automatism is followed by total amnesia because of the fact that the person is not able to register his conduct during the state of automatism.

Dr Jedaar concluded that the accused had the cognitive appreciation of the wrongfulness of his conduct in the killing of the deceased and was intellectually aware of the right-or wrongfulness of his conduct. Dr Jedaar stated that the accused's conduct during the killing was not uncontrolled or involuntary and the killing was not committed during a state of automatism. Dr Jedaar referred to the accused's conduct at the time of the killing and testified that each and every one of the acts amounted to conscious goal-directed and controlled behaviour which was

³⁷⁸ At 710 H-I.
³⁷⁹ At 711 C-J.

not consistent with a dissociative state and accordingly did not fulfil the criteria for sane automatism.³⁸⁰ With regard to the evidence of Dr Jedaar the court per Hlope J held the following:³⁸¹

“The problem with Dr Jedaar’s evidence, with respect, is that it flies in the face of South African law. According to our modern law, criminal capacity has two legs, namely the ability to decide between right and wrong (that is the cognitive appreciation), and the ability to act in accordance with that appreciation. Mr Moses’ defence is that, due to extreme provocation, he was unable to control himself. It was never part of his defence that he could not appreciate what he was doing. He could appreciate what he was doing but he could not stop. He was provoked to an extent that he lost control over his actions, that is non-pathological criminal incapacity which is a recognised defence in South African law.”

The court held the following with regard to the weight attached to the expert evidence:³⁸²

“In our view the evidence of Mr Yodaiken and that of Dr Gittleson is preferable to that of Dr Jedaar. Both defence experts are independent and have investigated the accused’s background extensively and spent far more quality time than Dr Jedaar. Dr Jedaar, as has been pointed out above, also made important concessions such as that the accused is suffering from a personality disorder. He conceded that a person who suffers from such

³⁸⁰ With reference to the accused’s conduct Dr Jedaar referred to the following acts:

- (1) Attempting to pick up an ornament in the bedroom.
- (2) Running to the lounge to find another weapon.
- (3) Picking up the black cat ornament.
- (4) Returning to the bedroom with the ornament.
- (5) Forcing open the door of the bedroom.
- (6) Hitting the deceased twice with the ornament.
- (7) Running to the kitchen to find another weapon.
- (8) Picking up a knife in the kitchen.
- (9) Returning to the bedroom with the knife.
- (10) Stabbing the deceased with the knife.
- (11) Running back to the kitchen to locate yet another weapon.
- (12) Finding a larger knife.
- (13) Returning to the bedroom with the knife.
- (14) Cutting the deceased’s neck and wrists.

³⁸¹ At 712 A-B.

³⁸² At 712 H-I.

personality disorder would have a fluctuation of mood state with frequent expressions of anger.

... the main problem with Dr Jedaar's evidence is that it flies in the face of South African law and that the bulk thereof was directed at showing that the accused did not act in a state of sane automatism at the time of the killing. That is not the issue. To a large extent therefore, his evidence was not much help to this court. We therefore have no hesitation in rejecting Dr Jedaar's evidence and accepting that of the defence experts.

In our view a proper basis for accepting defence experts' evidence has been laid."³⁸³

With regard to criminal incapacity Hlope J noted that it has repeatedly been reiterated that defences such as amnesia, automatism and non-pathological criminal incapacity should be carefully scrutinised³⁸⁴. The fact that the latter defences are supported by medical evidence, although of great assistance to the Court, will not necessarily relieve the Court from its duty of scrutinising them carefully. The latter is due to the fact that such medical evidence is often based upon the hypothesis that the accused has given a truthful account of the events in question³⁸⁵.

The court rejected the State's argument to the effect that the accused did not act in a state of sane automatism and held that it bared no relation to the case.

The court in this case takes a firm stance that the test for criminal capacity is purely subjective:³⁸⁶

"Thus the law is clearly to the effect that where provocation and emotional stress are raised as defence, it is a subjective test of capacity without any normative evaluation of how a reasonable person would have acted under

³⁸³ At 712 J-713 A.

³⁸⁴ At 713 B.

³⁸⁵ *Ibid.*

³⁸⁶ At 714 B.

the same strain and stress. What matters is what was going through the accused's mind at the relevant time.”

The court accordingly made the following findings³⁸⁷:

- (a) That the accused has a history of poor control and anger.
- (b) That the accused killed a person whom he cared for and saw as a “way out” of his past. He clearly had no motive to kill the deceased and it was not a premeditated killing.
- (c) The killing itself was a crystallisation of a number of factors such as the suppressed anger relating to the accused's dysfunctional family background and sexual abuse by his father, equating the deceased with his father and the sense of betrayal, the accused's vulnerability at the time of the killing, his symptoms of severe depression and the belief that he would die a horrible death.
- (d) The expert evidence by Dr Gittleston and Mr Yodaiken and the vital concessions made by Dr Jedaar supported a finding that it was reasonably possibly true that the accused lacked capacity at the time of the killing.
- (e) The State had failed to discharge the onus resting on it to prove beyond reasonable doubt that the accused had the requisite criminal capacity.
- (f) The accused was acquitted.

It is clear that this case did not centre on the first leg of the inquiry into criminal capacity. The guilt or innocence of the accused rather focused on the question as to whether the accused could control his action or not. Accordingly it focused on the conative function of the mind.

- Reflections on the *Moses*-decision

Various authors have commented on the *Moses*-decision given by Hlope J. The main arguments will be summarized.

³⁸⁷ At 714 D-H.

It is interesting that Boister³⁸⁸ discusses the importance that the psychologist and psychiatrist, who gave expert testimony on behalf of the appellant, attached to the effect the deceased's revelation of his HIV status had on the accused. When the deceased told the accused that he had Aids it completely destroyed the trust and image that the accused had built up of the deceased. As Boister notes, the defence psychiatrist described it as a combination of factors coupled with the "extraordinary stimulus" of being told by the deceased that he had Aids which led to a state of rage reaction.³⁸⁹ The psychiatrist called by the State was, however, of the opinion that a person can never lose control except in a state of automatism, and it was clear that the accused was not operating in a state of automatism. Accordingly, if one views this contention it means that while the accused was still able to function cognitively or understand what he was doing, he was also functioning cognitively or executing a choice when he chose to kill the deceased.³⁹⁰ This argument thus denies the defence of criminal incapacity. Hlope J, however, noted:

"... it flies in the face of South African law."³⁹¹

According to Boister³⁹² the court's circular reasoning in this regard ignores the fact that the defence of temporary non-pathological mental incapacity is rooted in psychology. Boister notes that the crucial aspect of the defence of temporary non-pathological criminal incapacity is not its psychological validity but its legal validity.³⁹³

According to De Vos³⁹⁴ the judgment in *Moses* seems to conflate two different scenarios: on the one hand, the case where an accused, owing to his volatile and emotional nature, acts criminally because of a lack of sufficient self-control, and, on the other where an accused through a long series of events, finds him or herself in a state where there has been a complete disintegration of his or her

³⁸⁸ Boister, N "General Principles of Liability" (1996) *SACJ* at 371-372.

³⁸⁹ At 710 G (as quoted in the discussion of the decision in *Moses supra*).

³⁹⁰ Boister (1996) *SACJ supra* note 388 at 372.

³⁹¹ At 712 A.

³⁹² Boister (1996) *SACJ supra* note 388 at 373.

³⁹³ Boister (1996) *SACJ supra* note 388 at 373.

³⁹⁴ De Vos, P "S v *Moses* 1996 (1) SACR 701 (C) – Criminal capacity, provocation and HIV" (1996) *SACJ* at 354.

controls and therefore a lack of criminal capacity. According to De Vos the reason for this confusion can be found in the court's misunderstanding of the true nature of the second leg of the criminal capacity test, in other words the conative aspect of criminal capacity. According to De Vos, this conative function of the mind which, when affected, excludes capacity, must be distinguished from the affective function of the mind which, when affected, does not automatically have any influence on the criminal capacity of the perpetrator. The affective function relates to a person's feelings and emotions and range from the pleasurable or unpleasant, barely perceptible, feelings of hopeful anticipation or disappointment to the most intense emotions of hatred, fury and jealousy. Where a person's affective function has been influenced by provocation or other factors it will not have a direct bearing on the criminal capacity of the accused. De Vos contends that the court failed to make a distinction between uncontrollable actions (which must lead to acquittal) and actions which are controllable, but which the accused failed to control. He accordingly submits that a person can only lack criminal capacity if it is found by the court that his actions were uncontrollable due to a complete disintegration of his emotions³⁹⁵.

According to De Vos the fact that Moses ran to the lounge and picked up the ornament, the fact that he later went to the kitchen to fetch a knife and again later went back to the kitchen to fetch a bigger knife, were all clear indications that a volitional element was present in Moses' actions. De Vos notes:³⁹⁶

“Never before in a South African court has a man been acquitted of murder where he flew into a sudden fit of rage and then systematically set about killing his victim. Never before, in the long line of cases in which the non-pathological criminal incapacity defence was developed, has a person been acquitted who became emotionally disturbed for only a brief period before and during the act. In case after case in which the defence was raised, or in which the court was prepared at least to consider it seriously, X's act was preceded by a very long period – months or years – in which his level of emotional stress increased progressively.”

³⁹⁵ *Ibid.*

³⁹⁶ At 358.

According to De Vos, the acceptance of the *Moses*-decision will give rise to a great danger that the non-pathological criminal incapacity defence will be abused by quick tempered individuals who would claim that they lacked criminal capacity as a result of being provoked³⁹⁷. Volatile members of society could then accordingly be acquitted for acts perpetrated in a state of rage when the law should in effect aim to punish those who fail to control their impulses and infringe upon the rights of others in the process³⁹⁸.

According to De Vos the court erred in its acquittal of Moses on the basis of an absence of non-pathological criminal incapacity. He submits that from the evidence of the expert witnesses, which was Dr Gittleson and Mr Yodaiken, Moses had diminished self-control and therefore diminished capacity, and should have been convicted³⁹⁹. He refers to the testimony of Mr Yodaiken who testified that the impact of the deceased telling the accused that he was HIV positive was in all likelihood so devastating that it collapsed his controls and although he might have known what he was doing, he would have been unable to stop himself. According to Dr Gittleson, his capacity to exert the normal degree of control over his actions and also to consider his behaviour in the light of what was wrong was significantly impaired at the time of the killing. According to De Vos Moses was acquitted because his control over his actions was significantly impaired, not because it was completely absent⁴⁰⁰.

De Vos's argument holds merit if one views the evidence of Moses after the revelation of the deceased's HIV status. It must be borne in mind that the psychiatrist and psychologists testifying in a matter such as this, can probably very seldom state a definite yes or no, in this case whether Moses's control over his actions was completely absent or sufficiently impaired, in order for the second leg to fall away and subsequently to result in the absence of criminal capacity. Each case has to be considered on its own merits. It is a pity that the expert evidence put forward on behalf of the State was not canvassed in a more appropriate

³⁹⁷ De Vos (1996) *SACJ supra* note 394 at 358.

³⁹⁸ *Ibid.*

³⁹⁹ De Vos (1996) *SACJ supra* note 394 at 359.

⁴⁰⁰ De Vos (1996) *SACJ supra* note 394 at 359-360.

manner. “Significantly impaired” could, however, also be construed as sufficiently enough to render the second leg of the capacity test to fall away. The latter is merely an alternative perspective to gather more clarity as to the approach most probably applied by the court in this regard. It should also be borne in mind that this illustrates the principle that the court should draw its own inferences from the psychiatric evidence tendered. The psychiatrist or psychologist tendering expert evidence are merely assisting the court in delivering judgment and are not appointed to deliver judgment on final issues which only the court can decide upon.

With reference to both the *Nursingh*-decision as well as the *Moses*-decision in respect of the provocation defence, Louw⁴⁰¹ takes the view that in both these cases the series of goal-directed acts constituted only one act in each case. In the *Nursingh*-judgment the court noted:⁴⁰²

“... nor was it possible ..., to distinguish between the three killings on the basis that the mother had caused, provoked the reaction more than the others. It was one and the same eruption, that resulted in the three separate acts. It is really as though one explosion achieved all three deaths.”

In the *Moses*-decision the court noted:⁴⁰³

“Mr Yodaiken did not contend that the accused was acting in a state of automatism during the killing. On being asked to comment on the different weapons used to inflict injuries on the deceased, he stated that to him the two facts, that is hitting the deceased with a blunt object and the stabbing, were in fact one. The accused was in an annihilatory rage, a rage which tends to damage or destroy.”

Louw notes that there are at least fourteen instances or factors indicative of goal-directed behaviour.⁴⁰⁴ According to Louw it is outrageous to describe all of these

⁴⁰¹ Louw (2001) *SACJ supra* note 1 at 212-213.

⁴⁰² *S v Nursingh supra* note 1 at 339 C-D.

⁴⁰³ *S v Moses supra* note 1 at 709 H-I.

acts as one in both the *Nursing* as well as the *Moses*-decisions. According to Louw, the correct finding in both of these cases might have been to find that the accused's capacities were diminished but not absent. Louw also refers to the evidence of the expert, Dr Gittleson, where he stated that the accused's capacity to exert normal control over his actions and also to consider his behaviour in the light of what was wrong, was significantly impaired at the time of the killing.⁴⁰⁵ The word "impaired" in this context, as stated above, does lead to a possible inference of diminished capacity, rather than lack of capacity. What is further distinctive of this decision is that it is the first case in which a provocation defence resulted in an acquittal where there was no long-term abuse of the accused preceding the killing, either by the deceased or at all.⁴⁰⁶ In most of the previous judgments, the final provocative act was the final incident in a long history of abuse.

It should be stressed once again, that in cases involving the defence of criminal incapacity, both the State as well as the defence should retain psychiatric experts to properly assess the accused in order to enlighten the court as to the frame of mind, emotional make-up as well as the particular personal characteristics of the accused at the time of the crime. In the *Moses*-decision, the expert evidence from the State was not strong enough to oppose the expert evidence of the defence. Louw's article will be discussed more elaborately at a later stage when the *Eadie*-judgment is discussed as this article is canvassed on the backdrop of the decision by Navsa JA.

11.6 Criminal incapacity should not be confined to a state where mental illness or mental defect is present – emotional factors can also lead to a lack of criminal capacity

⁴⁰⁴ Louw (2001) *SACJ supra* note 1 at 214.

⁴⁰⁵ At 710 C-D. Louw (2001) *SACJ supra* note 1 at 215.

⁴⁰⁶ Louw (2001) *SACJ supra* note 1 at 215 and also 216 where he notes: "The acquittal in *Moses* leaves us with a dangerous precedent. In future, whenever a person flies into an "annihilatory rage" and kills somebody, irrespective of the reason for the rage and the relationship between the accused and the relationship between the accused and the deceased, the killing will be permissible. This subjects society to the whims of the short-tempered. This is wrong. If we follow *Moses* then, unlike in *Eadie*, those who kill in circumstances of road rage, can expect to be acquitted."

In *S v Gesualdo*⁴⁰⁷ the facts were as follows. The accused was charged with the murder of Hugo Fernandez. The accused and the deceased were both Spanish speaking Argentinean immigrants who had come to South Africa in search of a better life and met soon after the accused's arrival in South Africa. The accused had left his wife and four children in Argentina when he came to South Africa and he cared for them deeply. The evidence revealed that the deceased was a dynamic person with many ideals for the making of large sums of money. The accused and the deceased decided to venture into business together. They intended to manufacture a certain type of slipper, buttons and babies' dummies. The concept of the slipper was that of the accused and accordingly the sample from which they intended to work was supplied by him. Pursuant to the manufacturing he took time off from work to prepare designs and also borrowed money and expended his own savings in developing the project. The relationship between the accused and the deceased, however, deteriorated. A witness, Mr Molina, who was employed by the deceased, stated that the deceased's greed destroyed the project. The deterioration of their relationship was aggravated by the fact that the deceased was determined to cut the accused out of the slipper project. The deceased registered what was referred to as a patent for the slippers in his own name and, when confronted by the accused, stated that the accused did not have any funds to pay for the registration and had thus been excluded from it⁴⁰⁸. This was done despite the fact that the accused had already invested considerable funds of his own in the development of the project.

As the business relationship between the two deteriorated, so too did the accused's composure and mental state. They had engaged in public arguments and the deceased resorted to foul language. There were stormy conversations on the telephone. The deceased had threatened the accused, which resulted in the accused visiting the police for assistance. Two days before the shooting the accused was involved in a discussion with the deceased and became very angry. In the presence of a witness, Mr Molina, he said he would visit the deceased at his factory the following day and that whatever happened, Mr Molina should not get

⁴⁰⁷ *S v Gesualdo* 1997 (2) SACR 68 (W). See also Boister, N "General Principles of Liability" (1997) SACJ at 315-318.

⁴⁰⁸ At 71 C-E.

involved. Mr Molina further testified that the accused's anger had been building up progressively as a result of the deceased's behaviour⁴⁰⁹. The two experts, Mr Carr and Dr Vorster, testified that the accused's condition at that stage could be described as deranged⁴¹⁰.

The accused testified that on the morning of the shooting he drove around aimlessly. He had his firearm on him. From the time he arrived at work he recalled breaking a machine but recalls nothing of the shooting incident. Mr Molina testified that the accused entered the deceased's premises carrying a packet in his hand. He pulled a firearm from it and pointed it at the deceased. The deceased taunted the accused and challenged him to discharge the firearm. The accused shot and killed the deceased and pointed the firearm at Mr Molina before running away. The accused was found several hours later wandering around and he did not appear to comprehend why he was being arrested. Mr Molina testified that the accused at the time of the shooting "... seemed totally out of his mind."⁴¹¹

Mr Molina also explained that he believed that the accused was very angry and not in control of himself. The accused was thereafter referred for psychiatric observation for a period of thirty days which was later renewed for a further thirty days. He was examined repeatedly by Dr Vorster and another psychiatrist. The two psychiatrists had no difficulty in certifying the accused free from mental illness and fit to stand trial.

Dr Vorster, who was in court throughout the proceedings together with Mr Carr, who examined the accused much later, agreed with many of Mr Carr's findings. The most important findings of Dr Vorster were:⁴¹²

- No mental illness existed but the accused was in such a state, or so emotionally overwrought, that Dr Vorster was of the view that at the time of

⁴⁰⁹ At 71 H-I.

⁴¹⁰ At 72 C-D.

⁴¹¹ At 73 C.

⁴¹² At 74 B-E.

the shooting he was in a state of diminished responsibility. She could not state the degree thereof.

- There was no reason to doubt the accused's honesty, and it was accepted that he was suffering from amnesia which extended to early on the morning prior to the shooting. It was stated that it does not follow from this fact that he was not criminally responsible for his actions at the state of shooting for the amnesia could have been psychogenic. It may thus have had its origin in psychological causes and may have intervened after the shooting as a mental reaction thereto.
- The accused has a repressive personality. Mr Carr's evidence on the other hand was that this manifests itself as a person who is calm and mild on the surface, who avoids confrontation and may seem tolerant and passive, but who represses these feelings to the extent that when the last straw is laid on the camel's back, he may suddenly explode with unexpected and extreme violence.
- The accused demonstrated great remorse for what he had done.

The court, per Borchers J, held that the central issue in this case was whether the accused had criminal capacity and was thus responsible for his actions at the time of the shooting. Borchers J noted:⁴¹³

"It is for the accused to lay some basis for the defence of lack of criminal capacity, whereupon the State assumes the onus of proving beyond reasonable doubt that the defence is not reasonably possibly true. Any reasonable doubt which exists on an overview of all the evidence, including that of the expert witnesses, must redound to the accused's favour."

And further:

"It goes without saying that a defence of this nature must be carefully scrutinised by the court, and that a court would be unlikely to find that such state may have existed only by virtue of the accused's *ipsissima verba*.

⁴¹³ At 74 F-G.

Nonetheless, this defence is on the same footing as any other defence available to the accused. He carries no onus to prove it.”

It was found that a sufficient basis had been laid in this case.

Mr Carr, who testified on the accused’s behalf, agreed that the accused suffered from no mental illness nor any physical cause which could have resulted in his losing control of himself⁴¹⁴. He was of the view that it was possible that the accused, at the time of the shooting, had been able to draw the necessary distinction between right and wrong and was thus, to some extent, aware of what he was doing but, he said, it was possible that the accused had not been able to act in accordance with this distinction because, due to emotional causes, he had lost control of himself. He motivates this view by stating that the act itself was out of character with the accused’s usual behaviour though not unexpected in a person with a repressive personality. He stated that the background and build up to the offence had resulted in the accused’s emotions being too high for his rational thought processes to contain them.⁴¹⁵ Borchers J held that the accused was a truthful witness.⁴¹⁶

Dr Vorster was called by the State at the close of the defence’s case in order to present her view on the accused’s state of mind at the time of the shooting. Her views were the following:⁴¹⁷

- The accused was not in a state of automatism as he was capable of performing complex actions, taking decisions, and the acts he performed were goal-directed.
- Dr Vorster expressed the view that the accused was in a position to distinguish between right and wrong.

Dr Vorster and Mr Carr differed in opinion as to whether the accused was able to act in accordance with his appreciation of the wrongfulness of his conduct. Mr

⁴¹⁴ At 74 B-C.

⁴¹⁵ At 75 A-C.

⁴¹⁶ At 76 H.

⁴¹⁷ At 76 J-77 C.

Carr was of the view that the accused was under such mental oppression that he was unable to control his actions. Dr Vorster, however, stated that a person who suffers from no mental illness and from no physical defects, such as concussion or hypoglycaemia, and who can distinguish between right and wrong, can *ipso facto* control his actions. She stated that this is because he is not in a state of altered consciousness or unconsciousness.⁴¹⁸ With regard to Dr Vorster's evidence, Borchers J noted:⁴¹⁹

“While conceding that Dr Vorster is a leading authority in her field, we believe that there is a possible logical hiatus in her reasoning. If it is possible that a person who can distinguish between right and wrong may by virtue of mental illness not be capable of acting in accordance therewith, it seems to us that psychological factors may have the same results. This question was put to Dr Vorster and she responded by saying that psychological factors, such as extreme emotion, cannot cause a person to lose consciousness. But this answer begs the question for it is clear that the accused did not lose consciousness, or act in a state of automatism. The question is whether, while acting consciously, he was able to control what he did. If the human mind is capable of unconsciously creating a retrograde amnesia because the mind cannot tolerate an appreciation of what it had done, it seems to us to be possible that it may also be unable to exercise control over a person's conscious actions in certain circumstances.”

Dr Vorster stated⁴²⁰ the reason she was of the view that a person, who suffered from no mental illness and no physical defect such as concussion or hypoglycaemia, and who could not draw a distinction between right and wrong, could not be held to have lost control of his actions, was due to the fact that she could advance no medical, scientific or psychiatric reason for such loss of control. Borchers J held:⁴²¹

⁴¹⁸ At 77 D.
⁴¹⁹ At 77 E-F.
⁴²⁰ At 77 H.
⁴²¹ At 77 I.

“We find this evidence very difficult to accept. For many years the courts of this country and of others have accepted that a sane individual (i.e. one free from mental illness), who can distinguish between right and wrong, may be subjected to such mental or emotional pressures that he may not be able to control his actions. He is unable, in other words, to act in accordance with the distinction which he can draw. The law reports abound with decisions to this effect ...”

It was accordingly held that the State had failed to prove that the accused had the mental capacity to commit a criminal act at the time he fired the shots and he was accordingly found not guilty and discharged.

- Reflections on the *Gesualdo*-decision

In this case the role of the two experts is once again brought to the fore. The two experts who testified did not doubt the genuineness of the accused's amnesia. The psychologist who testified in support of the accused's case stated that he was to some extent aware of what he was doing and able to distinguish between right and wrong but was unable to act in accordance with that distinction due to the fact that he had lost control of himself. He did not at any stage contend that the accused acted in a state of automatism. Dr Vorster, who testified on behalf of the state, testified that the accused had not acted in a state of automatism as he was capable of taking complex decisions and his actions were goal-directed. The court, similar to the *Moses*-case, rejected the view of the State psychiatrist on the basis that it flew in the face of previous decisions laid down by the court, where it was held that persons who could distinguish between right and wrong and who had not acted automatically may nevertheless, because of emotional stress, have lost control of their actions to such an extent that they would escape criminal liability.

It is clear that there were thus competing interpretations of the accused's behaviour. Both the psychologists testifying for the defence as well as Mr Carr and Dr Vorster believed that it was possible that the accused at the time of the shooting satisfied the first leg of the test for criminal capacity – the capacity to

appreciate the wrongfulness of his conduct. There were conflicting views as to the second leg of the test. Mr Carr contended that because the accused's emotions were too "high for his rational thought – processes to contain them"⁴²² he was not able to act in accordance with this appreciation. Dr Vorster contended that once the first leg of the test was satisfied, and the accused did not suffer from any pathological condition, the second leg of the test must inadvertently also be satisfied in every case. Her argument in support of the latter contention was that she could advance no medical, scientific or psychiatric reason for such loss of control.

Borchers J noted:⁴²³

"... In effect, she stated that because she could not find any medically accepted cause for such condition, in her view it did not exist."

Borchers J, however, differed from this view:⁴²⁴

"If it is possible that a person who can distinguish between right and wrong may by virtue of mental illness not be capable of acting in accordance therewith, it seems to us that psychological factors may have the same result."

The court also stated that South African and other courts have for many years accepted that a person free from mental illness who can appreciate the wrongfulness of his conduct, may be subject to such emotional pressures that he may not be able to control himself in accordance with this appreciation.⁴²⁵

What is abundantly clear from Borchers J's judgment is that the expert evidence tendered by Mr Carr was preferable to the evidence presented by Dr Vorster. Borchers J also made it clear that lack of self-control, in other words the absence

⁴²² At 75 A-B. Boister (1997) *SACJ supra* note 407 at 317.

⁴²³ At 77 H.

⁴²⁴ At 77 E.

⁴²⁵ Boister (1997) *SACJ supra* note 407 at 317.

of the second leg of criminal capacity, can derive from non-pathological factors in cases where the first leg has been established.

11.7 Lapse of time between commission of crime and mental health assessment – a factor to take into account when assessing the value of expert evidence

A case which serves as an excellent example of conflicting medical opinions within the domain of criminal capacity is the case of *S v Kok*.⁴²⁶ The facts of the case were the following:

The appellant was charged in the Natal Provincial Division with two counts of murder and one count of attempted murder. At the time of the alleged offences the appellant was a superintendent in the South African Police Service and head of the public order policing unit at Port Shepstone. He pleaded not guilty but was convicted on all three counts by Combrink J and sentenced to ten years' imprisonment on each of the murder counts and to five years' imprisonment on the attempted murder charge. The appellant appealed against both conviction and sentence.

From the evidence it appeared that a dispute had arisen between the appellant's wife and Mrs Botha, the wife of a colleague of the appellant, about the return of two tablecloths. Mrs Botha had instituted proceedings in the Small Claims Court against the appellant's wife for the return of the tablecloths and was awarded R600 in damages. One afternoon, whilst the appellant was discussing important club matters with two colleagues over a few drinks, he received a call from his wife to the effect that the sheriff was at their house making an inventory. The appellant then returned home and found his wife and disabled son, who suffered from cerebral palsy and who was confined to a wheelchair, in a very distressed state. The appellant collected his pistol and then proceeded to the police station where he removed a R1 rifle, ammunition, hand grenade and a combat jacket from a safe and loaded it into the boot of his car where there had already been a shotgun with

⁴²⁶ *S v Kok* 2001 (2) SACR 106 (SCA). See also *S v Kok* 1998 (1) SACR 532 (NPD).

a pistol grip. The appellant then proceeded to the home of Mr and Mrs Botha, entered their house and then shot and killed them both. Their son, Marius, emerged from the bathroom and the appellant pointed the shotgun at him but he ran into his bedroom and escaped through a window after breaking the window pane. The appellant fired the shotgun through the bedroom door but the deceased's son escaped unscathed. The defence raised by the appellant was that, at the relevant time, he lacked the necessary criminal capacity.

In support of this defence reliance was placed to a large extent on the evidence of Dr Futter, a practising psychiatrist, who first saw the appellant a little over a month after the incident. His diagnosis of the appellant was that the appellant was suffering from major depression as well as a condition known as post-traumatic stress disorder.⁴²⁷

He described this disorder as a disorder which has its origin in the person concerned experiencing, witnessing or being confronted by an event or events involving actual or threatened death or serious injury or a threat to his or her physical integrity with a response of intense fear, helplessness or horror.⁴²⁸ The symptoms were said to include recurrent and intrusive distressing recollections of the event, dissociative flash-back episodes, intense psychological distress upon exposure to internal and external cues that symbolize or resemble an aspect of the traumatic event or events, persistent avoidance of such stimuli and persistent symptoms of increased arousal indicated by irritability, outbursts of anger, hyper vigilance and the like.⁴²⁹

According to Dr Futter a further feature of the disorder was “dissociative re-enactments” of the traumatic event or events during which the person in question in effect “acted” in a state of automatism. Based largely on what the appellant recalled and revealed during the course of a number of consultations, Dr Futter concluded that the only explanation for the appellant's bizarre conduct was that it had to be seen as a “dissociative behavioural re-enactment” of what the police

⁴²⁷ At 109 C-D.

⁴²⁸ At 109 E.

⁴²⁹ At 109 F.

called “house penetrations” which related to a procedure adopted when forcibly entering a house or building with the object of apprehending possibly dangerous occupants.⁴³⁰ The appellant’s defence was rejected in the court *a quo*. The trial court, however, found that the appellant acted in a state of “diminished capacity”.

On appeal, Scott JA referred to the evidence of Dr Futter to the effect of a “dissociative re-enactment” arising from a post-traumatic stress disorder as correlating with the legal concept of automatism and also stated that Dr Futter pointed out that the cause of the suggested dissociative disorder or behaviour was not a psychotic disorder.⁴³¹ Dr Futter contended that as all mental disorders were not psychotic illnesses, it was therefore not correct to presume that, because an automatism flows from a mental disorder, the automatism had to be categorised as “insane or psychotic”. In other words provided the automatism is not caused by a psychotic illness or disorder it should be regarded as “sane automatism”. Scott JA was doubtful with regards to this opinion. With reference to section 78(6) of the Criminal Procedure Act⁴³², Scott JA stated⁴³³ that this section makes no reference to “sane automatism”. It was held that this is not a psychiatric term and no more than a useful tag to describe automatism arising from some cause other than a “mental illness” or “mental defect” within the meaning of the section. There is also no indication in the said section that requires the mental illness which results in an absence of criminal responsibility to be an illness of a kind which is categorised as psychotic, such as schizophrenia, before a court is required to direct the accused to be detained in a psychiatric hospital or prison. The only requirement that has to be present is a “mental illness” or “mental defect” which results in the absence of criminal responsibility.⁴³⁴ Dr Futter described post-traumatic stress disorder as a mental illness with a pathology that can be demonstrated. The treatment includes the use of various anti-depressants. He was also of the opinion that the appellant should continue with his psychiatric treatment which included both medication and psychotherapy.

⁴³⁰ At 109 H.

⁴³¹ At 110 A.

⁴³² Which will be discussed in chapter 3 below.

⁴³³ At 110 D-F.

⁴³⁴ At 110 F. See also *R v Burgess* (1991) 2 All ER 769 (CA) at 774 C-F.

Scott JA noted:⁴³⁵

“... I think, that if the correct finding of the court *a quo* would have been that the appellant was not criminally responsible for the shooting by reason of the condition suggested by Dr Futter, the appropriate order would not have been an acquittal but one in terms of section 78(6) of the Act.”

Scott JA noted that at common law a distinction has been drawn in the past between lack of criminal capacity arising from a pathological disturbance of the mental faculties, whether temporary or permanent, on the one hand and lack of criminal capacity arising from some non-pathological cause of a temporary nature on the other⁴³⁶. In terms of the presumption of sanity the burden of proof in the case of the former was upon the accused and was to be discharged on a balance of probabilities whilst in the case of the latter, the burden remained on the State to prove criminal capacity beyond reasonable doubt⁴³⁷. Scott JA notes: “Whether this anomaly can be upheld in our modern law with the enactment of the new Constitution is doubtful.”⁴³⁸

The day after the shooting, the appellant was sent for observation in terms of section 77 of the Criminal Procedure Act. He was assessed by Dr Dunn, who is the principal psychiatrist at the Midlands Hospital, Pietermaritzburg. Dr Dunn rejected the evidence of Dr Futter in its entirety.⁴³⁹ When he examined the appellant shortly after the event he observed obvious symptoms of stress which he categorised as “situational, occupational and social”. He found no indication of major depression or post-traumatic stress disorder. He also rejected the notion that the post-traumatic stress disorder could arise from what was described as a “loose and diffuse series of unhappy experiences.”⁴⁴⁰ As far as the behaviour of the appellant at the relevant time was concerned, Dr Dunn emphasised its goal-oriented nature and pointed to the account of the incident which the appellant had given him shortly after the event and which not only differed from that given to Dr

⁴³⁵ At 110 H.

⁴³⁶ At 110 I-J.

⁴³⁷ *Ibid.*

⁴³⁸ *Ibid.*

⁴³⁹ At 114 J.

⁴⁴⁰ At 115 A.

Futter but which was also inconsistent with the latter’s hypothesis. In Dr Dunn’s opinion the appellant was not re-enacting some previous event at the time of the shooting. He accepted that the appellant was under a great deal of stress and was suffering from what is colloquially called “burn-out”. Dr Dunn accordingly rejected⁴⁴¹ the notion that the appellant lacked cognitive control at the relevant time or that he was unable to distinguish right from wrong and act accordingly.

Scott JA held:⁴⁴²

“As correctly observed by the court *a quo* the ultimate inquiry was whether the appellant was criminally responsible for his actions. This is an issue that had to be determined, not by the psychiatrists, but by the Court in the light of all the evidence⁴⁴³. What immediately strikes one is the contrast between the version given to Dr Dunn and the version given more than a month later to Dr Futter and thereafter repeated by the appellant in evidence. The former, which was the appellant’s recollection shortly after the incident, makes it clear that his mood upon arrival at the Bothas’ house was both belligerent and confrontational. Indeed, he recalled going to the front door armed with his shotgun. There can be no doubt he was upset by the emotional state of his wife and his son. He said he lost his temper as a result of something Mrs Botha did or said and then fired first at Mrs Botha and then at her husband. Loss of temper, that is to say a failure to control one’s emotional reactions, is not to be confused with a loss of cognitive control.”

Scott JA accordingly rejected Dr Futter’s contentions as to house penetration and the re-enactment of a house penetration in a dissociative state. The court held that the appellant did have the necessary criminal capacity at the time of the incident and also that the defence of so-called “sane automatism” also had to be rejected. The appeal against sentence also failed.

- Reflections on the *Kok*-decision

⁴⁴¹ At 115 E-F.

⁴⁴² At 115 G-J.

⁴⁴³ This statement by Scott JA is a reiteration of the “ultimate issue” doctrine which will be discussed extensively in Chapter 4 below.

This case is a clear example of two conflicting opinions within the medical profession pertaining to whether the accused or appellant possessed the necessary criminal capacity at the time of the crime.

What is evident from the judgment by Scott JA is that a clear distinction is drawn between pathological and non-pathological criminal incapacity. It is a pity that the court did not shine more light on the contentious issue of burden of proof with regards to the defence of non-pathological criminal incapacity. Scott JA also warns that the decision as to the presence or absence of criminal capacity is to be determined by the court and not the psychiatrists. It is, however, true that the expert evidence in this case played a cardinal role in deliberating as to the accused's state of mind at the time of the incident. Much weight was attached to the opinion of Dr Dunn.

What is also apparent from this judgment is that a lapse of time can influence the value of expert testimony in the sense that Dr Futter examined the appellant a month after the incident. This lapse of time between the commission of the crime and the eventual assessment can result in the accused's emotional frame of mind changing due to factors such as remorse setting in which could lead to inferences such as those derived at by Dr Futter. On the other hand, Dr Dunn assessed the appellant the day after the incident at a point in time where the appellant's true mental state could probably have been ascertained more accurately.

11.8 Accused's conduct after the commission of the crime

In *S v Van der Sandt*⁴⁴⁴ the facts were as follows: The accused was charged in the Local Division with murder and theft. He pleaded not guilty. On the charge of murder, the accused relied on the defence of non-pathological criminal incapacity in that, as a result of his mental confusion, he had been unable to distinguish between right and wrong and also that he had been unable to conduct himself in accordance with his appreciation.

⁴⁴⁴ *S v Van der Sandt* 1998 (2) SACR 627 (WLD).

The accused and the deceased were engaged. They lived together in a flat. The relationship was romantic and generally there was no suggestion that there had ever been any noticeable disharmony between them. The accused told various blatant lies to the deceased and her mother, particularly as to past achievements in an attempt to impress the deceased. One day, after the deceased and the accused had returned from a camping trip, the accused decided to reveal the truth about himself to the deceased. Although the deceased was initially only moderately upset, after a while she abandoned her engagement ring and told the accused that she “no longer wanted him”⁴⁴⁵. He pleaded for a second chance, whereupon the deceased calmed down. Shortly thereafter the deceased again lost her temper and told the accused to pack his things and leave her. The accused was scared, as the deceased meant the world to him, and he would do anything to retain her affection. Thereafter, according to the evidence of the accused, he remembered nothing. When he again regained his senses, he was standing in the bathroom, with blood on his hands. He suspected that something bad had happened. The deceased was lying on a bed in the bedroom.

She had serious head injuries, which had been inflicted with a metal pipe, and of which she eventually died. After the accused had attempted to make the deceased comfortable on the bed and had clumsily attempted to bandage her wounds, he left the scene in the deceased’s car. He then withdrew money from her bank account and fled to Natal. The withdrawal of the money formed the basis of the theft charge. Before he left, he called the deceased’s mother from a public telephone, and requested her to have an ambulance sent to the flat. After his arrival in Natal the accused decided to commit suicide, but after he had spoken to his mother over the telephone he surrendered himself to the police.

In respect of the accused’s mental state at the time of the incident, Mr Kobus Truter, a clinical psychologist, tendered evidence on behalf of the accused, and Mrs Annelies Kramer, also a clinical psychologist, testified on behalf of the State. The two psychologists unanimously held that the accused did not suffer from any

⁴⁴⁵ At 634 D-E.

mental illness or mental defect at the time of the incident. They also unanimously found that the accused had the capacity to distinguish between right and wrong and also to act in accordance with such appreciation. In the course of the judgment delivered by Labuschagne J, certain general principles applicable to the defence of non-pathological criminal incapacity were once again canvassed.

It was held by Labuschagne J that two material psychological characteristics arose for consideration, namely the accused's ability to distinguish between right and wrong and to conduct himself in accordance with the ability to distinguish between right and wrong, in that he possessed the power to resist the temptation to act unlawfully⁴⁴⁶. If either of those psychological characteristics was absent, the actor lacked criminal capacity.⁴⁴⁷ In general, the law presumed that a person had the requisite criminal capacity.⁴⁴⁸ The court also held that the onus to prove all the required elements of the crime charged, in a case where the defence of non-pathological criminal incapacity is raised, rests on the State.⁴⁴⁹ Although no onus is placed on the accused in cases of this nature, it is still required of the accused to establish a factual foundation for such defence. This defence should also be viewed with caution.⁴⁵⁰

It was held that ultimately it was the court's task, with reference not only to any expert evidence, but to the totality of the evidence, to make a finding about the question whether or not a particular accused was criminally liable.⁴⁵¹

It was also held that where the case was concerned with a mental illness or mental defect in the form of a pathological disturbance, psychiatric evidence was indispensable, but in the case of a defence of non-pathological criminal incapacity that was not so: the court was in the latter instance itself able to determine, on the evidence as a whole, whether the defence had been established. The accused's

⁴⁴⁶ At 637 E-F.

⁴⁴⁷ At 635 E-H. The court reaffirms the quote from the *S v Laubscher* decision *supra* note 1 by Joubert JA at 166 G-167 A.

⁴⁴⁸ At 635 I. See also *S v Shivute supra* note 1 at 660 F.

⁴⁴⁹ At 636 A. See also *S v Calitz supra* note 1 at 119 I; *S v Wiid supra* note 1 at 564E-F.

⁴⁵⁰ At 636 B. See also *S v Ingram* 1995 (1) SACR 1 (A) at 4 1-5 B where Smalberger JA held: "A matter such as the present calls for a careful consideration of the evidence." See also *S v Kensley supra* note 1 at 658 G.

⁴⁵¹ At 636 F.

criminal liability had to be considered in the light of the facts and circumstances which gave rise to the incident in question, as well as the accused's conduct before, during and after the attack upon the deceased, and of the evidence of the psychologists.⁴⁵²

The court per Labuschagne J held that the accused had the capacity to distinguish between right and wrong. This view was supported by both Mrs Kramer and Mr Truter. Mr Truter, however, later changed his evidence and stated that the accused could not distinguish between right and wrong and did not have the capacity to act in accordance with such appreciation. In the light of the lengthy consultations Mr Truter had with the accused as well as other factors, the court rejected this statement. The court also indicated certain aspects of the accused's behaviour that indicated goal-directed conscious behaviour.⁴⁵³ The court also held

⁴⁵² At 636 F-H. Labuschagne J also refers to the judgment of *S v Kok*, an unreported decision case nr 22/97, dated 11 August 1997 where Borchers J laid down the requirements for a defence of an emotional storm: "In order therefore to ascertain whether such person was capable of distinguishing between right and wrong, and of acting in accordance with that distinction, Dr Stevenson postulates that certain features must be present for such conclusion to be reached, or at least for that conclusion to be reasonably possible for that is all that the law requires for an acquittal. These factors are really based upon a common sense approach to the problem. They are firstly, that there must be some trigger to cause the emotional storm, and, if such exists, one asks the question whether it was indeed of sufficient magnitude, secondly, that there should be a period of amnesia, which should commence with the trigger and not precede it, thirdly, that the actions performed during the period of amnesia should be involuntary, uncontrolled and not goal-directed, and fourthly, that when sufficient self-control and volition return to the person he should be bewildered and not know what had passed immediately before. Dr Stevenson cautioned that a defence of this nature should be carefully scrutinized, and so did Mr McKelsey for the state ... In order to test whether the alleged condition in fact existed, Dr Stevenson spoke of an objective test, "a template" he called it, derived from a summary of cases against which the conduct of the actor in the present case should be measured. I have some sympathy for this approach, for conduct may depart so radically from the norm that a court may conclude that the evidence tendered by an accused is so unreasonable, objectively speaking, that it cannot be accepted as being reasonably possibly true. But a court should in my view guard against the tendency to tick factors off a given list. Its task is to ascertain whether in any given case it is reasonably possible that that person's thought processes were so disturbed that it cannot be said that he had criminal capacity." What is worrying from Dr Stevenson's evidence with regard to criminal capacity is that it seems to relate more to the requirements of the defence of automatism, than that of capacity. Words such as "trigger", "involuntary" and "uncontrolled" refers to the defence of automatism. It is pivotal that the defences of automatism and criminal incapacity be kept apart as two distinct defences each with its own criteria and requirements.

⁴⁵³ At 638 C-H. The court considered the following as indicative of goal-directed behaviour:

- (1) On the accused's account he realized immediately upon entering the bathroom and seeing the blood on his hands that something had happened.
- (2) He clumsily attempted to bandage her wounds.
- (3) He made her comfortable on the bed.
- (4) He fled from the scene in the deceased's vehicle.
- (5) He went to withdraw money in order to escape.

that the accused possessed the capacity to act in accordance with an appreciation of the wrongfulness of his actions. It was accordingly held that the accused had the necessary criminal capacity as well as intention in the form of *dolus eventualis* and he was convicted of murder.⁴⁵⁴ The accused was acquitted on the charge of theft.

With regard to the amnesia⁴⁵⁵, the court held that in totality of all the evidence, the accused as a result of the gruesome nature and trauma of the incident, could not recall the incident and that he was most probably suffering from post-traumatic amnesia⁴⁵⁶. The latter is, however, the result of the accused's conduct and will not exclude criminal liability. The court also noted that irrational conduct is not necessarily indicative of an absence of self-control⁴⁵⁷.

- Reflections on the *Van der Sandt*-decision

This case is discussed due to its applicability to the defence of criminal incapacity. It is, however, evident that the role of the two psychologists was not over-emphasised and it does not provide a helpful tool with regard to value attached and the role of experts within the domain of this defence. The expert evidence did, however, still assist the court, at least, to understand the personality makeup and characteristics of the accused and his behaviour before, during and after the incident.

12 The impact of section 79(7) on the defence of non-pathological criminal incapacity

(6) He phoned the deceased's mother and requested her to call an ambulance and he informed the latter that something was wrong with the deceased and already at that stage remained silent as to the fact that something terrible had happened to the deceased.

(7) When he later phoned to find out what had happened with the deceased he was deceitful as to where he was at that stage.

⁴⁵⁴ At 640 the court sets out the factors indicating that the accused had the capacity to act in accordance with an appreciation of the wrongfulness of his actions. See also *S v Laubscher supra* note 1 at 173 A-B; *S v Els* 1993 (1) SACR 723 (O) at 724 E and *S v Kensley supra* note 1 at 653 b-654 b.

⁴⁵⁵ The role of amnesia will extensively be discussed in paragraph 16 below.

⁴⁵⁶ At 638 H-J.

⁴⁵⁷ *Ibid.*

In the midst of the uncertainty surrounding the role and place of expert evidence in support of the defence of non-pathological criminal incapacity, the contentious issue pertaining to the admissibility of statements made by an accused during an enquiry into his or her mental condition, arises.

Section 79(7) of the Criminal Procedure Act states:

“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.”

The question that has to be considered is whether statements by an accused during an enquiry in terms of section 79 of the Criminal Procedure Act, is admissible as evidence against the accused in order to determine the mental condition of the accused. When the defence relied on is one of pathological criminal incapacity, such statements are admissible. However, there is some uncertainty as to whether the same applies to the defence of non-pathological criminal incapacity. If one considers the amended section 78(2), the inference could be drawn that the same rule should apply to both pathological as well as non-pathological criminal incapacity. The latter would be dependent upon a proper construction of the term “mental condition”. It could be argued that mental condition should be restricted only to cases where the defence is one of pathological criminal incapacity.

In *S v Kok*⁴⁵⁸ Combrink J held that the exception contained in section 79(7) which renders admissible evidence of any statement made by an accused during an enquiry, had to be interpreted restrictively.⁴⁵⁹

⁴⁵⁸ *S v Kok* 1998 (1) SACR 532 (NPD).

⁴⁵⁹ At 543 G-544 H. See also *S v De Beer* 1995 (1) SACR 128 (SE) where Kroon J held that section 79(7) had to be interpreted restrictively so that the exception operates only where the statements are relevant to the mental condition for which the accused was referred for observation. See also *S v Forbes and Another* 1970 (2) SA 594 (C) and *S v Webb* (1) 1971 (2) SA 340 (T). These decisions will be discussed in chapter 3 below.

It was also held that if an accused raises the defence of lack of criminal responsibility by reason of non-pathological factors, such as alcohol, drugs or provocation, any statements made by him during the enquiry in terms of chapter 13 of the Criminal Procedure Act would not be rendered admissible in terms of the exception in section 79(7).⁴⁶⁰ Combrink J stated that the reason for the latter is not only as a result of a restrictive interpretation to be afforded to the term “mental condition” but also because the enquiry itself was irrelevant to the defence raised and that the accused should never have been referred for observation.⁴⁶¹ The situation was, however, changed by the amended section 78(2) in terms of which an accused can now, within the discretion of the court, be referred for observation.

It is, however, interesting that Combrink J states the following:⁴⁶²

“In the vast majority of cases the Court has no idea of what possible mental illness or defect the accused may be suffering from or for that matter whether he is suffering from a non-pathological condition. That is the task of the psychiatrist conducting the inquiry.”

The abovementioned quote illustrates the fundamental need for expert evidence – whether the defence raised is one of pathological or non-pathological criminal incapacity.

In *S v Leaner*⁴⁶³ the court followed an alternative approach in respect of section 79(7). The accused was charged with murder and raised the defence of non-pathological criminal incapacity alleging that he had acted under severe provocation and anger. He was accordingly referred to a psychiatric hospital for observation.

During the trial the defence objected to the leading of evidence by a doctor on the basis of section 79(7) of the Criminal Procedure Act. It was contended on behalf

⁴⁶⁰ At 544 G. See also Du Toit (2007) *et al supra* note 1 at 13-29.

⁴⁶¹ *Ibid.*

⁴⁶² At 544 D-E.

⁴⁶³ *S v Leaner* 1996 (2) SACR 347 (C).

of the defence that the term “mental condition” should be interpreted restrictively and should be limited to a consideration of mental illness and accordingly to a pathological disturbance of the accused’s mental faculties.

Traverso J dissented from previous decisions, in which it was held that section 79(7) should be interpreted restrictively,⁴⁶⁴ and held that even though sections 77, 78 and 79 of the Criminal Procedure Act formed an integrated unit, it was clear that the sections distinguished between “mental illness and mental defect” on the one hand, and “mental condition”, being an all-inclusive term, on the other.⁴⁶⁵ It was therefore held that if a restrictive interpretation was afforded to the term “mental condition” it would presuppose that the enquiry would necessarily reveal a mental illness or mental defect and that this was not the intention with subsection (2). Traverso J held that there was no reason why a witness cannot be questioned on the content of a statement made by the accused during an examination that was relevant to the determination of his or her mental condition irrespective of whether it revealed a state of mental illness or mental defect.⁴⁶⁶ Traverso J also noted that it should be borne in mind that there is also the defence of non-pathological criminal incapacity which, even though not constituting a recognised “mental illness” or “mental defect” also constitutes a valid defence. If a restrictive interpretation is followed it would entail that if it is established during the course of an enquiry that the accused is not suffering from a “mental illness” or “mental defect”, but from a non-pathological condition, evidence regarding the content of the statements made to a psychiatrist during the course of the enquiry that are in fact indicative of such non-pathological condition, would be inadmissible.⁴⁶⁷

It was accordingly held that in accordance with a proper construction of section 79(7), only a statement by an accused during an enquiry which is not relevant for purposes of establishing his or her mental state, will be inadmissible. The statements were thus allowed.

⁴⁶⁴ S v De Beer *supra* note 459 as referred to by Traverso J at 357 B.

⁴⁶⁵ At 357 C-D.

⁴⁶⁶ At 358 F.

⁴⁶⁷ At 358 H–359 G.

The abovementioned decisions were decided before the amendment to section 78(2) came into effect. It is submitted that in the light of the current section 78(2) referring also to criminal incapacity for “... any other reason”, the term “mental condition” should be construed to also include non-pathological states.

Accordingly the exception contained in section 79(7) should apply to the defence of non-pathological as well as pathological criminal incapacity. The latter approach would be more in line with the intention of the legislature with the amendment of section 78(2) and would create uniformity between the defences of pathological and non-pathological criminal incapacity. It is submitted that any statement by an accused having a direct bearing upon the mental condition into which an enquiry is being conducted, should be admissible.⁴⁶⁸

13 Provocation and non-pathological criminal incapacity

Before embarking on a discussion of the role of provocation pertaining to the defence of non-pathological criminal incapacity, it is necessary to briefly discuss the manner in which provocation can affect criminal liability.

13.1 General background on provocation as a defence

When an accused is charged with murder or assault the evidence often reveals that the accused’s conduct was preceded by some form of insulting or provocative

⁴⁶⁸ See *S v Forbes and Another* 1970 (2) SA 594 (C) at 599 A-B where Theron J states: “It seems to me highly undesirable that any statements made by the 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 is being conducted.” (emphasis added).

behaviour on the part of the victim which gave rise to aggressive conduct by the accused.⁴⁶⁹

The term provocation has not yet been clearly defined.

According to Bergenthuin it comprises of two elements:⁴⁷⁰

- (i) provocative and challenging behaviour of the provoker (objectively viewed),
- (ii) the specific state of mind of the accused (subjectively viewed).

According to Burchell and Hunt the general approach in most legal systems is that provocation is not a complete defence.⁴⁷¹ The most obvious reason for this could be found in the principle that people are expected to keep their emotions intact. The Roman and Roman Dutch Law only regarded anger, jealousy and other emotions as mitigating circumstances.⁴⁷²

The underlying reason for this principle was the acknowledgment that severe provocation could lead a person to act in the heat of the moment and without direct intention.⁴⁷³

According to Snyman there are two approaches to the effect of provocation:⁴⁷⁴

- (i) Separate doctrine approach: According to this approach provocation should be regarded as a completely separate doctrine with its own unique and

⁴⁶⁹ Snyman (2008) *supra* note 1 at 234; Snyman (2002) *supra* note 1 at 235; Burchell and Milton (2005) *supra* note 1 at 403; Burchell and Hunt (1997) *supra* note 1 at 201; Nel (2007) *supra* note 1 at 55; Visser and Maré (1990) *supra* note 158 at 389; Van der Merwe (1996) *supra* note 1 at 19; Louw in Kaliski (ed)(2006) *supra* note 1 at 51-54; Tredoux *et al* (2005) *supra* note 1 at 401-404; De Wet and Swanepoel (1975) *supra* note 1 at 127; Strauss, SA “Opmerkings oor Toorn as faktor by die vasstelling van Strafregtelike Aanspreeklikheid” (1959) *THRHR* at 14.

⁴⁷⁰ Bergenthuin (1985) *supra* note 1 at 20-21. See also *S v Mokonto* 1971 (2) SA 319 (A) at 324 where Holmes JA states:
“Provocation and anger are different concepts, just as cause and effect are. But in criminal law, the term provocation seems to be used as including both concepts, throwing light on the accused’s conduct.”

⁴⁷¹ Burchell and Hunt (1997) *supra* note 1 at 202.

⁴⁷² Burchell and Hunt (1997) *supra* note 1 at 202; Bergenthuin (1985) *supra* note 1 at 21.

⁴⁷³ Burchell and Hunt (1997) *supra* note 1 at 202.

⁴⁷⁴ Snyman (2008) *supra* note 1 at 235.

distinctive principles. According to this approach an accused's liability should not be determined by applying the ordinary principles of liability such as act, unlawfulness, criminal capacity and intention, but rather in terms of the application of a distinct set of rules which apply only to provocation.⁴⁷⁵

- (ii) General principles approach: In terms of this approach, provocation constitutes nothing more than a set of facts which must be evaluated in the same way as any other set of facts by simply applying the ordinary principles of liability such as compliance with the definitional elements of a crime, which is unlawful and whether he had the required criminal capacity and intention or negligence.

Before 1970 the separate doctrine approach mostly prevailed because of section 141 of the old Transkeian Penal Code of 1886.⁴⁷⁶ During this period provocation was never regarded as a complete defence which would lead to an acquittal.

In *S v Mokonto* Holmes JA held the following:⁴⁷⁷

- (i) Section 141 of the Transkeian Penal Code should be limited to the territory for which it was passed.
- (ii) In crimes of which a specific intention is an element, the question of the existence of such intention is a subjective one.
- (iii) Provocation, *inter alia*, is relevant to the question of the existence of such intention.

⁴⁷⁵ Snyman (2008) *supra* note 1 at 235 submits that the policy consideration in respect of this approach is that the law expects adult, mentally healthy people to control their emotions and tempers and that all people should be treated in the same way. See also *S v Kensley supra* at 658 G-I.

⁴⁷⁶ Snyman (2008) *supra* note 1 at 236; Burchell and Hunt (1997) *supra* note 1 at 203. Section 141 of the Transkeian Penal Code entailed the following:
"Homicide which would otherwise be murder may be reduced to culpable homicide if the person who causes death does so in the heat of passion occasioned by sudden provocation. Any wrongful act or insult of such a nature as to be sufficient to deprive any ordinary person of the power of self-control may be provocation, if the offender acts upon it on the sudden, and before there has been time for his passion to cool. Whether any particular wrongful act or insult, whatever may be its nature, amounts to provocation, and whether the person provoked was actually deprived of the power of self-control by the provocation which he received, shall be questions of fact." See also *S v Kruv* 1959(3) SA 392 (A).

⁴⁷⁷ *S v Mokonto* 1971 (2) SA 319 (A) 325; Visser and Maré (1990) *supra* note 158 at 394-397. See also *R v Thibani* 1949 (4) SA 7210 (A).

- (iv) Provocation, subjectively assessed, is relevant to extenuation or mitigation of punishment.

After 1970, the general principle approach gradually became popular.⁴⁷⁸ During this period it became a well-established principle that provocation could also exclude criminal capacity as the focus shifted to the accused's subjective criminal capacity and frame of mind.⁴⁷⁹

In cases where provocation excludes criminal capacity, an accused will be acquitted completely and an accused may not be convicted of culpable homicide. Snyman submits that after the decision in *S v Eadie*⁴⁸⁰ the general principles approach cannot be followed anymore.⁴⁸¹

Currently, provocation can affect criminal liability as follows:

- (i) It can exclude the voluntariness of conduct giving rise to the defence of automatism.
- (ii) It can exclude criminal capacity.
- (iii) It can exclude intention⁴⁸², or
- (iv) It may operate as a mitigating factor for purposes of punishment.⁴⁸³

Van Niekerk states that a crime committed under extreme anger can only exonerate an accused if such anger is regarded by the court as reasonable under the circumstances and states the following with regard to the position of provocation:⁴⁸⁴

- Provocation can give rise to temporary insanity in the sense that a person cannot control himself – a rare but not impossible situation.

⁴⁷⁸ Snyman (2008) *supra* note 1 at 236.

⁴⁷⁹ *Ibid.* See also *S v Mokonto* 1971 (2) SA 319 (A); *S v Wiid* *supra* note 1.

⁴⁸⁰ *S v Eadie* *supra* note 1. This section will be discussed below.

⁴⁸¹ Snyman (2008) *supra* note 1 at 236.

⁴⁸² Burchell and Milton (2005) *supra* note 1 at 425; Snyman (2008) *supra* note 1 at 237-239; *S v Lesch* *supra* note 1 at 825 A-826 A.

⁴⁸³ Snyman (2008) *supra* note 1 at 239; Nel (2007) *supra* note 1 at 55.

⁴⁸⁴ Van Niekerk, B "A Witch's Brew from Natal – Some thoughts on Provocation" (1972) SALJ 169 at 174; Visser and Maré (1990) *supra* note 158 at 398; *S v Mokonto* *supra* note 477.

- Provocation can be a factor which will be considered in determining the existence of intention to commit a crime – in many cases such provocation will include intention.
- Even where there is intention, a court will still regard such provocation as a mitigating circumstance.

It is therefore clear that the defence of non-pathological criminal incapacity and provocation can sometimes overlap. If the evidence indicates that an accused as a result of provocation, suffered emotional strain to such a degree that at the time of the commission of the act he or she lacked the ability to appreciate the wrongfulness of the act or to act in accordance with such appreciation, the accused must be found not guilty.⁴⁸⁵ On a charge of murder the latter will also have the effect that the accused cannot be convicted of a lesser crime such as culpable homicide. Snyman submits that only in exceptional cases will a court be willing to acquit an accused on the basis of lack of criminal capacity as a result of provocation.⁴⁸⁶ Snyman also submits that it is advisable that the defence leads expert evidence.⁴⁸⁷ The question that arises is what, if any, effect does provocation have on the criminal capacity of an accused? Should provocation succeed as a complete defence therefore excluding criminal capacity *in toto* or should it only be regarded as a “partial defence” in the sense that provocation will only be considered as a mitigating factor during sentencing and the imposition of an appropriate punishment? Should expert evidence be compulsory in support of a claim of lack of criminal capacity due to provocation?

Prior to 1981 it was accepted that provocation could at most amount to a partial defence. If the defence was accepted the accused would be found guilty to a less serious offence that was a competent verdict to the offence charged.⁴⁸⁸ In *S v Chretien*⁴⁸⁹ it was held that also provocation could in some cases constitute a

⁴⁸⁵ Snyman (2008) *supra* note 1 at 237.

⁴⁸⁶ *Ibid.*

⁴⁸⁷ *Ibid.*

⁴⁸⁸ Snyman (1989) TRW *supra* note 1 at 5; Van Oosten (1993) *supra* note 1 at 138-139; Bergenthuin (1985) *supra* note 1 at 300.

⁴⁸⁹ *S v Chretien supra* note 1 at 1103 H-1104 A.

complete defence. The “specific intent” theory was also rejected in *S v Chretien*.⁴⁹⁰

In *S v Van Vuuren* Diemont AJA stated the following:⁴⁹¹

“I am prepared to accept that an accused person should not be held criminally responsible for an unlawful act where his failure to comprehend what he is doing is attributable not to drink alone, but to a combination of drink and other facts such as provocation and severe mental or emotional stress. In principle there is no reason for limiting the enquiry to the case of he may be too drunk to know what he is doing. Other factors which may contribute towards the conclusion that he failed to realise what was happening or to appreciate the unlawfulness of his act must obviously be taken into account in assessing his criminal liability. But in every case the critical question is – what evidence is there to support such a conclusion?”

The first reported case in which provocation succeeded as a complete defence was in *S v Arnold*.⁴⁹² Snyman criticises this decision and takes the stance that neither emotional stress nor any form of provocation should ever be allowed as a complete defence on a charge of murder.⁴⁹³ Snyman submits that lack of criminal capacity should only be regarded as a defence when operating in conjunction with the defences of youth, mental illness or intoxication.⁴⁹⁴ Snyman submits further that the following policy considerations should be borne in mind, underlying the rule that provocation can never be a complete defence:⁴⁹⁵

- The law expects people to keep their emotions intact.
- The mere fact that some people are short-tempered, emotional or impatient should not afford them an excuse.

⁴⁹⁰ *S v Chretien supra* note 1 at 1103 H-1104 A.

⁴⁹¹ *S v Van Vuuren* 1983 (1) SA 12 (A) at 17G-H. See also *S v Arnold supra* note 1; Snyman (1985) SACJ *supra* note 1 at 240.

⁴⁹² *S v Arnold supra* note 1; Van Oosten (1993) *supra* note 1 at 140; Visser and Maré (1990) *supra* note 158 at 400. The facts and decision of *S v Arnold* has already been discussed *supra* and will not be repeated here.

⁴⁹³ Snyman (1985) SACJ *supra* note 1 at 251.

⁴⁹⁴ *Ibid.*

⁴⁹⁵ *Ibid.*

In two High Court decisions⁴⁹⁶ and one Supreme Court of Appeal decision⁴⁹⁷ accused persons were completely acquitted after raising the defence of non-pathological criminal incapacity based on evidence of provocation or emotional stress experienced by the accused persons at the time of, or before the commission of the act. These decisions indicated a willingness by the courts to accept that provocation could in some instances provide a complete defence.

Burchell and Milton also note that this revolutionary approach to provocation created the possibility of a complete acquittal if sufficient, compelling evidence was adduced in support of the defence to create reasonable doubt as to the existence of criminal capacity.⁴⁹⁸ The question that arises is whether these acquittals were founded on the court's approach to provocation or whether the evidence, which inadvertently included expert evidence, led to a successful plea of non-pathological criminal incapacity?

It is submitted that expert evidence should be a prerequisite when reliance is placed on provocation as ground for excluding criminal capacity.

Africa states⁴⁹⁹ that in cases of non-pathological criminal incapacity, which also includes provocation, there are difficulties inherent in a retrospective evaluation. Ultimately it is for the court to decide whether or not evidence can adequately be utilised⁵⁰⁰.

13.2 The controversial decision of *S v Eadie* 2002 (2) SA 719 (SCA)⁵⁰¹

⁴⁹⁶ *S v Nursingh supra* note 1 and *S v Moses supra* note 1. These decisions and the facts of these cases have already been discussed in this chapter and will not be repeated here. See also Burchell and Milton (2005) *supra* note 1 at 428.

⁴⁹⁷ *S v Wiid supra* note 1.

⁴⁹⁸ Burchell and Milton (2005) *supra* note 1 at 428.

⁴⁹⁹ Africa in Tredoux *et al* (2005) *supra* note 1 at 404.

⁵⁰⁰ *Ibid.*

⁵⁰¹ *S v Eadie* 2002 (1) SACR 663 (SCA). See also *S v Eadie* (1) 2001 (1) SACR 172 (C). See also Reddi M "General principles – non-pathological criminal incapacity" (2001) SACJ (14) at 241; Reddi M "General principles – non-pathological criminal incapacity" (2002) SACJ (15) at 250.

Probably one of the most controversial decisions dealing with the interface between provocation and incapacity is the case of *S v Eadie*. This decision changed the approach to provocation in respect of non-pathological criminal incapacity drastically. In this discussion the facts and decision of this case will first be provided whereafter the commentary of various authors pertaining to this decision will be discussed as well as the possible effect of this decision on the future existence of the defence of non-pathological criminal incapacity. The role of expert evidence in *S v Eadie* will also be addressed. The facts of this decision were as follows:

The appellant, a keen sportsman and competitive hockey player, had on Friday 11 June 1999, accompanied by his wife, attended a function of the Fish Hoek Hockey Club held in Cape Town. During the course of the evening he consumed at least seven bottles of beer. After the function the appellant and his wife joined another couple for a late meal at a restaurant in Rondebosch, where he consumed at least two more bottles of beer and two Irish coffees. In the early hours of Saturday morning the appellant and his wife drove home in their Volkswagen Jetta, stopping at his mother's house to pick up their two young children. They drove along Ou Kaapseweg in a southerly direction towards Fish Hoek. As they travelled home with the children asleep on the back seat they became aware of the headlights of a motor vehicle coming up behind them. The deceased, Kevin Andrew Duncan, was the driver and also the sole occupant of this vehicle, a Toyota Corolla. He drove right up to the Jetta, overtook them, and in the process flashed his headlights, which were on bright. The deceased then slowed down considerably. The appellant remained behind him for a short distance. When the deceased reduced his speed to approximately 40 km/h the appellant overtook him. The deceased increased his speed and once again drove up close to the Jetta's rear bumper, keeping his headlights on bright. The appellant accelerated but could not put distance between them. The Toyota then overtook the Jetta once more and the entire process was again repeated – the deceased slowed down and the appellant overtook him but could not get away. At this stage the appellant became angry and concerned as to his family's safety. At a set of traffic lights the appellant stopped the Jetta and the Toyota stopped behind him. The appellant emerged from the Jetta, took a hockey stick from behind the driver's seat, and

walked towards the Toyota. The appellant's wife drove off in the Jetta. The deceased remained seated behind the steering wheel of the stationary Toyota. The appellant initially intended to smash the Toyota's headlights but changed his mind and decided to smash the windscreen. When he approached the Toyota the deceased opened the driver's door, prompting him to divert his attention from the windscreen and to lunge at the deceased with the hockey stick, which eventually broke into two parts as it struck the vehicle. The appellant became extremely angry. The appellant then opened the driver's door of the Toyota. The appellant punched the deceased against the head whilst he was still in the Toyota and continued the assault by punching him repeatedly. He then pulled the deceased out of the vehicle and into the road. The deceased fell. The appellant repeatedly and savagely stamped on the deceased's head with the heel of his shoe. The appellant broke the deceased's nose by stamping on it with his heel. The appellant testified that whilst he was assaulting the deceased he could feel himself shouting but did not hear any sound. He could see some things whilst others were blurred. He testified that whilst perpetrating the assault he felt that he was "going, going, going".⁵⁰² He experienced these sensations from the time that the hockey stick broke. The appellant could nevertheless recall and relate what happened in the precise detail as discussed above.

Mr Graham Hill, a motorist who drove past the scene, witnessed a great part of the attack on the deceased and testified on behalf of the State. He testified that the appellant used the hockey stick as a weapon, jabbing it at the deceased while the deceased was still in the Toyota. The appellant's wife returned to the scene a short while after her initial departure and drove him home. Upon arrival at home the appellant almost immediately decided to return to the scene. There was no one else at the scene. The appellant established that the deceased was dead. Thereafter a tow-truck arrived driven by one Mr Jan Eksteen. Mr Eksteen saw that the jeans worn by the appellant was blood-spattered. The appellant told Mr Eksteen that he was at the scene attempting to assist the deceased, deliberately creating the impression of an innocent bystander. When the police arrived at the scene the appellant repeated this explanation for his presence at the scene.

⁵⁰² At paragraph 6.

When he departed from the scene he removed the hockey stick from the scene and later disposed of it by throwing it into bushes some distance away. The appellant was later requested by the police to return to the scene to point out the position of the hockey stick. He was also requested to bring along with him the blood-spattered jeans he wore. The appellant presented the police with different jeans from the pair he wore at the time of the assault on the deceased. This later became evident when Mr Eksteen pointed it out to the police. The appellant then disclosed the truth and was arrested. Blood-alcohol tests conducted on the appellant revealed that the appellant's blood-alcohol levels were significantly higher than the legal limit. The post-mortem examination performed on the deceased established that the deceased sustained significant fractures of the facial bones and skull and these injuries were noted as caused by the application of a considerable degree of blunt force.

The appellant stood trial in the Cape Provincial Division of the High Court, before Griesel J, on a charge of murder and on a charge of obstructing the ends of justice. In respect of the second charge it was averred that after the commission of the murder the appellant disposed of a hockey stick which he used in the attack on the deceased so that it could not be found by the police, and further, that he attempted to mislead the police by falsely showing them a pair of jeans other than the blood-spattered pair he was wearing at the relevant time. The appellant admitted that he assaulted and killed the deceased. He relied on the defence of temporary non-pathological criminal incapacity resulting from a combination of severe emotional stress, provocation and a measure of intoxication, thus placing in dispute whether at the material time he could distinguish between right and wrong and act in accordance with that distinction. The appellant's defence was rejected and he was convicted on both charges. On the murder charge the appellant was sentenced to 15 years' imprisonment, five years of which were conditionally suspended. On the charge of obstructing the ends of justice the appellant was sentenced to imprisonment for nine months. The appellant appealed against this conviction of murder.

The primary issue in this appeal was whether the appellant lacked criminal capacity at the time he killed the deceased. It was conceded on behalf of the

appellant that at the relevant time he was able to distinguish between right and wrong. It was contested that he was able to act in accordance with the appreciation. In the alternative it was submitted on behalf of the appellant that the State failed to prove beyond reasonable doubt that the appellant had the necessary intention to kill the deceased and that the proper verdict would be culpable homicide.

With regard to the defence raised, Navsa JA started by noting:⁵⁰³

“It is well established that when an accused person raises a defence of temporary non-pathological criminal incapacity, the State bears the onus to prove that he or she had criminal capacity at the relevant time. It has repeatedly been stated by this court that:

- (i) in discharging the onus the State is assisted by the natural inference that in the absence of exceptional circumstances a sane person who engages in conduct which would ordinarily give rise to criminal liability, does so consciously and voluntarily;
- (ii) an accused person who raises such a defence is required to lay a foundation for it, sufficient at least to create a reasonable doubt on the point;
- (iii) evidence in support of such a defence must be carefully scrutinised;
- (iv) it is for the court to decide the question of the accused’s criminal capacity, having regard to the expert evidence and all the facts of the case, including the nature of the accused’s actions during the relevant period.”

At the trial, expert evidence of a psychologist and two psychiatrists, who all conducted interviews with the appellant, was presented to the court. The evidence tendered by the three experts will accordingly be summarised.

Mr Stephen Lay, a psychologist employed at Valkenberg Psychiatric Hospital’s forensic unit, testified in support of the State’s case. His assessment of the appellant established the following.⁵⁰⁴

⁵⁰³ At 666 A-D. See also Schulze, H “Criminal Law – *S v Eadie* 2002 (3) SA 719 (SCA)” (2002) *De Rebus* (413) at 38.

- The appellant was someone who bottled up his emotions and who had personality problems, which gave rise to difficulties in his employment, family and other relationships.
- There were no indications of post-traumatic stress syndrome as a result of prior traumatic events in the appellant's life which could have resulted in the appellant's behaviour towards the deceased.
- In assaulting the deceased, the appellant was motivated by anger.
- The intake of alcohol played a role in the appellant's conduct.
- The appellant's actions were rational, purposeful and goal-directed.
- The appellant had the necessary cognitive ability to have realised that the deceased had fallen after the first blow.
- The appellant had a full recall of the events.
- The appellant had not "lost control" at the time he perpetrated the assault on the deceased. This term is also used much too loosely and is vague.
- Mr Lay did not accept that the appellant lacked criminal capacity when he assaulted and killed the deceased.

Dr Sean Kaliski, a psychiatrist and head of the forensic psychiatric unit at Valkenberg Psychiatric Hospital, also testified in support of the State's case. His evidence was as follows:⁵⁰⁵

- The appellant was able to appreciate the wrongfulness of the acts perpetrated by him and to act accordingly.
- Dr Kaliski is sceptical of the defence of non-pathological incapacity.
- According to Dr Kaliski the defence has never been successfully established.
- Dr Kaliski saw no difference in a defence of sane automatism and non-pathological incapacity.
- A person who acts in a state of sane automatism would typically have been subjected to a great deal of stress producing a state of internal tension

⁵⁰⁴ At 696 C-H.

⁵⁰⁵ At 696 I-670 A-J.

building to a climax which in most cases is reached after the person concerned has endured ongoing humiliation and abuse.

- The climax is triggered by an event unusual in its intensity or unpredictable in its occurrence.
- When one acts in this state one's cognitive functions are absent.
- Acts perpetrated in this state may appear to be purposeful but will typically be out of character.
- When the period of automatism has passed the person concerned regains his senses and is usually bewildered and horrified by the results of such actions. There would be no effort to escape from the scene.
- Persons acting in this manner usually claim amnesia.
- If the appellant did not know what he was doing his actions would have been less goal-directed.
- The appellant's assertion that he "lost control" must be carefully examined. The expression itself is used too loosely. It is common for people to lose their temper and to commit regrettable acts when they should have known better.
- The appellant did not show any signs of post-traumatic stress disorder following a prior incident.
- Even though the appellant had in the past not engaged in acts involving the degree of violence seen in the attack on the deceased, he nevertheless had a history of engaging in regrettable conduct and acting impulsively.
- The appellant was subjected to provocation and other stressors but faced no more than that faced by scores of people who do not resort to this kind of behaviour.
- Dr Kaliski accepted that courts have held that in certain circumstances a combination of factors such as stress, provocation and alcohol may cause a person to lack criminal capacity. His experience, however, led him to believe that temper and rage disinhibit people but do not rob them of control.
- Dr Kaliski stated that he may be willing to concede the validity of a defence of non-pathological criminal incapacity due to stress and provocation in the face of compelling facts.

Dr Ashraf Jedaar, a psychiatrist employed at Valkenberg Psychiatric Hospital's forensic unit, testified in support of the appellant's case. He testified the following:⁵⁰⁶

- In his view the appellant's description of the sensations experienced by him during the attack on the deceased is indicative of an altered state of consciousness, also referred to in psychiatry as a dissociative state. It indicated a heightened emotional state, which affected his cognitive functions and led to an inability to control his behaviour.

Dr Jedaar testified:⁵⁰⁷

“So although there was a perception or at least a recognition that there was an injury inflicted on the deceased, he was unable to control the continued assault on the deceased due to his disturbed cognition.”

- Dr Jedaar considered it important that the appellant was concerned about the safety of his family.
- Dr Jedaar differed from Dr Kaliski and stated that a defence of sane automatism differs from the defence asserted by the appellant in that a person acting in a state of sane automatism has an absolute absence of cognitive control due to intense emotional arousal whereas the appellant had intact but disturbed cognition due to emotional factors.
- Dr Jedaar was of the view that the appellant's purposeful, goal-directed and well-coordinated behaviour masks the fact that his cognition had been disturbed.
- Dr Jedaar concluded that due to the effect of the alcohol consumed by the appellant, his personality and the provocation by the deceased, he reached a point where his emotional state was such that his actions were involuntary.
- Dr Jedaar conceded that in this heightened emotional state the appellant would have been able to make decisions about what and whom he wanted to attack. The appellant lost his power to render decisions from the time that

⁵⁰⁶ At 671 B-J.
⁵⁰⁷ At 671 E.

the hockey stick broke due to the perceived threat from the deceased. This was the trigger that deprived him of the power of decision-making.

- The thrust of Dr Jedaar’s evidence was to the effect that the appellant was unable to control his actions at the relevant time.
- Dr Jedaar also testified that persons who have not had their cognitive ability disturbed might well experience the sensations experienced by the appellant.
- Counsel for the State referred Dr Jedaar to his evidence in another case in which he testified that it is only possible within the context of mental illness that a person can be driven by an irresistible impulse.⁵⁰⁸
- Dr Jedaar distinguished his evidence in this case from that in the former by stating that the appellant was acting with his cognitive faculties intact but distorted. Accordingly he conceded that the assault was the result of the appellant’s heightened emotional state and not from a conscious decision.

In the court *a quo* Griesel J referred to the confusion between the defences of temporary non-pathological criminal incapacity and sane automatism⁵⁰⁹. He noted that courts have scrutinised the asserted defences with circumspection⁵¹⁰. He noted that the appellant’s behaviour at the relevant time was focused and goal-directed and took into account against the appellant his deceitful behaviour after the incident. Griesel J was of the view that the appellant’s clear account of events established conscious behaviour. He further stated that neither the court nor the psychiatrists could rely on the appellant’s version relating to his defence of criminal incapacity. Griesel J held that the appellant did not lose control but that he merely lost his temper⁵¹¹. Griesel J also held that in the light of the savage and sustained nature of the attack on the deceased and also that it was directed at the head of the deceased, that the appellant had the necessary intention to kill⁵¹².

⁵⁰⁸ See *S v Moses supra* note 1 at 711 E: “A person can never lose control except in a state of automatism or other pathological states. Even in a state of rage or extreme anger. I am still of the same belief that you still have the cognitive ability to weight the expression of that rage.” The evidence presented by Dr Jedaar is discussed in detail *supra*, but Hlope J held: “... it flies in the face of South African Law.”

⁵⁰⁹ At 178 A.

⁵¹⁰ At 178 D-E.

⁵¹¹ At 182 H-I.

⁵¹² At 185 A.

On appeal the appellant’s counsel submitted that the court confused the defence of automatism and the defence of non-pathological criminal incapacity and that Griesel J failed to appreciate that since the appellant was able to distinguish between right and wrong, his cognitive abilities were in place and goal-directed behaviour could be expected. It was contended that the learned judge misdirected himself when he took into account against the appellant that his behaviour was focused and goal-directed.⁵¹³ It was submitted that the correct finding would have been to the effect that the appellant was unable to control himself as a result of the emotional stress and provocation he was subjected to.

With respect to Dr Kaliski’s evidence, Navsa JA held:⁵¹⁴

“Dr Kaliski equated automatism with the defence asserted by the appellant in the present case and his explanation makes it clear that in his view the only circumstance in which one could ‘lose control’ is where one’s cognitive functions are absent and consequently one’s actions are unplanned and undirected.”

Dr Jedaar’s testimony in this case stands in contrast to his testimony presented in the *Moses*-decision.⁵¹⁵ Navsa JA stated: “Jedaar, as we can see, has undergone a conversion since he testified in that case.”⁵¹⁶ Navsa JA also discussed the views of Louw⁵¹⁷ with regard to the question of automatism versus non-pathological criminal incapacity. Louw in his article submits:⁵¹⁸

“However, in one respect, capacity appears to be similar to conduct. This relates to the second leg of the capacity inquiry whether the accused was able to control himself in accordance with his appreciation of right and wrong. In other words, capacity is absent where the accused lacks self-control. It is far from clear in our law when self-control is absent.”

⁵¹³ At 673 B-C.

⁵¹⁴ At 683 B.

⁵¹⁵ See *S v Moses supra* note 1 at 711 E.

⁵¹⁶ At 686 A.

⁵¹⁷ Louw (2001) *supra* note 1 at 207-208.

⁵¹⁸ *Ibid.*

In Louw's view the decisions in the *Nursingh* and *Moses* cases added to the confusion and a decision needs to be rendered as to whether automatism and non-pathological criminal incapacity are two identical or distinct defences.⁵¹⁹

Louw also submits that logic dictates that we cannot draw a distinction between automatism and lack of self-control. He argues that if the two were distinct it would be possible to exercise conscious control over one's actions (the automatism test) while simultaneously lacking self-control (the incapacity test). Louw submits further that if there is no distinction, the second leg of the test as set out in the *Laubscher*⁵²⁰ case should fall away – capacity would then be determined solely on the basis of whether the person is able to appreciate the difference between right and wrong.⁵²¹

Navsa JA held the following:⁵²²

“I agree with Ronald Louw that there is no distinction between sane automatism and non-pathological incapacity due to emotional stress and provocation. Decisions of this court make that clear. I am, however, not persuaded that the second leg of the test expounded in *Laubscher's* case should fall away. It appears logical that when it has been shown that an accused has the ability to appreciate the difference between right and wrong, in order to escape liability, he would have to successfully raise involuntariness as a defence. However, the result is the same if an accused's verified defence is that his psyche had disintegrated to such an extent that he was unable to exercise control over his movements and that he acted as an automaton – his acts would then have been unconscious and involuntary. In the present contest, the two are flip sides of the same coin.”

And further:

⁵¹⁹ At 688 D where Navsa JA refers to the article of Louw (2001) *supra* note 1.

⁵²⁰ *S v Laubscher supra* note 1 at 166G-167A.

⁵²¹ At 688 G-I.

⁵²² At 689 B-C. See also *S v Scholtz* 2006 (1) SACR 442 (EPD) where a part of this dictum was again referred to. The latter decision will be discussed *intra*.

“Whilst it may be difficult to visualise a situation where one retains the ability to distinguish between right and wrong yet lose the ability to control one’s actions it appears notionally possible.”⁵²³

Navsa JA noted that the view espoused by Snyman and others, and reflected in some of the decisions of our courts, entailing that the defence of non-pathological criminal incapacity is a distinct and separate from a defence of automatism, followed by an explanation that the former defence is based on a loss of control, due to an inability to restrain oneself, or an inability to resist temptation, or an inability to resist one’s emotions, does injustice to the fundamentals of any “self-respecting system of law”⁵²⁴. Navsa JA noted⁵²⁵ that such approach proclaimed that someone who gives in to temptation may be excused from criminal liability, because he may have been so overcome by the temptation that he lost self-control giving rise to a variation on the theme: ‘the devil made me do it’.”

And further:⁵²⁶

“No self-respecting system of law can excuse persons from criminal liability on the basis that they succumbed to temptation.

... When an accused acts in an aggressive goal-directed and focused manner, spurred on by anger or some other emotion, whilst still able to appreciate the difference between right and wrong and while still able to direct and control his actions, it stretches credulity when he then claims, after assaulting or killing someone, that at some stage during the directed and planned manoeuvre he lost his ability to control his actions. Reduced to its essence it amounts to this: the accused is claiming that his uncontrolled act just happens to coincide with the demise of the person who prior to that act was the object of his anger, jealousy or hatred.”

⁵²³ At 689 I.

⁵²⁴ At 689J-690A.

⁵²⁵ *Ibid.*

⁵²⁶ At 690C-G (paragraphs 60-61)

With regards to a possible objective criterion to be used in assessing capacity, Navsa JA⁵²⁷ agreed that the greater part of the problem could be traced to the misapplication of the test for criminal capacity and a too-readily acceptance of the accused's *ipse dixit* concerning his state of mind. Navsa JA noted that it is desirable to test an accused's evidence about his state of mind, not only against his prior and subsequent conduct but also against the court's experience of human behaviour and social interaction.⁵²⁸

The court per Navsa JA made the following findings:⁵²⁹

- It was common cause that the appellant did not at the relevant time act in a state of automatism.
- The appellant intended to be violent and destructive.
- The appellant's deceitful behaviour immediately after the event should count against him.
- Dr Kaliski's approach to the defence relied upon is to be preferred to that of Dr Jedaar.
- The dismissal of Dr Jedaar's view of non-pathological criminal incapacity by the court in *Moses*, appears to be an explanation for the change in his approach to this particular defence.
- Dr Jedaar's evidence revealed a number of inconsistencies and unsatisfactory explanations.
- The appellant lost his temper and not control over his actions.
- The appellant had the intention to kill.

Navsa JA concluded by stating:⁵³⁰

"It must now be clearly understood that an accused can only lack self-control when he is acting in a state of automatism. It is by its very nature a state that will be rarely encountered. In future, courts must be careful to rely on sound

⁵²⁷ At 691 C-D.

⁵²⁸ *Ibid.*

⁵²⁹ At 691 F-692 F.

⁵³⁰ At 693 G-H.

evidence and to apply the principles set out in the decisions of this court. The message that must reach society is that consciously giving in to one's anger or to other emotions and endangering the lives of motorists or other members of society will not be tolerated and will be met with the full force of the law.”

The appeal was dismissed. This decision laid down by Navsa JA has been the subject of debate by many leading authors in Criminal Law. It is now necessary to discuss the various academic opinions and discussions advanced in respect of the *Eadie*-judgment.

13.2.1 Academic opinion advanced in respect of the *Eadie*-decision

According to Burchell and Milton⁵³¹ the Roman and Roman-Dutch law did not regard anger, jealousy or other emotions as excuses for any criminal conduct, but only as factors relevant to mitigation of sentence. It was only at a later stage when the partial excuse rule was rejected⁵³² when a new approach emerged in terms of which evidence of provocation became relevant, not only to the existence of intention, but also in respect of criminal capacity. The courts started accepting that any factor, albeit intoxication, provocation or emotional stress, could impair criminal capacity, which is assessed essentially subjectively, and lead to an acquittal.⁵³³

Eventually the concept of provocation was broadened to include emotional stress and the courts also started to distinguish between the concepts of non-pathological and pathological criminal incapacity.

As was discussed in the preceding sections, in three High Court decisions and one Supreme Court of Appeal decision, the defence of non-pathological criminal incapacity was raised successfully and the accused persons were acquitted.⁵³⁴

⁵³¹ Burchell and Milton (2005) *supra* note 1 at 427.

⁵³² See *S v Bailey* 1982 (3) SA 772 (A) at 796.

⁵³³ Burchell and Milton (2005) *supra* note 1 at 428.

⁵³⁴ See Burchell and Milton (2005) *supra* note 1 at 428. See also *S v Wiid supra* note 1; *S v Arnold supra* note 1; *S v Nursingh supra* note 1 and *S v Moses supra* note 1.

These acquittals were based on evidence of provocation or emotional stress experienced by the accused persons at the time of, or before, the killing which consequently resulted in the finding that criminal capacity had not been proved beyond reasonable doubt. Accordingly an accused person was afforded a possibility of a complete acquittal if sufficient, compelling evidence adduced in his or her favour could create a reasonable doubt regarding criminal capacity.⁵³⁵

It was, however, cautioned that, if the accused's version of events was unreliable, the psychiatric or psychological evidence adduced in favour of the defence of non-pathological incapacity, which was inevitably based on the accused's version of events, would also lack credibility.⁵³⁶

In *S v Eadie*, Navsa JA reviewed the jurisprudence on provocation and emotional stress, and indicated that, although the test of criminal capacity might still be essentially subjective, the test had to be approached with caution.

According to Burchell and Milton⁵³⁷ the judgment of the Supreme Court of Appeal in *S v Eadie*, is open to three possible interpretations:

- (a) The first interpretation which according to Burchell and Milton is the most likely to find resonance in future courts, focuses only on the accepted process of judicial inference of the presence or absence of subjective capacity from an examination of objective facts and circumstances.
- (b) The second interpretation implies a possible restriction of the ambit of the defence of lack of capacity (with specific reference to a lack of conative capacity) to a situation where automatism is present and involves a redefining of the actual subjective criterion of capacity, shifting the entire test of capacity from the subjective to the objective domain.

⁵³⁵ Burchell and Milton (2005) *supra* note 1 at 428-429.

⁵³⁶ See *S v Potgieter supra* note 1.

⁵³⁷ Burchell and Milton (2005) *supra* note 1 at 430. See also Burchell, J "A Provocative response to subjectivity in the Criminal Law" (2003) *Acta Juridica* at 23.

- (c) The third interpretation is that Navsa JA did not replace the entire existing subjective test of capacity with an objective test in provocation cases, but in fact identified an essential objective aspect in an otherwise subjective test of capacity that, as Burchell and Milton state, had always been lurking there, but had not received proper judicial recognition.

According to Burchell and Milton this third interpretation constitutes an intermediate position between (a) and (b) above and could develop the common law without infringing the principle of legality or necessitating lengthy legislative reform. Support for the first interpretation can be found in the judgment by Navsa JA where he states:⁵³⁸

“I agree that the greater part of the problem lies in the misapplication of the test. Part of the problem appears to me to be a too-readily acceptance of the accused’s *ipse dixit* concerning his state of mind. It appears to me to be justified to test the accused’s evidence about his state of mind, not only against his prior and subsequent conduct but also against the court’s experience of human behaviour and social interaction. Critics may describe this as principle yielding to policy. In my view it is an acceptable method for testing the veracity of an accused’s evidence about his state of mind and as a necessary brake to prevent unwarranted extensions of the defence.”

According to Burchell and Milton Navsa JA was not talking about revising the test for capacity, but rather applying it correctly, using permissible inferences from objective facts and circumstances.⁵³⁹ Accordingly, courts must not too readily accept the accused’s own evidence regarding provocation or emotional stress and a court is entitled to draw a legitimate inference from what hundreds of thousands of other people would have done under the same circumstances. This inference would also result in a more cautious approach when an accused simply states that he or she lacked capacity or acted involuntarily under provocation or emotional stress.

⁵³⁸ At 691 B-C paragraph 64. This part of the judgment was also quoted above during the exposition of the judgment.

⁵³⁹ Burchell and Milton (2005) *supra* note 1 at 431.

What also becomes apparent from Navsa JA's judgment⁵⁴⁰ is the distinction between instances of provocation that have accumulated over a period of time and those instances where a person merely loses his or her temper. A gradual disintegration of one's power will be more condonable than a sudden loss of temper.⁵⁴¹ The evidence adduced by an accused who, as a result of a sudden flare up of temper, kills someone, would have to be sufficiently cogent to create reasonable doubt in his or her favour, before a court would consider acquitting him or her. The court would then be entitled to factor an evaluation of the accused's version against judicial expectations of behaviour into the sequence of inferential reasoning, leading to a conclusion on the credibility of the accused's evidence.⁵⁴²

A realistic way for a court to rein the application of the purely subjective concept of capacity, short of engaging in judicial legislation in order to render the test objective in nature, would be to fall back on the drawing of legitimate inferences of the presence or absence of subjectively assessed capacity from objective circumstances.⁵⁴³

Inferential reasoning is resorted to most frequently when there is an absence of direct evidence and reliance is placed on circumstantial evidence. Evidence of the state of a person's mind or his or her capacity is most frequently circumstantial, or cannot be substantiated by direct evidence, apart from the evidence presented by the person himself or herself.⁵⁴⁴

Burchell and Milton submit that psychiatric or psychological evidence as to a person's state of mind or criminal capacity is notoriously unreliable, because it is essentially based on the accused's *ipse dixit* which leads to the need for inferential reasoning.

⁵⁴⁰ At 672 I.

⁵⁴¹ Burchell and Milton (2005) *supra* note 1 at 432.

⁵⁴² *Ibid.*

⁵⁴³ Burchell and Milton (2005) *supra* note 1 at 434.

⁵⁴⁴ Burchell and Milton (2005) *supra* note 1 at 436. See also Navsa JA's comments on the *Moses* and *Gesualdo* decisions in *S v Eadie* (2) *supra* note 1 at paragraphs 49 and 50.

It is submitted that psychiatric and psychological evidence as to a person's state of mind, plays a pivotal role in cases where the defence of criminal incapacity is raised. Even if the subjective test for capacity imports objective circumstances from which inferences can be deduced, psychiatric and psychological evidence will assist the fact-finder in order to better evaluate whether the accused's reliance on the defence of incapacity is merely fiction or whether it is reasonably possibly true that the accused lacked criminal capacity at the relevant time when the said crime was committed.

Psychological factors which have a bearing on a person's mental faculties which could result in criminal incapacity have to be assessed by practitioners trained in the discipline. Evidence in this regard has to be placed before the court in order to arrive at an informed decision.

With respect to the second interpretation, (b) set out above, Burchell and Milton correctly state that, in essence, the conative inquiry into criminal capacity relates to the capacity to act voluntarily or rationally and the voluntariness inquiry is focused on whether the accused actually did act voluntarily and control his or her conscious will. If a particular person lacks the capacity to act voluntarily in particular circumstances there would be no reason to inquire into whether he or she in fact acted voluntarily because an acquittal on the basis of non-pathological incapacity would result.⁵⁴⁵

Navsa JA states in his judgment "... there is no distinction between sane automatism and non-pathological incapacity due to emotional stress and provocation."⁵⁴⁶

Burchell and Milton, however, submit that it would be tendentious and incorrect to take this quotation out of its context and conclude that the entire defence of provocation, in its form of lack of capacity as opposed to involuntary conduct, virtually ceases to exist after *Eadie*. In the context of a person who acts involuntarily, there is no need to proceed any further in determining liability

⁵⁴⁵ *Ibid.*

⁵⁴⁶ At 689 B paragraph 57.

because such person will inevitably also lack capacity and, incidentally, *mens rea* as well.⁵⁴⁷

With regards to the third interpretation, (c) mentioned above, Burchell and Milton state that the second part of the capacity test involves an inquiry, in essence, as to whether the accused could have acted differently.⁵⁴⁸ If the second leg of the capacity inquiry is regarded as “the capacity to act differently”, then the inquiry must imply an evaluation of the accused’s conduct against some other standard of conduct, extrinsic to the accused himself or herself. In other words, the test for capacity must have a normative or evaluative dimension, as well as the subjective aspect of determining the accused’s conduct within the specific circumstances and against the standard of persons falling into a particular grouping. This criterion is not applicable to insane persons and persons suffering from mental illness or defect. Accordingly, the subjective test not only takes account of the accused’s subjective mental condition but also, in determining the conative aspect of capacity, the court must inquire whether the accused could reasonably be expected to have acted differently. This inquiry provides for a comparison of the accused’s conduct with the societal norms of sobriety and level-headedness. Burchell and Milton further submit that the central matter is not only whether the accused person in fact lacked criminal capacity, subjectively assessed⁵⁴⁹. The central issue is whether these accused persons could reasonably be expected to have acted differently, even taking into consideration the provocation they received or the emotional stress they endured.⁵⁵⁰ They also state that it would be timely if the courts were to acknowledge openly this hidden, but nevertheless implicit, normative aspect of the second part of the capacity inquiry⁵⁵¹.

Burchell and Milton further submit that the judgment in *Eadie* provides courts with a salutary reminder of how the legitimate process of inferential reasoning can help to bring some common sense back into the judicial approach to cases where

⁵⁴⁷ Burchell and Milton (2005) *supra* note 1 at 437. See also Snyman, CR “Criminal Justice in a New Society” (2003) *Acta Juridica* 1.

⁵⁴⁸ Burchell and Milton (2005) *supra* note 1 at 440.

⁵⁴⁹ Burchell and Milton (2005) *supra* note 1 at 443.

⁵⁵⁰ *Ibid.*

⁵⁵¹ *Ibid.*

provocation or emotional stress are raised as defences⁵⁵². They also state that the *Eadie*-judgment did not impart non-existent objective elements into the defence of lack of criminal capacity⁵⁵³. It could not have been introduced without specifically, rather than by implication, over-ruling various previous decisions where criminal capacity was in issue. The conative, or second part, of the capacity inquiry, which entails the subjective assessment of capacity of the accused to act in accordance with his or her appreciation of the unlawfulness (or wrongfulness) of his or her conduct inevitably contains an evaluative dimension.⁵⁵⁴

It is a pity that more could not be gathered as to the value attached to expert evidence in support of the defence of criminal incapacity as displayed in *Eadie*. In retrospect it almost seems as though the expert evidence in *Eadie* contributed more to confusion than to clarity. It is submitted that importing a normative or objective element to the subjective enquiry as discussed by Burchell and Milton and also by Navsa JA in *Eadie*, could be of much help to courts in the assessment of the validity of the defence of non-pathological criminal incapacity. In this regard expert evidence will also play a pivotal role in assessing not only the accused's conduct at a relevant stage, but also in the presentation of evidence of the characteristics, emotional makeup and profile of a person within the same circumstances and surrounding circumstances that the particular accused found himself or herself at the time of the crime.

It is clear from the judgment in *Eadie*, as delivered by Navsa JA, that there is, according to this judgment, no distinction between non-pathological criminal incapacity due to emotional stress or provocation, on the one hand, and the defence of sane automatism on the other. According to the court, there is no difference between the second (conative) leg of the test for criminal capacity, which connotes the accused's ability to act in accordance with the appreciation of the wrongfulness of the act, and the requirement which applies to the conduct element namely that a person's bodily movements must be voluntary. If an accused alleges that, as a result of provocation, his or her psyche had

⁵⁵² Burchell and Milton (2005) *supra* note 1 at 444.

⁵⁵³ *Ibid.*

⁵⁵⁴ Burchell and Milton (2005) *supra* note 1 at 445.

disintegrated to such an extent that he or she could no longer control himself or herself, it amounts to an allegation of inability to control bodily movements and, therefore, involuntary conduct.⁵⁵⁵ Snyman submits, and this view can respectfully be supported, that the Supreme Court of Appeal was correct in dismissing the appeal and confirming the accused's conviction of murder.⁵⁵⁶ Snyman submits that the argument followed by the court in arriving at its conclusion is wrong: "The judgment is a good example of a correct decision arrived at for the wrong reasons."⁵⁵⁷

As Snyman correctly submits, there is indeed a difference between the ability to control muscular movements, on the one hand, and the ability to act in accordance with insight into right and wrong, on the other. The test for determining whether somebody performed a voluntary act is merely to ascertain whether that person was capable of subjecting his or her muscular movements to his or her will or intellect. The person must be capable of making a decision about the conduct and of executing this decision.⁵⁵⁸ The ability to act in accordance with an appreciation of right or wrong is something different. Here the person does perform a voluntary act, but lacks the (conative) ability to set himself or herself a goal, to pursue it, and to resist impulse or desires to act in a manner contrary to what his or her insights into right and wrong reveal to him or to her.⁵⁵⁹ A person may thus have the ability to perform a voluntary act yet at the same time lack the ability to act in accordance with his or her appreciation of the wrongfulness of conduct. Snyman also indicates that to regard these two distinct tests as one, is furthermore incompatible with the provisions of both section 78(1) of the Criminal Procedure Act, dealing with the test for criminal responsibility of people alleged to be mentally ill, as well as section 1 of the Criminal Law Amendment Act,⁵⁶⁰ which creates the offence of "statutory intoxication". Snyman, respectfully, correctly states that by rejecting the basic difference between the test to determine the presence of a voluntary act and the conative test for capacity, some of the keystone concepts of criminal liability

⁵⁵⁵ Snyman (2003) *Acta Juridica supra* note 545 at 1.

⁵⁵⁶ See also Snyman (2006) *supra* note 1 at 164.

⁵⁵⁷ Snyman (2003) *Acta Juridica supra* note 545 at 15.

⁵⁵⁸ *Ibid.*

⁵⁵⁹ *Ibid* Snyman (2006) *supra* note 1 at 164.

⁵⁶⁰ Act 1 of 1988.

are losing their meaning.⁵⁶¹ It accordingly does not make sense to approach reliance upon the absence of one element of liability as reliance on another element of liability.⁵⁶²

Snyman also indicates that the court's equation of the inability to perform a voluntary act with the inability to act in accordance with an insight into right and wrong is irreconcilable with the same court's statement in the earlier case of *Chretien*⁵⁶³ where it was held that if someone commits an act, but he is so intoxicated that he does not know what he is doing or that what he is doing is unlawful, he does not have criminal capacity.

Snyman also refers to Navsa JA's statement that the phenomenon of sane people temporarily losing "cognitive control" is rare.⁵⁶⁴ Control within this context refers to the conative mental function, not to the cognitive function. The cognitive function refers to a person's reason or intellect which refers to his or her ability to distinguish between right and wrong.

Another pivotal observation by Snyman as to why the court's equation of the conative leg of the test for capacity with the requirement that the act must be voluntary cannot be supported is the fact that it is not only a positive act that may form the basis of criminal liability, but also an omission. Both a positive act as well as an omission must be voluntary to render a person liable for a crime.⁵⁶⁵ Accordingly, if the court is correct in equating the two abilities, then the same principles must apply *mutatis mutandis* to omissions: the requirement that the omission must be voluntary must then be the same as the ability to act in accordance with one's insight into right and wrong. It follows that the defences of automatism (involuntary conduct) and conative inability are not the same.

Snyman also indicates that the whole concept of criminal capacity with reference to Germany and Switzerland, hails to Continental Law, and one of the

⁵⁶¹ Snyman (2003) *Acta Juridica supra* note 545 at 17.

⁵⁶² Snyman (2006) *supra* note 1 at 166.

⁵⁶³ *S v Chretien supra* note 1 at 1106 F.

⁵⁶⁴ *S v Eadie supra* note 1 at 691 E paragraph 65.

⁵⁶⁵ Snyman (2003) *Acta Juridica supra* note 545 at 19.

fundamentals of liability in these systems is the distinction which is drawn between muscular movements performed in a state of automatism, on the one hand, and loss of self-control which denotes the absence of the conative leg of the test for capacity, on the other.⁵⁶⁶

Louw⁵⁶⁷ in his first article where he discussed the *Eadie*-judgment and also the article that Navsa JA refers to in the judgment in *Eadie*⁵⁶⁸ takes the view that a major obstacle in this case as well as with reference to the second leg of the capacity enquiry, is the fact that there is no clear understanding of the nature of “lack of self-control”. He states that the problem might lie in the fact that it is a legal construction without a psychological foundation. Louw is of the opinion that according to logic, we cannot draw a distinction between automatism and lack of self-control and that in the event of the two being distinct defences, it would be possible to exercise control over one’s actions. Louw further submits that if there is not distinction, then the second leg of the capacity inquiry should fall away⁵⁶⁹:

“Capacity should then be determined solely on the basis of whether a person is able to appreciate the difference between right and wrong. Once an accused is shown to have capacity, the accused may then raise involuntariness as a defence. We will then also have a sounder principle and body of law to rely on in assessing the defences.”

Navsa JA, however, in the *Eadie*-judgment, differed from Louw by stating:⁵⁷⁰

“I am, however, not persuaded that the second leg of the test expounded in *Laubscher’s* case should fall away.”

Louw in his second article submits that the motivation for the statement by Navsa JA in terms of which there is no distinction between sane automatism and provocation lies in the following statement by Navsa JA:⁵⁷¹

⁵⁶⁶ Snyman (2003) *Acta Juridica supra* note 545 at 20.

⁵⁶⁷ Louw (2001) *SACJ supra* note 1 at 206-216.

⁵⁶⁸ At 689 B-C paragraph 57.

⁵⁶⁹ Louw (2001) *SACJ supra* note 1 at 211.

⁵⁷⁰ At 689 B paragraph 57.

“... When an accused acts in an aggressive goal-directed and focused manner, spurred on by anger or some other emotion, whilst still able to appreciate the difference between right and wrong and while still able to direct and control his actions, it stretches credulity when he then claims, after assaulting or killing someone, that at some stage during the directed and planned manoeuvre he lost his ability to control his actions ...”

Louw in his second article agrees with the fact that the following statement by Navsa JA is impossible.⁵⁷²

“Whilst it may be difficult to visualise a situation where one retains the ability to distinguish between right and wrong yet lose the ability to control one’s actions it appears notionally possible.”

Louw, however, states that the second leg of the capacity test should be eliminated completely. The first leg of the capacity test should accordingly be linked to the *mens rea* inquiry⁵⁷³.

According to Louw, where an accused might not appreciate the difference between right and wrong, he would lack the capacity to form an intention. This would then expose the accused to a negligence inquiry where he would be acquitted. According to Louw this would re-introduce provocation as a “partial defence”. Louw further submits that it should first be asked whether the accused was acting voluntarily (self-control). If it is established that he was, then it should be asked whether he has the capacity to form intention. An accused who acted involuntarily will then be acquitted as there was no *actus reus*. However, if it is established that the accused did perform a voluntary act, the next question to be asked is whether the accused was able to distinguish between right and wrong such that he or she was able to form intention. If he is able to, he will be found

⁵⁷¹ At 690 E-G paragraph 61. This part of the judgment was also quoted in the discussion of the facts of and decision *supra*. See also Louw (2003) *SACJ supra* note 1 at 201-202.

⁵⁷² Louw (2003) *SACJ supra* note 1 at 205; *S v Eadie supra* note 1 at 689 I paragraph 59.

⁵⁷³ *Ibid*.

guilty, if he is not he will not necessarily be acquitted, but may still be liable on the basis of negligence.⁵⁷⁴ Louw concludes by stating:⁵⁷⁵

“If the non-pathological capacity test were eliminated as an inquiry separate from the inquiry into the *actus reus* and *mens rea*, the problems of the provocation defence would be resolved without having to artificially introduce an objective test.”

It is submitted that the view expounded by Louw is problematic. It will not only lead to confusion but will also be contrary to the principle of legality.

As Le Roux⁵⁷⁶ correctly points out, sane automatism is a defence excluding the voluntariness of an act. Voluntariness merely refers to the fact that a person’s muscular movements are controlled by the will. A person can lack criminal capacity either as a result of a lack of the capacity to appreciate the nature and the wrongfulness of an act or omission (absence of the cognitive function) or as a result of a lack of the ability to act in accordance with such appreciation (absence of the conative function).

Involuntariness of an act and lack of self-control are not the same. Le Roux also correctly submits that where a person (the accused) assaults another person until the victim eventually dies, the conduct of the accused is indicative of the fact that the accused focused on the deceased in such a manner that he did in fact act voluntarily. In the latter situation, an accused did in fact exercise control over his muscular movements and acted voluntarily. Le Roux correctly states that where a person temporarily lacks criminal capacity as a result of an inability to act in accordance with the appreciation of the wrongfulness of the conduct such a person, nevertheless still acts voluntarily. The lack of criminal capacity accordingly does not have a bearing on the voluntariness of the conduct of the accused.

⁵⁷⁴ Louw (2003) *SACJ supra* note 1 at 206.

⁵⁷⁵ *Ibid.*

⁵⁷⁶ Le Roux (2002) *THRHR supra* note 1 at 478.

Hector⁵⁷⁷ also correctly submits that lack of conative capacity does not result in involuntary behaviour. Hector notes:

“This tendency to mistakenly conflate these two concepts, giving rise to the perception that they are practically indistinguishable, has no doubt recently been aided by the South African Criminal Law Reports’ unfortunate way of reporting these matters.”⁵⁷⁸

Hector also correctly states that sane automatism relates to the *actus reus*, whereas capacity forms part of the *mens rea* inquiry.

Another aspect addressed in the *Eadie*-decision which is perhaps not of so much importance for this discussion, but nevertheless relevant, is whether the test for criminal capacity should be objective or provide for a normative element. Navsa JA stated that the “greater part of the problem lies in the misapplication of the test.”⁵⁷⁹ Navsa JA also stated:

“It appears to me to be justified to test the accused’s evidence about the state of mind, not only against his prior and subsequent conduct but also against the court’s experience of human behaviour and social interaction.”⁵⁸⁰

The abovementioned statement does indeed suggest an objective element to the current subjective test of criminal incapacity. Navsa JA, however, did not explicitly state whether the test should in future take an objective turn. It is, however, submitted that, as stated above, an objective or normative test could be of assistance and much value in cases where the defence of non-pathological criminal incapacity presents obstacles. Coupled with a strong body of expert evidence the court could be placed in a better position to render an appropriate judgment on the facts before it. In the *Moses*-decision *supra* it was unequivocally held that the test for capacity is subjective.⁵⁸¹

⁵⁷⁷ Hector (2001) SACJ *supra* note 1 at 202.

⁵⁷⁸ Hector (2001) SACJ *supra* note 1 at 204.

⁵⁷⁹ At 691 C paragraph 64.

⁵⁸⁰ At 691 C paragraph 64.

⁵⁸¹ *S v Moses supra* note 1 at 714 B-C.

Burchell and Milton⁵⁸² suggest that the conative or second part of the capacity inquiry contains an evaluative or normative dimension. Burchell and Milton state:

“It would seem that a court can only judge whether an accused had the capacity to control irrational conduct (or, perhaps more accurately, whether he or she could have acted differently) by assessing his or her conduct against a standard outside of the accused’s own capacities or capabilities.”

Louw⁵⁸³ takes the view that the introduction of an objective policy-based test for provocation does not make legal sense. It should be borne in mind that non-pathological criminal incapacity relates not only to provocation, but also to emotional stress, intoxication etcetera and it is submitted that a normative assessment could be useful in all of these instances not only determining whether an accused should be convicted or not, but even with reference to sentencing as well as a finding of diminished responsibility.

Snyman also supports the recognition of an objective element to the test for capacity and more specifically with reference to *mens rea*⁵⁸⁴ and also with reference to ignorance of the law and intoxication.⁵⁸⁵

13.2.2 The future of the defence of non-pathological criminal incapacity

The question that was raised after the *Eadie*-decision was whether this defence was abolished or not? Snyman⁵⁸⁶ is of the opinion that the defence was for all practical purposes abolished, but does still exist in situations where a person

⁵⁸² Burchell and Milton (2005) *supra* note 1 at 445.

⁵⁸³ Louw (2003) *SACJ supra* note 1 at 203.

⁵⁸⁴ Snyman (2008) *supra* note 1 at 237 and 169; Snyman (2006) *supra* note 1 at 167. Compare Burchell and Milton (2005) *supra* at 431 where it is stated: “The *Eadie* judgment signals a warning that in future the defence of non-pathological incapacity will be scrutinized most carefully”. The latter view is supported by the author and it submitted that the *Eadie* decision merely illustrates that in future an accused relying on this defence will have to establish a much stronger foundation for the defence and consequently the defence will be viewed with much more scrutiny than in the past. The latter inadvertently proclaims the essential need for expert evidence.

⁵⁸⁵ Snyman (2003) *Acta Juridica supra* note 545 at 22.

⁵⁸⁶ Snyman (2006) *supra* note 1 at 167.

alleges that he or she lacked capacity as a result of factors not directly linked to provocation such as shock, stress, fear, panic or tension. Many of these “mental states” are so closely linked to provocation that they cannot really be separated from it.⁵⁸⁷ Snyman submits that the field of application for the defence of non-pathological criminal incapacity is a limited one.⁵⁸⁸

Navsa JA states.⁵⁸⁹

“It is predictable that accused persons will in numbers continue to persist that their cases meet the test for non-pathological criminal incapacity. The law, if properly and consistently applied, will determine whether that claim is justified.”

It is submitted that this statement by Navsa JA indicates that the defence does still exist. It is a pity that the law was not better applied in the *Eadie*-decision.

Hocor⁵⁹⁰ also states the following in respect of the *Eadie*-decision:

“... the reflection of the apparently increasing tendency to conflate sane automatism and non-pathological incapacity is unwelcome. Not only is such a development retrogressive in that it is clearly unscientific (the concepts incontestably relate to different elements of criminal liability), it is also unwarrantable in that courts have typically not struggled to draw a distinction between these two concepts.”

The intended purpose behind the *Eadie*-decision remains a grey area. It seems clear that the court intended to send a warning to society to not succumb to their emotions and lose their temper in the heat of the moment and then seek to rely on the defence of non-pathological criminal incapacity to exonerate them from criminal liability. It is submitted that this goal could be achieved successfully by measuring the accused’s conduct against the established test for criminal

⁵⁸⁷ Snyman (2003) *Acta Juridica supra* note 545 at 21.

⁵⁸⁸ Snyman (2003) *Acta Juridica supra* note 545 at 22.

⁵⁸⁹ At 691 E paragraph 65.

⁵⁹⁰ Hocor (2001) *SACJ supra* note 1 at 205.

capacity. An accused's conduct, like *Eadie*, should be measured firstly to ascertain whether he or she acted voluntarily. It is clear that *Eadie* acted as such. Then the unlawfulness of the conduct should be assessed whereafter, before *mens rea* is determined, his or her criminal capacity should be determined – measured against the two legs of the capacity enquiry. Where an accused is found to have had the necessary capacity, but that it was impaired or diminished, a proper finding should be one of diminished capacity in which event the diminished capacity will only have a bearing on sentence.

The fact remains that the defences of sane automatism and non-pathological criminal incapacity are two oceans that will never meet. To conflate these two defences in order to ensure that a person does not walk out free from a crime where the circumstances indicate goal-directed behaviour, creates unnecessary confusion and doubt in our current criminal justice system. This confusion could have been avoided, had the established principles of criminal law been applied. To negate the existence of the defence of non-pathological criminal incapacity would be detrimental to our criminal law system as it would lead to one of the requirements for criminal liability to fall away in part.

13.2.3 The role of expert evidence in provocation as per the *Eadie*-decision

It is also necessary and relevant to look at the psychiatric evidence presented in the trial court in the original judgment passed by Griesel J.⁵⁹¹ It is again common cause that the defence raised by the appellant in the trial court was one of non-pathological criminal incapacity. The reason for elaborating on the aspect of expert evidence is firstly to ascertain if this in part did not play a role in the confusion that arose as to the distinction between the defences of sane automatism and non-pathological criminal incapacity. Secondly, it indicated the gap between law and medicine, specifically with reference to psychiatry and the definitions ascribed to concepts such as “automatism” and “criminal capacity”. Thirdly, it serves to illustrate that no matter how one views the scenario of non-pathological incapacity, expert evidence does play a pivotal role both in support of

⁵⁹¹ *S v Eadie* 2001 (1) SACR 172 (CPD); *S v Eadie* 2001 (1) SACR 185 (CPD) hereafter referred to as *S v Eadie* (1).

the defence and also in support of rebuttal of the defence by the State. In the absence thereof a court merely has the *ipse dixit* of the accused to rely on.

In *S v Eadie* (1) Griesel J also stated that there appears to be confusion between the defence of temporary non-pathological criminal incapacity, on the one hand, and sane automatism, on the other.⁵⁹² It was also stated by Griesel J:⁵⁹³

“At the same time, however, it is clear that in many instances the defences of criminal incapacity and automatism coincide. This is so because a person who is deprived of self-control is both incapable of a voluntary act and at the same time lacks criminal capacity.”

And further⁵⁹⁴:

“It has been repeatedly emphasised by our Courts, including the Supreme Court of Appeal, that reliance on phenomena such as automatism, amnesia and temporary non-pathological criminal incapacity must be carefully scrutinised and approached with circumspection.”

In delivering judgment, Griesel J dealt with the aspect of the psychiatric evidence separately.⁵⁹⁵ The following aspects are worth mentioning.

The essence of the accused’s defence was that at a certain stage during the events he “lost control” and was unable to stop himself. All three experts agreed that one has to look at the overall picture in order to make an assessment of his criminal capacity. In respect of the question of “losing control”, both Dr Kaliski and Mr Lay had great difficulty with the concept, which is not a psychological term.⁵⁹⁶

⁵⁹² At 178 A.

⁵⁹³ At 178 B.

⁵⁹⁴ *Ibid.*

⁵⁹⁵ At 178 F – 180 I.

⁵⁹⁶ At 179 A-J. Dr Kaliski in addition noted:

“I’d like to make two points; the first point is that I think one should just concentrate on the sequence of actions during the offence. If the man didn’t know what he was doing right, he wouldn’t have been aiming his blows specifically at the deceased because he didn’t know what he was doing. He would have been flailing about almost indiscriminately and the deceased would have been caught, by chance, by blows that were aimed at nothing in particular. ..., one can only deduce that if the blows were aimed solely at the deceased he

In response to a question put forward on behalf of the State Dr Kaliski testified the following:

When asked whether Dr Kaliski wanted to comment on Dr Jedaar's contention that the appellant (accused in this case) was not able to act in accordance with his appreciation of what is right and wrong Dr Kaliski stated:

"I just want to know why, for what reason? What were the reasons advanced for that?"

..., I think that this man was depressed, he was under a lot of pressure, he was feeling irritable, he was profoundly intoxicated – let's not forget that – he perceived what he thought to be a provocation and he lost his temper."

Dr Jedaar at the trial conceded that the behaviour of the accused at the critical time was consistent with someone making conscious decisions. He relied heavily on the allegations by the accused as to his altered sensory experiences during the attack. These sensations were indicative of a heightened state of arousal and Dr Jedaar stated that the accused may not have been in control of his actions at the relevant time. According to Dr Kaliski the symptoms described did not indicate loss of control and they are common in states of high arousal, especially when someone is extremely angry.

must have known what he was doing. ... The second point about being out of control, I don't know, this term is used so loosely and colloquially in the courts that I just want to make a few points. It is a common human characteristic to lose one's temper and when one loses one's temper one does highly regrettable things. One feels very funny about it, even afterwards and I'm sure every single person in this court has at some stage lost his or her temper and has either done something very regrettable or damaged something or even hurt someone. When they've thought about it afterwards they couldn't quite remember clearly what had happened, but it had happened. The interesting thing about losing one's temper and doing regrettable things is that you often, people often do it in situations where they know they should know better. ... People lose their tempers. As for how does one determine if someone is out of control, well the question is if you are out of control you are incapable of directing your actions purposefully and in a goal-directed fashion, you are totally out of control. If one nevertheless have a focused set of actions, albeit under the influence of anger, one cannot say you are totally out of control, all that one can say is that you have suspended your control for that period, you don't care about consequences any longer."

This clearly illustrated the unfortunate gap between law and medicine. This could probably have been a contributing cause to the confusion in this case in respect of a proper distinction between sane automatism and non-pathological criminal incapacity.

Griesel J held:⁵⁹⁷

“The fact of the matter is that in the final 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.”

And further:⁵⁹⁸

“In considering the issue of criminal capacity the court must have regard not only to the expert medical evidence but also to all the other facts of the case, including the reliability of the accused as a witness and the nature of his proved actions throughout the relevant period. By the very nature of things, he is the only person who can give direct evidence as to his level of consciousness at the time of the commission of the offence. His *ipse dixit* to the effect that his act was involuntarily and unconsciously committed or, as in the present case, that he had ‘lost control’, must therefore be weighed and considered in the light of all the circumstances and particularly against the alleged criminal conduct viewed objectively.”

Griesel J also noted that the actions, thoughts and recollections of the accused before, during and shortly after the attack on the deceased are indicative of focused, goal-directed behaviour.⁵⁹⁹

⁵⁹⁷ At 180 D.

⁵⁹⁸ At 180 G-I.

⁵⁹⁹ At 181 B-H Griesel J mentions the following actions by the accused indicative of goal-directed behaviour:

- After he stopped at the intersection he took his hockey stick from behind his seat.
- He decided to smash the headlights. He thereupon decided to smash the windscreen instead as he would inflict more damage on the deceased.
- During the whole attack he was fully conscious, to the extent that he was able to give literally a blow-by-blow account of the attack on the deceased.
- He returned to the scene after dropping his family off. He then gave a false explanation as to the presence of blood on his jeans as well as the reasons for his presence at the scene.
- He took the hockey stick and disposed of it a considerable distance away.
- He went home, took off his blood-spattered jeans and hid them.
- When requested to return to the scene with the pair of jeans worn earlier, he took with him a different pair and tried to persuade police that the jeans were in fact the right pair.
- All the witnesses who had seen him on the scene described his behaviour as normal.

Griesel J held that the accused was someone who did not hesitate to resort to lies and deceit as a way to evade criminal liability as a result of which neither the court nor the psychiatrists could rely with confidence on the version of the accused in evaluating the testimony in respect of the defence of criminal incapacity. His evidence that he lost control was therefore rejected. It was held that the accused succumbed to what has become known as “road rage”. It was held as stated above that he did not lose control, he rather lost his temper.⁶⁰⁰ Griesel J also distinguished this case from the decision delivered in *S v Wiid*.⁶⁰¹

Griesel accordingly held that the accused had the necessary criminal capacity and acted intentionally in that he did in fact foresee the possibility of his actions causing the death of the deceased, yet he consciously accepted that risk by continuing his attack on the deceased. In deriving of the later conclusion, Griesel J considered the savage and sustained nature of the attack and the seriousness of the injuries inflicted upon the deceased. He also considered the fact that the entire attack was directed at the head of the deceased, even when the latter was lying defenceless at the feet of the accused.

It is submitted that this set of facts disclosed in the *Eadie*-decision is an example of a person losing his temper as a result of provocation. It is upon a consideration of the facts and the surrounding circumstances that the defence of criminal incapacity could not avail the appellant. It is further respectfully submitted here that the defences of criminal incapacity and automatism are two distinct defences each with its own distinct requirements. These two defences cannot coincide. As was stated by the psychiatrists, “loss of control” is not a psychological term, which renders their evidence in this regard, contentious and speculative. Loss of conative ability, the ability to act in accordance with the appreciation of the wrongfulness of the act, can never be equated with conduct that is involuntary. Voluntariness refers to the muscular movements that are controlled by a person’s will or intellect.

⁶⁰⁰ At 182 G-I.

⁶⁰¹ See *S v Eadie (1) supra* note 1 at 183 A-E.

What is more problematic of the appeal judgment delivered by Navsa JA is that he stated that the second leg of the criminal capacity enquiry should not fall away. This indeed should be the case. But then after this finding, Navsa JA states:⁶⁰²

“It appears logical that when it has been shown that an accused has the ability to appreciate the difference between right and wrong, in order to escape liability, he would have to successfully raise involuntariness as a defence.”

Someone that is acting involuntary can *per se* not distinguish between right and wrong as he or she is not “acting” or performing an act in the legal sense required in order to incur criminal liability. If it is found that a person did not perform a voluntary act, he or she is acquitted on that basis. By the time the enquiry turns to criminal capacity, it was already established that the particular accused did in fact act voluntarily. If it is established that a person could not distinguish between right and wrong, he or she should be acquitted on the basis of a lack of criminal capacity. There cannot be a return to the enquiry into voluntariness when it has already been established that the accused acted voluntarily.

It is submitted that road rage is a serious phenomenon of our time and the public needs to take cognisance of the fact that such behaviour will not be tolerated. Courts should, however, be cautious not to unnecessarily confuse aspects of the material criminal law pertaining to the various defences available to an accused in order to teach the public a lesson.

The facts in *Eadie* merely indicate that reliance placed on the defence of non-pathological incapacity was unsuccessful as a result of the particular set of facts and surrounding circumstances. Any person who acted in a similar way would probably also have failed to establish the defence. This, however, does not mean that it is the end of the road for the defence of non-pathological criminal incapacity. Dr Kaliski stated that he may be willing to concede the validity of a defence of non-

⁶⁰² At 689 B-C.

pathological criminal incapacity due to stress and provocation in the face of “compelling facts”.⁶⁰³ Each case has to be considered on its own merits.

The precise role and impact of the expert evidence portrayed in the *Eadie*-decision is difficult to assess.

It is clear that Dr Kaliski’s evidence was taken in high regard by Navsa JA and preferred to the evidence by Dr Jedaar. It is a pity that the evidence tendered by Dr Kaliski contributed in part to the finding that there exists no difference in a defence of sane automatism and non-pathological criminal incapacity. Dr Jedaar’s evidence did not carry much weight as his views were viewed by the court to stand in dire contrast to those advanced by him in a prior decision. The question can be asked whether the situation would have been different had another psychiatrist other than Dr Jedaar, testified not in persuading the court to a different finding on the facts, but to clarify some of the confusion with regards to a proper distinction between the defences of sane automatism and non-pathological criminal incapacity.

What is apparent from the expert evidence is that there is a gap between law on the one hand and psychiatry and psychology on the other. This becomes clear from the expert evidence stating that “loss of control” is not a clinical term but a legal one. The medical perspective of sane automatism and non-pathological incapacity is not always in line with the legal perspective. This causes tension between law and medicine in cases where these defences are raised and this reduces the value of expert evidence.

Hocor⁶⁰⁴ states the following with regard to the expert testimony tendered in *Eadie*:

“Ultimately therefore, given the deficiencies of their reasoning, the imprecision of their terminology, and the resultant negative consequences for

⁶⁰³ At 670 J-671 A.

⁶⁰⁴ Hocor (2001) SACJ *supra* note 1 at 205.

legal clarity, those who comprise the ‘company’, in which Dr Kaliski finds himself are in fact not only peccable, but culpable.”

This view is perhaps too drastic. The conclusion that can be made as to the value that expert evidence played in *Eadie* is that it indicates that law and medicine are two completely different disciplines that view a set of facts from different perspectives. We need experts to address the court as to the mental states and attributes of an accused in order to assess the facts and circumstances properly. There is a gap between law and medicine as is evident in *Eadie*, which has to be addressed in order to obtain maximum benefit from expert evidence in cases of this nature.

Van der Merwe also notes:⁶⁰⁵

“Dit is belangrik om aan te dui en te verduidelik hoe die aanloop tot en die omstandighede van die gebeure op die beskuldigde ingewerk het en wat die uitwerking daarvan op die spesifieke persoon (met sy unieke persoonlikheid) was. Daarom is dit verkieslik om van deskundige getuies gebruik te maak om aan te dui hoedat die persoon op daardie kritieke tydstip nie kon onderskei tussen reg en verkeerd nie, en/of hy nie oor die nodige weerstand of selfbeheer beskik het nie.”

14 INTOXICATION AND NON-PATHOLOGICAL CRIMINAL INCAPACITY

14.1 General background on intoxication as a defence

Intoxication may, under certain circumstances, deprive an accused of the ability to appreciate the wrongfulness of his or her conduct or the ability or capacity to act in accordance with such appreciation.⁶⁰⁶ Intoxication can have numerous effects on

⁶⁰⁵ Van der Merwe, RP “Sielkundige perspektiewe op tydelike nie-patologiese ontoerekeningsvatbaarheid” (1997) *Obiter* 138 at 144.

⁶⁰⁶ Burchell and Milton (2005) *supra* note 1 at 403; Snyman (2008) *supra* note 1 at 220, Visser and Maré (1990) *supra* note 158 at 359; Burchell, JM “Intoxication and the Criminal Law” (1981) *SACJ* at 177; LAWSA (2004) *supra* note 12 at 86; De Wet and Swanepoel (1975) *supra* note 1 at 106; Du Toit *et al* (2007) *supra* note 1 at 13-11; Hiemstra (2007) *supra* note 1 at 216.

one's person. Intoxication may result in conditions such as impulsiveness, diminished self-criticism, over estimation of a person's abilities and underestimation of dangers.⁶⁰⁷

Burchell and Milton note that intoxication⁶⁰⁸ “removes and weakens the restraints and inhibitions which normally govern conduct and impairs the capacity to distinguish right from wrong, or to act in accordance with that appreciation.”

Curtin and Lang state the following pertaining to the effect of alcohol:⁶⁰⁹

“Among the properties of alcohol that define it as a ‘psychoactive substance’ are its ability to alter psychological processes that include emotion and cognition.”

Goldman, Brown and Christiansen also take the following view:⁶¹⁰

“If any characteristic has been seen as a central, defining aspect of alcohol use, it is the presumed capacity of alcohol to alter anxiety, depression and other moods.”

Many crimes, particularly crimes of violence, are committed when an accused is in a state of extreme or partial intoxication, usually as a result of the voluntary consumption of alcohol or drugs or a combination of the two.

⁶⁰⁷ Snyman (2008) *supra* note 1 at 221. In respect of intoxication as a defence in criminal law, see Burchell, J “Intoxication and the criminal law” (1981) *SALJ* at 177; Burchell, J “Intoxication after Chretien-Parliament intervenes” (1988) *SACJ* 274; Rabie, MA “Vrywillige dronkenskap as verweer in die Straffreg: die Chretien-saak” (1981) *South African Journal of Criminal law and Criminology* 111; Rabie, MA “Actions *liberae in causa* (1978) *THRHR* 60; Snyman, CR “Die *Actio Libera in causa*: Die benadering in die Duitse en Suid-Afrikaanse Reg” (1978) *De Jure* 227; Snyman, CR “Die *Actio libera in causa*: ‘n Onsekere wending in die Suid-Afrikaanse Reg (1984) *South African Journal of Criminal Law and Criminology* 227.

⁶⁰⁸ Burchell and Milton (2005) *supra* note 1 at 403.

⁶⁰⁹ Curtin, JJ and Lang, AR “Alcohol and Emotion: Insights and Directives from Affective Science” to appear in Rottenberg, J and Johnson, S “Emotion and psychopathology: Bridging affective and clinical science” (Washington) accessed at: [http://dionysus.psych.wisc.edu/lit/InPress/CurtinJ\(Rottenberg-chap\).pdf](http://dionysus.psych.wisc.edu/lit/InPress/CurtinJ(Rottenberg-chap).pdf) [accessed on 18/02/09].

⁶¹⁰ Goldman, MS, Brown, SA and Christiansen, BA (1987) “Expectancy theory: Thinking about drinking” in Blane, H and Leonard, K “Psychological theories of drinking and alcoholism” at 200.

The availability of a specific defence or defences to criminal liability founded on intoxication may have a pivotal effect on the perception of whether justice has been done.⁶¹¹

It is important to distinguish clearly between voluntary and involuntary intoxication:

Voluntary intoxication denotes the conscious consumption of alcohol or some drug or intoxicating substance. The individual must know or foresee that the substance may impair his or her awareness and understanding.⁶¹²

Involuntary intoxication refers to intoxication resulting from ignorant or unconscious consumption of an intoxicating substance by the accused or such consumption brought about by an absolute force over the accused. Intoxication can also be deemed involuntary if for example brought about by the use of prescribed drugs taken within the ambit of the doctor's instructions that is usually not liable to cause unpredictability or aggressiveness.⁶¹³ Involuntary intoxication is a complete defence to any crime due to the fact that the accused could not have prevented it.⁶¹⁴

The leading authority pertaining to the multiple effect of voluntary intoxication on criminal liability is the decision of the appellate division in *S v Chretien*.⁶¹⁵

⁶¹¹ See the Law Commission (Law Com 314) "Intoxication and criminal Liability" presented to the Parliament of the United Kingdom January 2009. ISBN: 9780 101752626 ("Law Commission United Kingdom").

⁶¹² Haque, Q and Cumming, I "Intoxication and Legal defences" (2003) The Royal College of Psychiatrists – Advances in Psychiatric Treatment (2003) (9) at 144-151.

⁶¹³ *Ibid.*

⁶¹⁴ Snyman (2008) *supra* note 1 at 221-222; Snyman (2006) *supra* note 1 at 222; Card, R "Criminal Law" 3rd ed (2004) at 773.

⁶¹⁵ *S v Chretien* *supra* note 1; Snyman (2008) *supra* note 1 at 224; Burchell and Milton (2005) *supra* note 1 at 405; Burchell and Milton (2007) *supra* note 1 at 362; The facts of *S v Chretien* *supra* note 1 are discussed in paragraph 4 *supra*. See also Badenhorst, CHJ "Vrywillige dronkenskap as verweer teen aanspreeklikheid in die Strafreg – 'n suiwer regswetenskaplike benadering" (1981) at 148; Badenhorst, CHJ "*S v Chretien* – vrywillige dronkenskap en strafregtelike aanspreeklikheid" (1981) *TSAR* at 185. See also *S v Baartman* 1983 (4) SA 393 (NC); *S v D* 1995 (2) SACR 503 (C); *S v Flanagan* 2003 (2) SACR 98 (E); *S v Hartyani* 1980 (3) SA 613 (T); *R v Holiday* 1924 AD 250; *R v Innes Grant* 1949 (1) SA 753 (A); *S v Johnson* 1969 (1) SA 201 (A); *S v Kelder* 1967 (2) SA 644 (T); *S v Lange* 1990 (1) SACR 1999 (W); *S v Lombard* 1981 (3) SA 198 (A); *S v Maki* 1994 (2) SACR 414 (E); *S v Mbele* 1991 (1) SA 307 (W); *S v Mpumgathe* 1989 (4) SA 169 (E); *S v Mula* 1975 (3) SA 208; *S v Ndhlovo* (2) 1965 (4) SA 692 (A); *S v Pienaar* 1990 (2) SACR 18 (T); *S v Saaiman* 1967 (4) SA 440 (A).

The legal position pertaining to intoxication as set forth by Rumpff CJ in *S v Chretien* is as follows:

- (i) If a person is so drunk that his muscular movements are involuntary, there is no act or conduct on his or her part, and accordingly although the condition can be ascribed to the use of an intoxicating substance, he or she cannot be found guilty of a crime.⁶¹⁶
- (ii) A person may also as a result of the excessive use of alcohol completely lack criminal capacity and accordingly not be criminally liable⁶¹⁷ - this will be the case where the person is so intoxicated that he or she is no longer aware of what he or she is doing or where his or her inhibitions were substantially affected.
- (iii) The “specific intent theory” was rejected.⁶¹⁸ Intoxication could also exclude ordinary intent. It was due to the latter principle that voluntary intoxication was held in this case to be a complete defence.
- (iv) It was also held by Rumpff CJ that a court should not lightly infer that, as a result of intoxication, an accused acted involuntarily or was not criminally responsible or that intention was absent as this would bring the administration of justice into discredit.⁶¹⁹

Snyman correctly summarises the four effects that intoxication could have:⁶²⁰

- (a) Intoxication might result in an accused acting involuntarily in which case he or she will not be guilty of a crime;
- (b) Intoxication may cause an accused to lack criminal capacity in which case he or she will not be guilty of a crime;

⁶¹⁶ Snyman (2008) *supra* note 1 at 225; LAWSA (2004) *supra* note 12 at 73.

⁶¹⁷ At 1104 E and 1106 E-F of the judgment.

⁶¹⁸ At 1103 H – 1104 A Snyman (2008) *supra* note 1 at 225 states that the “specific intent theory” entailed that crimes could be divided into two groups: those that required “specific intent” and those that required only “ordinary intent”. If an accused was charged with a crime requiring a “specific intent”, the intoxication could have the effect of excluding the “specific intent”. The accused could then not be convicted of the “specific intent” crime with which he or she was charged, but with a less serious crime that required only an “ordinary intent”.

⁶¹⁹ At 1105 H-1106 D; Snyman (2008) *supra* note 1 at 225.

⁶²⁰ Snyman (2008) *supra* note 1 at 226.

- (c) If, despite intoxication an accused was able to perform a voluntary act and also had criminal capacity, the intoxication may result in the accused lacking intention required for the particular crime. In the latter instance the accused will not necessarily escape the clutches of the criminal law – the evidence might reveal that he or she was negligent, in which case he or she might be convicted of a crime requiring culpability in the form of negligence;
- (d) Intoxication may also serve as a ground for the mitigation of punishment.

Before the decision in *S v Chretien*, voluntary intoxication was not regarded as a complete defence.⁶²¹ After *S v Chretien* it became clear that voluntary intoxication could in certain circumstances constitute a complete defence. What is of more importance for purposes of this thesis, is the fact that intoxication could also exclude criminal capacity. The question that arises is what role does expert evidence portray in cases where intoxication is the cause of non-pathological criminal incapacity?

In response to the lenient approach followed in *S v Chretien* regarding voluntary intoxication, the legislature enacted the Criminal Law Amendment Act 1 of 1988.⁶²²

Section 1 of Act 1 of 1988 reads as follows:

“(1) Any person who consumes or uses any substance which impairs his or her faculties to appreciate the wrongfulness of his or her acts or to act in accordance with that appreciation, while knowing that such substance has that effect, and who while such faculties are thus impaired commits any act prohibited by law under any penalty, but is not criminally liable because his or her faculties were impaired as

⁶²¹ See *S v Johnson* 1969 (1) SA 201 (A) at 205 C-E where Botha JA states: “Maar volgens ons reg blyk dit dat vrywillige dronkenskap, wat nie geesteskrankheid tot gevolg het nie, in die algemeen geen verweer is teen ‘n aanklag weens ‘n wandaad gedurende sodanige dronkenskap begaan nie.” See also Van Oosten (1993) SACJ *supra* note 1 at 134; *R v Bourke* 1916 TPD 303; *R v Holiday* 1924 AD 250; *R v Taylor* 1949 (4) SA 702 (A).

⁶²² Snyman (2008) *supra* note 1 at 228; Burchell and Milton (2005) *supra* note 1 at 408-409; LAWSA (2004) *supra* note 12 at 73; Du Toit *et al* (2007) *supra* note 1 at 13-11–13-14; Paizes, A “Intoxication through the looking-glass” (1988) SACJ at 776; Peter, LP “The effects of alcohol and substances” in Kaliski (ed)(2006) *supra* note 1 at 126.

foresaid, shall be guilty of an offence and shall be liable on conviction to the penalty which may be imposed in respect of the commission of that act.

- (2) If in any prosecution for any offence it is found that the accused is not criminally liable for the offence charged on account of the fact that his faculties referred to in (1) were impaired by the consumption or use of any substance, such accused may be found guilty of such a contravention of sub-section (1) if the evidence proves the commission of such contravention.”

The decision in *S v Chretien* was criticised severely in the sense that it was difficult to accept a situation where a sober person is punished for criminal conduct whilst the same conduct performed by an intoxicated person is condoned merely as a result of being intoxicated. The need accordingly arose to enact legislation in the terms as indicated above by means of Act 1 of 1988.

What is of importance is that this Act clearly recognises intoxication as a ground excluding criminal capacity. The section refers to impairment of an accused’s “faculties to appreciate the wrongfulness of his acts or to act in accordance with that appreciation.”⁶²³ The Act does, however, not cover instances where intoxication excludes intention.⁶²⁴ The Act does, however, include the situation where an accused is so intoxicated that he or she was unable to perform a voluntary act.

Snyman submits the following.⁶²⁵

“.....intoxication resulting in automatism is surely a more intense form of intoxication than that resulting in lack of criminal capacity, if, therefore the legislature intended to cover the latter situation, it is inconceivable that it

⁶²³ Snyman (2008) *supra* note 1 at 230.

⁶²⁴ *Ibid.*

⁶²⁵ Snyman (2008) *supra* note 1 at 231; Paizes (1988) *SACJ supra* note 620 at 785; Burchell and Milton (2005) *supra* note 1 at 410. See also *S v Ingram* 1999 (2) *SACR* 127 (WLD) where Cloete J at 131 a-b states:

“... for a conviction in terms of the section it matters not whether the appellant was without criminal capacity or was acting as an automaton. The first case is clearly covered by the section.”

could have intended to exclude the former, more serious, form of intoxication.”

The burden of proving all of the elements of the offence beyond reasonable doubt created in Act 1 of 1988 falls on the State. One of these elements entails that the State has to prove that an accused is not criminally liable for his or her act because he or she lacked criminal capacity.

According to Paizes the elements of this defence are:⁶²⁶

- (i) The consumption or use of an intoxicating substance;
- (ii) Impairment of the accused’s faculties;
- (iii) The accused’s knowledge of its effect;
- (iv) The commission by the accused of a prohibited act while his faculties are impaired.

The abovementioned elements present numerous procedural difficulties for the State:⁶²⁷

- In order to secure a conviction of contravening section 1, the State is required to establish exactly that which the accused is normally required to establish, namely that the accused is not guilty of a crime. The State thus has to prove the opposite of what it normally has to prove. The State accordingly either has to establish, beyond reasonable doubt, the presence of criminal capacity for a conviction on the offence charged or lack of criminal capacity in order to secure a conviction in terms of section 1.
- The State must prove lack of criminal capacity.
- The State must prove lack of criminal capacity beyond reasonable doubt.⁶²⁸

It is submitted that expert evidence will also play a vital role in cases where the State seeks a conviction in terms of section 1 of Act 1 of 1988. The reason for this

⁶²⁶ Paizes (1988) *SACJ supra* note 620 at 779.

⁶²⁷ Snyman (2008) *supra* note 1 at 232; Paizes (1988) *SACJ supra* note 620 at 780; Burchell and Milton (2005) *supra* note 1 at 411.

⁶²⁸ See *S v September* 1996 (1) *SACR* 235 (A); *S v D* 1995 (2) *SACR* 502 (C).

lies in the fact that the State has to prove that the accused is “not criminally liable”. Paizes correctly notes that non-liability is very different from non-conviction.⁶²⁹ If an accused is, for example, acquitted on a charge of assault, it merely indicates that the court was not convinced of his or her guilt beyond reasonable doubt – it does not mean he or she is “not liable”.⁶³⁰

Paizes observes the following.⁶³¹

“After seeking to establish X’s liability beyond reasonable doubt, the State now has to prove his non-liability beyond a reasonable doubt. An intoxicated wrongdoer will, therefore, escape the clutches of the criminal law if neither his liability nor his non-liability can be established on the stringent criminal standard or proof.”

In *S v Mbele*, Flemming J held:⁶³²

“Dit is derhalwe onvoldoende as die Staat sake net so ver voer dat daar onsekerheid is of die beskuldigde se vermoëns ‘aangetas is’ en ‘aangetas was’ tot die nodige mate.”

It is clear that mere uncertainty as to whether an accused lacked criminal capacity is not sufficient for the State to discharge its onus. It is at this stage where expert evidence becomes pivotal to the State. The State will have to lead expert evidence of a high degree in order to prove lack of criminal capacity due to intoxication beyond reasonable doubt.

In *S v Griessel*⁶³³ Muller AJA also held that a finding that the accused had “possibly” not known what he was doing was not sufficient to sustain a conviction under section 1(1) and accordingly a positive finding was required that the accused was not criminally responsible as a result of his consumption of alcohol when he committed the act complained of.

⁶²⁹ Paizes (1988) *SACJ supra* note 619 at 781; *S v Lange* 1989 (1) *SACR* 199 (W).

⁶³⁰ *Ibid.*

⁶³¹ *Ibid.*

⁶³² *S v Mbele* 1991 (1) SA 307 (WPD) at 311 C-D; Snyman (2008) *supra* note 1 at 232; *S v Mphungatje* 1989 (4) SA 139 (O).

⁶³³ *S v Griessel* 1993 (1) *SACR* 178 (O) at 181 D-E.

In *S v V Van Reenen J* made the following important findings:⁶³⁴

“In omstandighede waar die bepalings van art. 1(1) van Wet 1 van 1988 moontlik toepaslik kan wees is dit die hof se plig om op sterkte van deskundige getuïenis – wat nie in die onderhawige saak aangebied was nie – asook al die ander feite van ‘n besondere saak, insluitende die beskuldigde se betroubaarheid as ‘n getuie en die aard van sy bewese handeling gedurende die tersaaklike periode, te besluit of hy toerekeningsvatbaar was al dan nie.”

Van Reenen J also held that it is wrong to assume that a court will only in exceptional cases find that an accused lacked criminal capacity as a result of intoxication.⁶³⁵ Van Reenen J noted that the normal standard of proof in criminal cases should also apply to proof of incapacity for the purposes of the statutory crime.⁶³⁶ Snyman also submits that the courts ought not to require an unrealistically high degree of proof of criminal incapacity.⁶³⁷

As far as the procedural aspects of section 1(2) of Act 1 of 1988 is concerned the following should be noted:

- (i) Statutory intoxication is a competent verdict on any offence charged.⁶³⁸
- (ii) If any portion of a sentence flowing out of a conviction is suspended, the condition of suspension should refer to a future contravention of the actual offence – there should be a relationship between the offence of which the accused has been convicted and the one referred to in the condition of suspension.⁶³⁹

⁶³⁴ *S v V* 1996 (2) SACR 290 (C) at 294H - J. See also *S v September supra* at 328. See also *Louw, R* “Recent cases – Criminal Law Amendment Act 1 of 1988” SACJ (1997) at 104.

⁶³⁵ At 295 A-B, Snyman (2008) *supra* note 1 at 232.

⁶³⁶ *Ibid.*

⁶³⁷ Snyman (2008) *supra* note 1 at 233.

⁶³⁸ *S v Mphungatje* 1989 (4) SA 139 (EPD) at 143 H; *S v D supra* note 626 at 509 G-J.

⁶³⁹ *S v Oliphant* 1989 (4) SA 169 (EPD).

- (iii) When convicting an accused of the statutory crime, the description of the conviction of the initial charge the accused would have been convicted on had he or she not been intoxicated, should be stipulated.⁶⁴⁰

14.2 The role of expert evidence in cases of intoxication

Expert evidence in cases of intoxication plays a pivotal role especially for the State seeking a conviction in terms of section 1 of Act 1 of 1988. Peter submits that there is a very strong link between a person being intoxicated and becoming a victim of violent crime.⁶⁴¹ Peter also states that, when individuals become intoxicated, they often behave offensively and provocatively and behaviour may be ambiguous and unpredictable.⁶⁴²

Peter observes the following pertaining to the psychological effects of intoxication⁶⁴³ that as intoxication intensifies there is reduction in psychological efficiency and motor control, usually contrary to the sense of “subjective superiority” the person may feel. Thinking becomes slowed and superficial, and impaired judgment and reasoning occur. The abilities of learning, attention and concentration become impaired, and perceptual acuity decreases. Muscle control is impaired, with delay in reaction times, and later dysarthria (slurred speech), motor incoordination and ataxia (unsteady broad-based gait) or nystagmus (fast eye movements) can occur. There is generally a progressive loss of restraint and self-control, often resulting in disinhibited, unfavourable behaviour.

In respect of the standard of proof required in terms of section 1 of Act 1 of 1988, Snyman correctly submits that if there is sufficient expert evidence pertaining to the accused's criminal incapacity, the court's task of assessing the question of whether the accused lacked criminal capacity is made easier.⁶⁴⁴

⁶⁴⁰ *S v Flanagan* (2003) (2) SACR 98 (ECD) at 102 A-B; *S v Maki* 1994 (2) SACR 414 (E) at 416 A-C; *S v Pietersen* 1994 (2) SACR 434 (C) at 439.

⁶⁴¹ Peter, LP “The effects of alcohol and substances” in Kaliski (ed)(2006) *supra* note 1 at 132.

⁶⁴² *Ibid.*

⁶⁴³ Peter in Kaliski (ed)(2006) *supra* note 1 at 133.

⁶⁴⁴ Snyman, CR “n Koel ontvangs vir ‘Statutêre Dronkenskap’ “(1990) *TSAR* 504 at 509.

Snyman correctly submits the following:⁶⁴⁵

“Die hof volg maar ‘n ietwat robuuste benadering, deurdat hy gewoonlik sonder die hulp van deskundige getuienis en sonder om altyd veel hulp van ander getuies te kry, tot ‘n besluit aangaande die beskuldigde se toerekeningsvatbaarheid kom.”

In *S v Edley*⁶⁴⁶ the appellant had been charged with and convicted of contravening section 140 (1)(a) of Ordinance 21 of 1966 in that he drove a motor vehicle on a public road while under the influence of intoxicating liquor. The question the court, per Miller J, was called to decide upon was whether the State had discharged its onus to prove, not only that the appellant had taken alcohol and was under the influence of alcohol, but that, as a result of the consumption of alcohol, his judgment or skill was affected by the consumption of alcohol.

The State did not lead any expert evidence.

A policeman and three laymen who arrived within a very short time at the scene of the accident in which the appellant was involved gave evidence pertaining to the appellant’s condition. Their testimony was moderate in describing his condition. The defence presented evidence by a medical practitioner, Dr Gantovnik, who had treated the appellant for hypertension the day after the accident.

Miller J held that in some cases the onus resting on the State can be discharged by the State without the aid of medical evidence.⁶⁴⁷

Miller J noted:

“It seems to me that the more gross and manifest the physical manifestations of intoxication noted by credible and reliable laymen are, the more readily may medical evidence be dispensed with and that the more equivocal the

⁶⁴⁵ *Ibid.*

⁶⁴⁶ *S v Edley* 1970 (2) SA 223 (NPD). See also *S v Mhetoa* 1968 (2) SA 773 (O).

⁶⁴⁷ At 226 C.

physical manifestations or indications of intoxication may be, the greater would be the need for the State to lead medical evidence of the accused's condition at the relevant time.”

It was held that the court was unable, without the support of medical or other scientific evidence, to find that the accused's judgment was impaired and that the State had not discharged its onus to satisfy the court beyond reasonable doubt that the alcohol he consumed had the effect of impairing his (appellant's) judgment.

This decision did not deal directly with the defence of criminal incapacity but it nevertheless illustrates the importance of expert evidence being presented especially by the State in cases pertaining to intoxication. It is submitted that any qualified mental health professional can testify with regards to the effect of intoxication on an accused's ability to appreciate the wrongfulness of his or her act or to act in accordance with such appreciation.

In *S v Van Zyl*⁶⁴⁸ the appellant was charged in a magistrate's court with assault with intent to do grievous bodily harm. His defence was that at the time of the incident, due to the cumulative effect of the taking of two anti-histamine tablets and alcohol, he temporarily lacked criminal capacity. The magistrate held that the State had not succeeded in proving the appellant's criminal responsibility and convicted the appellant of section 1(1) of Act 1 of 1988 in respect of which he had not been charged but which was a competent verdict in terms of the provisions of section 1(2) of Act 1 of 1988, and sentenced the appellant to a fine of R160 or 40 days imprisonment⁶⁴⁹. An appeal to a Provincial Division was unsuccessful. In a further appeal it was contended on behalf of the appellant that it was an element of the offence of contravention of section 1(1) of Act 1 of 1988 that the accused at the time of the act in question was not criminally responsible and that in the present case there was reasonable doubt pertaining to the appellant's criminal

⁶⁴⁸ *S v Van Zyl* 1996 (2) SACR 22 (A).

⁶⁴⁹ At 24J-25A.

capacity and that neither the offence charged nor the statutory offence had been proved⁶⁵⁰.

The State, on the other hand, contended that the accused had the required criminal capacity and was accordingly criminally liable to the offence charged⁶⁵¹. The State requested that the conviction in terms of the statutory offence be substituted with a conviction of the original offence.

It is necessary to reflect on the expert evidence advanced in this case. Two experts presented expert evidence, namely Dr G Muller on behalf of the State and Dr Finkelstein on behalf of the defence. Their expert opinion were founded on the effect of Polaramine tablets and alcohol on the central nervous system. From the outset Howie JA stated that although this was important, the central issue was the appellant's ability to appreciate the wrongfulness of his actions and to act in accordance with such appreciation.⁶⁵²

Howie JA made the following important finding:⁶⁵³

“Die vraag was dus of die uitwerking van die tablette en alkohol die redelike moontlikheid geskep het dat die appellant nie die ongeoorlooftheid van sy optrede besef het nie of dat sy inhibisies totaal verdwyn het. Wat derhalwe ter sprake gekom het, was die aard en werking, nie van die liggaam nie, maar van die mens se denkvermoë en gedrag. Dit synde die geval sou mens deskundige getuienis van ‘n psigiater of ten minste ‘n sielkundige verwag het om werklik in ‘n posisie te wees om te oordeel of appellant se toerekeningsvatbaarheid nadelig geaffekteer was.”

Dr Muller testified that both the anti-histamine tablets and alcohol had a sedative effect⁶⁵⁴. Dr Muller stated that the appellant's conduct was not a normal reaction to anti-histamine tablets and that the conduct of the appellant was typical of a

⁶⁵⁰ At 25 E-F.

⁶⁵¹ At 25 F-G.

⁶⁵² At 32 B-C.

⁶⁵³ At 32 C-D.

⁶⁵⁴ At 32 G.

person who consumed too much alcohol and displayed conduct opposite to his normal behaviour. Dr Muller never referred to the concept of criminal capacity, but merely disagreed with Dr Finkelstein's contention that there was a possibility that the appellant could not distinguish between right and wrong and act in accordance with such appreciation. Accordingly, Dr Muller's evidence was not of great assistance to the court.

Dr Finkelstein's evidence also provided no assistance to the court as he could not conclusively or with reasonable certainty provide an opinion in respect of the appellant's criminal capacity or lack thereof. When asked whether the appellant could distinguish between right and wrong, Dr Finkelstein stated:⁶⁵⁵

"It's probably difficult to say whether he had the consciousness at that stage to realise whether he was doing something wrong. Because he could be under the influence of two drugs, which act on the central nervous system in whatever way, that there might be an altered consciousness. In which case he may not possibly be aware that he was – he – he may be aware that he's doing it, but might not be aware that it is either right or wrong.

Do you ... (intervention) – He ... Regard that as a reasonable possibility. - It's a reasonable possibility. Or, let's say, it's a reasonable speculation."

The abovementioned quotation is one example of the inconsistent evidence presented by Dr Finkelstein. This could be attributed either to the fact that the expert is presenting testimony on a fact not really in issue or that the expert is not an expert on the effects of intoxication on the criminal capacity of the accused.

Howie JA rejected the evidence of Dr Finkelstein and stated:⁶⁵⁶

"Die getuienis van dr Finkelstein – die hoeksteen van die verweer – verg nie veel bespreking nie. Dit is ongelukkig dat hy besluit het, of uitgenooi is, om 'n mening te waag op 'n onderwerp buite die perke van sy professionele en

⁶⁵⁵ At 33 G-H.

⁶⁵⁶ At 36 G-I.

akademiese kennis en ervaring. Die gevolg is dat sy getuienis met betrekking tot die toerekeningsvatbaarheidsaspek inherent weersprekend, onwaarskynlik en onoortuigend is. Dit berus ook op ‘n verkeerde opvatting van wat die getuienis ten opsigte van appellant se gedrag werklik was.”

The court held that on the accepted evidence it was not reasonably possible that the appellant did not appreciate the unlawfulness of his action and that the State had proved his criminal responsibility and that he was guilty of assault⁶⁵⁷.

The court per Howie JA held the following in respect of section 1(2) of Act 1 of 1988:⁶⁵⁸

- (i) Although the Criminal Procedure Act did not provide for a contravention of the statutory offence to be a competent verdict, section 1(2) of Act 1 of 1988 provided for this in unequivocal terms.
- (ii) Section 1(2) was not intended to cover the situation where the statutory offence was charged in a substantive charge, but was aimed to provide for the situation where the prosecution in respect of another offence charged failed for the reasons stated in section 1(2).
- (iii) The legislature accordingly provided for a built-in automatic alternative charge.
- (iv) The provisions of section 1(2) were not to be distinguished from any provisions of the Criminal Procedure Act which provided for competent verdicts.

The appellant was convicted of assault.

This decision reaffirms the fundamental need, also when intoxication is the cause of non-pathological criminal incapacity, for properly qualified mental health professionals to present expert evidence. The role of the mental health professional is dual functional, in the sense that, in the first place, there is an

⁶⁵⁷ At 37 E.

⁶⁵⁸ At 38 A-E.

essential need for expert evidence and secondly, it should pertain to the defence of criminal incapacity and be relevant thereto.

In *S v Scholtz*⁶⁵⁹ the appellant was charged and convicted in the magistrate's court of theft of use, malicious injury to property, culpable homicide driving whilst under the influence of alcohol, failure to stop after an accident and failure to ascertain damages and injuries after an accident. On an appeal against conviction and sentence, it was contended on behalf of the appellant that the State had failed to establish beyond reasonable doubt that the accused had criminal capacity at the time of the commission of the said crimes. It was further contended that the appellant was also not guilty of a contravention of section 1 of Act 1 of 1988 due to the fact that the reasonable possibility that the appellant had criminal capacity was also not proved by the State beyond reasonable doubt.

Froneman J held that in order to successfully raise the defence of non-pathological incapacity, the reasonable possibility must exist that the accused was not able to distinguish between right and wrong or that he was unable to act according to this appreciation⁶⁶⁰. The mere raising of the defence that the accused did not know what he was doing or that he could not act according to this knowledge, was not sufficient.⁶⁶¹ In this case no expert evidence was presented relating to the possible effect of alcohol on the accused's ability to distinguish between right and wrong or to act in accordance with such appreciation. The accused merely contended that he could not remember what happened.

Froneman J held:⁶⁶²

“... in die afwesigheid van verdere getuienis wat die feitelike grondslag kan bied om die afleiding van bewustelike en vrywillige optrede te ontsenu, die appellant se beroep op ontoerekeningsvatbaarheid nie kan slaag nie. Daar was geen sodanige verdere getuienis nie.”

⁶⁵⁹ *S v Scholtz* 2006 (1) SACR 442 (EPD); Du Toit *et al* (2007) *supra* note 1 at 13-13 – 13-14.

⁶⁶⁰ At 444 H.

⁶⁶¹ At 444 H-445 C.

⁶⁶² At 445 H-I.

The case was remitted to the trial court for a reconsideration of sentence.

This case further serves to illustrate the importance of expert evidence in support of the defence of non-pathological criminal incapacity.

Haque and Cumming⁶⁶³ state that a clinical assessment that will aid a court will require a thorough history of the events with a special focus on the accused's account of the event and the consumption of intoxicants in the period prior to the offence.

Expert evidence inadvertently plays a pivotal role also with reference to the cumulative effects of intoxication on the criminal capacity of an accused. According to Peter⁶⁶⁴ alcohol and substance abuse present the expert witness with a nexus of challenges as it is pivotal to have a clear understanding of their neuro-behavioural effects as well as an in depth appreciation of what the law and the courts require. In addition it is also crucial to have an ability to apply these insights in an assessment that almost always relates to a retrospective assessment and therefore subject to "the vagaries of what the examinee and witnesses can remember, rather than what can be ascertained by some objective means".⁶⁶⁵

15 Battered woman syndrome and non-pathological criminal incapacity

Battered Woman Syndrome

*The moon faded behind clouds,
as they drifted in the wind.
Streetlights flicker on and off,
and no other light can be found.*

*Alcohol was the scent on his breath,
his mind was always out of place.*

⁶⁶³ Haque and Cumming (2003) *supra* note 612 at 146-151. See also Taylor, PJ and Kopelman MD "Amnesia for criminal offences" (1984) *Psychological Medicine* vol 14 at 581-588.

⁶⁶⁴ Peter in Kaliski (ed)(2006) *supra* note 1 at 144.

⁶⁶⁵ Peter in Kaliski (ed)(2006) *supra* note 1 at 144.

*He is aggressive when he drinks,
and takes his anger out on her.*

*Her fingers carefully on the trigger,
tears and blood fall at her feet.
In a dream world, he won't know,
until he awakes, if he ever does.*

*Nerves send shivers down her spine,
hesitating and breathing heavily.
Her mind carries her into memories,
when she felt pain, anger and hate.*

*He cut her with a broken bottle,
she bleeds from under her left eye.
Tonight she will put an end to this,
for everything he has ever done.*

*When push comes to shove,
she was always facing down.
Shouts and screams echoing,
a gun shot puts it to silence.*

*The streetlights flicker on and off,
flashing lights rush to her home.
The moon crawls out of darkness,
and the moonlight shines again.”*

(Darren 2006)

15.1 General background on battered woman syndrome

The Battered Woman Syndrome has become highly controversial, particularly when used in support of a defence of non-pathological criminal incapacity and the ground of justification of private defence⁶⁶⁶.

⁶⁶⁶ Burchell, J and Milton, J “Principles of Criminal Law” (2005) 3rd ed 451 – 454; Peter, LP “Domestic Violence” in Kaliski (2006) *supra* note 1 at 146 – 161; Ludsin, H and Vetten, L “Spiral of Entrapment: Abused women in conflict with the Law” (2005) at 98-169; Pistorius, M “Fatal Females” (2005) 1 – 59; Burchell, J and Milton, J “Cases and Materials on Criminal Law” 3rd ed (2007) at 403 – 424; Arrigo, B and Shipley, S “Introduction to Forensic Psychology, Issues and Controversies in Law, Law Enforcement and Corrections” 2nd ed (2005) at 74; Johann, SL and Osanka, F “Representing ... Battered Women who kill” (1989) at 27-46; Walker, LE “Terrifying Love – Why Battered Women kill and How Society Responds” (1989) at 42-99; Ewing, CP “Battered Women who kill – Psychological self-defense as Legal Justification” (1987) (generally); Forward, S “Men who hate Women and The Women who love them” (2002); Bartol, CR and Bartol, AM “Criminal Behaviour – A psychosocial Approach” 7th ed at 316 – 317; Walker, LE “Abused Women and Survivor Therapy- A practical guide for the psychotherapist” (1994) at 55-80; Burchell and Hunt (1997) *supra* note 1 at 212; Horder, J “Provocation and Responsibility” (1992) at 186; Karsten, C “Dodelike Vroue – Wanneer passie in bloed eindig” (2007) at 129 – 145; Barnett, OW and LaViolette, AD “It could happen to Anyone – Why Battered Women Stay” (1993) at x-xx; Moore, D “Battered Women” (1979) at 33-100; Martin, D “Battered Wives” (1976) at 9-43; Walker, LE “The Battered Woman” (1979) at 11-165; Dershowitz, AM “The Abuse Excuse” (1994) at 3-47; Walker, LE “Women and Mental Health Policy” (1984) ; Reddi, M “Battered Woman Syndrome: Some reflections on the utility of this ‘syndrome’ to South African women who kill their abusers” (2005) *SACJ* at 259; Wolhuter, L “Excuse them though they do know what they do – the distinction between justification and excuse in the context of battered women who kill” (1996) *SACJ* at 151; Mather, VM “The Skeleton in the closet: The Battered Woman Syndrome, self-defense, and expert testimony (1988) *Merc. L. Rev.* (39) at 545; Pillay, K “Battered Women who kill: Avenues for legal/Political Recourse” (2005) (Legal opinion commissioned by the Centre for the Study of Violence and Reconciliation, (2005); Schuller, RA and Vidmar, N “Battered Woman Syndrome Evidence in the Courtroom” (1992) *Law and Human Behaviour* at 273; Hudsmith, R “The Admissibility of Expert Testimony on Battered Woman Syndrome in Battered Women’s self-defense cases in Louisiana” (1987) *Louisiana L. Rev.* at 979; Blackman, J “Potential Uses for Expert Testimony: Ideas Toward the Representation of Battered Women who kill” (1986) *Women’s Rights Law Reporter* at 227; Rogers, A “Prosecutorial Use of Expert Testimony in Domestic Violence Cases: From Recantation to Refusal to testify” (1998) *Columbia Journal of Gender and Law* at 67; Schuller, RA “Expert Evidence and its Impact on Juror’s Decisions in Homicide Trials Involving Battered Women” <http://www.law.duke.edu/journals/djglp.articles/gen10p225htm> [accessed on 2006-05-19]; Lenkevich, MH “Admitting Expert Testimony on Battered Woman Syndrome in Virginia courts: How Peoples changed Virginia self-defense law” (1998) *William and Mary Journal of Women and the Law* at 297; Ludsin, H “*Ferreira v The State*: A Victory for Women Who kill their Abusers in Non-Confrontational Situations” (2004) *SAJHR* at 642; Maguire, JB, Sigol J and Perrino, CS “Battered Women who kill: Variables Affecting Simulated Jurors’ verdicts” (2005) *Journal of Family Violence* at 403; Schuller RA and Rzepa, S “Expert Testimony Pertaining to Battered Woman Syndrome: Its Impact on Jurors’ Decisions” (2002) *Law and Human Behaviour* at 655; Shaffer, M “The Battered Woman Syndrome Revisited: Some complicating Thoughts five years after *R v Lavallee*” (1997) *University of Toronto L-J*. Baker, BM “Provocation as a defence for Abused Women who kill” *Canadian Journal of Law and Jurisprudence* at 193; Labuschagne, JMT “Die mishandelde vrou sindroom, Die Redelike Persoon-standaard en die Grense van Noodweer – *R v Malott* (1998) 121 CCC (3d) 456 (SCC)” (1998) *THRHR* at 538; Carstens and Le Roux (2000) *SACJ supra* note 1 at 180; Schuller, RA and Cripps, A “Expert evidence pertaining to Battered Women: the impact of Gender of expert and timing of testimony” (1998) *Law and Human Behaviour* at 17; Reddi, M “Violence against Women: Tears of triumph for Women in South Africa?” in Hoctor, SV and Schwikkard, PJ (eds) “The exemplary scholar: Essays in honour of John Milton” (2007); Bargai, N, Shakhar, GB and Shalev, AY “Posttraumatic Stress Disorder and Depression in Battered Women: The Mediating Role of Learned Helplessness” (2007) *Journal of Family*

Abuse against women is currently a worldwide societal phenomenon. The legal context of women who kill their abusive partners has given rise to a plethora of academic commentary, specifically aimed at addressing the criminal law's treatment of women who kill their abusive partners. Research indicates that one in every four women will experience abuse within an intimate relationship in their lifetime⁶⁶⁷.

Abused women are more commonly referred to as "battered women". The terminology of "Battered Woman Syndrome" was first coined by a prominent expert on battered women, Dr Lenore Walker, who described battered woman syndrome as "a pattern of psychological and behavioural symptoms found in women living in battering relationships."⁶⁶⁸

It is important to note that the "Battered Woman Syndrome" is not, and has never been, a legal defence in its own right⁶⁶⁹.

Battered woman syndrome evidence is described by Slovenko as "syndrome evidence" which constitutes "a cluster of systems in criminal cases, either to

Violence at 267; Burke, AS "Rational actors, self-defense, and Duress: Making sense, Not syndromes, out of the Battered Woman" (2002) *North-Carolina Law Review* at 211; Seymore, ML "Isn't it a Crime: Feminist Perspectives on Spousal Immunity and Spousal Violence" (1996) *Northwestern University Law Review* at 1032; Roberts, JW "Between the Heat of Passion and Cold Blood: Battered Woman's Syndrome as an excuse for Self-Defense in Non-confrontational Homicides" (2003) *Law and Psychology Review* 135; *S v Ferreira* 2004 (2) SACR 454 SCA; *S v Campher* 1987 (1) SA 940 (A); *S v Smith* 1990 (1) SACR 130 (A); *S v Wiid* 1990 (1) SACR 56A (A); *S v Potgieter* 1994 (1) SACR 61 (A); *S v Engelbrecht* 2005 (2) SACR 41 (WLD).

⁶⁶⁷ Statistics obtained from www.settlement.org/downloads/woman-Abuse-factsheet.pdf [accessed on 2009-03-16]. Statistics further indicate the following:

- 38 % of sexually assaulted women were assaulted by their husbands, common-law partners, or boyfriends.
- 21 % of women abused in an intimate relationship are abused during pregnancy.
- 40 % of women with disabilities have been or are in an abusive relationship.
- Only 26 % of woman abuse incidents are reported to the police.
- In an average year, 78 women are killed by their husbands or partners.

⁶⁶⁸ See Walker, LE "The Battered Woman Syndrome" (1984) at 95 – 97. For a detailed exposition of the term "Battered Woman Syndrome" see chapter 1 above. The definition of "Battered Woman Syndrome" will accordingly not be discussed in this section.

⁶⁶⁹ Reddi (2005) *SACJ supra* note 1 at 260; Ludsin and Vetten (2005) *supra* note 1 at 98; Johann and Osanka (1989) *supra* note 666 at 27.

establish that a particular traumatic event or stressor actually occurred or to explain the behaviour of the victim.”⁶⁷⁰

Battered woman syndrome evidence is accordingly used in order to explain a battered woman’s experiences and the specific psychological effects of battering and abuse on the woman⁶⁷¹. The psychosocial context of battering or abuse and its impact on battered women is relevant within the following contexts⁶⁷²:

- In circumstances where a battered woman is tried for a crime and relies on a defence of private defence, automatism or lack of criminal capacity.
- When a battered woman has been charged or convicted of a crime, and evidence of battering or its effects is adduced in support of mitigation of sentence⁶⁷³.
- Other instances, for example to prove a pattern of coercive control⁶⁷⁴.

Battered woman syndrome has also featured in numerous decisions pertaining to the defence of non-pathological criminal incapacity⁶⁷⁵. Although the terminology of “Battered Woman Syndrome” was not specifically used in these decisions, the evidence presented by expert witnesses in these decisions and the facts indicative of abuse, either physical or psychological, boils down to manifestations of the “Battered Woman Syndrome.”

⁶⁷⁰ Slovenko, R “Psychiatry and Criminal Culpability” (1995) at 209. Slovenko notes that recently in criminal cases expert testimony about a diversity of trauma syndromes such as the battered spouse, battered child, rape trauma and incest trauma is offered to prove, on the basis of the symptoms, that a particular stressor or crime actually happened. See also Slovenko, R “Psychiatry in Law – Law in Psychiatry (2002) at 135.

⁶⁷¹ Reddi (2005) *SACJ supra* note 1 at 98.

⁶⁷² Reddi (2005) *SACJ supra* note 1 at 98; Ludsin and Vetten (2005) *supra* note 1 at 98; Carstens and Le Roux (2000) *SACJ supra* note 1 at 182; Schuller and Rzepa (2002) *Law and Human Behaviour supra* note 666 at 655.

⁶⁷³ See *S v Ferreira* 2004 (2) *SACR* 454 (SCA).

⁶⁷⁴ See Dutton, DG “The Abusive Personality – Violence and Control in Intimate Relationships” 2nd ed (2007) at 74-122; Dutton, DG “The Abusive Personality – Violence and Control in Intimate Relationships” (1998) at 32-93C; Stark, E “Coercive Control – How Men Entrap Women in Personal Life” (2007) at 112.

⁶⁷⁵ *S v Campher supra* note 1; *S v Smith supra* note 1; *S v Wiid supra* note 1; *S v Potgieter supra* note 1.

Ludsin and Vetten indicate that expert evidence in cases where abused women kill their abusive spouses or partners is essential and pivotal in order to provide clarity on the following aspects⁶⁷⁶:

- Understanding why abused women do not leave their abusers.
- Why women's options to put an end to the abuse are very limited and often non-existent.
- The psychological impact of abuse on battered women.

Expert testimony pertaining to the social context and effects of domestic violence as well as the history of the abusive relationship are pivotal in order to provide an abused woman or battered woman with a fair trial⁶⁷⁷.

Moas similarly states⁶⁷⁸:

“A woman's actions can be fairly judged only if understood in the light of her experiences with the deceased and how these experiences shaped her perspectives.”

In the preceding part of this chapter, the author discussed the defence of non-pathological criminal incapacity with specific reference to its origin, development and the controversial role of expert evidence in support of this defence. Non-pathological criminal incapacity is one of the defences available to a battered woman who kills her abusive spouse or partner. In this part of the chapter, the author will contextualise the psychosocial dynamics of an abusive relationship and, in particular, the fundamental need for expert evidence in support of the defence of non-pathological criminal incapacity on the backdrop of the battered woman who kills her abusive spouse or partner.

⁶⁷⁶ Ludsin and Vetten (2005) *supra* note 1 at 12.

⁶⁷⁷ Ludsin, H “South African Criminal Law and Battered Women who kill: Discussion Document II” (2003) (Research Report written for the Centre for the Study of Violence and Reconciliation) at 8.

⁶⁷⁸ Moas, EB “Domestic Violence: Competing Conceptions of Equality in the Law of Evidence” (2001) 47 *Loyola Law Review* 81 at 127.

15.2 The psychosocial dynamics of an abusive relationship

15.2.1 Domestic violence and manifestations of abuse

The preamble to the Domestic Violence Act⁶⁷⁹ summarises the plight of the battered woman. In South Africa, domestic violence is currently a common phenomenon⁶⁸⁰. Domestic violence occurs in all cultures, and people of all races, ethnicities and religions can be perpetrators of domestic violence. Within the context of the battered woman, the battered woman is typically the victim of domestic violence at the hands of her abusive husband or partner⁶⁸¹.

⁶⁷⁹ Act 116 of 1998. See *Omar v Government of the Republic of South Africa and Others* (Commission for Gender Equality, Amicus Curiae) 2006 (1) SACR 359 (CC) at 363 – 364 paragraph 13 where Van der Westhuizen J states: “The high incidence of domestic violence in our society is utterly unacceptable. It causes severe psychological and social damage. There is clearly a need for an adequate legal response to it. Whereas women, men and children can be victims of domestic violence, the gendered nature and effects of violence and abuse as it mostly occurs in the family, and the unequal power relations implicit therein are obvious. As disempowered and vulnerable members of our society, women and children are most often the victims of domestic violence”. In *S v Baloyi (Minister of Justice and Another Intervening)* 2000 (1) SACR 81 (CC) (2000) (2) SA 425, 2000 (1) 86 Sachs J stated at paragraph 11: “All crime has harsh effects on society. What distinguishes domestic violence is its hidden, repetitive character and its immeasurable ripple effects on our society and in particular, on family life. It cuts across class, race, culture and geography, and is all the more pernicious because it is so often concealed and so frequently goes unpunished.”

See also Stark (2007) *supra* note 674 at 84. See also Gelles, RJ and Strauss, MA “Intimate Violence: The Definitive Study of Causes and Consequences of Abuse in the American Family” (1988) at 14 where they define violence as an “act carried out with the intention or perceived intention of causing physical pain or injury to another person.”

The preamble to Act 116 of 1998 interestingly reads as follows: “RECOGNISING that domestic violence is a serious social evil; that there is a high incidence of domestic violence within South African society; that victims of domestic violence are among the most vulnerable members of society; that domestic violence takes on many forms; that acts of domestic violence may be committed in a wide range of domestic relationships; and that the remedies currently available to the victims of domestic violence have proved to be ineffective; AND HAVING REGARD to the Constitution of South Africa, and in particular, the right to equality and to freedom and security of the person; and the international commitments and obligations of the State towards ending violence against women and children, including obligations under the United Nations Conventions on the Elimination of all forms of Discrimination Against Women and the Rights of the Child.”

⁶⁸⁰ Peter in Kaliski (ed) (2006) *supra* note 1 at 146; Kruger, HB “Addressing domestic violence: to what extent does the Law provide effective measures” (2004) *TRW* at 152.

⁶⁸¹ It is interesting to quote the words of an anonymous abused woman who recently wrote to Dr Louise Olivier, Clinical Psychologist, in the *You* magazine pleading for help and advice: “Afraid to leave abusive husband

I’m 41 and have been married for 22 years. The first few years were happy even though he had affairs. Then he accused me of having affairs. Things got worse when he stopped working in March 2008.

He beats me if I go anywhere without telling him. He insists on taking me everywhere. He reads my diaries and checks my cellphone. He’s badmouthing me at work.

He stabbed me because I didn’t tell him I was going to town to buy our children shoes.

Domestic violence entails any controlling or abusive behaviour that harms the health, safety or well-being of a person or child in the care of such person. It further includes any form of actual or threatened physical, sexual, emotional, verbal and psychological abuse which is regarded as being a pattern of degrading or humiliating conduct, including repeated ridicule, threats or possessiveness and jealousy or serious invasion of privacy⁶⁸².

According to Walker, women are battered by partners they are married to or with whom they live or whom they date⁶⁸³. Even though the majority of reported abuse is inflicted by men on women, there are also reports of women abusing their partners⁶⁸⁴. Walker notes the following pertaining to abuse⁶⁸⁵:

“The goal of woman abuse is usually to exert power and control over the victim. Most physical and sexual abuse is accompanied by psychological intimidation and bullying behaviour used to maintain power and control over the woman. The pattern of abuse usually has an obsessional quality to it rather than a lack of control by the batterer.”

Domestic violence within the context of the battered woman usually encompasses one or more of the following manifestations of abuse which include, but is not limited to, the following:

- Physical abuse⁶⁸⁶

I went to a lawyer to arrange a divorce but when he got the papers he asked me to change my mind. He says I can't be separated from him because one of us will die. I'm afraid he'll kill me and go to jail – then what will happen to my three children?” (*You* magazine 26 March 2009, 34). This desperate cry for help illustrates that the battered woman scenario is still plaguing many women in our society and is currently still a highly controversial issue.

⁶⁸² Peter in Kaliski (ed)(2006) *supra* note 1 at 150; Domestic Violence Act 116 of 1998; Walker, (1979) *supra* note 666 at 71 – 165.

⁶⁸³ Walker, LE “Abused Women and Survivor Therapy – A Practical guide for the Psychotherapist” (1994) at 56. Walker notes that an intimate relationship is “one in which there is a close, loving, romantic, emotional bond, usually including sex.”

⁶⁸⁴ Walker (1994) *supra* note 683 at 57. Statistics obtained from POWA suggest that 95 % of the time, it is women who are the victims of domestic violence.

⁶⁸⁵ Walker (1994) *supra* note 683 at 56; Dobash and Dobash (1992) *supra* note 666 at 8 – 10.

⁶⁸⁶ See Ewing (1987) *supra* note 666 at 8 where it is noted that in Walker's study of 435 battered women, she observed that two-thirds of the battering incidents included pushing, slapping,

“For most of my married life I have been periodically beaten by my husband. What do I mean by ‘beaten’? I mean that parts of my body have been hit repeatedly, and that painful bruises, swelling, bleeding wounds, unconsciousness and combinations of these things have resulted.” (Letter from a Battered Woman as quoted in Moore, D “Battered Woman” 1979).

This form of abuse is most prevalent within the context of domestic violence and includes the following:

- Slapping;
- Shoving;
- Hitting;
- Torture;
- Stabbing;
- Beating;
- Assault with a weapon and/or murder⁶⁸⁷.

Within the ambit of battered women who murdered their abusive husbands or partners and relied on the defence of non-pathological criminal incapacity, this form of abuse was most prevalent in all of the cases.

Threats of physical violence is often regarded as sufficient to gain control of the woman as long as she truly believes that her partner will beat her in order to get what he wants or to punish her for disobeying him⁶⁸⁸.

Walker notes⁶⁸⁹:

shoving, hitting and arm twisting. In approximately a half of the incidents women reported having been punched or thrown around by their abusers. Dobash and Dobash (1992) *supra* note 666 at 1 – 15; Walker (1994) *supra* note 683 at 57.

⁶⁸⁷ Statistics provided by POWA (People Opposing Women Abuse) <http://www.powa.co/za/Display.asp?ID=12> [accessed on 2009-03-16], Woman Abuse Fact Sheet www.settlement.org/downloads/woman-abuse-factsheet.pdf [accessed on 2009-03-16]. Walker (1994) *supra* note 683 at 57; Dobash and Dobash (1992) *supra* note 666 at 1 – 15.

⁶⁸⁸ Walker (1994) *supra* note 683 at 57. Walker notes that some battered women have been chained to bedposts, locked in houses with the windows and doors nailed shut, kept inside coffinlike boxes and some even kept under surveillance at gunpoint.

“Whether imprisonment is enforced by physical means or not, most women know that the batterer is willing to use physical force to get what he wants. These women soon learn to obey rather than face the escalating violence that inevitably follows if they fight back.”

In *S v Campher*⁶⁹⁰, the evidence of the accused was summarised as follows:

“Sy het verder verduidelik dat hy het nie genoeg geneem as sy enigins teëgepraat het nie – hy het baie woedend geword as sy dit gedoen het. Hy het sy humeur verloor en haar geslaan as sy dit gedoen het.”

In *S v Potgieter*⁶⁹¹ evidence similarly stated:

“He reacted by hitting her. She fell from the bed and he started kicking her where she lay ...”

In *S v Wiid*⁶⁹² the following was observed from the appellant’s evidence:

“Op daardie stadium het die oorledene die appellante ‘n hele aantal klappe teen die kop toegedien.”

- Sexual abuse

This form of abuse includes the following:

⁶⁸⁹ Walker (1994) *supra* note 683 at 57. See also Dobash and Dobash (1992) *supra* note 666 at 2 where they quote the words of numerous women from various countries who stated:

“I was always terrified. My nerves were getting the better of me ... He knew this and I think he loved it.”

“The fear of not knowing what he would do – I feared for my life.”

“I remember the tension of becoming aware that I had to notice what I was saying all the time, to make sure I didn’t offend him. I had become afraid of him.”

See also Dobash, RE and Dobash, RP “Violence against Wives” (1979) at 111.

⁶⁹⁰ *S v Campher* 1987 *supra* note 1 at 945 A-B.

⁶⁹¹ *S v Potgieter* 1994 *supra* note 1 at 63 H.

⁶⁹² *S v Wiid supra* note 1 at 566 A-B. See also *S v Engelbrecht* 2005 (2) SACR 41 (WLD) at 61 A-H – this decision will be discussed in more detail below as well as *S v Ferreira* 2004 (2) SACR 454 (SCA).

- Any act of a sexual nature that is not desired;
- Forcing the woman to participate in sexual practices of an offensive or degrading nature⁶⁹³;
- Rape.

Sexual abuse and sexual assault are examples of the most brutal and severe expressions of masculine violence towards women⁶⁹⁴.

Sexual violence is generally used as a broad conceptualization of male violence or in narrow terms to refer to assaults and intrusions that have an explicit sexual content⁶⁹⁵. Sexual abuse within a battering or abusive relationship is usually accompanied by physical and psychological abuse⁶⁹⁶. Battered women sometimes subject themselves to the abusive partner's unwanted sexual desires as a way of calming him down and to protect themselves from further abuse⁶⁹⁷.

Walker notes⁶⁹⁸:

“The coercion and violence that accompanies sex may include forced shaving of pubic hair, mutilating the genitals, stabbing the breasts, brutal anal rapes, holding the woman's head down on the man's erect penis to force oral sex, inserting objects in her vagina and anus, punching her pregnant abdomen, and kicking at the vagina and other vulnerable areas.”

This quote, as shocking and disturbing as it is, illustrates the sexual perversity of some abusive men⁶⁹⁹.

⁶⁹³ *S v Engelbrecht supra* note 689 at 61 A-B; *S v Ferreira supra* note 689 at 463 E-G.

⁶⁹⁴ Kelly, L and Radford, J “Sexual Violence against Women and Girls” in Dobash, RE and Dobash, RP “Rethinking Violence Against Women” (1998) at 53; Dobash, RE and Dobash, RP “Women, Violence and Social change” (1992) at 1 – 15.

⁶⁹⁵ Kelly and Radford in Dobash and Dobash (1998) *supra* note 694 at 57.

⁶⁹⁶ Walker (1994) *supra* note 683 at 57.

⁶⁹⁷ *Ibid.*

⁶⁹⁸ *Ibid.*

⁶⁹⁹ See *S v Visser* unreported decision case number cc 545/07. This case will be discussed in detail below.

Walker notes that women are sometimes coerced into sex with other people and often with children⁷⁰⁰.

- Emotional and Psychological abuse

In terms of the Domestic Violence Act, “emotional, verbal and psychological abuse” constitutes a pattern of degrading or humiliating conduct towards a complainant which include:

- repeated insults, ridicule or name calling;
- repeated threats to cause emotional pain⁷⁰¹;
- repeated exhibition of obsessive possessiveness or jealousy which constitutes an invasion of privacy.

According to Mills there are various typologies of emotional abuse within an abusive relationship to which a battered woman is subjected which includes the following⁷⁰²:

- Rejection – this occurs where the abusive husband or partner subjects the woman to criticism, punishment or harsh judgment including threats of punishment if the woman opposes him or attempts to assert her own opinion.
- Degradation – this manifestation of emotional abuse occurs when the batterer or abusive partner publicly humiliates the battered woman or when, for example, he criticizes her parenting skills.
- Terrorization – this occurs when the batterer induces fear or anxiety in the battered woman often manifested in threats of abuse if the battered woman does not comply with the demands of the batterer.
- Social isolation – this form of abuse occurs when the batterer discourages the battered woman from taking part in social activities. Mills states that this is often accomplished by either:

⁷⁰⁰ *Ibid.*

⁷⁰¹ See *S v Ferreira supra* note 689 at 463 F-G - 464 D-G.

⁷⁰² Mills, LG “Killing her Softly: Intimate Abuse and the Violence of State Intervention” (1999) *Harvard Law Review* 550 at 586.

- physically preventing the battered woman from visiting friends or family, or
- degrading the battered woman in public so that she will rather avoid being embarrassed in public⁷⁰³.
- Missocialization – this occurs when the batterer coerces the battered woman to become involved in antisocial behaviour or illegal activities. According to Mills batterers often force women to commit crimes for them, for example engaging in prostitution for the batterer’s financial benefit⁷⁰⁴.
- Exploitation – exploitation is also often used by the batterer to coerce the battered woman into criminal activity such as prostitution.
- Emotional Unresponsiveness – this dynamic can be traced by a batterer’s detachment from the battered woman by ignoring her and accordingly it can be defined rather as an omission on the part of the batterer as opposed to a commission⁷⁰⁵.
- Close confinement – this occurs when the batterer restricts the battered woman’s physical mobility. This form of confinement can be achieved in a variety of ways, for example confining the battered woman to closet a or room.

As soon as serious violence has been used on a woman, she may react with similar terror to less serious abuse or even the threat of abuse⁷⁰⁶. The abusive partner sometimes also attempt to control every aspect of the woman’s life by, for example, subjecting her to constant scrutiny by means of questioning her, telling her how she should spend her time and subjecting her to constant surveillance⁷⁰⁷.

Walker illustrates⁷⁰⁸ the escalating effect of abuse on a woman and explains that there is a point in most abusive relationships at which a woman recognizes the possibility that she will be killed by the batterer. As soon as that point is reached,

⁷⁰³ Mills (1999) *Harv. L. Rev. supra* note 699 at 591.

⁷⁰⁴ Mills (1999) *Harv. L. Rev. supra* note 702 at 592.

⁷⁰⁵ Mills (1999) *Harv. L. Rev. supra* note 702 at 594.

⁷⁰⁶ Walker (1994) *supra* note 683 at 58.

⁷⁰⁷ Walker (1994) *supra* note 683 at 58 – 59. Walker states that some forms of harassment such as surveillance, sleep deprivation and periods of intense, prolonged questioning are similar to methods applied by torturers and could constitute a form of torture. See also Pope, KS and Garcia-Peltoniemi, RE “Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources” (1991) *Professional Psychology: Research and Practice* 221, 269 – 276.

⁷⁰⁸ Walker (1994) *supra* note 683 at 59.

the woman is more prone to react to threats or actual violence with a greater sense of terror and understanding of its dangerous consequences.

15.2.2 Myths and misconceptions surrounding the battered woman

It is important to take note of the various myths that surround the battered woman. Expert evidence pertaining to the battered woman syndrome is commonly presented with the specific aim of dispelling these myths.

Walker correctly states⁷⁰⁹:

“It is important to refute all the myths surrounding battered women in order to understand fully why battering happens, how it affects people, and how it can be stopped.”

It is accordingly important to briefly analyse some of the most important myths surrounding the battered woman.

- Myth: The Battered Woman Syndrome affects only a small percentage of the population

Research suggests that one in every four women is in an abusive relationship⁷¹⁰. Research further supports the assumption that a woman is killed every six days by her intimate male partner in South Africa⁷¹¹. Walker notes that battering of women is an extremely underreported crime⁷¹². Experts tend to suggest that between one-half and two-thirds of all marriages will experience at least one incident of abuse during the course of the relationship⁷¹³. The frequency of domestic violence

⁷⁰⁹ Walker (1979) *supra* note 666 at 18.

⁷¹⁰ Statistics obtained from POWA (People Opposing Woman Abuse) <http://www.powa.co.za/Display.asp?ID-12> [accessed on 2009-03-16].

⁷¹¹ *Ibid.*

⁷¹² Walker (1979) *supra* note 666 at 19; Mather (1988) *Merc. L. Rev. supra* note 666 at 545; Strauss, M, Gelles, R and Steinmetz S “Behind closed Doors: Violence in the American Family” (1980) at 32 – 33.

⁷¹³ Walker (1979) *supra* note 666 at ix; Mather (1988) *Merc. L. Rev. supra* note 666 at 545; Strauss, A “A sociological Perspective on the Prevention and Treatment of Wifebeating” in Roy, M “Battered Women: A Psychological Study of Domestic Violence” at 194.

is thus clearly underestimated. The lack of comprehension of the precise dynamics of an abusive relationship and the frequency of occurrence “undermines society’s ability to deal with the legal and moral complexities arising from the abusive relationship.”⁷¹⁴

Battering should not be regarded as isolated incidents arising from minor disputes, but should be viewed as a pattern of repeated abuse from which the battered woman frequently sees her escape.

- Myth: Battered women choose abusive relationships because they are masochistic

Masochism within the context of the battered woman means that she experiences some form of pleasure when beaten or assaulted by her husband or partner⁷¹⁵. This myth has the negative result of displacing the blame for the battering or abuse on the battered woman and also perpetuating the violent behaviour of the male⁷¹⁶.

- Myth: Women abuse happens to uneducated working class women

Walker indicates that lower-class women have more frequent contact with the community and accordingly signs of abuse will become evident and visible as opposed to middle and upper class who often fear making their abusive relationships public as a result of fear of social embarrassment⁷¹⁷. The fact, however, remains that abuse against women can affect women of all races, classes, language groups as well as educational groups⁷¹⁸.

⁷¹⁴ Mather (1988) *Merc. L. Rev. supra* note 666 at 546. See also Walker (1984) *supra* note 666 where a study of over 400 battered women was conducted and Browne (1987) *supra* note 666 at 2 and 3 where it is stated: “... the privacy of the middle-class life-style preserves an illusion of greater domestic tranquility ...” but this was “only an illusion.”

⁷¹⁵ Walker (1979) *supra* note 666 at 20.

⁷¹⁶ *Ibid.* Research by POWA *supra* suggests that this myth blames and stigmatises women and provides an excuse for abuse.

⁷¹⁷ Walker (1979) *supra* note 666 at 22; POWA *supra* note 710 at 5.

⁷¹⁸ Mather (1988) *Merc. L. Rev. supra* note 666 at 548; Moore (1979) *supra* note 666 “Editor’s Introduction” in *Battered Women* 7, 15 – 16 in Flemming, J “Stopping Wife Abuse” (1979) at 330 – 332; Martin (1976) *supra* note 666 at 11 – 14.

- Myth: Women could leave their abusive partners if they wanted to

“Surely all women are born knowing the men they love could kill them in a minute, that we are kept alive by kindness, that we are always in peril. This is the source of our desire for obedience, for the inherited knack, the alert readiness – even in women who rage or live their lives in solitude – for giving in.”⁷¹⁹ (Mary Gordon “The Company of Women” [1980] 245)

Probably the most difficult myths about battering or abusive relationships to dispel, is the question as to why the woman doesn’t just leave or escape from the abusive relationship.

Browne notes the following⁷²⁰:

“Denial and minimization are consequences of escalating fear that allow a woman to remain in her violent home and make it difficult for her to see the ‘forest for the trees’.”

Various factors⁷²¹ motivate an abused woman to remain in an abusive relationship. These include circumstantial factors such as:

- Economic dependence – Martin⁷²² correctly states that often battered women, who in many of the cases are housewives, do not have the financial means in order to leave an abusive relationship.

⁷¹⁹ Gordon, M “The Company of Women” (1980) at 245.

⁷²⁰ Browne (1993) *supra* note 666 at 47.

⁷²¹ See “Women’s Rural Advocacy Programs – Why Women Stay – The Barriers to leaving” <http://www.letswrap.com/dvinfo/whystay.htm> [accessed 2006-03-27]; POWA *supra* note 710; Martin (1976) *supra* note 666 at 72 – 86; Carstens and Le Roux (2000) SACJ *supra* note 1 at 183. See also *State v Kelly*, 478 A.2d 364, 375 – 376 (NJ 1984) where the Court at 372 advanced the following motivation for why battered women remain in abusive relationships: “In addition, battered women, when they want to leave the relationship, are typically unwilling to reach out and confide in their friends, family, or the police, either out of shame and humiliation, fear of reprisal by their husband, or the feeling that they will not be believed.” The New Jersey court also found Walker’s explanation of external factors that motivate battered women to remain in an abusive relationship such as financial constraints, limited child care options, and the general lack of support from society for women, as helpful in dispelling myths as to why women would want to stay in such relationships. (at 372)

⁷²² Martin (1976) *supra* note 666 at 83; Carstens and Le Roux (2000) SACJ *supra* note 1 at 183.

- Fear of greater physical danger to herself and her children if the abused woman and her children attempts to leave.
- Fear of being hunted down and suffering worse abuse than before.
- Fear of emotional damage to the children or losing custody over children.
- Lack of employment opportunities.
- Social isolation as a result of a lack of support from family and friends.
- Fear of getting involved with the legal process.
- Fear of the abuser stalking or harrassing her.

Emotional factors, such as:

- Insecurity within the battered woman as to her own ability to cope on her own.
- Loyalty, although displaced, to the abuser.
- Denial – “It’s really not that bad. Other people have it worse.”
- Love for the abuser.
- Shame and humiliation.
- Unfounded optimism that the abuser will rehabilitate.
- Personal, religious and cultural beliefs.
- Guilt – the woman believes that the cause of the violence is some inadequacy on her part.
- Demolished self-esteem.

Of all the factors playing a role in inducing an abused woman to stay in an abusive relationship, fear is the most common and important factor.

Martin notes⁷²³:

“Fear immobilizes them, ruling their actions, their decisions, their very lives.”

According to Pistorius, a possible explanation for the fact that a battered woman would remain in an abusive relationship could also be traced to the Victorian “ideal

⁷²³ Martin (1976) *supra* note 666 at 76.

woman” perspective⁷²⁴. According to the latter ideology women are expected to be unselfish, self-sacrificing and they will accordingly rather make excuses for their abuser’s behaviour instead of making an end to the relationship⁷²⁵. According to Ludsin women remain in an abusive relationship for a variety of reasons including economic and emotional dependence⁷²⁶.

Alsdurf and Alsdurf state that according to Dr Constance Doran, the founding director of Fuller Theological Seminary’s SAFE (Stop Abusive Family Environments) Programme, there are both external sociological as well as internal psychological motivations for a woman to stay in an abusive relationship⁷²⁷.

Doran advances the following explanation for why a woman remains in an abusive relationship:

“It’s very much like what victims of political terrorism experience: a psychological numbing process goes on, so that the person is able to tolerate the violent situation as well as possible. Victims tend to minimize the risk they are experiencing. An extension of this may occur when the victim actually becomes a supporter or advocate of her captor. ... The whole process of becoming psychologically paralyzed is significant in keeping women in abusive situations.”⁷²⁸

It is accordingly clear that battered women remain in abusive relationships for various reasons sometimes incomprehensible to the lay person who does not understand the dynamics of the abusive relationship that the battered woman finds herself in. Expert evidence⁷²⁹ is pivotal in dispelling this myth and providing clarity as to the exact reasons for remaining in an abusive relationship.

⁷²⁴ Pistorius (2004) *supra* note 1 at 20.

⁷²⁵ *Ibid.*

⁷²⁶ Ludsin (2003) *supra* note 666 at 7. See also Alsdurf, J and Alsdurf, P “Battered into Submission – The Tragedy of Wife Abuse in the Christian Home” (1989) at 34 where they state that factors such as guilt, fear, religion, helplessness or just a lack of options motivate battered women to stay with their abusive husbands.

⁷²⁷ Alsdurf and Alsdurf (1989) *supra* note 726 at 14-34.

⁷²⁸ *Ibid.*

⁷²⁹ The role of expert evidence in cases of battered woman syndrome will be extensively discussed in paragraph 15.3 below.

- Myth: Stress and/or substance abuse causes battering

Despite the fact that there is often a link between intoxication or drinking and battering, research suggests that abuse occurs whether or not the abusive husband or partner was drinking or not⁷³⁰. It is important to note that stress, substance abuse and battering are all separate issues and should be understood as such⁷³¹.

- Myth: Battered women deserve to get beaten

The myth suggests that the battered woman should seek answers for her abusive husband or spouse's violence in her own behaviour⁷³².

Walker summarises the problematic nature of this myth by stating⁷³³:

“... philosophically this myth robs the men of responsibility for their own actions. No one could deserve the kind of brutality reported in these pages.”

15.2.3 The psychological profile of the battered woman *versus* the batterer

It is important to concisely summarise the psychological profiles of both the battered woman and the abusive husband or partner.

In order to successfully introduce expert evidence of the battered woman syndrome it is necessary to indicate that the woman exhibited characteristics of a

⁷³⁰ POWA *supra* note 710 at 4; Mather (1988) *Merc. L. Rev. supra* note 663 at 549.

⁷³¹ *Ibid.* See also Walker (1989) *supra* note 666 at 114 where she indicates that the presence of alcohol increases the risk for serious injury or assault. See also Walker (1994) *supra* note 683 at 67.

⁷³² Walker (1979) *supra* note 666 at 29, “Women’s Rural Advocacy programs – Battering – the facts” at <http://www.letswrap.com/dvinfo/myths.htm>; Mather (1988) *Merc. L. Rev. supra* note 663 at 550 – 551.

⁷³³ Walker (1979) *supra* note 666 at 29 – Walker conducted a study of battered women that indicated that batterers lose self-control because of their own internal reasons, not because of what the woman did or did not do.

battered woman at the time of the killing and also that the abusive husband or partner displayed the characteristics of a batterer.

Walker personifies the typical psychological profile of a battered woman as opposed to the batterer as follows⁷³⁴:

Battered Woman		Batterer	
1.	Has low self-esteem ⁷³⁵ .	1.	Has low self-esteem.
2.	Believes all the myths about battering relationships.	2.	Believes all the myths about battering relationships.
3.	Is a traditionalist about the home, strongly encourages family unity and the prescribed feminine sex-role stereotype.	3.	Is a traditionalist believing in male supremacy and the stereotyped masculine sex role in the family.
4.	Accepts responsibility for the batterer's actions.	4.	Blames others for his actions.
5.	Suffers from guilt, yet denies the terror and anger experienced by her.	5.	Is pathologically jealous ⁷³⁶ .
6.	Presents a passive face to the	6.	Presents a dual personality ⁷³⁷ .

⁷³⁴ Walker (1979) *supra* note 666 at 31 – 36; Walker (1989) *supra* note 666 at 101 – 106; Johann and Osanka (1989) *supra* note 666 at 27 – 28.

⁷³⁵ See *S v Potgieter supra* note 1 at 64 G-H where the accused stated: “it’s so humiliating that it is not worth living if I’m such a bad useless person.”

⁷³⁶ See *S v Engelbrecht supra* note 1 at 61 A-C where Satchwell J summarises evidence of the deceased’s harassment and stalking of the accused:

“... telephone calls to Mrs Engelbrecht at work by Mr Engelbrecht sometimes two or three times per day and sometimes in a disguised voice; Mr Engelbrecht coming into the hospital wards, casualty and the data office looking for Mrs Engelbrecht while she was working; Mr Engelbrecht stalking and spying on her; peering in hospital doors and windows and standing across the street to watch Mrs Engelbrecht at work and during smoke breaks during both the day and the night ...”

See also Walker (1994) *supra* note 683 at 60 where she states that jealousy, overpossessiveness and intrusiveness often results in the isolation of the battered woman. She may cease normal social activities, neglect seeing her friends and family and tends to become a prisoner in her own home. During the times when the battered woman is allowed to engage in social activities, the abuser controls and monitors with whom the battered woman has contact and all aspects of such contact and accordingly as a result of the woman becoming increasingly isolated, she becomes more vulnerable to the abuser. See also Moore (1979) *supra* note 666 at 15 – 16.

⁷³⁷ *S v Potgieter supra* note 1 at 65 g where it is stated: “The pattern of inconsistent and deplorable behaviour continued. Initially he was kind and considerate, saying he wanted to marry her in August. But he soon reverted to his former misconduct.”

	outside world and has the power to manipulate her environment enough to prevent further violence or even being killed.		
7.	Has severe stress reactions, with psycho-physiological complaints.	7.	Experiences severe stress reactions as a result of which he uses drinking and wife battering to cope.
8.	Uses sex as a means of establishing intimacy.	8.	Frequently uses sex as an act of aggression to enhance self-esteem
9.	Believes that no one will be able to assist her in the difficult situation that she finds herself in except herself.	9.	Does not believe his violent behaviour should have negative consequences.

According to Browne, the only markable difference between battered women who kill as opposed to battered women who do not, lies in the perceptions of violence⁷³⁸. According to Browne women who eventually killed their abusive husbands or partners perceived them as being more violent more frequently which caused more severe physical injuries as opposed to battered women who did not kill⁷³⁹.

15.2.4 The cycle of violence

According to Walker violent relationships are cyclical in nature and typically consist of three stages⁷⁴⁰:

⁷³⁸ Browne (1979) as discussed in Walker (1989) *supra* note 666 at 103.

⁷³⁹ *Ibid.*

⁷⁴⁰ Walker (1979) *supra* note 66 at 55 – 69; Ludsin and Vetten (2005) *supra* note 666 at 62 – 66; Mather (1988) *Merc. L. Rev. supra* note 666 at 553; Roberts, JW “Between the Heat of Passion and Cold Blood: Battered Woman’s Syndrome as an Excuse for Self-Defense in Non-Confrontational Homicides” (2003) *Law and Psychology Review* 135 at 140; Veinsrerderis, ME “The Prospective Effects of Modifying Existing Law to Accommodate Preemptive Self-Defense by Battered Women” (2000) *University of Pennsylvania Law Review* at 613; Walker, LE “How Battering Happens and How to Stop it” in Moore (1979) *supra* note

Phase one: The tension-building stage

During this phase the abusive male engages in minor battering incidents and verbal abuse. The battered woman will then attempt to calm the batterer by employing various strategies such as becoming nurturing and compliant⁷⁴¹. The battered woman will attempt to be as passive as possible in order to avoid further violence. According to Walker, the woman believes that what she does and how she reacts will prevent the abuser's anger from escalating. Within this phase, the battered woman is often in denial as to her own feelings of anger as a result of being physically or psychologically abused. The tension between the battered woman and the batterer escalates to a point where it becomes more difficult to successfully apply their coping techniques and the tension between the two eventually becomes unbearable⁷⁴².

Phase two: The acute battering incident

At some point during phase one, the tension build-up between the battered woman and the batterer becomes intolerable and consequently more serious violence becomes inevitable. The cause of phase two is often an internal or external event in the life of the battering male, but provocation for more serious violence is often provided by the woman who can no longer tolerate or control her phase-one anger and anxiety. Phase two is accordingly characterized by the uncontrollable discharge of the tensions that have built up during phase one⁷⁴³. According to Walker, the anticipation of what might happen during this phase causes severe psychological stress for the battered woman who often displays signs of anxiety, depression and also complains of psychophysiological symptoms⁷⁴⁴.

666 at 59 – 73; Lenkevich (1999) *William and Mary Journal of Women and the Law* *supra* note 666 at 308; Reddi (2005) *SACJ* *supra* note 666 at 261; Tabak and Ehrenfeld (1998) *Medicine and Law* *supra* note 666 at 614; Johann and Osanka (1989) *supra* note 666 at 28; Walker (1989) *supra* note 666 at 42 – 47; Dutton (2007) *supra* note 674 at 74; Moore (1979) *supra* note 666 at 64; Browne (1993) *supra* note 666 at 16.

⁷⁴¹ *Ibid.*

⁷⁴² *Ibid.*

⁷⁴³ Walker (1979) *supra* note 666 at 59; Dutton (2007) *supra* note 674 at 75.

⁷⁴⁴ *Ibid.*

Walker describes the acute-battering phase as follows⁷⁴⁵:

“During the acute phase – set apart from minor battering incidents by its savagery, destructiveness, and uncontrolled nature – the violence has escalated to a point of rampage, injury, brutality, and sometimes death.”

Phase three: Kindness and loving behaviour

This phase of the cycle of violence is characterized by extreme contrition and loving behaviour on the part of the abusive male. The abusive male behaves in a charming and loving manner constantly asking for forgiveness with promises to seek professional help, to stop drinking as well as to refrain from further violence. During this phase of loving contrition, the battered woman is often victimized psychologically.⁷⁴⁶ Walker notes that during this phase, the battered woman and the batterer become interdependent on each other – she for his caring behaviour, and he for her forgiveness.⁷⁴⁷ In some cases phase three may last as long as several months, but within an abusive relationship, the affection and contrition of the man will eventually fade and phase one of the cycle will start afresh.⁷⁴⁸

It is important to take note of the cycle of violence within an abusive relationship in order to comprehend the psychosocial dynamics of the relationship. Expert evidence pertaining to the cycle of violence within an abusive relationship is also pivotal in order to understand why a battered woman reacted in a particular way, for example by murdering her abusive partner or husband. In order to provide a practical exposition of the cycle of violence, the table of Dutton is important. The cycle theory of violence has been used to explain why the battered woman believed that her abusive husband or partner presented a threat of imminent harm when she attacked him.⁷⁴⁹

⁷⁴⁵ Walker (1989) *supra* note 666 at 43; Dutton (2007) *supra* note 674 at 75 – 77.

⁷⁴⁶ Walker (1989) *supra* note 666 at 45.

⁷⁴⁷ *Ibid.* See also Dutton (2007) *supra* note 674 at 78. According to Dutton a process of “traumatic bonding” begins to operate between the battered woman and the abusive partner or husband. Dutton states: “This process is an attachment to the abuser formed by the prior power differential in the relationship coupled with intermittent abuse.”

⁷⁴⁸ Lenkevich (1999) *William and Mary Journal of Women and the Law supra* note 666 at 308.

⁷⁴⁹ Walker (1979) *supra* note 666 at 55 – 71; Burke (2002) *North Carolina Law Review supra* note 666 at 230; Walker (1984) *supra* note 666 at 95.

Burke similarly concludes the following pertaining to the cycle theory of violence⁷⁵⁰:

“Expert testimony describing the cycle theory is said to explain the reasonableness of a domestic violence victim’s perception that serious harm was ‘imminent’ despite the fact that her abuser was seemingly calm or even sleeping when she killed him.”

Walter’s research on Battered Woman Syndrome and accordingly the cycle of violence has also been held to assist the court in explaining the effect of the Battered Woman Syndrome on the woman’s behaviour throughout the relationship and explaining why the woman entered the relationship, remained in the abusive relationship and failed to escape sooner.⁷⁵¹

The cyclical nature of the abuse together with the loving behaviour displayed by the abusive husband or partner during phase three reinforces the hope that these women experience that their abusers will reform and accordingly keeps them entrapped in the relationship.⁷⁵²

15.2.5 The theory of learned helplessness

Psychologists often observe that battered women suffer from what they refer to as learned helplessness.⁷⁵³ The concept of learned helplessness has been used by experts to explain the failure of battered women to leave their batterers and

⁷⁵⁰ *Ibid.*

⁷⁵¹ See Lenkevich (1999) *William and Mary Journal of Women and the Law supra* note 666 at 308 – 309; *State v Kelly*, 478 A-2d 364, 375 – 376 (N.J. 1984). In the latter case Walker’s work on Battered Woman Syndrome was taken into high regard.

⁷⁵² *Ibid.*

⁷⁵³ Walker (1979) *supra* note 666 at 45; Walker (1989) *supra* note 666 at 49; Le Roux, J “Geweldsmisdade Binne Huweliksverband” (1994) (Unpublished LLD thesis University of Pretoria) at 159; Burke (2002) *North Carolina Law Review supra* note 666 at 231; Ewing (1987) *supra* note 666 at 20; Mather (1988) *Merc. L. Rev. supra* note 666 at 554; Browne (1987) *supra* note 666 at 122; Johann and Osanka (1989) *supra* note 666 at 62 – 63; Okun, L “Woman Abuse – Facts replacing myths (1986) 83 (1993).

escape from an abusive relationship. Walker designed the theory of learned helplessness to explain the passive behaviour of battered women.⁷⁵⁴

The theory of learned helplessness was originally developed by experimental psychologist Martin Seligman who placed dogs in cages from which they could not escape and subjected these dogs to electric shocks randomly and at variable times. According to Seligman these dogs quickly learned that there was nothing they could do to control the shocks. Eventually the dogs in the experiment completely ceased all voluntary attempts to escape. When the procedure was changed by researchers in order to teach the dogs to escape, they remained entirely passive, refusing both to escape or to avoid the administered electric shocks. Upon closer scrutiny, however, it became evident that these dogs were not passive, but had instead developed coping skills in order to minimize the pain, by lying in their own fecal matter in a part of the electrical grid that received the least amount of electricity. Accordingly, once these dogs learned how to escape in this manner, their “learned” helplessness which was to trade the unpredictability of escape for the more predictable coping strategies, disappeared.⁷⁵⁵ Mather notes that if animals or humans are continuously exposed to situations in which they have no control over outcomes, these experiences weaken their capacity to react in a situation in which they could have some control.⁷⁵⁶

Within humans, and accordingly battered women, Seligman discovered that even if a battered woman has control over a particular situation, but believes that she does not, she will rather respond to that situation with coping strategies, than trying to escape. Battered women are repeatedly exposed to painful events over which they have no control, for example psychological or sexual abuse, and

⁷⁵⁴ Walker (1979) *supra* note 663 at 45; Walker (1989) *supra* note 663 at 49.

⁷⁵⁵ *Ibid.* According to Martin Seligman, there are three components to learned helplessness:

- (a) motivational impairment (“passivity”)
- (b) intellectual impairment (lack of problem-solving ability)
- (c) emotional trauma (increased feelings of helplessness, incompetence, frustration and depression)

Seligman also identified a similarity between learned helplessness and clinical depression. See Barnett and LaViolette (1993) *supra* note 666 at 103.

⁷⁵⁶ Mather (1988) *Merc. L. Rev.* *supra* note 663 at 554. According to Mather there is a view that some battered women lose their ability to “save” themselves due to the fact that they feel they have no control over the battering situation.

respond to these stressors with classic symptoms of learned helplessness.⁷⁵⁷ Walker notes that battered women within this context becomes passive, lose their motivation to respond and start believing that nothing they do will change their fate.⁷⁵⁸ Similar to Seligman's experiment with the dogs, battered women eventually refrain from avoiding the painful stressors and fail to cease opportunities for escaping.⁷⁵⁹ Walker states that the theory of learned helplessness has three components:⁷⁶⁰

- information about what will happen
- cognitive representation as to what will happen
- behaviour toward what happens.

If a person does have control over response outcome variables but believes he/she does not, he or she is likely to respond with learned helplessness.

If a battered woman is repeatedly abused, similarly to electrical shocks, the woman's motivation to respond becomes diminished and she becomes more passive and her cognitive capacity to perceive success is altered.⁷⁶¹ Accordingly the battered woman subjectively believes nothing she does will alter her circumstances. Walker states:⁷⁶²

“Battered women don't attempt to leave the battering situation, even when it may seem to outsiders that escape is possible, because they cannot predict their own safety ...

People suffering from learned helplessness are more likely to choose behavioural responses that will have the highest predictability of an effect within the known, or familiar, situation, they avoid responses – like escape, for instance – that launch them into the unknown.”

⁷⁵⁷ Ewing (1987) *supra* note 666 at 20 – 21; Walker (1989) *supra* note 666 at 51.

⁷⁵⁸ *Ibid.*

⁷⁵⁹ *Ibid.*

⁷⁶⁰ Walker (1979) *supra* note 666 at 47.

⁷⁶¹ *Ibid.*

⁷⁶² Walker (1989) *supra* note 666 at 50; Johann and Osanka *supra* note 666 at 62 – 63.

The battered woman accordingly fails to leave not because of an inherent desire to stay, but because of a lack of cognitive capacity in respect of her escape options.⁷⁶³

Walker identifies seven factors associated with the development of learned helplessness:⁷⁶⁴

1. A pattern of violence – this pattern refers to the cycle theory of violence with an increased frequency and severity of abuse;
2. Sexual abuse of the woman;
3. Jealousy, overpossessiveness and isolation of the woman;
4. Threats to hurt or kill the woman;
5. Psychological torture;
6. Violence correlates;
7. Alcohol or drug abuse by either the man or woman.

Understanding these factors and comprehension of the psychological concept of learned helplessness, will provide an explanation of the psyche and psychological disposition of the battered woman and reasons for the decisions the battered woman took and the motivation for remaining in an abusive relationship.

15.2.6 The theory of coercive control

“It was as if he transplanted his brain into mine. I started to think like him. Dirk made me believe that we were untouchable and that we could do what we wanted.”⁷⁶⁵

“Dirk was my god. He made me believe he was almighty and that he was in control ...”⁷⁶⁶

⁷⁶³ Burke (2002) *North Carolina Law Review* *supra* note 666 at 232; Walker (1979) *supra* note 666 at 49 – 50; Ludsin and Vetten (2005) *supra* note 666 at 59.

⁷⁶⁴ Walker (1989) *supra* note 666 at 52.

⁷⁶⁵ Pretoria News 11 March 2009. See unreported judgment *S v Cezanne Visser* (hereafter *S v Visser*) per Eksteen AJ dated 27 October 2009 page 58.

⁷⁶⁶ Pretoria News 14 March 2009. These quotations were extracted from the evidence by the accused in the currently controversial and highly publicised trial of *S v Visser* case number CC

Another theory of explaining the nature and effects of domestic abuse, is the theory of coercive control.⁷⁶⁷

A domestic assault is often part of a much larger system of controlling, coercing, intimidating and violent behaviours employed by an abusive partner to control the

545/09 also often referred to as the “Barbie trial”. See unreported judgment *S v Visser supra* note 853 at 58. The facts of the case in *S v Visser* are the following:

Cézanne Visser, better known as “advocate Barbie” faced fourteen charges against her which includes fraud, the incitement of minors to commit indecent acts, indecent assault, rape, possession of child pornography, the manufacturing of child pornography as well as the possession of drugs. The case was heard in part in the Pretoria High Court when Patel J in April 2007, passed away. The case again commenced on 16 February 2009. Cézanne Visser initially stood trial on all of the charges together with her former lover and fiancé, Dirk Prinsloo. Dirk Prinsloo, however, left the country in 2006 and was one of Interpol’s most wanted criminals. On 12 June 2009 Dirk Prinsloo was arrested in Balarusia for attempted robbery in a bank. He also faced charges of theft, hooliganism and torture. On 1 February 2010 he was subsequently convicted of theft, bank robbery and hooliganism and sentenced to thirteen years in jail. Visser, who was a bright student and obtained her law degrees with distinction, moved in with Prinsloo shortly after she failed her Bar examination and subsequently joined the independent bar. Visser testified that when she had met Prinsloo, she was naive and eventually got trapped in his sex web. Some of the charges against Visser relate to occasions where she and Prinsloo performed indecent acts with minor girls they had collected from an orphanage in Pretoria for so-called “weekend-visits”. According to the evidence these girls were provided with drinks, often “Milo”, that contained sedative drugs after which indecent sexual acts were performed on them by Prinsloo. Prinsloo also subjected Visser to various forms of brutal and sadistic sexual abuse. Visser, according to her testimony, also suffered immense psychological and emotional abuse at the hands of Prinsloo. Visser’s defence relates to the battered woman syndrome but also more specifically to the coercive control that Prinsloo exerted over her. Her defence also encapsulates manifestations of the Stockholm-syndrome, and the compliant victim syndrome which will be discussed below. See Beeld 16 February 2009; 17 February 2009, 19 February 2009; 20 February 2009; Rapport 22 February 2009; 27 February 2009; Beeld 28 February 2009; Rapport 1 March 2009; Beeld 10 March 2009; Pretoria News 10 March 2009; Beeld and Pretoria News 11 March 2009; Beeld and Pretoria News 12 March 2009; Pretoria News 14 March 2009; Beeld 18 March 2009; Beeld and Pretoria News 17 March 2009; Rapport 15 March 2009; Beeld 19 March 2009; Beeld 20 March 2009; Beeld and Pretoria News 21 March 2009; Beeld and Pretoria News 27 March 2009; Beeld and Pretoria News 28 March 2009; You magazine 26 March 2009 10 – 11. See also Rapport 29 March 2009; Rapport 5 April 2009; Pretoria News 18 June 2009; Beeld 16 June 2009; Rapport 14 June 2009; Beeld 18 June 2009; Pretoria News 19 June 2009; Beeld 24 June 2009; Beeld 26 June 2009; Beeld 29 June 2009; Pretoria News 29 August 2009; Beeld 7 October 2009; Pretoria News 7 October 2009; Pretoria News 8 October 2009; Beeld 8 October 2009; Beeld 10 October 2009; Rapport 11 October 2009; Beeld 10 February 2010; Pretoria News 10 February 2010; Pretoria News and Beeld 12 February 2010. See also page 58 of the unreported judgment where Eksteen AJ notes that Visser’s love for Prinsloo comprised of various aspects including:

“A. Vrees vir die man; B. Afhanklikheid van hom; C. Die mag wat hy oor haar gehad het” and also page 63 where Eksteen AJ notes the following in respect of Visser’s defence:

“Sy beweer sy was vasgevang in Dirk Prinsloo se mag. Sy het in haar binneste gevoel dit is nie reg nie, maar dit was nie sterk genoeg om teen Prinsloo se mag in opstand te kom nie. “Ek het nie gedink wanneer hierdie goed gebeur nie” het beskuldigde gesê.”

⁷⁶⁷ Stark, E “Coercive Control – How men Entrap women in Personal Life” (2007) at 84-112; Ludsin and Vetten (2005) *supra* note 666 at 67; Stark (2007) *supra* note 767 at 12.

victim. Stark indicates that according to evidence, violence in abusive relationships is an ongoing phenomenon rather than episodic in nature.⁷⁶⁸

According to Stark there is a general perception that abused women stay in an abusive relationship and develop mental health and behavioural problems due to the fact that exposure to severe forms of violence induces syndromes such as Post Traumatic Stress Disorder and Battered Woman Syndrome which prevents the woman from escaping from the abusive relationship.⁷⁶⁹ Stark, however, indicates that only a small percentage of abuse victims display these symptoms and many of them do not develop psychological problems.⁷⁷⁰

This dominant approach to domestic violence accordingly fails to adequately address two important facts:

- the entrapment of victims in relationships where ongoing abuse is virtually inevitable;
- the development of a problem profile that distinguishes abused women of every other class of assault victim.⁷⁷¹

Stark states the following:⁷⁷²

“Work with battered women outside the medical complex suggests that physical violence may not be the most significant factor about most battering relationships. In all probability, the clinical profile revealed by battered women reflects the fact that they have been subjected to an ongoing strategy of intimidation, isolation and control that extends to all areas of a woman’s

⁷⁶⁸ Herman, JL “Trauma and Recovery” (1992) at 74; Stark, E “Symposium on reconceptualizing violence against women by intimate partners” (1995) 58 *Albany Law Review* 973; Stark, E “Coercive Control” justiceformothers.com/Documents/coercivecontrol.pdf [accessed on 23-03-2009]. See also Okun, L “Woman Abuse: Facts Replacing Myths” (1986) at 86.

⁷⁶⁹ *Ibid.*

⁷⁷⁰ *Ibid.*

⁷⁷¹ *Ibid.*

⁷⁷² Stark, E “Re-presenting woman battering: From battered woman syndrome to coercive control” (1995) *Albany Law Review* 973 at 5 as quoted in Ludsin and Vetten (2005) *supra* note 666 at 61 – 62. See also Stark (2007) *supra* note 767 at 57 where he states that protecting women from severe assaults has resulted in the substitution of physical abuse with coercive control.

life, including sexuality, material necessities, relations with family, children and friends, and work. Sporadic, even severe violence makes this strategy of control effective. But the unique profile of the battered woman arises from the deprivation of liberty implied by coercion and control as it does from violence induced trauma.”

Coercive control is a model of abuse that includes various strategies employed by an abusive partner to dominate women in their personal life.⁷⁷³ According to Stark coercive control “describes an ongoing pattern of sexual mastery by which abusive partners, almost exclusively males, interweave physical abuse with three equally important tactics: intimidation, isolation and control.”⁷⁷⁴

Stark notes that it is important to distinguish the coercive control model from the traditional domestic violence model. Stark highlights the following essential differences:

- The domestic violence model typically emphasizes the familial, cultural and psychological foundations of abusive behaviour. The coercive control model on the other hand, views the dynamics in abusive relations on the backdrop of the historical battle for women’s liberation and men’s motivation for preserving their traditional privileges in personal life amidst this battle.
- Domestic violence laws generally follow an incident-specific approach and accordingly measure the severity of abuse against the level of force or injuries inflicted. The coercive control model, on the other hand, is predicated on the premise that most battered women who seek help experience “coercion” as “ongoing” rather than merely “repeated” and that the most important aspect of these assaults lies in their frequency or even their “routine” nature, rather than its severity which results in a “cumulative” effect found in no other assault crime.

⁷⁷³ Stark, E “Coercive Control” at justiceformothers.com/Documents/coercivecontrol.pdf [accessed on 23-05-2009]. Coercive control is also sometimes referred to as coerced persuasion; conjugal, patriarchal or intimate terrorism, emotional or psychological abuse; indirect abuse or emotional torture.

⁷⁷⁴ *Ibid.* See also Stark (2007) *supra* note 767 at 5.

- Physical harm and psychological trauma, that are generally very important phenomena in the domestic violence model, remain important in the coercive control model, but its theory of harms substitutes the violation of physical integrity with an emphasis on infringements of “liberty” that includes the deprivation of rights and resources essential to personal autonomy.⁷⁷⁵
- In the coercive control model, what men do to women is less important than what they prevent women from doing for themselves.

With increasing efforts by women to ensure their equality in a previously male dominant society, men find it more difficult to ensure women’s obedience and dependence through the application of violence alone. Accordingly, in the face of reality, men have expanded their oppressive techniques to encompass a range of constraints on women’s autonomy formerly imposed by law, religion, and women’s exclusion from the economic, cultural and political mainstream, “in essence trying to construct a ‘patriarchy in nature’ in each individual relationship, the course of malevolent conduct known as coercive control.”⁷⁷⁶

The theory of coercive control originated in the experiences of people who lived in situations of captivity or people who were taken hostage and displayed symptoms of the “Stockholm-syndrome” or “traumatic bonding.”⁷⁷⁷

According to Herman, captivity “brings the victim into prolonged contact with the perpetrator, and creates a special type of relationship, one of coercive control.”⁷⁷⁸

The motivations for this behaviour are the following:⁷⁷⁹

- Complete control over the victim;
- Making the victim acquiesce in her domination;
- Due to the fact that it appears that the victim accepts this abusive treatment, the likelihood of outside assistance is reduced.

⁷⁷⁵ *Ibid.*

⁷⁷⁶ *Ibid.*

⁷⁷⁷ Ludsins and Vetten (2005) *supra* note 666 at 67; Stark (2007) *supra* note 767 at 198, 203. The concepts of “Stockholm-syndrome” and “traumatic bonding” will be discussed below.

⁷⁷⁸ Ludsins and Vetten (2005) *supra* note 666 at 67; Herman, JL “Trauma and Recovery” (1992) at 74.

⁷⁷⁹ *Ibid.*

Coercive control can also in some cases result in the victim identifying with the abuser. The latter entails that the abused woman will attempt to view the world through the eyes of the abuser in an attempt to prevent further harm and danger.⁷⁸⁰

The main reason for incorporating a discussion of the theory of coercive control into the present discussion, is that it could provide an alternative approach to assessing the situation where an abused woman kills her abusive husband or partner. It will be illustrated below that various techniques of coercive control were present in case law pertaining to battered women even though it was never identified as such, as the concept of coercive control is relatively novel despite the fact that the manifestations thereof have always been present in abusive relationships.

Stark correctly states:⁷⁸¹

“Viewing woman abuse through the prism of the incident-specific and injury-based definition of violence has concealed its major components, dynamics and effects, including the fact that it is neither “domestic” nor primarily about “violence”. Failure to appreciate the multidimensionality of oppression in personal life has been disastrous for abuse victims.”

Stark accordingly conceptualizes coercive control as follows:⁷⁸²

“Coercive control entails a malevolent course of conduct that subordinates women to an alien will by violating their physical integrity (domestic violence),

⁷⁸⁰ Ludsin and Vetten (2005) *supra* note 666 at 67. Ludsin and Vetten note that the essential difference between abused women and prisoners is that women do not need to be captured or detained within the relationship as they remain within the relationship out of love for the abusive partner. Accordingly they will be less inclined to offer resistance than other captives as a result of their commitment to the relationship. The shocking reality is, however, that when affection has faded, many women may have been made captive through economic dependence, physical force and social, psychological and legal subordination. See also Herman (1992) *supra* note 767 at 74.

⁷⁸¹ Stark (2007) *supra* note 767 at 14 – 15.

⁷⁸² Stark (2007) *supra* note 767 at 15.

denying them respect and autonomy (intimidation), depriving them of social connectedness (isolation), and appropriating or denying them access to the resources required for personhood and citizenship.”

According to Stark some of the rights abusers deny women are already protected within the public sphere, such as the right to physical integrity, but other harms entailed in coercive control are gender-specific infringements of adult autonomy that have no counterpart in public life and remains invisible to the law.⁷⁸³

Stark states that⁷⁸⁴ the combination of these big and little indignities most adequately explains why women suffer and respond as they do within abusive relationships, and also why so many women become entrapped, why some battered women kill their partners as well as the reasons as to why they are prone to develop a range of psychosocial problems and exhibit behaviours that are contrary to basic common sense behaviour.

15.2.6.1 Methodology and techniques of coercive control

Ludsin and Vetten state that through the systematic and repetitive infliction of psychological trauma together with violence, terror and helplessness become part of the abused woman and her sense of self is slowly eliminated.⁷⁸⁵

According to Stark, coercion implies the use of force or threats to compel or dispel a particular response.⁷⁸⁶

Accordingly, apart from inflicting immediate pain, injury, fear or death, coercion also causes long-term physical, behavioural or psychological trauma.

According to Stark, control consists of various forms of deprivation, exploitation, and command that compel obedience in an indirect manner by monopolizing

⁷⁸³ *Ibid.*

⁷⁸⁴ Stark (2007) *supra* note 767 at 15 – 16.

⁷⁸⁵ Ludsin and Vetten (2005) *supra* note 666 at 68. See also Okun, L “Woman Abuse: Facts replacing Myths” (1986) at 119.

⁷⁸⁶ Stark (2007) *supra* note 767 at 228.

important resources, dictating choices, microregulating the woman's behaviour, restricting her options and depriving her of support essential to the execution of independent judgment.⁷⁸⁷

Stark notes⁷⁸⁸ that control may be implemented by means of specific acts of prohibition such as keeping the victim from going to work or denying the victim access to a car or phone.

Despite the fact that violence is one of the essential features of coercive control, it need not necessarily recur constantly or in the same brutal degree on every occasion.⁷⁸⁹ An abusive partner can use violence only when necessary and to the extent that is required to instill fear and obedience into the victim. Thereafter mere threats of violence will suffice to render the woman into compliance.⁷⁹⁰

Threats of violence may also sometimes extend to the abused woman's children and her family and result in fear and anxiety.⁷⁹¹ Ludsin and Vetten state that in order to understand what will make an abusive partner happy and so reduce further harm and violence, the abused woman often attempts to get inside the abuser's head.⁷⁹²

Accordingly the woman becomes sensitive to the abuser's moods and whims as well as submissive to his demands. In attempting to view aspects in the light that

⁷⁸⁷ *Ibid.*

⁷⁸⁸ *Ibid.* Stark in addition notes at 228: "Control may be implemented through specific acts of prohibition or coercion, as when a victim is kept home from work, denied access to a car or phone, or forced to turn over her paycheck. But its link to dependence and/or obedience is usually more distal than coercion and so harder to detect, making assigning responsibility a matter of working back from its effects through a complex chain of prior events. The result when coercion and control are combined, is the condition of unreciprocated authority often identified as domination and victims such experience as entrapment."

⁷⁸⁹ Ludsin and Vetten (2005) *supra* note 666 at 68.

⁷⁹⁰ Ludsin and Vetten (2005) *supra* note 666 at 68; Herman (1992) *supra* note 768 at 77. See also Forward (2002) *supra* note 666 at 44 where she states that one of the most frightening and therefore one of the most successful tactics an abuser can use to gain control carries with it the implied threat of physical attacks. See also Stark (2007) *supra* note 767 at 250 where he states that threats violate the person's right, physical and psychic security. Stark notes that in an English study, 79,5 % of the women reported that their partner threatened to kill them at least once, and 43,8 % did so often. In addition 60 % of the men threatened to have the children taken away, 36 % threatened to hurt the children, 32 % threatened to have the woman committed, 82 % threatened to destroy things that the woman cared for.

⁷⁹¹ Ludsin and Vetten (2005) *supra* note 666 at 69.

⁷⁹² *Ibid.*

the abuser does, the abused woman adopts the abuser's outlook and believes that she is the cause for the abuse and that she deserves it.⁷⁹³ This is also referred to as the "identification with the aggressor" and eventually results in the woman's identity being defined by the abusive partner.⁷⁹⁴

As a result of the woman in effect losing her identity to an extent, leaving the abusive relationship becomes increasingly difficult.

Ludsin and Vetten state:⁷⁹⁵

"Undermining the victim's self-image, identity, integrity and inviolability is another way of reshaping her thoughts, values and identity. This may take various forms including humiliating, reviling and verbally abusing her."

Severe emotional and psychological abuse breaks down the woman's personality and eventually makes her believe that such degradation defines who she is. According to Ludsin and Vetten, women are often induced into taking responsibility for the abuse by means of forcing the woman to make false "confessions".⁷⁹⁶ These include forcing the woman to admit to transgressions, non-existent sexual relationships or even a confession that the woman is to be blamed for the abuse. These admissions are sought to justify the abuser's abuse and results in further breakdown in the woman's identity and self-esteem causing her to feel responsible and deserving of abuse.⁷⁹⁷

⁷⁹³ *Ibid.*

⁷⁹⁴ *Ibid.* See also Graham, DLR, Rawlings, E I and Rigsby, PK "Loving to Survive: Sexual Terror men's violence and Women's lives" (1994) at 37 – 39.

⁷⁹⁵ Ludsin and Vetten (2005) *supra* note 666 at 70.

⁷⁹⁶ *Ibid.*

⁷⁹⁷ Ludsin and Vetten (2005) *supra* note 666 at 70. According to Ludsin and Vetten, these forced confessions are often accompanied by other methods employed to instill a misplaced guilt in the victim with the aim of rendering her to feel responsible for abuse, these include:

- Guilt by association in the sense that the woman is scorned if she associates with people the abuser doesn't approve of, such as friends or family.
- Guilt by intention in holding the woman culpable for having motives which could result in behaviour harmful to the abuser.
- Guilt for negative attitudes towards the abuser or for doubting his decisions.
- Guilt for having knowledge which could incriminate the abuser.
- Guilt for taking actions which is harmful to the abuser, regardless of the fact that harm was not intended for example where the woman was delayed on her way home and could not prepare dinner.

In terms of coercive control, sexual coercion is often a prominent feature of the exercise of control. Stark notes that women are frequently forced to have sex against their will often or all the time.⁷⁹⁸ According to Ludsin and Vetten sexual abuse serves not only as a means of control, but also constitutes a form of degradation.⁷⁹⁹ In situations of coercive control, an abuser may also regulate what the woman eats, when she sleeps and what she should wear.⁸⁰⁰ Coercive control can also comprise of various monitoring and surveillance tactics which may include phoning or arriving at the woman's place of work in order to ensure that she is indeed at work or checking the calls made from her cell phone.⁸⁰¹

Isolation is another prominent feature of the coercive control model. Controllers generally isolate their partners with the aim of preventing disclosure, instill dependence and also to restrict the woman's skills and resources in order to prevent the woman from seeking help and support.⁸⁰² The abusive partner will accordingly isolate the woman from her friends, family and other support systems and limit her contact with others to those who support the controller's or abuser's perspectives.⁸⁰³

Friends and family often become the controller's co-conspirators and sometimes reject the woman's claims of abuse with disbelief, furthering the woman's

-
- Guilt for not supporting the coercive controller's interests – in these relationships women are expected to stand up and abide their abusive partners, regardless of the nature of the abuser's actions.
 - Guilt for personal faults.

⁷⁹⁸ See also Stark (2007) *supra* note 767 at 250 – 271; Okun (1986) *supra* note 785 at 130 – 132. Stark (2007) *supra* note 767 at 243. See also *S v Visser supra* note 766 where Visser testified that her ex-lover, Prinsloo, had sex on various occasions per day. See Beeld and Pretoria News 11 March 2009. Visser states: "Ek weet nie hoe hy dit kon regkry nie, maar dit was baie."

⁷⁹⁹ Ludsin and Vetten (2005) *supra* note 666 at 71; Herman (1992) *supra* note 768 at 79.

⁸⁰⁰ Ludsin and Vetten (2005) *supra* note 666 at 72. See also *S v Visser supra* in Beeld and Pretoria News 27 February 2009 where Visser testified that when she and her former lover, Dirk Prinsloo, went out, he laid out the skimpy outfits she had to wear. She also testified that while he had wholesome meals, she was forced to go to the gym and lived on protein shakes as Dirk hated fat.

⁸⁰¹ Ludsin and Vetten (2005) *supra* note 666 at 72. Stark (2007) *supra* note 767 at 255. Stark notes that in coercive control surveillance entails a range of monitoring tactics and is aimed at establishing that the abuser is omnipotent and omnipresent. See also *S v Engelbrecht supra* note 1 at paragraph 49.

⁸⁰² Stark (2007) *supra* note 767 at 262.

⁸⁰³ Ludsin and Vetten (2005) *supra* note 666 at 72.

isolation.⁸⁰⁴ Isolation of the woman can be very traumatic and damaging for the woman, who for example, after an abusive incident, will receive little or no support from family and friends. The only means of support left in such a situation, will be the abuser himself which will inadvertently strengthen his power and weaken the woman's strength and capacity to leave the abusive relationship.⁸⁰⁵

Eventually the abusive partner becomes omnipotent and omnipresent with complete power over the abused woman. Herman encapsulates this control in the following dramatic terms:⁸⁰⁶

“The repeated experience of terror and reprieve, especially within the isolated context of a love relationship, may result in a feeling of intense, almost worshipful dependence upon an all powerful, godlike authority. The victim may live in terror of his wrath, but she may also view him as the source of strength, guidance and life itself. The relationship may take on an extraordinary quality of specialness. Some battered women speak of entering a kind of exclusive, almost delusional world, embracing the grandiose belief system of their mates and voluntarily suppressing their own doubts as proof of loyalty and submission.”

15.2.6.2 The Stockholm syndrome

Another theory used within abusive relationships to explain powerful emotional attachments between an abused woman and her abusive partner, is the so-called Stockholm syndrome.⁸⁰⁷ The Stockholm syndrome is addressed in this study as it is often present within abusive relationships and evidence pertaining to this syndrome often forms part of Battered Woman Syndrome evidence advanced in support of criminal incapacity.

⁸⁰⁴ Stark (2007) *supra* note 767 at 263. Stark notes that the abuser's family may also conspire in a woman's isolation. See also Ludsin and Vetten (2005) *supra* note 666 at 72.

⁸⁰⁵ Ludsin and Vetten (2005) *supra* note 666 at 72; Stark (2007) *supra* note 767 at 262 – 263.

⁸⁰⁶ Herman (1992) *supra* note 768 at 92 as quoted in Ludsin and Vetten (2005) *supra* note 666 at 72 – 73.

⁸⁰⁷ Wikipedia encyclopedia <http://en-wikipedia.org/wiki/stockholm-syndrome> [accessed on 2009-02-23] “Love and Stockholmsyndrome: The Mystery of Loving an Abuser” <http://counsellingresource.com/quizzes/stockholm/index/html> [accessed on 2009-02-23], Ludsin and Vetten (2005) *supra* note 666 at 73 – 74; Forward (2002) *supra* note 666 at 95.

The Stockholm syndrome is a psychological response often observed in abducted hostages, in which the hostage displays signs of loyalty to the hostage taker, regardless of the danger or risk they find themselves in. The syndrome is named after the Norrmalmstorg robbery of the *kreditbanken* at Norrmalmstorg, Stockholm, Sweden in which the bank robbers held bank employees hostage from August 23 to August 28 1973. The victims became emotionally attached to their victimizers and eventually even defended their captors after they were freed from their six-day ordeal.⁸⁰⁸

In terms of the Stockholm syndrome captives begin to identify with their captors initially as a defensive mechanism, out of fear of further violence. Stockholm syndrome is also commonly encountered in abusive relationships and is accordingly used as a model of explaining why an abused woman did not leave her abusive husband.

Every syndrome has symptoms or behaviours, and Stockholm syndrome is no exception. While a clear-cut list has not been established due to varying opinions by researchers and experts, several of these features will be present:⁸⁰⁹

- Positive feelings by the victim toward the abuser/controller;
- Negative feelings by the victim toward family, friends, or authorities trying to rescue/support them or win their release;
- Support of the abuser's reasons and behaviours;
- Positive feelings by the abuser toward the victim;
- Supportive behaviours by the victim, at times helping the abuser;
- Inability to engage in behaviours that may assist in their release or detachment.

⁸⁰⁸ *Ibid.* The term "Stockholm syndrome" was coined by the criminologist and psychiatrist Nils Bejerot, who provided assistance to the police during the robbery.

⁸⁰⁹ "Love and Stockholm Syndrome: The mystery of Loving an abuser"
<http://counsellingresource.com/quizzes/stockholm/index/html> [accessed 2009-02-23].

It has been found that four situations or conditions are present that serve as a foundation for the development of Stockholm syndrome. These four situations can be found in hostage, severe abuse, and abusive relationships:⁸¹⁰

- The presence of a perceived threat to one's physical or psychological survival and the belief that the abuser would carry out the threat;
- The presence of a perceived small kindness from the abuser to the victim;
- Isolation from perspectives other than those of the abuser;
- The perceived inability to escape the situation.

According to Ludsin and Vetten this traumatic bond develops over time and by the time women realise that the abuse is inescapable, the emotional bond created by the domestic violence is very strong.⁸¹¹ The Stockholm syndrome produces an unhealthy bond with the controller and abuser. It is the reason many victims continue to support an abuser even after a relationship has ended. It could also be used to explain why abused women continue to see "the good side" of an abuser and appear sympathetic to someone who has mentally and most often, psychologically abused them.

15.2.7 The Compliant victim of coercive persuasion or "brainwashing"

"Emotional abuse is a devastating, debilitating heart and soul mutilation.

The deepest lasting wound with any abuse is the emotional wound." (Robert Burney)

An alternative explanation as to why women often submit themselves to abuse at the hands of an abuser or even commit crimes against third parties while under the overwhelming influence of an abusive partner is the so-called "defence" of "brainwashing".⁸¹²

⁸¹⁰ *Ibid.*

⁸¹¹ Ludsin and Vetten (2005) *supra* note 666 at 74; Dutton, D and Painter, S "Emotional attachments in abusive relationships: a test of traumatic bonding theory" (1993) *Violence and Victims* at 105.

⁸¹² Chapman, FE "The Compliant Victim of the Sexual Sadist and the Proposed Canadian Defence of Coercive Persuasion". Paper submitted at The International Society for the Reform

According to Chapman, brainwashing which is also known as coercive persuasion, mind control, thought control, thought reform and coercion, has not been acknowledged as a valid defence.⁸¹³ Chapman states that brainwashing is exceptionally difficult to define as it relates to both reason and emotion.⁸¹⁴ Brainwashing is also terrifying as it causes fears of losing self-control, of being used and dominated by another and losing one's own self and identity.⁸¹⁵

15.2.7.1 The History of Brainwashing

According to Chapman, the Czars adapted the concept of brainwashing, from the French who in turn adopted it from the Church.⁸¹⁶ The inquisitorial technique of brainwashing dates back more than 700 years to some decretals of Innocent II and consequently it was the inquisitorial technique which was made more relentless by the power of an authoritarian State that the Chinese coined as brainwashing.⁸¹⁷ The term brainwashing was used by Chinese informants to describe the Communist takeover and their programme of re-education they called “*szu-hsiang kai-tsao*” which, if loosely translated, means “ideological reform” or “thought reform.”⁸¹⁸

15.2.7.2 Brainwashing defined

Brainwashing has been defined as the “forcible application of prolonged and intensive indoctrination sometimes including mental torture in an attempt to induce someone to give up basic political, social, or religious beliefs and attitudes and to

of Criminal Law – 22nd International Conference Codifying the Criminal Law: Modern Initiatives (2008) Dublin, Ireland; Okun (1986) *supra* note 785 at 115.

⁸¹³ Chapman (2008) *supra* note 812 at 2. See also Schefflin, AW and Opton, EM “The Mind Manipulators: A non-fiction Account” (1978) at 7.

⁸¹⁴ Chapman (2008) *supra* note 812 at 2.

⁸¹⁵ Chapman (2008) *supra* note 812 at 2. See also Taylor, K “Brainwashing: The Science of Thought control” (2004) at 98 as discussed by Chapman in Chapman (2008) *supra* note 812 at 2 – 3.

⁸¹⁶ Chapman (2008) *supra* note 812 at 4.

⁸¹⁷ *Ibid.*

⁸¹⁸ *Ibid.* See also Lunde, DT and Wilson, TE “Brainwashing as a Defense to Criminal Liability: Patty Hearst Revisited” (1977) *Criminal Law Bulletin* 314 at 343.

accept contrasting regimented ideas.”⁸¹⁹ Abusers brainwash their victims using methods similar to those of prison guards who recognize that physical control is never easily accomplished in the absence of the cooperation of the prisoner. The most effective means of gaining such cooperation is through subversive manipulation of the mind and feelings of the victim, who then becomes a psychological as well as a physical prisoner.⁸²⁰

General methods used to achieve brainwashing include:

- The “death of self” where everything previously known is taken away.
- The so-called “transition” phase where the victim is tortured to the point of nervous collapse – the captives are then shown kindness leading to a “rebirth” where they submit themselves to saying whatever is required to survive while beginning to believe their conditional responses.⁸²¹
- Finally, the repetition of questions and demands together with the fatigue and stress of the interrogation served an educative as well as a spirit-breaking motive. According to Okun, many techniques are employed by abusive partners in the course of brainwashing which include imprisonment or confinement, social isolation, beatings, torture, starvation or malnourishment, sleep deprivation, threats of murder or torture, humiliation, complete control of the use of time and space and coerced false confessions.⁸²²

The popular methodology of brainwashing entails a total change from one belief system to another not being aware of the continuum of conversion.⁸²³ The term coercive persuasion is also often preferred and can be defined as follows:⁸²⁴

⁸¹⁹ Chapman (2008) *supra* note 812 at 5. See also Warburton, IG “The Commandeering of Free Will: Brainwashing as a legitimate Defense” (2003) *Cap. def. J* 73 at 76 as discussed in Chapman (2008) *supra* note 812 at 5.

⁸²⁰ Abusive brainwashing techniques <http://www.heart-2-heart.ca/men/page3/html> [accessed on 2009-04-07].

⁸²¹ Chapman (2008) *supra* note 812 at 5.

⁸²² Okun (1986) *supra* note 785 at 87.

⁸²³ *Ibid.*

⁸²⁴ *Ibid.* Coercive persuasion attempts to force people to change beliefs, ideas, attitudes or behaviours by applying psychological pressure, undue influence, threats anxiety, intimidation and/or stress. Coercive persuasion attempts to overcome critical thinking and informed choice. Critical thinking, values, ideas, relationship, attitudes and conduct are undermined by hypnotic communication, covert threats and intimidation strategies. See “Prevent and

“... a person is subjected to intense and prolonged coercive tactics and persuasion in a situation from which that person cannot escape. It may lead to the committing of illegal or antisocial acts and to conversion to the coercive power’s system of political or religious beliefs.”

According to Meerloo brainwashing entails taking possession of both the simplest and also most complicated nervous patterns of man.⁸²⁵

According to Meerloo, various factors are needed to effect this conversion, including physical pressure, moral pressure, fatigue, hunger and “confusion by seemingly logical syllogisms.”⁸²⁶ The abused person under these circumstances explains this as the total “confusion” in which “nothing had any meaning” by means of mental disintegration or “depersonalization.”⁸²⁷

15.2.7.3 Brainwashing and the Battered woman

“This delay in revealing brainwashing left the public with a twisted conception of it. People still think it has something to do only with prisoners of war, and possibly foreigners put under arrest ... Brainwashing only incidentally concerns military prisoners or foreigners.”⁸²⁸

Steinmetz correctly states the following as to research on the Battered Woman Syndrome:⁸²⁹

Remedy Coercive Persuasion, Brainwashing and Mind Control”:
<http://www.systemiccoaching.com/coercion.htm> [accessed on 2009-04-07].

⁸²⁵ Meerloo, JAM “The Rape of the Mind: The Psychology of Thought Control, Menticide, and Brainwashing” (1956) 49; Chapman (2008) *supra* note 812 at 6.

⁸²⁶ *Ibid.*

⁸²⁷ *Ibid.*

⁸²⁸ Hunter, E as quoted in Chapman (2008) *supra* note 812 at 8.

⁸²⁹ Steinmetz, SK “Wife-beating: A Critique and Reformulation of Existing Theory” 2978 *Bulletin of the American Academy of Psychiatry and the Law* 322 at 322 as discussed in Chapman (2008) *supra* note 812 at 8.

“Our burgeoning body of knowledge about family violence requires such a reformulation of the dynamics of wife battering in order to resolve discrepancies between previously held assumption and recent findings.”

This quote could also apply today where current reform is needed in respect of the battered woman. The theory of brainwashing could be used in order to explain why a battered woman committed crimes against third parties. This could be constructed on the backdrop of the defence of non-pathological criminal incapacity as it could be argued that the woman as a result of this coercive persuasion or “brainwashing” could not distinguish between right or wrong or act in accordance with such appreciation. Brainwashing within the context of the battered woman is constructed to the effect that despite the existence of *mens rea*, the woman is morally blameless due to the fact that her will was no longer hers.⁸³⁰ Within the South African context, however, criminal capacity precedes the enquiry as to *mens rea*. Brainwashing could also have a bearing on criminal capacity. According to Warburton, persons with a low self-esteem are more susceptible to coercion, but that no two persons will respond similarly to the same coercive persuasion.⁸³¹ Warburton identifies the following similarities between the battered woman syndrome and brainwashing:⁸³²

- Both involve a person coerced to act in a manner in which he or she would not have acted if not under such influence;
- Expert evidence is necessary to explain concepts and dispel myths;
- Lay witness evidence is often useful to support the expert’s assertion that the actor exhibited signs of coercion;
- They are most effective when used for mitigation purposes.

According to Chapman there is a shocking similarity between prisoners of war and the experiences of battered women.⁸³³ Abusive partners will typically propose to maintain power over an abused or battered woman by applying “brainwashing”

⁸³⁰ Chapman (2008) *supra* note 812 at 9.

⁸³¹ Warburton (2003) *supra* note 819 at 84 as discussed in Chapman (2008) *supra* note 812 at 9.

⁸³² *Ibid.*

⁸³³ Chapman (2008) *supra* note 812 at 10.

techniques similar to those used on prisoners of war, hostages or members of a cult.⁸³⁴

Mega *et al* state the following:⁸³⁵

“Common features of brainwashing include isolation, humiliation, accusation, and unpredictable attacks. The abusive environment produces real and anticipated fear, which contributes to the battered woman’s belief that her situation is hopeless and that she must depend on her abuser. She develops coping strategies to deal with her oppressive environment, but eventually exhibits symptoms of ‘battering fatigue’, similar to the battle fatigue of soldiers in combat who, like battered women, live in fear of being killed or severely injured.”

With respect to thought reform which is an essential aspect of brainwashing, Okun⁸³⁶ states that the intended results of both thought reform and woman abuse are also similar. Thought reform is intended to produce a psychological breakdown causing the prisoner to become malleable. The latter is said to induce a personality change in the prisoner, brainwashing him into compliance with his captors. In woman abuse, the process involves a male captor (the batterer) breaking a woman’s spirit and shaping her to his will.

⁸³⁴ Mega, LT, Mega, JL, Mega BJ and Harris, BM “Brainwashing and Battering Fatigue: Psychological Abuse in Domestic Violence” (2000) 61 *North Carolina Medical Journal* 260 as discussed in Chapman (2008) *supra* note 812 at 10.

⁸³⁵ *Ibid.*

⁸³⁶ Okun (1986) *supra* note 785 at 132 and also at 87 where he states ten similar phenomena between battered women and concentration camp prisoners. They are the following:

1. Guilt feelings with a sense of deserving victimization;
2. Significant loss of self-esteem;
3. Detachment of emotion from incidents of severe violence;
4. Failure to observe the controller’s rules because of the arbitrariness of the punishment;
5. Extreme emotional reactions;
6. Difficulty planning for the future and delaying gratification;
7. Fear of escaping the coercive situation
8. Child-like dependency on the controllers;
9. Imitation of the controller’s aggressiveness and adoption of their values;
10. Maintenance of the honest belief that the controller or abuser is kind and caring.

Similar to brainwashed captives, battered women are also subjected to verbal abuse, beatings and physical confinement.⁸³⁷

There are also differences between brainwashing and woman abuse. These differences are the following:⁸³⁸

- Battered women will generally not have a strong inclination not to cooperate with their husband or partner once they are married. Thought reform prisoners who are subjected to imprisonment and abuse would generally be more susceptible to resist their coercive controllers.
- In the case of battered women, the abuser often fulfils the function of abuser as well as the victim's source of love and support. Accordingly verbal, physical, and sexual humiliations from a husband or lover will have a much graver impact as opposed to similar behaviour by a foreign individual which will be accomplished with much more difficulty.

Okun⁸³⁹ also states that the fact that the batterer often is simultaneously the most rewarding and most dangerous person in the battered woman's life poses tremendous psychological difficulties for the victim. In the final analysis of coercive persuasion, those who are battered tend to perceive the abuser as their savior and protector.

15.2.7.4 The compliant victim of the sexual sadist

In this section the author will illustrate the effects of brainwashing on women with a discussion of a case of an abused woman who fell prey to a sexual sadist.⁸⁴⁰

⁸³⁷ Okun (1986) *supra* note 785 at 116; Chapman (2008) *supra* note 812 at 12 – 13.

⁸³⁸ Okun (1986) *supra* note 785 at 119 – 120; Chapman (2008) *supra* note 812 at 13.

⁸³⁹ Okun (1986) *supra* note 785 at 119; Chapman (2008) *supra* note 812 at 13.

⁸⁴⁰ "Sexual sadism" is a pathological disturbance or sexual deviancy which will not be discussed in this chapter, but in chapter 3 below pertaining to pathological criminal incapacity. Ebing states that sadism is the experience of sexual pleasurable sensations produced by acts of cruelty, bodily punishment afflicted on one's own person or when witnessed in others, be they animals or human beings. It may also entail an innate desire to humiliate, hurt, wound or even destroy others in order thereby to create sexual pleasure in one's self. See Van Kraft-Ebing, R "Psychopathia sexualis: With Especial Reference to the Antipathic Sexual Instinct: A medico-forensic Study" (1933) 80 as quoted in Chapman (2008) *supra* note 812 at 14.

Women who are victims of a sexual sadist will typically be victims of coercive persuasion or brainwashing. The reason why this topic is addressed in the current study pertaining to non-pathological criminal incapacity, is that it offers an alternative perspective to the plight of battered women and it also places emphasis on the vital role of mental health professionals in the assessment of these women who are deemed to be convicted of crimes whilst they might have a valid defence.

Abused women involved in sexual and violent crimes have been referred to as “compliant victims” in order to illustrate their submissive cooperation in their own and others’ victimization.⁸⁴¹ These relationships are typified by the most brutal forms of sexual violence and comprises of the complete transformation of the woman’s sense of self and also her behaviour in response to intimate contact, sexual fantasies and desires of the sadistic male.⁸⁴² Hazelwood, Warren and Dietz state that a battered woman of a sexual sadist experiences a process of coercion similar to brainwashing.⁸⁴³ Accordingly these women experience a process of manipulation of various rewards and punishments within a context of social isolation which “can alter self concept, expectations, and behaviours among at least some victims.”⁸⁴⁴ To the average lay observer these women seem to be experiencing abuse despite the opportunities they have of escaping.⁸⁴⁵

Hazelwood, Warren and Dietz state that in this form of domestic violence the “captor” seeks compliance as well as opportunities for continued abuse.⁸⁴⁶ Chapman indicates that the motivation for the woman to submit herself to the acts of the abuser is not simply to please him and in some instances the women become assimilated into the sexual aggression of their partners.⁸⁴⁷ Hazelwood, Warren and Dietz further note that the woman’s response to the paraphilic interest

⁸⁴¹ Chapman (2008) *supra* note 812 at 15. See also Warren JI and Hazelwood, RR “Relational patterns Associated with Sexual Sadism: A study of 20 Wives and Girlfriends” (2002) 17 *Journal of Family violence* 75 at 77.

⁸⁴² *Ibid.*

⁸⁴³ Hazelwood, R, Warren, J and Dietz, P “Compliant Victims of the Sexual Sadist” (1993) 22 *Australian Family Physician* at 474.

⁸⁴⁴ *Ibid.* See also Chapman (2008) *supra* note 812 at 15.

⁸⁴⁵ *Ibid.*

⁸⁴⁶ *Ibid.*

⁸⁴⁷ Chapman (2008) *supra* note 812 at 16.

of the man could be conceptualized by the gradual assimilation of behaviour that integrates the sadist's sexual fantasies into her own behaviour.⁸⁴⁸

What is striking is that most women within these abusive relationships are successful professionally when they meet the abuser.⁸⁴⁹ Sexual sadists, however, prefer professional women as they have the desire to prove that they can transform a woman from an individual who comes from a nice middle class family and reduce her to a "sexual slave" willing to join them in any act no matter how degrading or humiliating.⁸⁵⁰ These relationships are also categorized with physical, emotional and psychological and sexual abuse.⁸⁵¹

A further intrinsic and prominent feature of abuse within this context relates to the process of transformation women undergo from relatively normal patterns of living to complete bizarre, destructive and dangerous forms of exploitation and perversion.⁸⁵²

There is a striking pattern of coercive persuasion among women within these relationships of abuse. Five factors are present in most women:⁸⁵³

1. Selection of a vulnerable woman – the men generally sought naive, passive and vulnerable women which the sadist would be able to use for his own need for dominance, control and sexual desires.
2. Seduction of the targeted woman – Hazelwood, Warren and Dietz state that all of the women they studied indicated that the abuser was charming,

⁸⁴⁸ Hazelwood, Warren and Dietz (1993) *supra* note 843 at 474.

⁸⁴⁹ Hazelwood, Warren and Dietz (1993) *supra* note 843 at 99.

⁸⁵⁰ Chapman (2008) *supra* note 812 at 20.

⁸⁵¹ Chapman (2008) *supra* note 812 at 20 – 21 notes that the research suggests that the physical abuse on women in these relationships is shocking. In a study conducted on various women in these relationships, most of the women were frequently beaten by the abuser or with objects. One woman was tied with adhesive tape over her entire body while being beaten. All of the women were sexually abused, sometimes with foreign objects. A wide range of degrading acts were performed on them including ejaculating on their face or mouth, being urinated on, forced enemas, sex with third parties and sex with kidnapped parties. All of the women suffered psychological as well as emotional abuse. All of the women were verbally abused in order to lower their self-esteem.

⁸⁵² Hazelwood, Warren and Dietz (1993) *supra* note 843 at 99.

⁸⁵³ Chapman (2008) *supra* note 812 at 21 – 22; Hazelwood, Warren and Dietz (1993) *supra* note 843 at 99 – 100; Hazelwood R and Michaud, SG "Dark Dreams" (2001) at 112 – 113.

considerate, and unselfish when they met and all of the women entered into the relationship quickly regardless of the fact that they identified a sinister side to the abusers.

3. Shaping sexual behaviour – shaping of the woman’s sexual behaviour was dependent on readiness of the woman to engage in alternative sexual acts, and the abuser typically express gratitude for the participation in these activities or disappointment if she did not participate. The sexual sadist typically persuades the woman to engage in sexual activity beyond her normal repertoire.
4. Social isolation – the sadist become possessive and jealous of activities that does not include him and rejects the woman’s friends and family thereby isolating her.
5. Punishment – psychological and physical abuse constitutes the final step in the transformation process. Hazelwood, Warren and Dietz state:

“Having met, seduced and transformed a ‘nice’ woman into a sexually compliant and totally dependent individual, the sadist has validated his theory of women. The woman is now a subservient inferior being who has allowed herself to be recreated sexually and has participated in sexual acts that no decent woman would engage in, thereby confirming that she is a ‘bitch’ and deserving of punishment.”

The degradation, humiliation, emotional and psychological suffering that women within these abusive situations endure, “illustrates the exploitative and inhumane behaviour that one person can intentionally inflict on another.”⁸⁵⁴

The problematic issue pertaining to the compliant victim is that she remains compliant for so long despite the abuse. In most cases of the compliant victim, the sadist selected a woman of higher status and transformed her into a sexually and

⁸⁵⁴ Hazelwood, Warren and Dietz (1993) *supra* note 843 at 100.

psychologically compliant slave.⁸⁵⁵ Vulnerable women are prime targets for the sexual sadist. The dynamics in other kinds of brainwashing or “mind control” also feature in these contexts. The sadist isolates the woman, physically abuses her, deprives her of sleep, degrades and humiliates her.⁸⁵⁶ Hazelwood, Warren and Dietz similarly conclude:

“The pleasure in complete domination over another person is the very essence of the sadistic drive.”

Expert evidence in cases of this nature will be crucial to explain why the woman engaged in criminal activities with the abusive partner who can also very well be a sexual sadist. The coercive control model for explaining attachment and bonding within an abusive relationship has always been present, yet it is relatively new in terms of the recognition of this theory in explaining the behaviour of abused women.

The theory of coercive control in the face of the compliant victim of the sexual sadist is also currently a highly controversial aspect within the South African context.

When applying the abovementioned principles pertaining to the abused woman as a compliant victim of sexual sadistic abuse, there are striking resemblances to the evidence tendered in the highly controversial trial of Cézanne Visser.⁸⁵⁷

The facts of this case are as follows:

Cézanne Visser (“Visser”) met Dirk Prinsloo (“Prinsloo”) at the age of 23. Prior to meeting Prinsloo, Visser failed her bar examination and was also the victim of a failed relationship. Soon after she met Prinsloo, she moved in with Prinsloo. A romantic relationship arose between Visser and Prinsloo. Initially Prinsloo showered Visser with gifts and compliments and also referred to her as his

⁸⁵⁵ *Ibid.*

⁸⁵⁶ *Ibid.*

⁸⁵⁷ *S v Visser* case number CC 545/07. See also note 766 *supra*.

“princess”. Soon after Visser moved in with Prinsloo she was exposed to having oral sex with him. At that stage she was still naive as to aspects involving sex, but thought that what Prinsloo expected of her, was normal. At the time when she met Prinsloo, Visser testified that she had an extremely low self-esteem and was very vulnerable. Prinsloo soon displayed signs of sex addiction. Visser testified that Prinsloo watched pornographic films every morning at breakfast. Prinsloo requested Visser to have tattoo’s engraved on her body and also to have breast enlargements. Prinsloo did not get on well with Visser’s parents and eventually on his demand, they got a protection order in terms of the Domestic Violence Act 116 of 1998 against Visser’s parents which prohibited any means of contact between the parents and Visser. Prinsloo also controlled what Visser ate and the clothes she had to wear. Prinsloo requested that Visser go on a protein-shake diet to the exclusion of other food, as he “hated cellulite”. When asked why she tolerated this Visser testified “I wanted to please Dirk”. Visser testified that sex with Prinsloo was brutal and without love and that she was subjected to degrading acts with foreign objects such as cucumbers, carrots and a firearm and was also forced into acts with dogs. Visser testified that she was once forced to have sex in a chapel. Visser stated:⁸⁵⁸

“Hy het bo-op my geklim en seks met my gehad. Dit was brutaal. Hy het my hare gepluk terwyl hy my in die gesig gespoeg het.”

Visser testified that Prinsloo instructed her to have threesome sessions with other women and that she (Visser) had to recruit prostitutes for him (Prinsloo). Prinsloo also provided Visser with a book called “The Story of O” which entailed a story of a man who subjected his wife to bizarre and brutal sex. She (Visser) also had to pierce her body and she testified⁸⁵⁹:

“Dirk thought it was pretty. It was how his slut had to look.”

Prinsloo also fantasised about having sex with young girls. Some of the charges against Prinsloo and Visser relate to young girls they fetched from an orphanage

⁸⁵⁸ Beeld, 27 February 2009.

⁸⁵⁹ Beeld, 27 February 2009; Pretoria News, 27 February 2009.

under the guise of wanting to treat the girls for weekend-visits at their home. The one girl was 15 years old, the other girl 11 years. The charges relate to various sexual offences including indecent assault, rape and incitement of a minor into sexual acts.

Visser admitted performing oral sex on Prinsloo in front of the 15-year old girl and having sex with Prinsloo in front of the 11-year old girl. When asked why she performed these acts, Visser stated:⁸⁶⁰

“I said it before and I say it now, Dirk spoke and I did. I have no idea why, but that is how it was.”

Prinsloo subjected Visser to various forms of degradation such as to drink his urine and smear his faeces on her. The latter was her punishment if she did not behave as Prinsloo wanted her to. Visser also testified that Prinsloo was addicted to sex. Accordingly, Prinsloo displays signs of sexual sadism, whilst Visser displays signs of the typical compliant victim. Visser also testified that kinky sexual acts were as normal as “brushing teeth”. Visser testified that she was a victim in a relationship which was not normal.

In support of Visser’s defence that she suffered from Battered Woman Syndrome, Professor Jonathan Scholtz, head of clinical psychology at Weskoppies Hospital, testified that although Prinsloo initially appeared to be Visser’s knight in shining armour, charming her and purporting to save her from an abusive family situation, he systematically and deliberately took control of her and shaped her to his needs. Scholtz further stated that Visser’s parents’ unhappy marriage, the values installed in her during childhood and her low esteem made her the perfect target for Prinsloo.

Scholtz testified that while Visser was highly intelligent, she was naive and mentally immature. According to Scholtz, Prinsloo took complete control over Visser – her appearance, what she ate, when she slept and with whom she spoke.

⁸⁶⁰ Pretoria News 10 March 2009.

She was exposed to perverse acts with multiple people. Scholtz testified that in his opinion, Visser was subjected to severe domestic abuse and coercive control. Scholtz indicated that Prinsloo was a sexual sadist, a paedophile and suffered from other sexual deviations. According to Scholtz sexual sadists often displayed various disorders, collected pornography and had serious personality disorders such as narcissism.⁸⁶¹

Visser was subsequently convicted on eleven of the fourteen charges on 6 and 7 October 2009.⁸⁶² In delivering judgment, Eksteen AJ ultimately rejected Visser's defence of having been under the "spell" or coercive control of Prinsloo.⁸⁶³ It was in addition held that Prinsloo was often not present when Visser exposed herself to

⁸⁶¹ Beeld and Pretoria News 27 March 2009; 28 March 2009; Rapport 5 April 2009. The author sourced the information from his personal attendance of the trial. See page 79 of the unreported judgment of *S v Visser supra* note 761 where it is noted that Professor Scholtz found that Visser was exposed to "severe domestic abuse and coercive control" and her capacity to act in accordance with her appreciation of the wrongfulness of her actions was severely compromised. Professor Scholtz in addition elaborated on the phenomenon of the battered woman syndrome and noted that it comprises more than mere physical violence and also included coercive control and intimidation. Professor Scholtz described the bond which develops between the woman and her aggressor as "ambivalent" and noted that such bond comprises two components:

- "A. Die vrees vir die magsoeker;
- B. Die adoratie of verliefdheid"

Professor Scholtz described this bond as "traumatic bonding" or "paradoxical attachment" and defined coercive control as: "... die proses waartydens die wil van die vrou onderwerp word aan die wil van die man. 'n Vrou in die situasie van vrees of dwang en belonging kan iets doen sonder dat die teenwoordigheid van die magsoeker 'n vereiste is om 'n handeling uit te voer (page 81 of the unreported judgment).

⁸⁶² Visser was convicted on counts of fraud; on three counts of soliciting a fifteen year old to commit indecent acts by showing the child her private parts, by showing her pornography and conducting sexually explicit conversations with her; one count of indecent assault of an eleven year old orphan by showing pornography to her, by demonstrating to her how a vibrator worked, exposing herself to the child and having sex with Prinsloo in her presence; one count of being a beneficiary to the indecent assault of a twenty year old woman; one count of indecent assault of an adult woman by fondling her breasts and private parts and suggesting that she have sex with her and Prinsloo; one count of indecent assault on a fourteen year old drug addict who was drugged and fondled; one count of indecent assault of a twenty year old woman who was fondled after being given drugs which induced drowsiness; one count of possession of child pornography; one count of manufacturing child pornography relating to her committing indecent acts on a child, of which pictures were taken. Visser was acquitted on one count of indecent assault on an eleven year old as it was held that the child was not forced to take off her clothes during an incident at the swimming pool of the residence of Prinsloo and Visser; one count of possession of 13.2g of dagga and one count of manufacturing child pornography pertaining to a fourteen year old girl as it could not be ascertained whether pictures were indeed taken. See also Pretoria News 8 October 2009 at 1 and Beeld 8 October 2009 at 1. It is to be noted that at the stage of completion of this chapter, the Visser-judgment had not yet been reported.

⁸⁶³ Pretoria News 8 October 2009 at 1 and Beeld 8 October 2009 at 1. See page 110 of the unreported judgment where Eksteen AJ held: "Daar is geen sprake dat beskuldigde willoos gehandel het nie. Die hof het geen twyfel om vanweë die inherente onwaarskynlikhede en onbetroubaarheid van haar relaas, beskuldigde se weergawe as vals te verwerp....."

the children.⁸⁶⁴ Eksteen AJ found that Visser did not follow everything Prinsloo instructed her to do and held that Visser sought to hide behind Prinsloo's conduct to justify her own conduct with specific reference to Visser claiming that Prinsloo was manipulative and as a result she had no wil of her own.⁸⁶⁵ Eksteen held that it was improbable that Visser was caught in Prinsloo's web as she had freedom of movement and there was also evidence to the effect that Visser could stand up to Prinsloo.⁸⁶⁶ Eksteen AJ in addition held the following.⁸⁶⁷

- Visser was a willing partner in the sexual abuse of the three children and the three young women;
- Visser willingly participated in the various sexual acts perpetrated on the victims at the Prinsloo home and she embraced the new life Prinsloo offered her;
- Visser took the initiative in locating some of the victims;
- Visser's conduct was aimed at obtaining children and women to sexually abuse for her and Prinsloo's own gain;
- Visser and Prinsloo had sex in front of some of the children to solicit them to commit indecent acts;
- Visser was aware of the fact that medication was utilised by Prinsloo to drug some of the victims and that their drinks were spiked;
- Many of the acts against the children were committed in the absence of Prinsloo;⁸⁶⁸

⁸⁶⁴ *Ibid.*

⁸⁶⁵ *Ibid.* Eksteen AJ stated: "She accepted little or any of the blame herself. She is, everytime, the victim of the conduct of others. She blames everyone else, except herself." (Pretoria News 8 October 2009). See page 95 of the unreported judgment where Eksteen AJ states: "min of enige blaam aanvaar beskuldigde self. Sy is telkens die slagoffer van ander se optrede".

⁸⁶⁶ *Ibid.* Eksteen AJ specifically referred to the evidence of one of the witness, Laurie Pieters, a former friend of Visser, who on various occasions offered help to Visser specifically with reference to Pieters offering Visser a home to stay. Pieters in addition testified that Prinsloo "...was a coward and a bully. His bark was worse than his bite". See pages 92-94 of the unreported judgment. See also pages 97-100 of the unreported judgment where Eksteen AJ states that Visser's freedom of movement was not constricted by Prinsloo and that it was improbable that she was caught in his "web".

⁸⁶⁷ *Ibid.* See pages 124-139 of the unreported judgment.

⁸⁶⁸ *Ibid.* These acts include the following:

- Demonstrating the use of a vibrator on herself in front of an eleven year old;
- Fondling the child's private parts;
- Inviting the child to remove all her clothes at the swimming pool;
- Offering to have the child's private parts waxed;

- Visser went to an orphanage and informed management that she and Prinsloo were married in order to persuade them to allow the children to visit them for weekends.
- Visser took the children home well-knowing what fate awaited them there.

On 24 February 2010 Visser was sentenced to an effective term of seven years' imprisonment.⁸⁶⁹ Leave to appeal to the Supreme Court of Appeal in Bloemfontein against her conviction was rejected on 13 May 2010 by Judges Mohamed Navsa and Belinda Van Heerden. Visser has currently resumed serving her sentence.⁸⁷⁰

- Reflections on the Visser-decision

The *Visser*-decision not only gave rise to immense publicity, but also shed light on the age old phenomenon of abuse within an intimate relationship. The aspects of coercive control, Stockholm-syndrome and the compliant victim of the sexual sadist were brought to the fore and even though their value within this decision remains dubious, the emphasis placed on these phenomena could be seen as a positive step towards taking cognisance not only of the visible or physical aspects of abuse within intimate relationships, but also the invisible and often concealed forms abuse conducted behind closed doors. Abuse encapsulates numerous manifestations of which physical abuse is but one example. It is crucial to also acknowledge the various other manifestations of abuse such as coercive control, the Stockholm syndrome and the compliant victim – theory as these are manifestations frequently encountered within abusive relationships often underscored for its impact and intensity.⁸⁷¹ Every abusive relationship will have its own distinctive semantics distinguishing it from other abusive relationships. The fact that the defence as put forward in the *Visser*-decision was rejected should not

-
- Visser also insisted on her own initiative to take the eleven year old home for a weekend visit;
 - Visser also instructed the children not to tell anyone about what happened to them.

⁸⁶⁹ See also page 61 of the unreported judgment of *S v Visser supra* note 766.

⁸⁶⁹ See Pretoria News 25 Februarie 2010 at 1; Beeld 25 February 2010 at 1 and Rapport 28 February 2010 at 1.

⁸⁷⁰ See Pretoria News 14 May 2010 at 1 and Pretoria News 17 May 2010 at 1. For purposes of the current study, expert evidence adduced during the sentencing of Visser will not be addressed. Eksteen AJ refused to grant leave to appeal on the merits and Visser's legal team had to petition to the Supreme Court of Appeal which petition failed.

⁸⁷¹ See also *S v Engelbrecht supra* note1 and *S v Ferreira supra* note1 as discussed below where traits of coercive control were present.

be construed as closing the door for this defence in cases where abused partners subjected to coercive control and manipulation commits crimes whilst under such control or manipulation. What becomes abundantly clear is that courts will approach such defences with circumspection thus necessitating the need for effective expert testimony in support thereof. It could further be argued that the defence in the *Visser*-decision contributed to mitigation of sentence. The distinguishing factor of the *Visser*-decision as opposed to other cases dealing with abuse, such as the *Engelbrecht* and *Ferreira*-decisions,⁸⁷² is the fact that Visser's actions were not directed against her abuser, but primarily against innocent third parties or victims. Usually within an abusive relationship the abused partner retreats and directs his or her actions against the abuser. The conduct of Prinsloo towards Visser was, however, at certain stages so vile and shocking that it could be argued that the probabilities indicate that she must have been subjected to some form of control by Prinsloo.⁸⁷³ Whether such control was of such a nature and degree in order to render Visser powerless to Prinsloo, however, remains questionable. The undeniable fact is, however, that no matter how much empathy a court retains for a victim of abuse such as Visser, the court also has a duty in upholding justice for the innocent victims and also protecting the interests of minor children and their right to be protected from all forms of sexual abuse. It is submitted that the latter could be construed as one of the overriding factors negating Visser's defence.

It is accordingly clear that Visser and Prinsloo fit the profile of the sexual sadist and compliant victim discussed above. Whether a defence founded on these principles will succeed will depend on the circumstances and evidence presented.

⁸⁷² Which will be discussed below.

⁸⁷³ Visser's testimony to this effect included the following: that Prinsloo on various occasions forced her to take part in threesomes with prostitutes; Prinsloo inserted various objects into her private parts; Prinsloo forced Visser to have sex in a chapel and swear at God whilst spitting in her face; Prinsloo forced Visser to perform acts on dogs; Prinsloo did not hesitate to ejaculate in her mouth; Prinsloo urinated in her mouth and forced her, in order to obtain forgiveness, to collect his faeces and rub it over her body and lick it off her hands. These are examples of some of the horrific acts Visser was subjected to. It could be argued that a woman in her sound and sober senses would not allow such acts to be performed on her. At page 121 of the unreported judgment Eksteen AJ also notes: "Die aanvaarde getuienis binne en buite beskuldigde se relaas dui onomwonde dat Prinsloo moontlik met 'n proses van isolasie of "coercive control" besig was. Die aanvaarde getuienis dui na die Hof se oordeel nie daarop dat beskuldigde tydens die pleeg van die ten las gelegde misdrywe ten volle onder die mag of dominansie van Prinsloo was nie."

In conclusion, Ludsin and Vetten encapsulate the theory of coercive control as follows:⁸⁷⁴

“Coercive control theory explains many features of abusive relationships that puzzle people – such as the woman’s loyalty and attachment to her partner in the face of her great fear of him. It illustrates how these features exist not only in situations of domestic violence but also in other situations where people are held captive. Like others who have been prisoners of war, political prisoners, hostages, or cult survivors, battered women have been subjected to ongoing processes of intimidation and abuse that systematically degrade their sense of self over time and isolate them from others.”

15.3 The role of expert evidence in cases of battered woman syndrome

Central to all of the theories explaining why an abused woman reacted to abuse in the particular way she did, stands the mental health expert called to assess the battered woman. The rules pertaining to expert evidence and admissibility of expert evidence as a form of opinion evidence will be explored comprehensively in Chapter 4 below. This section will accordingly only encapsulate the role of the expert witness in respect of the assessment of the battered woman syndrome. Within the context of the battered woman who eventually kills her abusive partner, the mental health expert who will typically be a psychologist or a psychiatrist will have to assist the court in explaining the battered woman’s dilemma and why she eventually resorted to deadly force instead of exploring alternative options. Expert evidence is generally presented to combat the existing myths about battered women and not to address the ultimate issue of guilt or innocence. Expert evidence on the battered woman syndrome entails the psychological traits that

⁸⁷⁴ Ludsin and Vetten (2005) *supra* note 666 at 75.

typify battered women as well as their perceptions of the potential dangerousness of the abuser's potential violence.⁸⁷⁵

According to Ewing⁸⁷⁶, expert evidence pertaining to the battered woman syndrome, consists of two components:

- In the first instance, the expert describes the battered woman syndrome. This will typically relate to the three-stage cycle of violence explained by Walker which entails the “tension-building” stage, the “acute battering” stage and the stage of “loving contrition” as discussed above⁸⁷⁷. The expert will then elaborate on how physical and psychological abuse increase as the cycle is repeated. The expert will then explain the psychological consequences for the battered woman which include learned helplessness, depression and could also, as discussed above, entail a discussion and explanation of coercive control present in the abusive relationship. The expert will similarly indicate how economic and social factors, for example

⁸⁷⁵ Blackman, J “Potential uses for expert testimony: Ideas toward the representation of Battered Women who kill” (1986) *Women’s Rights Law Reporter* 227 at 228. See also Walker (1979) *supra* note 666 at 56-70 and Walker (1984) *supra* note 666; Ludsin and Vetten (2005) *supra* note 666 at 93; Reddi (2005) *SACJ supra* note 666 at 261; Johann and Osanka (1989) *supra* note 666 at 157; Tredoux *et al* (2005) *supra* note 1 at 366 – 367; Walker (1989) *supra* note 666 at 302; Ewing (1987) *supra* note 666 at 51. According to Blackman (1986) *supra* note 666 at 228 – 229 studies in psychology and sociology indicate that battered women may find it virtually impossible to leave abusive relationships as a result of psychological changes that follow after staying in an abusive relationship after a second episode of abuse. Blackman notes that there are three categories of change that occur in battered women motivating them to remain in an abusive relationship.

1. Most battered women experience psychological changes inducing them to believe that they are unable to control their fate and that they are unable to put an end to the abuse. They may become depressed and “learned helplessness” may ensue.
2. Battered women often show “high tolerance for cognitive inconsistency” in that they express two ideas that appear to be inconsistent with one another by for example claiming that the abuser was violent while drunk, but later recall an episode during which he was not drunk but was nevertheless abusive.
3. Battered women often experience a sense that alternatives are not available to them. They experience an inability to stop the violence and believe there is no escape from the relationship.

Expert evidence is accordingly necessary to clarify these issues.

⁸⁷⁶ Ewing (1987) *supra* note 666 at 51. See also Veinsrerderis, ME “The Prospective Effects of Modifying Existing Law to Accommodate Preemptive Self-defense By Battered Women” (2000) *University of Pennsylvania Law Review* 613 where he states that during the “cycle” of abuse, the woman falls victim to a “cumulative terror” of violence, fearing harm even during the peaceful interlude between episodes of abuse. See also Walker (1979) *supra* note 663 at 56 – 70.

⁸⁷⁷ See paragraph 15.2.4 above.

lack of financial resources and inadequate support from the police, prevent women from escaping the abusive environment.

- In the second instance, the expert presents evidence that the battered woman suffered from battered woman syndrome and explains the woman's perceptions and behaviour at the time of the killing.

Hudsmith⁸⁷⁸ notes that as a result of the non-traditional nature of a battered woman's resort to the use of deadly force, the reasonableness of her perceptions of danger may not always be transparent. Expert evidence is accordingly crucial to explain the dynamics of the abusive relationship and the effect the violence may have on a battered woman's perceptions of danger.⁸⁷⁹

Potential uses of expert evidence pertaining to the Battered Woman Syndrome are the following:⁸⁸⁰

⁸⁷⁸ Hudsmith, R "The admissibility of Expert Testimony on Battered Woman Syndrome in Battered Women's Self-Defense cases in Louisiana" (1986 – 1987) *Louisiana Law Review* 979 at 985 – 986. See also Crocker "The meaning of Equality for Battered Women who kill men in Self-Defense (1985) *Harvard Women's Law Journal* 121 at 127.

⁸⁷⁹ Ewing (1989) *supra* note 666 at 53; Hudsmith (1986) *supra* note 666 at 985; Mather (1988) *supra* note 666 at 574 – 576. See also *State v Kelly*, 478 A.2d 364, (1984) at 377 where the New Jersey Supreme Court stated the following in respect of expert evidence: "Experts point out that one of the common myths, apparently believed by most people, is that battered wives are free to leave. To some, this misconception is followed by the observation that the battered wife is masochistic, proven by her refusal to leave despite the severe beatings, to others, however, the fact that the battered wife stays on unquestionably suggests that the beatings could not have been too bad for it they had been, she certainly would have left. The experts could clear up these myths, by explaining that one of the common characteristics of a battered wife is her inability to leave despite such constant beatings, her "learned helplessness", her lack of anywhere to go, her feeling that if she tried to leave, she would be subjected to even more merciless treatment, her belief in the omnipotence of her battering husband, and sometimes her hope that her husband will change his ways."

⁸⁸⁰ Johann and Osanka (1989) *supra* note 666 at 159 – 160; Walker (1989) *supra* note 666 at 322 – 327; Ludsin and Vetten (2005) *supra* note 666 at 93; Ewing (1987) *supra* note 666 at 52 – 60; Roberts, JW "Between the Heat of Passion and Cold Blood: Battered Woman's Syndrome as an excuse for Self-Defense in Non-Confrontational Homicides" (2003) 27 *Law and Psychology Review* 135 at 149 and 151 where Roberts quotes an extract from the decision in *Ex parte Haney*, 603 50.2d at 412 (Ala. 1992) where the court states: (at 414) "expert testimony on the battered woman syndrome would help dispel the ordinary lay person's perception that a woman in a battering relationship is free to leave at any time. The expert evidence would counter any "common sense" conclusions by the jury that if the beatings were really that bad the woman would have left her husband earlier. Popular misconceptions about battered women would be put to rest, including the beliefs that the women are masochistic and enjoy the beatings and that they intentionally provoke their husbands into fits of rage."

- To introduce the court to a class of persons – battered women, and their profile. Experts can also explain the cycle of violence, learned helplessness and also coercive control and other dynamics in respect of battering relationships.
- To provide the trier of fact with an explanation as to why the mentality and personality make-up and behaviour of battered women differ from the lay person's perspective of how someone would react towards an abusive partner.
- To indicate to the court that the accused and the victim were involved in an abusive relationship.
- To explain why the woman remained in the abusive relationship.
- To refute popular myths and misconceptions concerning battered women, including:⁸⁸¹
 - The myth that these women are masochistic.
 - The myth that these women stay with their abusers because they enjoy beatings.
 - The myth that these women could freely leave these abusive relationships, if they really wanted to.
- To provide the court with an opinion of the accused's state of mind at the time of the commission of the crime.
- To rebut the implication of premeditation or planning.
- To support a defence of not guilty as a result of mental illness or mental defect.⁸⁸²
- Battered Woman Syndrome evidence can be used in support of diminished responsibility and mitigation of sentence.

The function of expert evidence on battered women is to provide the court with an alternative perspective or social framework for understanding the particular woman's beliefs and actions. Expert evidence will also attempt to dispel any myths or misconceptions the court may have as to the psychosocial dynamics and

⁸⁸¹ See "Myths and Misconceptions about battered women" above at paragraph 15.2.2.

⁸⁸² See chapter 3 below. This chapter will address the defence of insanity also with reference to the battered woman and exploring this defence as an alternative defence available to the battered woman.

consequences of abuse.⁸⁸³ In most instances the expert will explain the general research findings regarding battered women and also provide a clinical opinion that the particular accused displays signs of the syndrome or suffers from the syndrome.⁸⁸⁴

Non-pathological criminal incapacity is one defence available to a battered woman who kills her abusive husband or partner. The rules and legal principles pertaining to this defence have already been outlined earlier in this chapter. The main obstacle in respect of expert evidence in support of the defence of non-pathological criminal incapacity is that it is not compulsory to advance expert evidence in support of this defence. Within the context of the battered woman who kills her abusive partner, the prejudicial effect of the absence of expert evidence has already been illustrated by means of the *Campher*-decision above.⁸⁸⁵ Women who kill their abusers often do not do so in the midst of immediate confrontation. It is often only after a specific incident when a woman resorts to deadly force. Reliance on the defence of non-pathological criminal incapacity becomes difficult as a result of the non-confrontational killing of the abusive partner. The latter has resulted in abused women relying on alternative defences, often unsuccessful. This section will illustrate the importance of expert evidence in cases where battered women eventually killed their abusers. It is from the outset important to keep in mind that expert evidence should not only be advanced in order to exonerate the accused, but also in mitigation of sentence and also generally to provide the battered woman with a fair and just trial. Expert evidence also plays a pivotal role in explaining the theories enunciated above, such as learned helplessness and coercive control and the presence thereof in an abusive relationship and how such presence eventually resulted in the battered woman killing her abuser. The reason why these theories were explained in relative detail above, is to indicate its inherent complexity which will inadvertently lead to

⁸⁸³ Schuller, RA and Vidmar, N “Battered Woman Syndrome evidence in the Courtroom” (1992) *Law and Human Behaviour* 273 at 277; See also Monahan, J and Walker, L “Social Science and Law: Cases and Materials” (1990) 2nd ed at 277; Schneider, EM “Describing and changing women’s self-defense work and the problem of expert testimony on battering” (1986) *Women’s Rights Law Reporter* at 195 – 222.

⁸⁸⁴ Schuller and Vidmar (1992) *supra* note 883 at 277.

⁸⁸⁵ See paragraph 9.2 above.

confusion or misapprehension if not properly explained by a trained expert in the field.

Typical partner killings by abused women have been described⁸⁸⁶ as follows:

“Domestic homicides committed by women tend to be defensive and victim-precipitated. Typically, battered women who kill do so in response to an attack or following a threat from the abuser to harm another, usually a child. Some kill whilst the abuser sleeps after an attack, convinced that it will continue when he awakens. They kill because they feel there is simply no other way out. After previous failed attempts, they lose hope of escaping. The violence, tension and fear reach a point where death seems inevitable: a choice between suicide and homicide.”

Ludsin and Vetten indicate that there are four main types of evidence that should be advanced on behalf of a battered woman who killed her abusive partner.⁸⁸⁷

- Evidence pertaining to the history and pattern of abuse that the battered woman endured during the relationship with the abuser.
- Evidence pertaining to other violent acts of the abuser that the accused was aware of.
- Social context evidence.
- Evidence in respect of other violent acts of abuse performed against the accused.

The history and pattern of abuse between the battered woman and the deceased are important aspects in support of a defence raised by a battered woman to a charge of murder or in support of mitigation of sentence.⁸⁸⁸ This history and pattern of abuse are important factors in explaining the battered woman’s mental

⁸⁸⁶ Radford, L “Pleading for time: Justice for Battered Women who kill” in Bridgeman, J and Millns, S “Feminist Perspectives on Law: Laws Engagement with the Female Body” (1998) at 630. See also Dutton, MA “Understanding Women’s Responses to Domestic Violence: A Redefinition of Battered Women’s Syndrome” (1993) 21 *Hofstra Law Review* 1191.

⁸⁸⁷ Ludsin and Vetten (2005) *supra* note 666 at 187.

⁸⁸⁸ *Ibid.*

state at the time of killing her abusive husband or partner.⁸⁸⁹ The history and pattern of abuse could also be used to assist in explaining the cumulative effect of fear, stress and/or provocation that induced non-pathological criminal incapacity or diminished criminal capacity.⁸⁹⁰

Ludsin and Vetten state:⁸⁹¹

“Expert testimony regarding the psychological effects of abuse ... should discuss the importance of the history and pattern of abuse to the woman’s perceptions as they relate to her state of mind or other elements of the defences.”

The history of the deceased’s violence against others also assists in explaining the woman’s reasonable fear of death or serious bodily harm which could ensue from the abuser.⁸⁹² Social context evidence advanced by a battered woman who kills her abuser either in support of a defence or in support of mitigation, can be divided into two subcategories:⁸⁹³

1. The first category explains how women are treated by the government, courts, family members and society in general. This type of evidence accounts for a woman’s limited options for escaping the abusive relationship.

⁸⁸⁹ Ludsin and Vetten (2005) *supra* note 666 at 189; Schuller and Vidmar (1992) *supra* note 883 at 276 where they state: “The violence that battered women faces is continual and is at the hands of an intimate partner rather than a stranger. Furthermore, the woman is generally not on equal physical grounds with the batterer. As a result, when she strikes back, her actions cannot be the same as a fight between ‘two equals’, and usually this is reflected in the circumstances surrounding the killing.” See also Roberts (2005) *supra* note 666 at 143 – 144; Veinsrerderis (2000) *supra* note 876 at 613; Ewing (1989) *supra* note 666 at 52 – 54.

⁸⁹⁰ Ludsin and Vetten (2005) *supra* note 666 at 189. See also Alsdurf and Alsdurf (1989) *supra* note 726 at 114; Dobash and Dobash (1992) *supra* note 663 at 6 state: “When the man dies, it is rarely the final act in a relationship in which she has repeatedly beaten him. Instead, it is often an act of self-defence or a reaction to a history of the man’s repeated attacks”. See also Dobash, RE and Dobash, RP “Violence Against Wives” (1979) at 31 – 74; Browne (1987) *supra* note 666 at 109 – 130; Mather (1988) *supra* note 666 at 547 – 555.

⁸⁹¹ Ludsin and Vetten (2005) *supra* note 666 at 189. Ludsin and Vetten state that legal practitioners representing women who killed their abusers should gather as much information as to the nature, duration and extent of abuse as possible. This information should provide a detailed account of the specific incidents of abuse.

⁸⁹² Ludsin and Vetten (2005) *supra* note 666 at 190.

⁸⁹³ *Ibid.* See also Ludsin, H “South African Criminal Law and Battered Women who kill: Discussion Document II – Research Report written for the Centre for the Study of Violence and Reconciliation” (2003).

This evidence elucidates the woman's frame of mind and attempts to place the court within the frame of mind of the battered woman. This evidence could also substantiate the credibility of the accused who claims non-pathological criminal incapacity or diminished criminal capacity.⁸⁹⁴

2. The second category of social context evidence relates to psychosocial evidence. This type of evidence specifically pertains to the psychological effects of abuse on women.

Ludsin and Vetten⁸⁹⁵ state that evidence of the psychology of batterers promotes the reasonableness of the effects of abuse on women, whilst evidence of social judgment explains that which motivates abused women to kill. Battered women who kill their abusers need to provide expert evidence pertaining to the psychological effects of abuse on women in general and also with specific reference to the accused in order to establish the factual foundation for the defence of non-pathological criminal incapacity.⁸⁹⁶ In *Lavallee v The Queen*, the Canadian Supreme Court per Wilson J explained the importance of this type of evidence and held the following:⁸⁹⁷

“Expert evidence on the psychological effect of battering on wives and common law partners must, it seems to me, be both relevant and necessary in the context of the present case. How can the mental state of the appellant be appreciated without it? The average member of the public (or the jury) can be forgiven for asking; why would a woman put up with this kind of treatment? Why would she continue to live with such a man? How could she love a partner who beat her to the point of requiring hospitalisation? We would expect the woman to pack her bags and go. Where is her self-

⁸⁹⁴ Ludsin and Vetten (2005) *supra* note 666 at 192.

⁸⁹⁵ Ludsin and Vetten (2005) *supra* note 666 at 192 – 193; Mather (1988) *supra* note 666 at 550 – 554.

⁸⁹⁶ *Ibid.*

⁸⁹⁷ *Lavallee v The Queen* (1990), SCR 85 (55 ccc) (3d) 97 (SCC). See also *S v Engelbrecht* *supra* note 1 paragraph 27. See also Reddi (2005) *SACJ* *supra* note 666 at 267. See also *R v Malott* (1998), SCR 123 at 140 – 141 where Justice L Heureux-Dube states: “The expert evidence is admissible, and necessary, in order to understand the reasonableness of a battered woman's perceptions ... that she had to act with deadly force in order to preserve herself from death ...”

respect? Why does she not cut loose and make a new life for herself? Such is the reaction of the average person confronted with the so-called battered wife syndrome. We need help to understand it and help is available from trained professionals.”

Within the context of non-pathological criminal incapacity, the effects of abuse on the woman are vital in order to provide clarity why she lost control at the time of the act.⁸⁹⁸ Evidence of prior acts of violence committed against the battered woman should also be tendered in expert testimony pertaining to the psychological effects of abuse on the particular woman, also with specific reference to the defence of non-pathological criminal incapacity.⁸⁹⁹

There are generally three categories into which battered woman syndrome cases fall where the abused woman kills her abuser:

- Confrontational homicide
- Non-confrontational homicide
- Contract killing

These three categories will accordingly be addressed below.

Confrontational killings occur when the abuse victim kills her abuser during the course of an assault. Examples of confrontational killings have already been illustrated in paragraph 9.2 above by means of the *Campher*, *Potgieter* and *Wiid*-decisions.⁹⁰⁰ In the case of non-pathological criminal incapacity, expert evidence

⁸⁹⁸ Ludsin and Vetten (2005) *supra* note 666 at 193. Ludsin and Vetten also state that expert evidence can counter the presumption of goal-directed behaviour that normally leads to the suggestion of full criminal capacity. See also Lenkevich (1999) *supra* note 666 at 318.

⁸⁹⁹ Ludsin and Vetten (2005) *supra* note 666 at 196; Ludsin and Vetten (2005) *supra* note 666 at 196 note that when the defence of non-pathological criminal incapacity is raised, legal practitioners need to ascertain the following:

- Why the woman killed her husband
- Whether there was a triggering event
- How the woman reacted before, during and after the killing
- When the incapacity started
- Whether she regained capacity at any point between when she first lost criminal capacity and when she killed.

⁹⁰⁰ See *S v Campher supra* note 1; *S v Wiid supra* note 1 and *S v Potgieter supra* note 1. The facts and decisions of these cases will not be repeated here.

will be adduced to illustrate that the battered woman at the time of the killing lacked the capacity to appreciate the wrongfulness of the act or to act in accordance with such appreciation as a result of the abuse suffered by the abuser.⁹⁰¹

Non-confrontational homicide is typically the situation where a battered woman kills her abusive spouse or partner and prior to the killing the abuse ceased for a brief period.⁹⁰² Cases of non-confrontational homicide presents a challenge for the defence of non-pathological criminal incapacity as it will be difficult to prove that the abused woman lacked the capacity to understand the wrongfulness of her actions or to act in accordance with an appreciation of the wrongfulness for the period between the last incident of abuse and the eventual killing. The question to be asked is whether the defence of non-pathological criminal incapacity should be viewed in a strict sense and be construed as incident specific, or whether the actions of the battered woman should not be viewed within the complete psychosocial context of the abuse suffered during the abusive relationship. Accordingly the question which will fall to be assessed is whether the abused woman in the light of the various forms of abuse suffered during the abusive relationship, had the ability to appreciate the wrongfulness of her actions and to act in accordance with such appreciation. The role of the expert becomes inescapable. An example of non-confrontational homicide can be found in the case of *S v Engelbrecht*.⁹⁰³

⁹⁰¹ See *S v Wiid supra* note 1. This is one of the few reported decisions in which an abused woman who killed her abuser relied successfully on the defence of non-pathological criminal incapacity.

⁹⁰² Roberts (2003) *supra* note 880 at 144; Dressler, J “Understanding Criminal Law” (2001) at 240. See also O’Donovan, K “Defences for Battered Women who kill” (1991) 18 *Journal of Law and Society* 219 at 228 where it is stated: “Cases of battered women tend to follow a pattern. The woman waits until the batterer is quiet, in bed or asleep. Then she attacks.” See also Sheehy, E, Stubbs, J and Tolmie, J “Defending Battered Women on Trial, the Battered Women’s Syndrome and its Limitations” (1992) at 16 *Criminal Law Journal* 369 at 372 where they state: “Many women ... protect themselves in advance by surprise attacks, arm themselves before being attacked, or kill during a lull in violence in the course of a battering incident”; Graycar, R and Morgan, J “Including Gender Issues in the Core Law Curriculum Project: Work and Violence Themes” in Stubbs, J “Self-defence and Defence of others” (1996) at 3, Schneider, E and Jordan, S “Representation of Women who Defend Themselves in Response to Physical or Sexual Assault” (1978) at 4 *Women’s Rights Law Reporter* 148 at 153.

⁹⁰³ *S v Engelbrecht* 2005 (2) SACR 41 (WLD); Ludsin and Vetten (2005) *supra* note 666 at 103 – 116; Burchell and Milton (2005) *supra* note 1 at 196 – 220; Snyman (2008) *supra* note 1 at 105; Karsten (2007) *supra* note 663 at 129; Vetten, L “Addressing Gender Bias in the sentencing of Men and Women Convicted of killing their Intimate Partners” (October 2002) in

Jaco (hereinafter referred to as the deceased) and Anne-Marie Engelbrecht (hereinafter referred to as the accused) married each other on 23 January 1993. On 29 June 2002 the accused killed the deceased. The evidence revealed that the accused had suffered an abusive childhood in which she, her mother as well as her three siblings, were violently assaulted by their father on a regular basis. The accused and the deceased met each other when she was a student nurse and he was a security guard at Paardekraal Hospital. The couple later had a daughter, C, aged four years at the time of the killing. The evidence revealed that throughout their marriage the accused was subjected to serious forms of abuse at the hands of the deceased, including physical, emotional, verbal and psychological abuse. It was apparent from the evidence that the deceased had an obsessive and jealous personality which caused him to behave extremely violent and aggressive towards the accused which culminated in the deceased assaulting the accused on various occasions. The deceased monitored the whereabouts and behaviour of the accused constantly. The evidence further revealed that the deceased stalked the accused, physically assaulted her on a regular basis and forced her to take part in and perform various humiliating and diminutive acts with him. The evidence also revealed psychological abuse perpetrated by the deceased, who exhibited a pattern of humiliating conduct including repeated insults, ridicule and name-calling, threats to cause emotional and physical pain as well as repeated exhibitions of possessiveness and jealousy. On the day on which the accused killed the deceased, she had been subjected to verbal, sexual and emotional abuse by the deceased. The facts also revealed that on the particular day the deceased had phoned the accused at her work and requested that she purchase a package at a sex shop. The accused found this very embarrassing and humiliating but nevertheless complied with the request out of fear. The deceased also viewed a pornographic video at a time when C, their daughter, would be exposed to it. During the course of the evening the deceased struck C and assaulted the accused. When they challenged his authority and control, he reacted violently towards them. The particular manner in which the deceased

Gender Bulletin 4 – 5; Reddi, M “General Principles – Private defence” (2005) *SACJ* at 335; Reddi, M “Violence against Women: Tears or triumph for women in South Africa?” in “The exemplary Scholar: Essays in honour of John Milton” (2007) 64 at 74.

struck C had alarmed the accused as it was more aggressive than on previous occasions. The deceased also locked C in a bedroom and prevented the accused from comforting her which resulted in the accused experiencing a feeling of total disempowerment and helplessness. The deceased then repeatedly threatened to kill the accused. The deceased had been drinking and when he later went to sleep the accused had used thumb cuffs to secure his hands behind his back and placed a plastic bag over his head which was tied to him with the belt of her dressing gown. The deceased subsequently suffocated as a result of this treatment. The cause of death was recorded in the *post mortem* report as being consistent with asphyxiation or smothering or suffocation. The accused was charged with murder. The accused pleaded not guilty to the charge of murder contending that she had been in an abusive relationship with the deceased and had sought to extricate herself from it, including having approached the police, family violence courts and having attempted to move out of the common home and seek a divorce.

It was argued on behalf of the accused that the normative theory of culpability should be developed in a manner consistent with the Constitution of the Republic of South Africa 1996, as none of the existing defences comprehensively articulate the variety of experiences that constitute the phenomenon of intimate murders.⁹⁰⁴ In terms of such a defence an accused woman is tested against a standard of reasonableness which in appropriate circumstances negatives the blameworthiness of her conduct. The defence submitted that this case is indicative of the inadequacies of the psychological theory of culpability which enjoys hegemony in our criminal law and argued for the recognition and application of a normative dimension to the evaluation of culpability. The normative dimension imports a value judgment to the evaluation of the state of mind of the accused at the time she had the intention to kill her abusive husband. It was argued that the accused's actions should not be regarded as blameworthy because the law could not fairly have expected the accused to have acted differently and, notwithstanding her intention, to have refrained from killing her abusive husband in response to his own criminal violations. Considerations of

⁹⁰⁴ At paragraph 15.

reasonableness would, in the circumstances of the abuse suffered by her and the failure of the legal system to protect her, absolve her of blameworthiness in her intention to kill. The accused's defence was premised on the proposition that while it may be theoretically possible for the accused to have avoided killing her husband, it is not "reasonable" to have expected her to have done so. It was argued that reasonableness could be located under both culpability and unlawfulness, excuse and justification.

It is interesting to note that the defence of criminal incapacity was never relied on as a defence in this case.

The two experts who presented expert evidence in this case were Mr Leonard Carr, a clinical psychologist and Ms Lisa Vetten, Gender Coordinator for the Centre for the Study of Violence and Reconciliation.

The evidence revealed that where there is a pattern of violence and psychological denigration, the interludes between violent episodes may be just as stressful as actual assaults. Assaults become more frequent and the incessant periods between assaults become exhausting and terrifying and render the victim with anxiety and fear.⁹⁰⁵ It was submitted⁹⁰⁶ that the level of violence within a relationship, the frequency and severity of assaults and the extent of injuries are not always indicative of the true nature and extent of the subordination of the woman. It is accordingly always present in the mind of the abused woman that the violence may be repeated with greater levels of injury.

Ms Vetten testified as to the cycle theory of abuse developed by Walker as well as the theory of "learned helplessness".⁹⁰⁷ Ms Vetten also explained the theory of coercive control and testified that the accused felt like a prisoner in her own home and that the deceased's constant invasion in her life and work, resulted in a "monopolisation of her perceptions."⁹⁰⁸

⁹⁰⁵ Paragraph 52.

⁹⁰⁶ Paragraph 53.

⁹⁰⁷ These theories are explained at length in paragraphs 15.2.4 and 15.2.5 above.

⁹⁰⁸ Paragraphs 181 and 182.

Ms Vetten testified:

“So successful were the deceased’s attempts to control Mrs Engelbrecht that she began restricting her own activities. She avoided speaking to men, including her neighbours, for fear the deceased would suspect something was going on ... The deceased did not need to assault Mrs Engelbrecht very severely or very often. Those occasions when he did use violence were sufficient to instill fear in Mrs Engelbrecht.”⁹⁰⁹

Ms Vetten also testified⁹¹⁰ that the deceased abused the accused physically, sexually, verbally and psychologically and the abuse intensified during the course of the relationship. According to Ms Vetten, the pattern of coercion and control to which the accused was subjected, extended to every aspect of her existence, resulting in her isolation and entrapment within the relationship. The accused had been depersonalized and dehumanized, experiencing herself as no more than a thing.⁹¹¹ According to Ms Vetten, the breaking point was when the deceased hit C.⁹¹²

Mr Carr also testified that the level of threat within the mind of the accused was not based on the level of force that she was confronted with at any given moment, but very well rested on the potential for violence which had been demonstrated by the deceased.⁹¹³

Mr Carr concluded⁹¹⁴ by stating that, when the threat of abuse spread so blatantly onto her daughter, her need to protect her child, her lack of concern for any consequences for herself and her own abused inner child fighting back for the first time in her life, in conjunction with her fatigue and burnout, her sense of isolation, and abandonment from the outside world which offered her no help, she reached

⁹⁰⁹ Paragraphs 185 and 186. See also paragraph 191 where she (Ms Vetten) states: “She began to believe that she would always be with him and that he had a hold over her. Her return was therefore not voluntary and could be construed as a kind of resignation to captivity.”

⁹¹⁰ Paragraph 200.

⁹¹¹ Paragraph 201.

⁹¹² Paragraph 202.

⁹¹³ Paragraph 203.

⁹¹⁴ Paragraph 213.

the boundaries of her capacity and in a situation of do or die, she killed her husband to save her own physical life and “psychological self”.

With regard to the need for expert evidence, Satchwell J reiterated the importance of opinion evidence by experts such as psychologists and social workers. In this regard the court emphasised the importance of expert evidence by stating the following:⁹¹⁵

- The matter in respect of which the witness is called to give evidence should call for specialised skill and knowledge.
- The witness must be a person with experience or skill to render him or her an expert in a particular subject.
- The guidance offered by the expert should be sufficiently relevant to the matter in issue to be determined by the court.
- The expertise of any witness should not be elevated to such heights that the court’s own capabilities and responsibilities are abrogated.
- The opinion offered to the court must be proved by admissible evidence, either through facts within the personal knowledge of the expert or on the basis of facts proven by others.
- The opinion of such a witness must not usurp the function of the court.

Satchwell J also held that expert evidence on both the social context of domestic violence and on the specific effects of abuse on the psyche of an abused woman who kills, is essential.⁹¹⁶ Expert evidence can assist the court to understand the unequal power relations in an abusive relationship which impact on the woman’s ability to leave and the manner in which she resorts to violence; why abused women often do not leave the abusive relationship; and the process leading to the point at which she becomes psychologically unable to adjust to and accommodate the ever-present danger of abuse. Such evidence is necessary to refute widely recognized myths and misconceptions concerning battered women that would interfere with judge or juror ability to assess the woman’s actions fairly.⁹¹⁷

⁹¹⁵ Paragraph 26.

⁹¹⁶ Paragraph 28.

⁹¹⁷ Paragraph 28.

The court proceeded to summarise the principles upon which expert testimony should properly be admitted in cases such as this:⁹¹⁸

- Expert testimony is admissible to assist the fact-finder in drawing inferences in areas where the expert has relevant knowledge or experience beyond that of the lay person.
- There are stereotypes, for instance, that battered women are not really beaten as badly as they claim otherwise they would have left the relationship, alternatively, that women enjoy being beaten because they have a masochist strain in them – which stereotypes may adversely affect consideration of a battered woman’s claim to have acted in self-defence in killing her mate and expert evidence can assist in dispelling these myths.
- Expert testimony relating to the ability of an accused to perceive danger from her mate may go to the issue of whether she “reasonably apprehended” death or grievous bodily harm on a particular occasion.
- Expert testimony pertaining to why an accused remained in the battering relationship may be relevant in assessing the nature and extent of the alleged abuse.
- By providing an explanation as to why an accused did not flee when she perceived her life to be in danger, expert testimony may also assist in assessing the reasonableness of her belief that killing her batterer was the only way to save her own life.

Satchwell J also stated⁹¹⁹ that both Mr Carr and Ms Vetten contributed to the court’s understanding of the behaviour of the deceased, the impact of these experiences upon the deceased as well as the various and variable responses in relation thereto.

It was generally accepted that the “reasonableness” test in relation to justification defences was the criterion used to ascertain the legal convictions of the

⁹¹⁸ Paragraph 29. See also Chapter 4 below dealing explicitly with expert evidence.

⁹¹⁹ Paragraph 31.

community.⁹²⁰ In conducting an enquiry a court should be driven by the values and norms underpinning the Constitution. The approach to the “legal convictions” test should be founded on the values of the Constitution, namely “human dignity, equality and freedom”. Premeditation of the defensive act was not necessarily inconsistent with reliance placed upon that ground of justification.⁹²¹ The defence implemented by the abused woman had to be necessary to protect the threatened interest: the execution of the defensive act had to be the only way in which the attacked party could avert the threat to her rights or interests. The latter has to be decided on the facts of each case.⁹²² To the extent that the abused woman’s failure to leave the abusive relationship earlier could be used in support of the proposition that she had been free to leave at the final moment, expert evidence could provide useful insights.⁹²³ Judgment should not be passed on the fact that an accused battered woman stayed in the abusive relationship.⁹²⁴ There ought to be a balance between the attack and the defence. In determining proportionality, account should be taken of the particular circumstances of each case, which included the parties’ relative ages, relative strengths, gender socialisation and experience, the nature, duration and development of their relationship including power relations on an economic, sexual, social, familial, employment and socio-religious level; the nature, extent, duration and persistence of the abuse; the purpose of and achievements of the abuser; the impact upon the body, mind, heart, spirit of the victim; the effect on others who are aware of or implicated in the abuse.⁹²⁵

The court held that the deceased *in casu* had inflicted multiple forms of domestic violence upon the deceased.⁹²⁶ These forms included bodily manhandling and beating, verbal insults and threats, sexual violation and ridicule, attempts to isolate her from others, electronic monitoring and physical surveillance, sleep deprivation, enforcement of trivial demands, economic restrictions, physical, psychological and emotional humiliation and degradation, both publicly and privately, as well as ever

⁹²⁰ Paragraph 330.

⁹²¹ Paragraph 350.

⁹²² Paragraph 351.

⁹²³ Paragraph 355.

⁹²⁴ Paragraph 356.

⁹²⁵ Paragraph 357. See also Snyman (2008) *supra* note 1 at 98-106; Burchell and Milton (2005) *supra* note 1 at 452-454.

⁹²⁶ *Ibid.*

present control and domination.⁹²⁷ In the pattern of violence and cycle of abuse which comprised the accused and deceased's relationship, the interludes between violent or cruel episodes could be as stressful as the actual assaults. Domestic violence had accordingly been imminent or inevitable.⁹²⁸ It was held⁹²⁹ that the enquiry as to whether the actions of the accused were necessary to protect her and her daughter's interests, regard had to be had to the family and home context of the cyclical nature of the violence, the effectiveness of the "law of the land" in enforcing the law and protecting its subjects and the possibilities of flight, which included the obtaining of refuge.

The majority of the court accordingly held that the accused had not afforded the legal system, the South African Police Service and society a fair chance of helping her.⁹³⁰ The minority decision of the court, per Satchwell J, found that the accused did attempt to and did partially succeed in utilising the services of the institutions and individuals legally charged with protection of herself and C but that they were unsuccessful in doing so and that she was reasonable in losing faith in and abandoning further approaches thereto. Nevertheless, the majority of the court held that it had not been objectively reasonable in all the circumstances for the accused to kill the deceased when she did.⁹³¹ The court held⁹³² that the killing had been premeditated and planned and that the accused had suffered from and operated under a state of diminished criminal capacity on the night of killing her husband.

As to the arguments by the defence in support of a general defence of reasonableness instead of an individual defence known as private defence, the court held that it would be difficult to comprehend how such a general defence could be utilised without making the same enquiries and applying the same criteria which had been applied in terms of the defence of private defence. No competing criteria had been suggested to determine "reasonableness" as a more general defence and accordingly the court declined the invitation to develop the

⁹²⁷ Paragraphs 361 and 379.

⁹²⁸ Paragraph 398.

⁹²⁹ Paragraph 399.

⁹³⁰ Paragraph 402-408.

⁹³¹ Paragraphs 418 and 448.

⁹³² Paragraphs 305, 386 and 456.

law in that direction without further proposals and debate as to the value of such a development. The court further declined the invitation to develop a new approach to culpability based on reasonableness or to develop an objective approach to a subjective state of mind.⁹³³ The accused was accordingly found guilty of murder.

The accused was sentenced to be detained until the rising of the court.

Although this decision did not deal with the defence of non-pathological criminal incapacity, as also expressed by Satchwell J,⁹³⁴ but rather related to other defences, the principles pertaining to the fundamental need for expert evidence in cases of this nature, should be welcomed. This case reaffirms the essential need for expert evidence. Interestingly, it is the first case in which expert evidence was tendered pertaining to specifically the “battered woman syndrome”. In the case law discussed earlier in the chapter pertaining to abused women, the evidence was never coined in terms of the presence of battered woman syndrome. This case illustrates how experts can educate courts as to various theories explaining why women endure abuse despite alternative options available to them.⁹³⁵

In cases of contract killings where an abused woman makes use of the services of a third party to kill her abusive husband, it goes without saying that the battered woman will most probably not be able to rely on the defence of non-pathological criminal incapacity. Expert evidence pertaining to the abuse she suffered will, however, still play a pivotal role in terms of sentencing. The latter was specifically established in the decision of *S v Ferreira*.⁹³⁶ The facts of the decision are as

⁹³³ Paragraph 470.

⁹³⁴ See paragraph 455 – 456.

⁹³⁵ See also Schneider, EM “Describing and changing: Women’s Self-defense work and the problem of Expert testimony on Battering” (1986) 311 – 326 at 312 in Weisberg, K “Applications of feminist legal Theory to Women’s Lives: Sex, Violence, Work and Reproduction” (1996) where it is stated:

“Judges and jurors may accept the appropriateness of woman abuse as part of the marital relationship, assume that the woman deserved or was responsible for the brutality, and blame her for not ending the relationship. Expert testimony can present a different picture by demonstrating that the battered woman was a victim.”

⁹³⁶ *S v Ferreira* 2004 (2) SACR 454 (SCA); Burchell and Milton (2007) *supra* note 1 at 403; Pistorius (2004) *supra* note 1 at 45; Madikizela, PG and Foster, D “Psychology and Human Rights” in Tredoux *et al*, (eds)(2005) *supra* note 1 at 367 – 368; Ludsin, H “*Ferreira v The State*: A victory for Women who kill their Abusers in Non-confrontational Situations” (2004) 20 *SAJHR* at 642; Ludsin, H “Legal Defences for Battered Women who kill their Abusers: Discussion Document 1” (2003) Centre for the Study of Violence and Reconciliation Chapter

follows: The first appellant together with the second and third appellants, were sentenced to life imprisonment for murder. The murder involved the killing of Cyril Parkman. The first appellant had been living with him in an intimate relationship for more than seven years. During the period of their relationship, the deceased repeatedly and extensively abused the first appellant mentally and physically. She eventually caused the other appellants, young black men then aged 22 and 20 respectively, to kill the deceased.

Due to the fact that the murder was premeditated, the trial court was obliged in terms of Section 51 (3) of the Criminal Law Amendment Act 105 of 1997⁹³⁷ to impose life imprisonment unless there were “substantial and compelling circumstances” present in which event a lesser sentence could be imposed. The trial court held that the evidence established none. The experts who presented expert evidence were Ms Kailash Bhana and Ms Lisa Vetten, employees of the

4. See also the decision of *S v Marais* 2010 (2) SACR 606 (SCA). The facts of the latter case also related to very severe domestic violence. The applicant was charged together with five other people for the murder of her husband. The essence of the charge entailed that the applicant had arranged for the murder of her husband by engaging the other accused to commit a so-called “contract murder”. During her trial the applicant raised the defence that she was a battered woman who had been suffering at the hands of her deceased husband for many years. She had eventually reached a point where she could no longer stand the abuse, assaults and what she perceived as repeated rape by her husband. She then arranged that her husband be given a “hiding” which hiding was not planned to kill the deceased, but to scare him in the hope that he would thereafter treat her better and with more respect. The High Court eventually rejected her defence as improbable and untrue. The issue before the Constitutional Court entailed that the applicant challenged her conviction and sentence on the basis that the trial court breached her right to a fair trial as guaranteed in terms of section 35 of the Constitution when it had dismissed her defence of being a battered woman and consequently found her guilty. The Constitutional Court, however, held that the applicant’s dissatisfaction with the trial court’s finding does not in itself amount to a constitutional issue (paragraph 15). The application for leave to appeal to the Constitutional Court was accordingly dismissed. The court in addition had to decide as to whether to receive further evidence pertaining to the battered woman syndrome. It was held that once an application for leave to appeal had been disposed of, the High Court that had finally determined the matter was rendered *functus officio* and ceased to have the power to entertain an application to lead further evidence, unless the matter was remitted to it by the Supreme Court of Appeal. It was further held that once the Supreme Court of Appeal had refused an application for leave to appeal, it was not open to the High Court or the Supreme Court of Appeal to consider an application to receive further evidence. It was held that as this case did not raise a constitutional issue, the Constitutional Court held no power to either to reopen the case for further evidence or to remit the matter to the High Court or the Supreme Court of Appeal (paragraphs 17-22).

⁹³⁷

Section 51 (3) reads as follows:

“If any court ... is satisfied that substantial and compelling circumstances exist which justify the imposition of a lesser sentence than the sentence prescribed in those sub-sections, it shall enter those circumstances on the record of the proceedings and may thereupon impose such lesser sentence”. See also *S v Dodo* 2001 (3) SA 382 (CC) and *S v Malgas* 2001 (2) SA 1222 (SCA).

Centre for the Study of Violence and Reconciliation in Johannesburg, the former as social worker, the latter as gender coordinator. These experts opined that the first appellant's reaction to the abuse, including her decision to have the deceased killed, fitted a well-known pattern of behaviour of abused intimate partners in terms of which the mind of the abused partner is eventually so overborne by maltreatment that no realistic avenue of escape other than homicide was possible.⁹³⁸ The facts reveal that the deceased hired the first appellant as his housekeeper. Initially she stayed in the staff quarters on his farm but after three months he requested her to move in with him as he stated he was in love with her. The deceased was like a father to the first appellant. The relationship deteriorated and the deceased became abusive and eventually violent towards the first appellant.

The deceased treated the first appellant as an unpaid servant. He gave her daily tasks, including heavy manual work. Whenever she failed to complete her daily task he punished her. Her punishment included being locked in a room without food, sometimes for up to two weeks at a time. She survived because a farm worker smuggled food to her.⁹³⁹ During the course of the relationship the assaults became more violent. The deceased made excessive sexual demands and sexually abused the first appellant. The first appellant was also subjected to constant criticism and demeaning verbal abuse often of a sexually degrading nature.⁹⁴⁰ The deceased isolated the first appellant and made her totally financially dependent on him. The appellant left the deceased on four occasions whereafter the deceased persuaded her to return.⁹⁴¹ The appellant called for police assistance on three occasions. They only arrived once and said the deceased was drunk and that the appellant should sober him up.

The turning point in the abusive relationship for the appellant was two weeks before the murder. The deceased assembled fifteen of the black labourers and called the appellant outside. When she did he told her to remove her underwear and show her genitals to the men. She refused. That evening the deceased

⁹³⁸ Paragraph 10.

⁹³⁹ Paragraph 18.

⁹⁴⁰ Paragraphs 22 and 23.

⁹⁴¹ Paragraph 24.

raped the appellant and threatened that he would hire black men to rape the appellant should she ever try to leave him again. The appellant appraised this threat with extreme fear. The appellant believed that leaving the deceased was not an option, as he would, in her mind, find her eventually. In the mind of the appellant death was the only way of escaping and getting her life back. The murder was committed by the second and third appellants by means of strangulation. The appellant paid them R5 700 each.

Ms Vetten stated that the forms of abuse suffered by the first appellant and her psychological and behavioural responses were consistent with case studies in this country and overseas.⁹⁴² She testified⁹⁴³ that the appellant eventually felt trapped and isolated:

“The pattern of coercion and control to which she was subjected appears to have extended to every aspect of the existence, resulting in her entrapment within the relationship. The effects of the abuse upon Ms Ferreira were ultimately nothing short of disastrous ...

I am common with other abused women I have worked with who used third parties to kill their abusive partners. Ms Ferreira’s decision was based on her personal inability to use physical violence against the deceased. Being personally unable to defend herself against Mr Parkman she turned to others. The decision to kill Mr Parkman appears to have been a desperate act of self-preservation aimed at maintaining what little physical and psychological integrity Ms Ferreira felt she still possessed.”

The court was impressed with the expert evidence tendered during the trial and Howie J stated⁹⁴⁴ that the experts conveyed an explanation as to why abused women, subjectively, feels unable to escape by any other route than by homicide. Howie JA held⁹⁴⁵ that on the day the deceased raped the first appellant she was subjected to intolerable degradation. Together with the rape came the threat to

⁹⁴² Paragraph 29.

⁹⁴³ Paragraph 29.

⁹⁴⁴ Paragraph 35. Ludsin and Vetten (2005) *supra* note 666 at 175.

⁹⁴⁵ Paragraph 39.

have her raped by black men. Accordingly, given her personal history and the stage to which her life had come, the reason for her killing him rather than leaving was adequately established by the evidence.

Howie JA was of the opinion⁹⁴⁶ that her decision to kill and to hire others for that purpose is explained by the expert witnesses in accordance with what experience and research has shown that abused women do and it is an aspect which has to be judicially assessed not from a male perspective or an objective perspective but by the court's placing itself as far as it can in the position of the woman concerned, with a fully detailed account of the abusive relationship and the assistance of expert evidence. In addition Howie JA held that only by judging the case on the latter basis can the offender's equality right under S 9(1) of the Constitution be given proper effect.

The Supreme Court of Appeal accordingly overturned the first appellant's sentence, ultimately suspending her sentence for three years in light of the time she had already served. The court concluded that the abuse the first appellant suffered at the hands of the deceased was substantial and compelling circumstances which justified deviating from the mandatory life sentence.⁹⁴⁷

- Reflections on the *Ferreira*-decision

It is striking from this judgment that the words "battered woman" were never used. Instead the word "abused" was preferred. It is submitted that this is correct as the terminology of "battered woman" should be substituted with "abused partner syndrome" as the former could be construed as gender-specific and abuse-specific in the sense that the inference could be drawn that "battered" only refers to physical abuse which most often is only one form of abuse present in an abusive relationship.

⁹⁴⁶ Paragraph 40. The court concluded that the woman's constitutional rights to dignity, freedom from violence and to bodily integrity had been violated by her abuser. See also Ludsin and Vetten (2005) *supra* note 666 at 174 – 175.

⁹⁴⁷ Paragraph 43.

The *Ferreira*-decision further highlights the importance of expert evidence also with reference to sentencing and mitigation of sentence. It is clear that the expert evidence was gladly accepted by the court and of much assistance to the court.

The court in this case accepted the fact that the first appellant honestly believed that there was no other means of escaping the abuse other than killing the abuser. Howie J stated:⁹⁴⁸

“This is not a case where the first appellant’s motive was anything other than to end the relationship so as to preserve her bodily integrity.”

In respect of the moral blameworthiness of contract killers Howie J questioned whether hiring killers increased an accused’s moral blameworthiness. Howie J stated:⁹⁴⁹

“The criterion for determining moral blameworthiness, it is said, is subjective. This means one must look solely at what an accused believed and intended when deciding for purposes of sentence whether moral blameworthiness has been reduced.”

What is of most importance also for purposes of the defence of non-pathological criminal incapacity, is the hypothetical scenario the court canvassed⁹⁵⁰ to illustrate situations where there is a time span between the last incident of abuse and the eventual killing of the abuser. This hypothesis can be explained as follows: Three women, A, B and C, are victims of abuse and guilty of the murder of their respective abusive partners in the subjective belief that there was no alternative way to protect their rights to bodily integrity and freedom from violence. Each case is characterized by a long history of substantially similar abuse and a triggering event which instilled that belief. A committed the offence a day later, by herself. B committed it one week later, by herself. C, feeling mentally and physically weak, hired contract killers two weeks later. The court questioned whether any of these

⁹⁴⁸ Paragraph 40. Ludsin and Vetten (2005) *supra* note 666 at 175.

⁹⁴⁹ Paragraph 44.

⁹⁵⁰ Paragraphs 44 and 45. Ludsin and Vetten (2005) *supra* note 663 at 176; Ludsin (2004) *SAJHR supra* note 666 and 931 at 648.

three women is more morally blameworthy than the other which would justify different sentences to murder.

Howie J answered this question as follows:⁹⁵¹

“It seems to me that the true question to be answered is whether the threat from which each sought to escape was still, subjectively perceived to be real and present danger (albeit not imminent enough to escape criminal liability altogether) at the time of the offence.”

An abused woman relying on the defence of non-pathological criminal incapacity, who subjectively believed threats to be real and present, could argue that at the time of killing her abuser, she lacked the capacity to act in accordance with an appreciation of the wrongfulness of her actions. In the alternative, that her capacity to either appreciate the wrongfulness of her actions or to act in accordance with such appreciation, was significantly diminished at the time of the killing.⁹⁵² Central, however, to proving the latter, stands the mental health expert. The *Ferreira*-decision portrays the value of well-established expert evidence in cases of abused women.

Ludsin indicates that the *Ferreira*-decision is welcoming for the following reasons:⁹⁵³

- It highlights the importance of the proper understanding of women’s experiences with violence and specifically their motivations for killing when determining whether any mitigating circumstances exist at the sentencing stage.
- It demonstrates how women who kill their abusers in non-confrontational situations may be able to prove putative private defence.⁹⁵⁴ The court specifically evaluated the common question in cases of abuse as to why the

⁹⁵¹ Paragraph 45.

⁹⁵² Diminished criminal capacity will be discussed below.

⁹⁵³ Ludsin (2004) *SAJHR supra* note 932 at 646 – 648.

⁹⁵⁴ *Ibid.* The defence of private defence in respect of battered women who kill their abusers was not addressed in this Chapter as it relates to a different element of criminal liability, namely unlawfulness.

woman did not just leave the abuser by assessing possible alternatives available to the first appellant. The court per Howie J noted the threat of harm would have continued even if the first appellant left as the deceased's threats entailed that she would be raped if she left. The two options available to the first appellant were the police and a civil protection order.⁹⁵⁵ Despite the availability of these two options, the court concluded that the first appellant subjectively believed she had no choice but to kill to escape further abuse.⁹⁵⁶ The most important aspect is that the court supported this conclusion with expert evidence of experts who founded their opinions on research on domestic violence as well as international research.⁹⁵⁷

- Abused women who kill using a hired killer as well as women who do not kill in the midst of a confrontation, are accorded some understanding by the law.

The decision in *Ferreira* also affirms the importance of an abused woman's fundamental rights that are infringed in cases of abuse and that these rights deserve protection. These rights include the right to human dignity, bodily integrity and freedom and security of the person and also not to be treated or punished in a cruel, inhumane or degrading way.⁹⁵⁸

From a psychological perspective, Madikizela and Foster indicate⁹⁵⁹ that the *Ferreira*-decision is significant for establishing a new trend in South Africa that is predicated on protecting the rights of accused persons according to the dictates of a Constitution that is founded on human rights principles. Expert evidence in cases of abused women, should, however, be presented rigorously and with precision.⁹⁶⁰

⁹⁵⁵ *Ibid.*

⁹⁵⁶ Paragraph 59.

⁹⁵⁷ Paragraphs 30 and 35.

⁹⁵⁸ See paragraph 3.4 *supra*.

⁹⁵⁹ Madikizela, PG and Foster, D "Psychology and Human Rights" in Tredoux *et al* (eds) (2005) *supra* note 1 at 367 – 368; Arrigo, BA and Shipley SL "Introduction to Forensic Psychology – Issued and Controversies in Law, Law Enforcement and Corrections" (2005) at 82 – 83; Bartol, CR and Bartol, AM "Criminal Behaviour – A Psychological Approach" 7th ed (2005) at 322 – 323.

⁹⁶⁰ *Ibid.*

Madikizela and Foster in addition state⁹⁶¹ that other victims' experiences of abuse and their reactions thereto, will differ, as well as the behaviour exhibited as a result of the abuse and that it is "these nuances that a rigorous investigation should capture in order to lend credibility to a defence based on an analysis of the dynamics of domestic violence and the range of legal and psychological factors associated with it."

Ludsin in addition recommends that within the context of domestic violence, the accused should be allowed to introduce any or all of the following evidence to establish loss of self-control.⁹⁶²

- (a) Evidence that the accused is or has been the victim of acts of physical, sexual or psychological harm or abuse at the hands of the abuser,
- (b) Expert evidence regarding abusive relationships, the nature and effects of physical, sexual or psychological abuse and response thereto, the relevant facts and circumstances that form the basis for such opinion as well as any other expert evidence important and relevant to a claim of diminished capacity.

In this section the pivotal and essential role of expert evidence in respect of abused women was clearly illustrated and contextualized on the backdrop of the various manifestations of abuse and the various explanations advanced as to why women endure abuse rather than escaping the abusive relationship. The complexity of the issue and also the fact that expert evidence in cases of non-pathological criminal incapacity fulfils an indispensable function, contrary to the traditional approach in terms of which expert evidence does not fulfil an indispensable function, was elucidated. The presentation of expert evidence will ensure the accused's right to adduce and challenge evidence and also lead to a fair and a just trial provided that the State also presents experts to challenge the

⁹⁶¹ *Ibid.*

⁹⁶² Ludsin, H "South African Criminal Law and Battered Women who kill: Discussion Document II – Research report written for the Centre for the Study of Violence and Reconciliation" (2003) 70 – 71.

expert evidence advanced on behalf of the accused. In cases where non-pathological criminal incapacity is raised by abused women, the full purport of their constitutional rights infringed during the abuse, will also receive due recognition in line with a Constitutional State founded on the values of human dignity, equality and freedom.

16 Amnesia and non-pathological criminal incapacity

“Memory is what we are: if we lose our memories, we lose our identity and sense of self.” (Ford, 1996)

Amnesia is generally a state of mind in which a person tends to suffer from partial or complete memory loss. Amnesia is also often referred to as a short-term memory condition in which the memory is disturbed.⁹⁶³ The role of amnesia is addressed in this study as it frequently comes to the fore in respect of both non-pathological as well as pathological criminal incapacity.

Vorster notes that memory is a complex function which is not limited to a certain area of the brain, but entails various parts functioning in conjunction with each other and that memory can be divided into three processes: registration, storage and retrieval.⁹⁶⁴

⁹⁶³ Wikipedia encyclopedia <http://en.wikipedia.org/wiki/Amnesia> [accessed on 2009.02.04]; Ellis, J “Emotional stress” – ‘n Nuwe Handelingsuitsluitingsgrond” (1986) *De Jure* (1) 340 at 348; Kaliski, SZ “The Criminal defendant” in Kaliski (2006) *supra* note 1 at 108-109; Van Rensburg, PHJJ and Verskhor, T “Medies-geregtelike Aspekte van Amnesie” (1989) *TRW* 40-55; Rubinsky, EW and Brandt, J “Amnesia and Criminal Law: A Clinical Overview” (1986) *Behavioural Science and the Law* at 27; Rogers, R and Cavanaugh J “Amnesia” (1986) *Behavioural Science and the Law* (Introductory Note to volume (4)); Morse, S “Why Amnesia and the Law is Not a useful topic” (1986) *Behavioural Science and the Law* at 99; Hctor, S “Amnesia and Criminal responsibility” (2000) *SACJ* at 273; Vorster, M “An Analysis of the Amnias with Specific Reference to ‘Non-Pathological Sane Automatism’ “(2002) University of Witwatersrand (Unpublished PHD thesis) at 24-32; Strauss, SA “Doctor, patient and the Law – A Selection of practical issues” (1991) at 129-130.

⁹⁶⁴ Vorster (2002) *supra* note 963 at 24. See also Whitty, CWM and Zongwill, OL “Amnesia – Clinical, Psychological and Medicolegal Aspects” (1977) 2nd ed at 60; Hctor (2000) *SACJ* at 274. According to Vorster, the following factors may affect each stage of the process:

- Registration – levels of arousal – any factors that could have a bearing on this.
 - relationship of importance of information to the self
 - emotional state
 - intelligence and filtering processes
- Storage – structure and physiology of the brain
- Retrieval - emotional factors

During amnesia there is a defect in one or more of these stages.

Rubinsky and Brandt define amnesia as:⁹⁶⁵

“... a behavioural syndrome marked by a severe inability to acquire and retain new permanent memories (anterograde amnesia) often coupled with some degree of impairment in the retrieval of previously acquired memories (retrograde amnesia).”

Kaplan and Sadock define amnesia as the “partial or total inability to recall past experiences.”⁹⁶⁶

According to Kaplan and Sadock, amnesia can be sub-divided into two categories:⁹⁶⁷

- Anterograde – loss of memory for or pertaining to events occurring after a point in time;
- Retrograde – loss of memory for or pertaining to events occurring before a point in time.

According to Schacter, there are four types of amnesia:⁹⁶⁸

- Chronic organic amnesia – “... pathological forgetting that is associated with a wide variety of neurological dysfunctions, including head injury, encephalitis, ruptured aneurysm, Korsakoff’s disease, anoxia, Alzheimer’s

-
- arousal and all factors affecting this
 - situation – specific associations

Vorster notes that memories related to extreme emotion may sometimes be easily recalled but may also just as easily be erased (Vorster [2002] *supra* note 963 at 24).

⁹⁶⁵ Rubinsky and Brandt (1986) *supra* note 963 at 33; Hoctor (2000) *SACJ supra* note 963 at 274.

⁹⁶⁶ Sadock, BJ and Sadock, VA “Kaplan and Sadock’s Synopsis of Psychiatry – Behavioural Sciences/Clinical Psychiatry” 9th ed (2003) at 286. (Hereafter “Kaplan and Sadock”).

⁹⁶⁷ Kaplan and Sadock (2003) *supra* note 966 at 286.

⁹⁶⁸ Schacter, DL “On the relation between genuine and simulated amnesia” (1986) *Behavioural Sciences and the Law* 47 at 48 as discussed in Hoctor (2000) *SACJ supra* note 963 at 274-275.

disease” – patients typically display signs of both anterograde as well as retrograde amnesia.

- Functional retrograde amnesia – “... memory loss of one’s name and personal past that is produced by severe psychological and emotional trauma ...”
- Multiple personality amnesia – “... memory deficits observed in patients with multiple personality disease: Any one of the patient’s personalities may have little or no access to memories acquired by another ...”
- Limited amnesia – “... a pathological inability to remember a specific episode, or small number of episodes, from the recent past ...”

It is important to briefly discuss the sources of amnesia relevant to the discussion of non-pathological criminal incapacity. Rubinsky and Brandt⁹⁶⁹ also note that a specific manifestation of amnesia plays an important role in the different criminal defences. According to Rubinsky and Brandt, the most prominent causes of amnesia are alcoholism, epilepsy, head injury and psychogenic amnesia.⁹⁷⁰

16.1 Sources of Amnesia

16.1.1 Alcohol

There are mainly two instances in which alcohol could affect a person who subsequently claims amnesia at a later stage:⁹⁷¹

- Where acute ingestion of alcohol causes amnesia during the period of intoxication, or
- Where long-term alcoholism results in a chronic memory disorder.

Acute alcohol intoxication produces a state in which new information is inefficiently stored, and old information is difficult to retrieve.⁹⁷² Short-term memory is

⁹⁶⁹ Rubinsky and Brandt (1986) *supra* note 963 at 36.

⁹⁷⁰ *Ibid.* See also Hoctor (2000) *SACJ supra* note 963 at 275-278; Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 50-54.

⁹⁷¹ Rubinsky and Brandt (1986) *supra* note 963 at 36; Hoctor (2000) *SACJ supra* note 963 at 275.

impaired during intoxication with the severity of impairment being positively correlated with the level of alcohol in the blood.⁹⁷³ Rubinsky and Brandt state that as soon as blood-alcohol levels rise, the information processing strategies used by alcoholics as well as social drinkers alternate from sophisticated strategies founded on semantic associations, to more primitive, idiosyncratic strategies.⁹⁷⁴

Information gathered whilst a person is intoxicated is often only recalled when a person is in a similar physiological state. After a bout of heavy intoxication, there may be anterograde amnesia pertaining to events that occurred during this period of the so-called alcoholic “blackout”.⁹⁷⁵

Whenever a blackout arises, remote and immediate memory remain intact, but a short-term memory loss occurs in the sense that the intoxicated person is unable to recall events that occurred in the preceding five or ten minutes.⁹⁷⁶ Van Rensburg and Verschoor⁹⁷⁷ state that a person with alcoholic amnesia is clearly aware of what he is doing from moment to moment while intoxicated, but as a result of a lack of retention of information her or she is unable to recall the events at a later stage.

16.1.2 Epilepsy

Cases dealing with individuals with epilepsy usually involve those with complex partial seizures.⁹⁷⁸ There are mainly three types of epileptic seizures: grand mal, petit mal and psychomotor seizures.⁹⁷⁹

⁹⁷² Rubinsky and Brandt (1986) *supra* note 963 at 36; Hoctor (2000) *SACJ supra* note 963 at 275.

⁹⁷³ *Ibid.*

⁹⁷⁴ *Ibid.* See also Ryan, C and Butters, N (1983) “Cognitive deficits in alcoholics” in Kissen, B and Begeiter, H “The Pathogenesis of Alcoholism” Volume 7 at 485-538.

⁹⁷⁵ Rubinsky and Brandt (1986) *supra* note 963 at 37-38.

⁹⁷⁶ Hoctor (2000) *SACJ supra* note 963 at 275.

⁹⁷⁷ Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 51; Hoctor (2000) *SACJ supra* note 963 at 275; *R v H* 1962 (1) SA 197 (A).

⁹⁷⁸ Rubinsky and Brandt (1986) *supra* note 963 at 38.

⁹⁷⁹ Van Rensburg and Verschoor (1989) *supra* note 963 at 51. According to Van Rensburg and Verschoor “Grand Mal” seizures are associated with convulsions which can result in injury on the part of the person suffering the seizure whereas “Petit Mal” seizures are fleeting moments of unconsciousness, which usually lasts a few seconds. See also Hoctor (2000) *SACJ supra* note 963 at 276.

Rubinsky and Brandt state that⁹⁸⁰ criminal cases pertaining to individuals with epilepsy usually relate to those with complex partial ('psychomotor') seizures. These complex partial seizures are often associated with abnormal electrical discharges from limbic structure underlying the temporal lobes, and accordingly they were once termed "temporal lobe epilepsy".⁹⁸¹ Whilst experiencing a complex partial seizure, the individual does not experience a convulsion, but rather suffers a 'clouding' of consciousness and may engage in automatic behaviour and as such "(h)e behaves in quasi-purposeful ways, yet is unresponsive to the environment and is not storing new information. When the episode is over, the events which transpired during the *ictus* are not remembered".⁹⁸²

According to Van Rensburg and Verschoor epileptic amnesia can be characterised as being well defined.⁹⁸³ The person can generally recall all activities undertaken until the point where the seizure occurred.⁹⁸⁴ Epileptic amnesia covers the period surrounding the attack but does not relate to the person's past.⁹⁸⁵

Rubinsky and Brandt note that the interface between epilepsy-related cognitive impairments and criminal behaviour remain uncertain. They observed that physicians and legal professionals who have written on the medicolegal aspects of amnesia emphasising epilepsy, have often conflated the states of amnesia, automatism, and impaired consciousness."⁹⁸⁶

16.1.3 Head trauma

An accused person who commits a crime while in clear consciousness and full possession of his or her mental capacities and, either in the course of the act or subsequent thereto, sustains an injury to the head may suffer from retrograde amnesia for the act and events prior to it, as well as anterograde amnesia (post-

⁹⁸⁰ Rubinsky and Brandt (1986) *supra* note 963 at 38; Hoctor (2000) *SACJ supra* note 963 at 276.

⁹⁸¹ *Ibid.*

⁹⁸² *Ibid.*

⁹⁸³ Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 52.

⁹⁸⁴ Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 52; Hoctor (2000) *supra* note 963 at 276.

⁹⁸⁵ *Ibid.*

⁹⁸⁶ Rubinsky and Brandt (1986) *supra* note 963 at 38.

traumatic amnesia) afterwards.⁹⁸⁷ It is, however, true that courts are generally not very sympathetic to claims of amnesia if during the initiation of the act and at the time of the trial there is no anterograde amnesia.⁹⁸⁸

16.1.4 Psychogenic amnesia or “dissociative amnesia”

“‘I have done that’ says my memory. ‘I cannot have done that’ says my pride and remains adamant – at last memory yields.” (Nietzsche)

Psychogenic amnesia can be defined as a sudden inability to remember important information.⁹⁸⁹ Rubinsky and Brandt state that memory loss in respect of psychogenic amnesia is too extensive to be described by ordinary forgetfulness and is typically confined to incidents that took place before or surrounding the critical event or events.⁹⁹⁰ The memory impairment could accordingly be classified as the retrograde type. The memory loss in these instances can be for a certain period of time or for the rest of the person’s life.⁹⁹¹

Psychogenic amnesia is commonly known to be a method of suppressing unpleasant memories, but it could also be a reflection of a certain personality type predisposed to this type of memory loss.⁹⁹²

Psychogenic amnesia is often the result of an “emotional block”. A person may experience an incident which he or she does not want to remember or experience a traumatic event and escape from this by forgetting.⁹⁹³ Emotional trauma in

⁹⁸⁷ Rubinsky and Brandt (1986) *supra* note 963 at 39; Hoctor (2000) *supra* note 963 at 276. See also *S v Cunningham* 1996 (1) SACR 631 (A) at 639 B-C.

⁹⁸⁸ Rubinsky and Brandt (1986) *supra* note 963 at 39; Hoctor (2000) SACJ *supra* note 963 at 277. See also *Watkins v People*, 158 Col. 485, 408P.2d 425 1965 where the defense claimed that amnesia precluded the formation of criminal intent. The latter claim was unsuccessful. Amnesia does not preclude a normal state of consciousness, intelligence and rational thought.

⁹⁸⁹ Rubinsky and Brandt (1986) *supra* note 963 at 41; Hoctor (2000) SACJ *supra* note 963 at 277; Van Rensburg and Verschoor (1989) *supra* note 963 at 46. American Psychiatric Association “Diagnostic and Statistical Manual of Mental Disorders” 4th ed (1994) at 477 (hereafter “DSM-IV”)

⁹⁹⁰ Rubinsky and Brandt (1986) *supra* note 963 at 41.

⁹⁹¹ *Ibid.*

⁹⁹² Vorster (2002) *supra* note 963 at 28.

⁹⁹³ Van Rensburg and Verschoor (1989) *supra* note 963 at 46.

respect of the commission of the crime can thus bring about psychogenic amnesia.

According to the DSM-IV, the diagnostic features unique to dissociative (psychogenic) amnesia are the following:⁹⁹⁴

- The essential feature of dissociative amnesia is an inability to recall important personal information, usually of a traumatic nature.
- It constitutes a reversible memory disturbance in which memories of personal experience cannot be retrieved verbally.
- Dissociative amnesia most commonly manifests as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history.
- It does not occur exclusively during the course of dissociative identity disorder, dissociative fugue, post traumatic stress disorder, acute stress disorder, or somatization disorder and is not due to the direct physiological effects of a substance.
- The symptoms induce clinically significant distress or impairment in social, occupational or other important areas of functioning.

Psychogenic amnesia usually starts abruptly, usually after the occurrence of serious psychosocial stress.⁹⁹⁵ It usually also ends abruptly with complete recovery and it seldomly repeats itself.⁹⁹⁶

According to the DSM-IV there are distinct types of psychogenic amnesia:⁹⁹⁷

- (i) Localized amnesia – the individual fails to recall events that occurred during a circumscribed period of time, usually the first few hours after a profoundly traumatic event;
- (ii) Selective amnesia – a person can recall some, but not all, of the events during a specified period of time;

⁹⁹⁴ DSM-IV (1994) *supra* note 989 at 478.

⁹⁹⁵ Van Rensburg and Verschoor (1989) *supra* note 963 at 47; Hoctor (2000) *SACJ supra* note 963 at 277.

⁹⁹⁶ Van Rensburg and Verschoor (1989) *supra* note 963 at 47.

⁹⁹⁷ DSM-IV (1994) *supra* note 989 at 478; Hoctor (2000) *SACJ supra* note 963 at 278.

- (iii) Generalized amnesia – failure of recall relates to the person’s entire life;
- (iv) Continuous amnesia – this form of amnesia is defined as the inability to recall events subsequent to a specific time up to and including the present.

It is extremely difficult to distinguish psychogenic amnesia from simulated amnesia, which renders the assessment of amnesia problematic.

In *S v Henry*⁹⁹⁸ the defence that was raised by the appellant was one of sane automatism. The court nevertheless made important findings which could also be of importance to the defence of non-pathological criminal incapacity as well as the concept of psychogenic amnesia.

The appellant, a television technician in his late thirties, was charged in the Cape Provincial Division with two counts of murder and a third count of pointing a firearm in contravention of the Arms and Ammunition Act 75 of 1969. The first count of murder related to the killing of the appellant’s ex-wife (“Mrs Henry”) and the second to the killing of his ex-mother-in-law (“Mrs Symon”). The complainant in the alleged statutory offence was Mrs Symon’s fiancé, Mr Thomas Davids.

The appellant and the first deceased were divorced in 1993 and both became involved in relationships with new partners. They saw little of each other. There were three daughters born of the marriage, to which the appellant had access in terms of the decree of divorce. The first deceased adopted a flexible attitude to the appellant’s rights of access, and, especially in regard to the youngest of the daughters, Robyn, who had maintained a close relationship with her father, and accordingly permitted him greater access than provided for in the decree. Robyn spent the weekend of 27-29 January 1995 with the appellant. During the evening of Sunday 29 January, when she was scheduled to return home, Robyn telephonically requested the first deceased for permission to remain with the appellant until the following morning. However, the first deceased indicated that she wanted her daughter to return home that evening. Two further requests, one voiced by the appellant himself, were similarly dismissed. The appellant then

⁹⁹⁸ 1999 (1) SACR 13 (SCA). See also Le Roux (2000) *De Jure supra* note 1 at 190-193.

drove Robyn to her mother's house. He told Robyn to wait in the car. He announced himself at the door and, after he had spoken to his two elder daughters, entered the house, intending yet again to seek the first deceased's permission for Robyn to remain with him until the following morning. He was in possession of a firearm, which was strapped down in its holster. When he encountered the first deceased there was a confrontation. According to the appellant she shouted at him to leave the house and started pushing him out. He also remembered her grabbing at the holster, and a struggle taking place. Thereafter, according to the appellant, he became enraged, and "just heard this noise zinging in my ears and there was shouting going on"⁹⁹⁹. He also claimed that he had heard "banging noises" and that he had seen "this blur coming towards (him)"¹⁰⁰⁰. What he remembered after this was looking for the exit, because he knew something must have taken place. He stormed by mistake into the second deceased's room, where he saw Mr Davids and pointed his firearm at him.

When the appellant returned to his vehicle he told his daughter, Robyn, that he had killed her mother. He then drove to a family member whom he also informed that he had shot his ex-wife. He then informed the police in Houtbay but thereafter claimed to have been suffering from amnesia with regard to the preceding events. The appellant raised the defence of sane automatism, claiming that he had no recollection of the shooting or of pointing the firearm at Mr Davids. The defence was rejected by the trial court and the appellant was convicted as charged.

On appeal, it was held per Scott JA¹⁰⁰¹ firstly that it is trite law that a cognitive or voluntary act is an essential element of criminal responsibility. It is also well established that where the commission of such an act is put in issue on the ground that the absence of voluntariness was attributable to a cause other than mental pathology, the onus is on the State to establish this element beyond reasonable doubt.

⁹⁹⁹ At 19 b-c.

¹⁰⁰⁰ At 19 c-d.

¹⁰⁰¹ At 19 I-J.

Scott JA stated¹⁰⁰² that it has been repeatedly emphasised in the past that defences such as non-pathological automatism require careful scrutiny and circumspection. The *ipse dixit* of the accused to the effect that his act was involuntarily and unconsciously committed must accordingly be weighed up and assessed against the backdrop of all the circumstances and particularly against the alleged criminal conduct viewed objectively.¹⁰⁰³ Scott JA in addition held that criminal conduct arising from an argument or some or other emotional conflict is frequently preceded by some sort of provocation and such loss of temper is a common occurrence and in appropriate circumstances it might possibly mitigate, but it will not exonerate.¹⁰⁰⁴ Scott JA held that non-pathological loss of cognitive control or consciousness as a result of some emotional stimulus and resulting in involuntary conduct, i.e. psychogenic automatism, is most uncommon¹⁰⁰⁵ and in respect of expert evidence Scott JA held: “Generally speaking expert evidence of a psychiatric nature will be of much assistance to the court in pointing to factors which may be consistent or inconsistent as the case may be, with involuntary conduct which is non-pathological and emotion-induced. These, for example, may relate to such matters as the nature of the emotional stimulus which it is alleged served as a trigger mechanism for the condition or the nature of the behaviour or aspects of it which may be indicative of the presence or absence of awareness and cognitive control”.

Scott JA discussed the occurrence of psychogenic amnesia and noted that it generally refers to the subconscious repression of an unacceptable memory. It was held that whilst it is generally accepted that automatism results in amnesia it does not follow that the converse is true. In other words, amnesia is not necessarily indicative of automatism and an accused person may therefore genuinely have no subsequent recollection of a voluntary act giving rise to criminal

¹⁰⁰² At 20 C-I. See also *S v McDonald* 2000 (2) SACR 493 (NPG) where a clinical psychologist for the State presented expert evidence to the effect that the appellant on account of the trauma surrounding the shooting which was the reason of the charge against the appellant, suffered from a state of retrograde dissociative amnesia – lacking the ability to recall matters after the event.

¹⁰⁰³ *Ibid.*

¹⁰⁰⁴ *Ibid.*

¹⁰⁰⁵ *Ibid.*

responsibility and consequently expert evidence may be of assistance to the court in explaining the accused's behaviour.¹⁰⁰⁶

Scott JA in addition noted ultimately, however, it is for the court to decide the true nature of the alleged criminal conduct which it will do not only on the basis of the expert evidence but in the light of all the facts and the circumstances of the case.”

The only question in this case was whether the appellant was “acting” in a state of psychogenic automatism at the relevant time and accordingly could not commit an act or acts giving rise to criminal liability.

Although this case did not deal specifically with non-pathological criminal incapacity, it is interesting to note the aspects of expert evidence pertaining to the facts.

Mr Reyner van Zyl, a clinical psychologist of Cape Town, who gave evidence on behalf of the appellant, was of the view that the appellant was indeed in a state of psychogenic automatism at the time of the shooting.¹⁰⁰⁷ Dr Jedaar, who was called by the State in rebuttal, took the opposite view holding that the appellant had not been in a state of psychogenic amnesia.¹⁰⁰⁸

It appears from the evidence that there was no difference of opinion between Mr Van Zyl and Dr Jedaar as to the nature of the stimulus or trigger mechanism that was required to induce a state of psychogenic automatism. There had to be some emotionally charged event or provocation of extraordinary significance to the person concerned and the emotional arousal that it caused had to be of such a nature as to disturb the consciousness of the person concerned to the extent that it resulted in unconscious or automatic behaviour with consequential amnesia. Dr Jedaar testified that there was nothing that he could find in the appellant's account of what had been said on the fatal evening or in the appellant's account of his own emotions at the time to suggest a stimulus of the kind required to trigger a state of

¹⁰⁰⁶ *Ibid.*

¹⁰⁰⁷ At 21 A.

¹⁰⁰⁸ At 21 B-C.

automatism.¹⁰⁰⁹ Mr Van Zyl suggested that what triggered the appellant's state of automatism was his intense frustration arising from Mrs Henry's refusal to let him have Robyn for the extra night.¹⁰¹⁰ This explanation, however, did not carry much weight.

Initially Dr Jedaar confined his evidence to certain general observations regarding automatism as he had not interviewed the appellant. At the request of the appellant's counsel the case was later postponed to enable Dr Jedaar to interview the appellant and investigate the matter further. Dr Jedaar subsequently testified that when he interviewed the appellant, the latter told him that he recalled grappling with Mrs Henry for possession of the firearm and that he feared that if she gained possession of it she would use it against him.¹⁰¹¹ According to Dr Jedaar, his subjective experience immediately prior to the shooting was not one of anger or rage, but one of fear. According to Dr Jedaar, this was wholly at variance and inconsistent with an emotional stimulus of a kind that would induce automatism.

Another aspect of the appellant's behaviour upon which the State relied in order to demonstrate that he was acting consciously was what Dr Jedaar described as "avoidance behaviour".¹⁰¹² By this he referred to the appellant's hurried departure from the scene which on his own version took place even before he had found out what had happened. Dr Jedaar considered this to be wholly inconsistent with the behaviour of a person who had just had an episode of automatism.¹⁰¹³ He testified that he would expect such a person to be in a bewildered and confused state.¹⁰¹⁴ The court accordingly held, on the facts, both objectively and on the appellant's own account of his emotions, revealed nothing to suggest a stimulus of the kind required to trigger a state of automatism.

It was held by Scott JA that in the absence of evidence of an identifiable trigger mechanism, and in the light of indications of conscious behaviour inconsistent with automatism, that the evidence did not reveal a reasonable possibility that the

¹⁰⁰⁹ At 21 D-F.

¹⁰¹⁰ At 22 B-C.

¹⁰¹¹ At 22 H-I.

¹⁰¹² At 23 E-F.

¹⁰¹³ At 23 E-G.

¹⁰¹⁴ At 23 F-G.

appellant was in a state of automatism at the relevant time. The appeal accordingly had to be dismissed.

- Reflection on the *Henry*-decision

The court per Scott JA notes that the incidence of psychogenic automatism, which entails the non-pathological loss of cognitive control due to an emotional stimulus, is rare. The court also states that automatism often results in amnesia but that the converse is not always true. Psychogenic amnesia, which entails the subconscious suppression of unacceptable memories of the event is a relatively common occurrence. It is accordingly possible for a person to suffer from amnesia whilst the preceding conduct was completely voluntary.¹⁰¹⁵

Now that the clinical aspects of amnesia have been discussed, it is necessary to discuss the legal approach to claims of amnesia.

16.2 The legal approach to amnesia

In *R v H*¹⁰¹⁶ the court expressed great caution in respect of amnesia:

“(D)efences such as automatism and amnesia require to be carefully scrutinised. That they are supported by medical evidence, although of great assistance to the Court, will not necessarily relieve the Court from its duty of careful scrutiny for, in the nature of things, such medical evidence must often be based upon the hypothesis that the accused is giving a truthful account of the events in question.”

It is generally accepted that mere amnesia or loss of memory does not constitute a valid defence.¹⁰¹⁷

¹⁰¹⁵ See Le Roux (2000) *De Jure supra* note 1 at 192.

¹⁰¹⁶ *R v H* 1962 (1) SA 197 (A) at 208 B. See also *S v Piccione* 1967 (2) SA 334 (N) at 336, *S v T* 1986 (2) SA 112 (O) at 124 A-D where it was held that the accused’s amnesia was not attributable to involuntary or unconscious behaviour, but rather the desire to avoid the unpleasant. See also Ellis (1986) *De Jure supra* note 958 at 348.

¹⁰¹⁷ Strauss (1991) *supra* note 1 at 129; Ellis (1986) *De Jure supra* note 963 at 348; *S v Piccione* 1967 (8) SA 334 (N) at 336; *R v Johnson* 1970 (2) SA 405 (R); Kaliski (2006) *supra* note 1 at

It is, however, true that the assessment of amnesia is extremely difficult with specific reference to the establishment of the authenticity thereof. It remains an undeniable fact that expert evidence from forensic mental health professionals will play a pivotal role in establishing the validity of a claim of amnesia. Rogers and Cavanaugh¹⁰¹⁸ expound on the difficulties encountered during the assessment of amnesia:

“Much of forensic practice is predicated on the successful reconstruction of the criminal or civil issue in question. The assessment process is greatly complicated when the evaluatee claims partial or total amnesia regarding his/her thoughts, emotions, perceptions, and behaviour. Of these, only occasionally can behaviour be fully reconstructed. The others are interpersonal phenomena which, at best, can be inferred from observed behaviour. This is problematic both for forensic clinicians attempting to address comprehensively specific legal standards, and for participating attorneys in the effective presentation and advocacy of their cases.”

In *S v Pederson*¹⁰¹⁹ the appellant was convicted in a regional court of the murder of his wife. On the day of the murder the appellant, who apparently suspected that the deceased was committing adultery, made enquiries as to her whereabouts, and was heard to say that he was going to kill her. The deceased was warned about this threat, but ignored it. On the morning of the murder the deceased returned to her flat. While she was there the appellant stabbed her as a result of which she died. The appellant’s defences at the trial were:

108. See also *Bratty v Attorney-General for Northern Ireland* (1961) 3 A11 ER 523 (HL) at 532 G-H:

“The term ‘involuntary act’ is, however, capable of wider connotations and to prevent confusion it is to be observed that in the criminal law an act is not to be regarded as an involuntary act simply because the doer does not remember it. When a man is charged with dangerous driving, it is no defence for him to say ‘I don’t know what happened, I cannot remember a thing’ ... Loss of memory afterwards is never a defence in itself, so long as he was conscious at the time.”

See also *S v Van Zyl* 1964 (2) SA 113 (A) at 120; *S v Cunningham* 1996 (1) SACR 631 (A) at 635 J–636A.

¹⁰¹⁸ Rogers and Cavanaugh (1986) *supra* note 963 at i.

¹⁰¹⁹ *S v Pederson* 1998 (2) SACR 383 (NPD). See also Reddi, M “General principles of liability” (1999) SACJ 87-91.

- that he had not acted voluntarily when he stabbed the deceased;
- even if there had been a voluntary act, that he had not at the time of the stabbing been capable of forming the intention of killing the deceased.

The court made important observations pertaining to amnesia. The Court per Marnewick AJ stated that a decisive feature of cases where the accused had been held not to have acted voluntarily, was that the accused in those matters had truly retained no memory of the events concerned.¹⁰²⁰ This was crucial, as true absence of memory was a strong indication that an accused had acted involuntarily. Marnewick AJ explained¹⁰²¹ that retrograde loss of memory is a device employed by the psyche to suppress unpleasant memories and an individual can only have a memory of an incident or event if he had a sufficient intellectual capacity at the time of the incident or even have exercised a measure of control over his or her conduct.

Expert evidence by Dr LG Pillay, a psychologist, was advanced in support of the appellant's defences. He testified¹⁰²² that the appellant had probably suffered an "acute catathymic crisis":

"Okay, what I'm suggesting is Mr Pederson does have the experience, encoded in his memory. What I'm contending is his ability to recall being affected by the nature of the trauma itself."

Later in his evidence Dr Pillay stated that he disagrees that Mr Pederson suffered from true amnesia. Dr Pillay opined that the memory was still present but that Mr Pederson was not able to recall it. Dr Pillay diagnosed the appellant's condition as post-traumatic amnesia due to the fact that the appellant's mind was unable to accept or integrate the experience, thus suppressing it. He stated that this was used as a defence mechanism to protect the individual from total disintegration.¹⁰²³

¹⁰²⁰ At 390 G.

¹⁰²¹ At 390 G-H.

¹⁰²² At 397 A-B.

¹⁰²³ At 396 I-J.

In evaluating¹⁰²⁴ the appellant's amnesia Marnewick AJ explained that for the defence of sane amnesia to succeed, the absence of control by the mind over the actions of the appellant must have been present and that mere loss of memory is not and it has never been a defence to a charge of murder and such loss of memory should form part of a wider concept to be relevant at all. Retrograde amnesia, on the other hand, falls in a category of its own as it is premised on the very basis that the accused had some memory of the relevant events, but has since lost such memory.¹⁰²⁵ According to Marnewick J the statements of Dr Pillay destroyed the defence based on the absence of a voluntary or conscious act. For the events to be in the appellant's memory it would have been necessary for his cognitive functions to remain operative to a sufficient extent to record as memory the events which are witnessed and perceived by his senses and if the cognitive functions of his mind were intact to that extent, there is sufficient control of his mind over his actions to constitute his acts as voluntary acts in terms of the criminal law.

Dr B Gilmer, a clinical psychologist called by the State in rebuttal, was of the opinion that Dr Pillay's opinion was dependent on the veracity of the appellant's own evidence. He explained¹⁰²⁶ that a catathymic episode requires a "splitting off of emotion, thought and action."

According to Dr Gilmer this did not occur with the appellant as there was a coherency between the appellant's emotions, thoughts and actions which ruled out the existence of a catathymic episode or emotional storm.

It was accordingly held on the facts, including the evidence of Dr Pillay's evidence as to the nature of the appellant's alleged amnesia, that the appellant's conduct before and after the stabbing of the deceased, as well as the poor impression that the appellant made as a witness, that the magistrate had rightly found that the

¹⁰²⁴ At 396 G-H.

¹⁰²⁵ *Ibid.*

¹⁰²⁶ At 397.

appellant had acted voluntarily when he stabbed the deceased.¹⁰²⁷ The appeal against conviction was dismissed.

In *S v Van der Sandt*¹⁰²⁸ Labuschagne J held that the accused suffered from post-traumatic amnesia created as a defence mechanism as a result of the gruesome and traumatic nature of the crime. Such amnesia, it was held,¹⁰²⁹ does not exclude criminal liability.

In *S v Majola*¹⁰³⁰ the appellant had been convicted of murder in a regional court and sentenced to 15 years' imprisonment in terms of the provisions of section 51(2) of the Criminal Law Amendment Act 105 of 1997. The evidence revealed that he had stabbed his lover, who was eight months pregnant, with a penknife in her throat. The appellant's only defence was that he was unable to recall what had happened and that he thus did not remember stabbing the deceased. Penzhorn AJ rejected¹⁰³¹ this as a self-serving piece of evidence which was contradicted by the evidence of the State witnesses to the effect that the appellant simply came in and embarked on his aggressive path. Penzhorn AJ in addition held that even if the appellant really did not remember, it did not assist him in the light of the evidence, which was before the court. It was held¹⁰³² that no factual foundation was established for a defence of criminal incapacity, sane or insane automatism, but simply that the appellant could not remember what had happened. It was accordingly held that apart from a bare claim of amnesia there was simply nothing before the court indicative of unconscious or involuntary behaviour. The appeals against conviction and sentence were dismissed.

What becomes abundantly clear from case law where amnesia was either raised as a sole defence or in support of a defence is that it is and should be carefully scrutinized by courts.

¹⁰²⁷ At 395 G-H as well as 399 G-J.

¹⁰²⁸ *S v Van der Sandt* 1998 (2) SACR 627 (W) – the facts of this decision have already been discussed earlier in this chapter.

¹⁰²⁹ At 638 i-j. See also *Du Toit et al* (2007) *supra* note 1 at 13-16 – 13-17; *S v Calitz supra* note 1 at 120 d-e; *S v Els* 1993 (1) SACR 723 (E) at 730 d-e; Reddi (1999) *supra* note 1014 at 88.

¹⁰³⁰ *S v Majola* 2001 (1) SACR 337 (NPD).

¹⁰³¹ At 340 E-F.

¹⁰³² At 341 A.

It is also clear that amnesia is most often raised in support of a claim of involuntary conduct or put differently, a defence of automatism.¹⁰³³

Morse correctly states¹⁰³⁴ that behavioural conditions such as amnesia do not require special legal treatment, but should instead be regarded as evidentiary factors which should be assessed when adjudicating more general legal doctrines.

It is important that courts approach the defence of amnesia with scrutiny and circumspection even where medical evidence is advanced in support of such claim, since medical evidence is often based upon the assumption that the accused has provided a truthful account of the relevant facts in question.¹⁰³⁵

Amnesia does not constitute a valid defence and will not affect criminal liability unless it is connected to either automatism or criminal incapacity.¹⁰³⁶ It is clear that, when a person acts in a state of automatism, there is usually true amnesia, but the opposite is not always true.¹⁰³⁷ Where the defence is one of lack of criminal capacity, the presence of amnesia will also not be the decisive factor.

In *S v Chretien Rumpff* CJ stated:¹⁰³⁸

“Een van die probleme in verband met dade gepleeg in dronkenskap is natuurlik dat die beskonkene wel weet wat hy doen terwyl hy dit doen, maar dikwels later vergeet het wat hy gedoen het. Die blote feit dat hy vergeet het wat hy gedoen het, maak hom nie ontoerekeningsvatbaar nie.”

In assessing whether an accused's conduct was involuntary, it is clear that courts distinguish clearly between “true absence of memory” and “retrograde loss of memory after the event.”¹⁰³⁹

¹⁰³³ Hoctor (2000) *supra* note 963 at 282. See also generally *S v Henry supra* note 1, as discussed above.

¹⁰³⁴ Morse (1986) *Behavioural Science and the Law supra* note 963 at 99.

¹⁰³⁵ Hoctor (2000) *supra* note 963 at 279; *S v Moses supra* note 1 at 713 A-C; *S v Gesualdo supra* note 1 at 74 G-H.

¹⁰³⁶ Hoctor (2000) *supra* note 963 at 280; *S v Piccione* 1967 (2) SA 334 (N) at 335 C-D.

¹⁰³⁷ Hoctor (2000) *supra* note 963 at 280; *S v Potgieter supra* note 1 at 83 A-B.

¹⁰³⁸ *S v Chretien* 1981 (1) SA 1097 (A) at 1108 C-D.

¹⁰³⁹ Hoctor (2000) *supra* note 963 at 284.

In *S v Gesualdo* the court took into account the fact that the accused had amnesia in supporting the finding that the accused lacked conative capacity at the time of the commission of the crime.¹⁰⁴⁰ Evidence of amnesia could also be advanced in support of a finding of diminished criminal capacity.¹⁰⁴¹

16.3 Malingering or “simulated amnesia”

One of the main considerations underlying the reluctance of courts to accept claims of amnesia is the fact that many accused persons claiming amnesia are doing so deceptively. This problem is further exacerbated by the fact that there are no reliable procedures to distinguish true amnesia from simulated or feigned amnesia.¹⁰⁴²

Van Rensburg and Verschoor state¹⁰⁴³ that it is difficult to distinguish simulated amnesia from psychogenic amnesia. In cases of psychogenic amnesia a person simulates amnesia but he or she does generally not realise the reason for it except for gaining sympathy.¹⁰⁴⁴ In cases of simulated amnesia a person simulates amnesia in order to escape serious problems encountered at that point in time.¹⁰⁴⁵ Research suggests, however, that simulators or malingerers tend to overplay their role and perform less successful on memory tests than true amnesics.¹⁰⁴⁶

Rubinsky and Brandt note that statements concerning malingered amnesia within the legal literature which are at odds with neuropsychological knowledge tend to impair the courts’ ability to effectively assess claims of amnesia.¹⁰⁴⁷

Kaliski correctly states¹⁰⁴⁸ that amnesia should only be regarded as a supportive indicator that, for example, an automatism occurred, and not as an excuse in itself.

¹⁰⁴⁰ *S v Gesualdo* 1997 (2) SACR 68 (W).

¹⁰⁴¹ Hoctor (2000) *supra* note 963 at 285.

¹⁰⁴² Rubinsky and Brandt (1986) *supra* note 963 at 42.

¹⁰⁴³ Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 49.

¹⁰⁴⁴ *Ibid.*

¹⁰⁴⁵ *Ibid.*

¹⁰⁴⁶ Rubinsky and Brandt (1986) *supra* note 963 at 43.

¹⁰⁴⁷ *Ibid.*

¹⁰⁴⁸ Kaliski (2006) *supra* note 1 at 106.

Peter also cautions¹⁰⁴⁹ that within the psycholegal context, malingering should always be borne in mind, especially when the amnesia conveniently shuts out important events. An accused person will typically have a detailed and specific recall for events up to and soon after the crime, with a period of so-called amnesia.¹⁰⁵⁰ In such cases the nature and quality of the accused's actions should be carefully assessed.

16.4 Assessment of amnesia

During the assessment of amnesia it is pivotal to evaluate the accused's conduct before, during and after the commission of the crime in order to ascertain whether he or she was aware of what he or she was doing.¹⁰⁵¹

Kaliski provides the following guidelines for the assessment of amnesia:¹⁰⁵²

- Amnesia is a symptom that may be indicative of a disorder, but is not a diagnosis and accordingly amnesia cannot be raised as a defence.
- There should exist an identifiable cause or reason for the amnesia, such as a blow to the head or intoxication.
- The pattern of the amnesia should be assessed with as much detail as possible. Anterograde amnesia should be more serious than retrograde amnesia. Kaliski also notes that persons claiming severe amnesia for events that took place relatively long ago but with a relatively intact short-term memory are usually malingering.
- Memory for the triggering event may vary – where the alleged reason for the amnesia was a head injury, the person will lack memory for the moment of injury due to the fact that it will be submerged in the retrograde as well as the anterograde (post-traumatic amnesia). When the alleged cause is emotional events the triggering event is usually recalled.

¹⁰⁴⁹ Peter in Kaliski (ed)(2006) *supra* note1 at 136.

¹⁰⁵⁰ *Ibid.*

¹⁰⁵¹ Van Rensburg and Verschoor (1989) *TRW supra* note 963 at 54; Ellis (1986) *De Jure supra* note 963 at 349; Hoctor (2000) *supra* note 963 at 286.

¹⁰⁵² Kaliski (2006) *supra* note 1 at 109.

- Intoxication, especially when an alcohol “blackout” is present, generally results in either an *en bloc* memory loss which entails lack of memory of events for the period of intoxication or *fragmentary amnesia* which entails some “islets of recall” in a general sea of amnesia.
- An accused may have a valid reason for having amnesia, but nevertheless be criminally accountable for his actions during the commission of the alleged crime.

The role of mental health professionals in the assessment of claims of amnesia is pivotal. It is, however, true that the interface of law and medicine during the assessment of amnesia is also often blurred and conflated.

Rubinsky and Brandt note¹⁰⁵³ that there are “glaring gaps between psychological knowledge about amnesia, especially of the psychogenic variety, and knowledge needed by courts in determining the effect of alleged memory disorders on legal responsibility.” There are also marked gaps between psychological knowledge about amnesia and judicial application of such knowledge and principles.¹⁰⁵⁴ Most instances of psychogenic amnesia tend to be more the result of the crime and not the cause thereof.

Claims of amnesia in support of defences such as automatism or criminal incapacity should be assessed by courts with caution and scrutiny.

The distinct cooperation between law and medicine in respect of the assessment of amnesia is summarised by Rubinsky and Brandt as follows:¹⁰⁵⁵

“Psychologists who testify as experts should expend greater energy in efforts to clearly and completely present relevant and timely scientific knowledge. Emphasis should be placed on elucidating both what is currently known and what is not currently known about amnesia. In return, legal professionals

¹⁰⁵³ Rubinsky and Brandt (1986) *supra* note 963 at 43.

¹⁰⁵⁴ *Ibid.*

¹⁰⁵⁵ Rubinsky and Brandt (1986) *supra* note 963 at 43.

should attempt to understand and to apply correctly neuropsychological research findings to amnesia cases.”

With sufficient cooperation between law and behavioural sciences in claims of amnesia, there will be less interdisciplinary confusion.

17 Diminished criminal capacity

Diminished criminal capacity is currently not a partial defence in South Africa, but merely serves in support of mitigation of sentence.¹⁰⁵⁶ The concept of diminished criminal capacity has already been addressed in chapter 1.

Section 78(7) of the Criminal Procedure Act provides for diminished criminal capacity in cases where pathological criminal incapacity is raised.¹⁰⁵⁷ The question to be asked is whether the time has not arrived for legislative reform providing for statutory non-pathological diminished criminal incapacity as well? Despite the absence of statutory reference, various decisions have recognised diminished criminal capacity in cases of non-pathological criminal incapacity.¹⁰⁵⁸

The most recent decision pertaining to non-pathological diminished criminal capacity, is the case of *Director of Public Prosecutions v Venter*.¹⁰⁵⁹ The facts of the decision are as follows: The Director of Public Prosecutions appealed against sentence in terms of section 316B of the Criminal Procedure Act. The respondent was convicted in the court *a quo* on one count of attempted murder and two counts of murder. He was sentenced to eight years’ imprisonment for the attempted murder. On one count of murder he was sentenced to ten years’ imprisonment and on the other count to fifteen years’ imprisonment of which five years were suspended. The complainant in the attempted murder count was the

¹⁰⁵⁶ Burchell and Milton (2005) *supra* note 1 at 400 – 401. Burchell and Milton interestingly indicate that in England and Scotland diminished responsibility operates in dual nature of both a plea in mitigation as well as being a partial defence. See also Snyman (2008) *supra* note 1 at 176, Strauss (1991) *supra* note 1 at 133.

¹⁰⁵⁷ See chapter 1 for a discussion of this section.

¹⁰⁵⁸ See generally *S v Campher supra* note 1 at 964C-E; *S v Di Blasi supra* note 1; *S v Ingram* 1995 (1) SACR (1) (A) at 8d-i; *S v Laubscher* 1988 *supra* note 1 at 173F-G; *S v Shapiro* 1994 (1) SACR 112 (A) at 123c-f; *S v Smith* 1990 (1) SACR 130 (A) at 135b-e.

¹⁰⁵⁹ *Director of Public Prosecutions v Venter* 2009 (1) SACR 165 (SCA).

respondent's wife, Millie, and the deceased in the murder counts were Millize, the respondent's five-year old daughter and Janco, his four-year old son. The incident took place on 26 April 2006 in the family home in Hoedspruit, Limpopo.

On the day of the incident, the respondent had attended a function with members of his unit at O'Hagans where he consumed three beers. He later accompanied his wife to another function where he drank another three beers. On their arrival at home that evening the respondent confronted his wife about his discomfort at her having danced with her boss, at the abovementioned function. An argument arose between them where the respondent's wife told him that, should he be convicted on certain charges he was facing regarding the rape and murder of a fourteen-year old girl in Burundi, she would divorce him and take their children with her. The argument escalated to the point where the children became unsettled. She (the complainant) asked for the car keys telling him that she wanted to leave so that he could calm down, but he refused to give it to her. The complainant and the two children ran out the back entrance with the respondent following them into the street. Janco was at that stage holding on to the complainant, crying. The respondent then took Janco back to the house. The complainant and Millize followed. The respondent returned shortly thereafter, after smoking a cigarette, and said "My bolla, dankie vir alles wat julle vir my beteken het." The next moment the complainant heard Janco scream and a shot went off. She and Millize ran into the house and saw the respondent carrying a R4 rifle. She tried to wrestle the rifle from him but he pulled the trigger, hitting her in the stomach. When Millize ran away he also shot her.

In mitigation of sentence the respondent testified as to his unhappy childhood. He was also arrested on charges of rape and murder involving a fourteen-year old girl in Burundi. As a result of the Burundi episode he had to attend sessions with a clinical psychologist. He also displayed suicidal tendencies. He testified that he was very emotional on the day of the incident and that seeing his wife dance with the colonel upset him tremendously.¹⁰⁶⁰ The respondent claimed that he could not

¹⁰⁶⁰ Paragraphs 10 – 12.

remember what had happened and accordingly remembered waking up in hospital and being informed by the policeman guarding him that his children had died.¹⁰⁶¹

Mlambo JA held that temporary non-pathological diminished responsibility was recognised in law, and was especially relevant to sentence.¹⁰⁶² Properly understood, Mlambo JA held, this state of mind can be stated to be diminished capacity to appreciate the wrongfulness of one's actions and/or to act in accordance with an appreciation of that wrongfulness.¹⁰⁶³ It was further held¹⁰⁶⁴ that in a number of cases, whilst the state of mind was rejected as a defence, it was found that it had an overwhelming effect on the conduct of the accused to such an extent that very lenient sentences were imposed. In this case the respondent had started consuming alcohol as early as 11 am on the day of the incident. It was also established that he was diagnosed during clinical psychological assessments as displaying suicidal tendencies before the incident, while a psychiatric report compiled afterwards stated that he was experiencing ongoing stress from the Burundi incident as well as domestic problems.¹⁰⁶⁵

Mlambo JA held¹⁰⁶⁶ that it was quite possible that the respondent had become consumed by the threatened break up of his marriage and separation from his wife and children and losing some sense of objectivity. Mlambo JA further held that this should not be viewed in isolation as there was uncontested testimony from his wife that she had stood by him throughout his incarceration in Burundi and that she had constantly reassured him of her support up to the day of the incident. There was further undisputed evidence that he had sobered up by the time he had committed the offences and clearly the alcohol intake had played a minimal role, if any, in his conduct.¹⁰⁶⁷

¹⁰⁶¹ Paragraph 12.
¹⁰⁶² Paragraph 21.
¹⁰⁶³ Paragraph 21.
¹⁰⁶⁴ Paragraph 22.
¹⁰⁶⁵ Paragraph 25.
¹⁰⁶⁶ Paragraph 26.
¹⁰⁶⁷ Paragraph 27.

The following statement by Mlambo JA encapsulates the tragedy of this set of facts:¹⁰⁶⁸

“*In casu* we have a father who shot and killed his 4-5 year old son and daughter, respectively. He perpetrated these dastardly deeds within the confines of their home where they should be at their safest. The respondent abdicated his role as protector and provider to his wife and children and became a predator and turned their safe sanctuary into a killing field. It chills one’s blood when one learns how the tearful Janco had clung to his mother in the street before the respondent picked him up and returned to the house with him and that the little boy had followed the respondent into one of the bedrooms not knowing he was walking to his death. ... In my view the court *a quo* underplayed the seriousness of the offences viewed within the context of the respondent as a husband and father.”

Mlambo JA held¹⁰⁶⁹ that society views the respondent’s conduct in a very serious light and that within the context of this case the injunction to protect children from violent crimes assumes a prominent role. Mlambo JA held that this called for a sentence cognisant of the respondent’s personal circumstances and also the seriousness of the offences and the need for deterrence.¹⁰⁷⁰ The appeal was successful and the sentences on the charges of murder were replaced with a sentence of 18 years’ imprisonment.

Cloete JA, however, dissented and held that the respondent was acting with substantial diminished responsibility when he committed the offences. Cloete JA stated:¹⁰⁷¹

“If I had any doubt, I would propose that the sentences be set aside and the matter be remitted to the court *a quo* for expert evidence to be led on the issue, for to do otherwise could result in the imposition of a sentence not in accordance with justice.”

¹⁰⁶⁸ Paragraph 29.

¹⁰⁶⁹ Paragraph 30.

¹⁰⁷⁰ Paragraph 31.

¹⁰⁷¹ Paragraph 45.

This statement could also act in favour of the general argument that expert evidence is crucial in these cases.

Cloete JA in addition held that¹⁰⁷² it is pivotal to distinguish between temporary non-pathological criminal incapacity, which is a defence because it excludes culpability, and diminished responsibility, which is not a defence but is relevant for sentencing as it reduces culpability.

Cloete JA further remarked¹⁰⁷³ that the fact that the defence of temporary non-pathological criminal incapacity fails, or is not raised, does not necessarily entail that the accused must be sentenced if he/she was acting normally. A person who acted with diminished responsibility is guilty, but his/her conduct is morally less reprehensible due to the fact that the criminal act was performed when the accused was not fully in control and therefore acting with impaired judgment.

Cloete JA held in a dissenting judgment that the sentences imposed by the trial court were not shockingly inappropriate and that the appeal should be dismissed.

This decision serves the important role of reaffirming both the defence of non-pathological criminal incapacity as well as the principles relating to diminished non-pathological criminal capacity, despite the horrific nature of the facts.

In *S v Di Blasi*¹⁰⁷⁴ also increased the sentence of the accused on appeal as in the *Venter*-decision. The facts of this case were that the accused felt aggrieved and revengeful after his wife had instituted divorce proceedings against him in the United Kingdom. He felt aggrieved and insulted and decided to kill her. In a state of depression and anger he pursued her to South Africa from the United Kingdom. The accused watched and followed his wife and when the opportunity presented itself, he shot her in the street in front of her flat. He fired three shots, two of which killed her. After a failed suicide attempt he was arrested and brought to trial. The

¹⁰⁷² Paragraph 47.

¹⁰⁷³ Paragraph 51.

¹⁰⁷⁴ *S v Di Blasi* 1996 (1) SACR 1(A)

court *a quo* sentenced the accused to four years' imprisonment on the murder charge. The Attorney-General appealed against this sentence. It was common cause at his trial that he had had the necessary criminal capacity to be held responsible for the killing of the deceased, but it was argued in mitigation of sentence that he acted with diminished criminal capacity due to non-pathological causes. Two experts, Dr Venter and Dr Zabow, testified that he suffered from a temporary non-pathological emotional disintegration at the relevant time.¹⁰⁷⁵

Vivier JA accordingly indicated the essential steps to be followed in cases of non-pathological in criminal incapacity as well as diminished non-pathological criminal capacity. They are the following:

- Diminished criminal capacity is the diminished capacity to appreciate the wrongfulness of the particular act in question or to act in accordance with the appreciation of the wrongfulness.¹⁰⁷⁶
- The accused is required to lay a factual foundation for his defence that non-pathological causes had diminished his criminal capacity.¹⁰⁷⁷
- In making a finding about capacity the court must have regard not only to the expert evidence but to all the facts of the case, including the nature of the accused's actions during the relevant period.¹⁰⁷⁸
- The court must subject the evidence of the accused person in support of a defence of non-pathological incapacity to careful scrutiny.¹⁰⁷⁹

The court per Vivier JA held that the murder was premeditated, cold and calculated.¹⁰⁸⁰

It was held that he did not act with diminished criminal capacity and his conduct was indicative of a clear moral blameworthiness and it was in the best interest of society to increase his sentence to fifteen years' imprisonment.¹⁰⁸¹

¹⁰⁷⁵ At 6 E – 7 A.

¹⁰⁷⁶ At 7 B.

¹⁰⁷⁷ At 7 C.

¹⁰⁷⁸ At 7 C.

¹⁰⁷⁹ At 7 F.

¹⁰⁸⁰ At 8 D-E.

¹⁰⁸¹ At 11 D.

These two decisions illustrate that the circumstances of each case will dictate whether a court will make a finding of diminished non-pathological criminal capacity. These decisions discussed above need to be contrasted with decisions in which the courts have been willing to render a finding of diminished capacity.

In *S v Mnisi*,¹⁰⁸² the appellant was convicted upon a plea of guilty on a count of murder and sentenced to eight years' imprisonment. The facts of the case were that the appellant shot and killed the deceased, Joshua Hlatswayo, on 11 August 2001.

Prior to the incident the appellant's wife and the deceased were involved in an adulterous relationship. The appellant resented this and found her actions to be extremely humiliating and degrading. His wife, after he confronted her about this adulterous relationship, promised that she would no longer see the deceased but she did not keep her promise. On the day of the incident the appellant found his wife and the deceased embracing each other in a car. The appellant immediately drew his firearm and shot the deceased. The appellant stated that when he found his wife in the embrace of the deceased all the hurt and pain he had suffered through the adulterous affair flooded his mind and provoked him to the extent that he momentarily lost control of his "inhibitions" and he shot the deceased.¹⁰⁸³

The argument of the appellant was that the trial court had not given due consideration to the fact that the appellant acted with diminished criminal capacity as a result of provocation and emotional stress which preceded the shooting and accordingly that the shooting occurred when the appellant's powers of restraint and self-control were diminished.

¹⁰⁸² *S v Mnisi* 2009 (2) SACR 227 (SCA). See also Carstens, PA "Criminal liability and sentencing for murder committed with diminished criminal capacity due to provocation – *S v Mnisi* 2009 (2) SACR 227 (SCA)" (2010) *De Jure* 388-394.

¹⁰⁸³ Paragraph 2.

Boruchowitz AJA held¹⁰⁸⁴ that the appellant did not rely on the defence of non-pathological criminal incapacity but rather upon diminished capacity which is not a defence but relevant to the question of sentence.

Boruchowitz AJA further held that whether an accused acted with diminished capacity must be determined in the light of all the evidence, expert or otherwise.¹⁰⁸⁵ The accused is accordingly required to lay a factual foundation which gives rise to the reasonable possibility that the accused acted with diminished capacity. Such evidence should also be carefully scrutinised in the light of all the circumstances. Boruchowitz AJA indicated¹⁰⁸⁶ that the statement by the appellant established a sufficient factual foundation that he acted with diminished capacity when he committed the offence. It was further held that the trial court placed undue emphasis on the element of deterrence as an object of punishment. The appeal was accordingly upheld and the sentence was replaced with a sentence of five years' imprisonment.

Carstens correctly notes that it is regrettable that the accused in the *Mnisi*-decision decided to invoke a plea of guilty and not to rely on the defence of non-pathological criminal incapacity or non-pathological automatism, as it could have resulted in a reassessment of the much debated and controversial *Eadie*-decision.¹⁰⁸⁷ Carstens in addition notes, and this view is supported, that expert evidence is not only pivotal in support of the defences of non-pathological criminal incapacity and sane automatism due to provocation, but should also be advanced in respect of of an accused relying on diminished criminal capacity due to provocation as such diminished criminal capacity is a question of degree which should also be assessed by experts.¹⁰⁸⁸ Carstens submits that when an accused pleads guilty to a charge of murder and relies on diminished criminal capacity, the court should consider noting a plea of not guilty and order the State to prove the charge against the accused beyond reasonable doubt. The latter procedure will inadvertently result in the prosecution and defence to adduce expert evidence in

¹⁰⁸⁴ Paragraph 4.

¹⁰⁸⁵ Paragraph 5.

¹⁰⁸⁶ Paragraph 6.

¹⁰⁸⁷ Carstens (2010) *De Jure supra* note 1082 at 394.

¹⁰⁸⁸ *Ibid.*

respect of the accused's criminal capacity at the time of the commission of the offence and will empower the court to assess whether such criminal capacity was diminished as well as the degree of such impairment.¹⁰⁸⁹

Another decision where the court took diminished criminal capacity into account is *S v Smith*.¹⁰⁹⁰ In this case the appellant, a twenty-year old woman, shot the deceased with whom she had been romantically involved in an emotional relationship for almost a year. During the course of the relationship the deceased had left his wife on a number of occasions for the appellant telling her that he loved her but had on each occasion become reconciled with his wife. On the day of the incident the appellant was informed by the deceased's wife that she and the deceased had become reconciled. The deceased's conduct caused the appellant severe emotional stress. At her trial on a charge of murder the appellant pleaded that the shots had been fired when she was under extreme emotional stress and that she lacked criminal capacity. This defence, however, failed and the appellant was convicted of murder with extenuating circumstances. In an appeal against the conviction and sentence, the court per Kumleben JA held the following:¹⁰⁹¹

“... it is nevertheless clear that her shooting of the deceased was the final result of a prolonged period of sustained and mounting mental strain, of which the deceased was the cause. Whether it was the result of anger, frustration or humiliation, or more than one of these emotions, is immaterial. What is plain is that they must have substantially reduced her power of restraint and self-control. This fact, though highly relevant to the question of sentence, cannot affect her criminal liability. The conviction of murder was, in my view, fully justified.”

Taking into account that the appellant was a first offender who had never, apart from the day of the incident, acted violently, the court held that there was no need for a sentence which would serve as a personal deterrent.¹⁰⁹² The sentence of six

¹⁰⁸⁹ *Ibid.*

¹⁰⁹⁰ *S v Smith* 1990 (1) SACR 130 (A).

¹⁰⁹¹ At 135 F – G.

¹⁰⁹² At 136 B.

years was replaced with a sentence of three years' imprisonment and the appeal was accordingly upheld in part.

The case law discussed above illustrates that the circumstances of each case will dictate whether a finding of diminished criminal capacity will be justified or not. The two recent decisions of the Supreme Court of Appeal in *Mnisi and Venter* illustrate that the defence of non-pathological criminal incapacity still firmly exists in our current criminal law. These two decisions further confirm the important alternative to a defence of non-pathological criminal incapacity – diminished non-pathological criminal capacity which, as was illustrated, was successful in numerous decisions in imposing a lesser sentence taking into account that the accused's capacity to appreciate the wrongfulness of his or her actions and/or to act in accordance with such appreciation was significantly diminished at the time of the commission of the act in question.¹⁰⁹³ Diminished criminal capacity could also serve an important role in cases where abused women kill their abusive partners in non-confrontational situations as was illustrated in the discussion above pertaining to the *Ferreira*-decision. The *Di Blasi*-decision illustrated that the procedural aspects pertaining to reliance sought on diminished criminal capacity are substantially in accordance with the defence of non-pathological criminal

¹⁰⁹³ See also *S v Larsen* 1994 (2) SACR 149 (A) where the appellant shot her husband to whom she had been married for 20 years. The evidence revealed that the deceased assaulted and abused the appellant on various occasions. The appellant was sentenced to five years' imprisonment. On appeal the court per Nicholas AJA held that since the appellant had been sentenced, correctional supervision had become available as a sentencing option and that the appellant might not fall into the category of persons who ought to be removed from society by a sentence of imprisonment. The court accordingly ordered that the matter be remitted to the trial court for sentencing afresh after compliance with the provisions of section 276 A (1) (a) of the Criminal Procedure Act 51 of 1977. See also *S v Shapiro* 1994 (1) SACR 112 (A) where the Attorney-General of Witwatersrand in terms of section 316 B of the Criminal Procedure Act appealed against a sentence of seven years' imprisonment, of which four years were conditionally suspended. The respondent (accused) had shot the deceased who was a drug addict and a drug dealer in cold blood in the foyer. The trial court rejected the respondent's reliance on the defence of non-pathological criminal incapacity but accepted that the respondent suffered from a non-pathological reduced criminal responsibility. Dr Eriksson, a psychiatrist, stated the following in respect of the respondent: (at 120 I – J) "It is my opinion that at the time of the alleged incident the accused experienced a decreased ability to appreciate the moral, ethical, social and legal consequences of his act. His ability to appreciate the wrongfulness of his act was therefore, in my opinion, diminished." Nicholas AJS held that although the crime with which the respondent was charged is viewed with abhorrence, right-thinking members of the community would not condign punishment in a case where the accused had acted with substantially reduced criminal responsibility. It was accordingly held that the sentence was not inappropriately lenient and the appeal was dismissed. See also *S v Ingram* 1995 (1) SACR 1 (A) where Smalberger JA considered correctional supervision an appropriate sentence. See also generally *S v Meyer* 1981 (3) SA (A).

incapacity. The crucial aspect in the latter regard relates to the foundation that has to be established. It is submitted that such foundation will inadvertently have to be substantiated with a proper body of expert evidence. The *Ferreira*-decision illustrated the essential value of expert evidence in establishing substantial and compelling circumstances to deviate from mandatory sentences in cases of premeditated murder. The same applies to cases of diminished criminal capacity. Only with proper expert evidence will a court be able to evaluate allegations that an accused's capacity to appreciate the wrongfulness of his or her actions or to act in accordance with such appreciation were substantially diminished to the extent that a lesser sentence is justified. The expert evidence of the accused or appellant in the case where the accused lodges an appeal against sentence, should also preferably be challenged by the State in order to ensure a just and fair trial.

18 Conclusion

In this chapter the author illustrated the role of expert evidence in cases where the defence of non-pathological criminal incapacity is raised as a defence. The merit and value of the defence of non-pathological criminal incapacity was also assessed. The author further evaluated controversies surrounding the presentation of Battered Woman Syndrome testimony also with specific reference to abused women who kill their abusive husbands or partners. The following conclusions can be drawn from the research presented in this chapter:

- The defence of non-pathological criminal incapacity in its current status is in need of reform.
- In order to create legal certainty, legislative reform is needed to firmly establish this defence in our criminal justice system.
- Due to the fact that the defence of non-pathological criminal incapacity is founded mainly on common law principles, development could be

constructed in terms of section 39(2) of the Constitution by means of the indirect application of the Bill of Rights.

- The probative value attached to and the application of expert evidence in cases of non-pathological criminal incapacity has not been consistent. The inherent inconsistency could be traced to the fact that expert evidence is not a prerequisite in order to rely on this defence.
- Expert evidence and referrals in terms of section 78(2) of the Criminal Procedure Act 51 of 1977 should be compulsory whenever criminal incapacity is relied on, regardless of the alleged cause of incapacity, provided a sufficient foundation is established for reliance on the defence of criminal incapacity.
- The onus of proof in cases of non-pathological criminal incapacity should fall on the accused.
- Recent Supreme Court of Appeal decisions confirm the existence of the defence of non-pathological criminal incapacity.
- The author illustrated the fundamental distinction between non-pathological criminal incapacity and sane automatism despite some evidentiary similarities between these two defences.
- The current common law rule entailing that expert evidence in cases of non-pathological criminal incapacity does not fulfil an indispensable function is inconsistent with the constitutional right of an accused in terms of section 35(3)(i) to adduce and challenge evidence. In this sense the common law should be developed in order to promote the spirit, purport and objects of the Bill of Rights as stated in section 39(2) of the Constitution. The procedure and rules relating to such development was discussed comprehensively in paragraph 3.3 *supra*.
- Upon a careful analysis of the role of expert evidence in case law pertaining to the defence of non-pathological criminal incapacity as well as analysis of the cases pertaining to abused women who killed their abusive partners, it could be argued that the defence of non-pathological criminal incapacity is founded more in the field of psychology than psychiatry.
- Due to the fact that the defence of criminal incapacity, whether non-pathological or pathological, lies inherently within the psyche of the accused,

the assessment of this defence cannot properly be conducted in the absence of expert evidence.

- Diminished non-pathological criminal capacity should be incorporated and provided for within the framework of section 78(7) of the Criminal Procedure Act.

In the following chapter the defence of pathological criminal incapacity and the role of expert evidence in support of such defence will be discussed.

“The general aim of law is to serve human justice rather than, solely, to achieve a logically perfect application of abstract rules.” (The Honorable Albert Tate, 1980)

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 Psigiatry" (1983) *TRW* at 121 – 131; Van Rensburg, PHJ, Verschoor, T and Snyman, JL "Psigiatry 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 Strafbreg” (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*, *furie* 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 verantwoordelikebesef 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 obsessional 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 deduct 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 Amnesic 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 multiaxial 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 multiaxial 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 multiaxial 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 multiaxial 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 Loubscher*.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 Loubscher* 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, Yechezkiel, 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 psigiatriese getuienis kom, is van ‘n inkennige, humentlike 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 eiewaas 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 heeltomal 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 dinging 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 versagterende 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 versagterende omstandigheid sal geld, en nie die taak van mediese deskundiges nie. Natuurlik sal die verhoorregter die menings van psigiateres 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
Scoptophilia	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 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 staatspatiënte (1994) SACJ 358-363; Henning, PH "Beleid ten Op sigte 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)

CHAPTER 4

THE ROLE OF FORENSIC EXPERT EVIDENCE IN ESTABLISHING CRIMINAL INCAPACITY

Melrose said: “But of course, perjury seldom plays a role in the testimony of so-called expert witnesses. It is only too easy for both defense and prosecution to find honest authorities who oppose each other diametrically in regard to the same phenomenon, even in such a supposedly exact science as ballistics, and when the human element enters, consistency goes right out the window. Dr Brixton, for example, believes that a man who has tried to get himself mutilated can be held responsible for no subsequent act however criminal. I wager that the prosecution psychiatrist will find the same fact utterly negligible.” (Thomas Berger)¹

1 Introduction

Mental health professions are increasingly being utilised by the criminal justice system to provide assistance in the assessment of issues beyond the knowledge or experience of the courts. One of the most important domains where the expertise of qualified psychiatrists and psychologists is becoming essential denotes the assessment and application of the defence of criminal incapacity. These mental health professionals will accordingly be requested by courts to assess individuals allegedly having lacked criminal capacity at the time of the commission of the offence and to consequently provide an opinion as to the mental state of the individual at the time of the offence. It is trite that the evidence presented by psychiatrists and psychologists within the paradigm of criminal capacity takes the form of expert opinion evidence.²

¹ Meyer, RG, Landis, ER and Hays, JR “Law for the Psychotherapist” (1988) at 220.

² Zeffert, DT and Paizes, AP “The South African Law of Evidence” 2nd ed (2009) at 309-329; Schwikkard, PJ and Van der Merwe, SE “Principles of Evidence” 3rd ed (2009) at 83-103; Meintjes-Van der Walt, CM “Expert evidence in the criminal justice process” (2001) at 63-84; Allan, A “The psychologist as expert witness” in Tredoux, C, Foster, D, Allan, A, Cohen, A and Wassenaar, D (eds) “Psychology and Law” (2005) at 287-314 (hereafter Tredoux *et al*); Allan, A and Meintjes-Van der Walt, L “Expert evidence” in Kaliski, S (ed) “Psycho-legal Assessment in South Africa” (2006) at 342-355; Schmidt, CWH “Bewysreg” (1998) at 429-442; Hoffman, LH and Zeffert, DT “The South African Law of Evidence” (1988) at 83-104; Dennis, I “The law of evidence” (2007) 846-878; Murphy, P “Murphy on evidence” (2008) at 361-384; Hoffman, LH “South African law of Evidence” (1963) at 175-186; De Villiers, DS “Evidence through the

Cases” (2007) 77-122; Tapper, C “Cross and Tapper on Evidence” (2007) at 565-586; Keane, A “The modern law of Evidence” (2006) at 552-584; Delisle, R and Stuart, D “Evidence – Principles and Problems” (2001) at 645-704; Bond, C, Solan, M, Harper, P and Davies, G “The expert witness – A practical guide” (2007) at 1-10 (hereafter Bond *et al*); Sales, BD and Shuman, DW “Science, experts and law, reflections on the past and the future” in Costanzo, M, Krauss, D and Pezdek, K (eds) “Expert psychological testimony for the courts” (2007) at 9-28; Freckelton, I and Selby, H “Expert evidence – law, practice, procedure and advocacy” (2005) at 11-20; Bronstein, DA “Law for the expert witness” (1999) at 63-85; Ziskin, J “Coping with psychiatric and psychological testimony” (1988) at 1-63; Paciocco, DM “The Law of Evidence” (2005) at 172-200; Schiffer, ME “Mental disorder and the criminal trial process” (1978) at 189-221; Halleck, SL “Law in the practice of psychiatry – a handbook for clinicians” (1980) at 195-206, 207-224; Shapiro, DL “Forensic psychological assessment – an integrative approach” (1991) at 162-183, 199-204; Guttmacher, MS “The role of psychiatry in law” (1968) at 74-92; Zuckerman, AAS “The principles of criminal evidence” (1989) at 59-71; Gutheil, TG and Appelbaum, PS “Clinical Handbook of Psychiatry and the Law” (2000) at 337-352; Redmayne, M “Expert evidence and criminal justice” (2001) at 94-127; Faurie, A “The Admissibility and Evaluation of Scientific Evidence in Court” (2000) at 1-37; Brodsky, SL “The Expert Expert Witness – more Maxims and Guidelines for Testifying in Court” (1999) at 5-10; Memon, A, Vrij, A and Bull, R “Psychology and Law – Truthfulness, Accuracy and Credibility” (2003) at 169-180; Hess, AK “Serving as an expert witness” in Hess, AK and Weiner, IB (eds) “The Handbook of Forensic Psychology” (1999) at 501-520; Moenssens, AA, Moses, RE and Inbau, FE “Scientific Evidence in Criminal Cases” (1973) at 2-27; Curran, WJ “Courtroom Presentation of Forensic Scientific Evidence” in Curran, WJ, McGarry, AL and Petty, CS (eds) “Modern Legal Medicine, Psychiatry and Forensic Science” (1980) at 1279-1286; Sales, BD and Shuman, DW “Experts in Court – Reconciling Law, Science and Professional Knowledge” (2005) at 3-12; Meintjes-Van der Walt, L “Many a slip ... The need for strengthening the chain of expert evidence” (2000) *CILSA* at 348-365; Meintjes-Van der Walt, L “The proof of the pudding: The presentation and proof of expert evidence in South Africa” (2003) *Journal of African Law* at 88-106; Casey, P “Expert testimony in Court – General Principles” (2003) *Advances in Psychiatric Treatment* at 177-182; Meintjes-Van der Walt, L “A few plain rules? A comparative perspective on exclusionary rules of expert evidence in South Africa” (2001) *THRHR* at 236-256; Meintjes-Van der Walt, L “Expert evidence and the right to a fair trial: a comparative perspective” (2001) at 301-319; Meintjes-Van der Walt, L “Expert Odyssey: Thoughts on the Presentation and Evaluation of Scientific Evidence” (2003) *SALJ* at 352-372; Meintjes-Van der Walt, L “The Presentation of Expert Evidence at Trials in South Africa, the Netherlands and England and Wales” (2001) *Stell LR* at 283-305; Meintjes-Van der Walt, L “Science Friction: The Nature of Expert Evidence in General and Scientific Evidence in Particular” (2000) *SALJ* at 771-790; Meintjes-Van der Walt, L “Decision-makers’ Dilemma: Evaluating Expert Evidence” (2000) *SACJ* at 319-343; Meintjes-Van der Walt, L “S v Huma (1) 1995 (2) SACR 407 (W) – Shooting at Science: expert evidence and equality of arms” (1996) *SACJ* at 361-367; Cook, CM and Missouri, C “The Role and rights of the Expert Witness” (1964) *Journal of Forensic Sciences* at 456-460; Gilmer, BT, Louw, DA and Verschoor, T “Forensic expertise: the psychological perspective” (1995) *SACJ* at 259-270; Verschoor, T, Calitz, FJW and Van Rensburg, PHJJ “Deskundige getuienis” (1994) *Geneeskunde* at 5-10; Carstens, PA “Setting the Boundaries for Expert Evidence in Support of the Defence of Medical Negligence – *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA)” (2002) *THRHR* at 430-436; Marwick, C “What Constitutes an Expert Witness?” (1995) *Journal of the American Medical Association* at 2057; Slovenko, R “Expert testimony: Use and Abuse” (1993) *Medicine and Law* at 627-641; Pipkin, W “Expert Opinion Testimony: Experts, Where did they come from and why are they here?” (1989) *Law and Psychology Review* at 103-118; Roberts, P “Science in the Criminal Process” (1994) *Oxford Journal of Legal Studies* at 469-506. See also Du Toit, E, De Jager, FJ, Paizes, A, Skeen, A STQ and Van der Merwe, S “Commentary on the Criminal Procedure Act” (2007) at 24-12-24-17 (hereafter Du Toit *et al*); Kriegler, J and Kruger, A “Hiemstra’s Criminal Procedure” (2009) at 24-12-24-27 (hereafter Hiemstra); Melton, GB, Petrila, J, Poythress, NG and Slobogin, C “Psychological Evaluations for the Courts” (2007) at 577-605; Schmidt, CWH and Rademeyer, H “Bewysreg” 4th ed (2000) at 456-471; Carstens, PA and Pearmain, D “Foundational Principles of South African Medical Law” (2007) at 860-862; Wolmarans, A “Die Sielkundige as Deskundige getuie in Strafsake”

Expert evidence is one of the exceptions to the general rule that evidence of opinion is inadmissible.³ The general rule is that opinion evidence is inadmissible due to the irrelevance thereof. The exception to the latter rule is when the issue is of such a nature that the opinion of the expert, in this case that of the psychiatrist or psychologist, can provide assistance to the court to adjudicate the matter.⁴ The opinion of an expert will accordingly be admissible to provide the court with scientific information which is likely to fall outside the experience and knowledge of the court.⁵ The converse is, however, also true. If the particular opinion evidence deals with a matter that the court can decide upon in the absence of such evidence, the opinion evidence will be deemed irrelevant and inadmissible. The main criterion for assessing the admissibility of such evidence can be traced to the relevance thereof.⁶ According to Zeffert and Paizes an opinion will be relevant if it can assist the court and if the witness is better qualified to form such an opinion.⁷ There are generally two exceptions to the general “ban” against opinion evidence. The first exception entails the opinion of a lay person as to facts observed by such a person and where it is reasonably inevitable for the witness to separate observed facts from the inferences drawn from the observed facts.⁸ It is

(1986) Unpublished Masters Dissertation in Clinical Psychology University of Johannesburg at 7-18.

³ Zeffert and Paizes (2009) *supra* note 2 at 309; Schwikkard and Van der Merwe (2009) *supra* note 2 at 83-84; Hoffman (1963) *supra* note 2 at 175; Schmidt (1998) *supra* note 2 at 429; Hoffman and Zeffert (1988) *supra* note 2 at 83; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 236-237. See also Dennis, I “The Law of Evidence” (2007) 847 where it is stated that the general rule according to the common law entails that a witness may only present evidence of facts to which they have personal knowledge of and may not express their opinions of what happened or may have happened. See chapter 1 paragraph 2.6. See also Du Toit *et al* (2009) *supra* note 2 at 24-12-24-17.

⁴ *Ibid.* See also Cross and Tapper (2007) *supra* note 2 at 566 where they define “opinion” as: “... any inference from observed facts”. See also Delisle and Stuart (2001) *supra* note 2 at 645-646.

⁵ Alan and Meintjes-Van der Walt in Kaliski (2006) *supra* note 2 at 342-343; Alan in Tredoux *et al* (2005) *supra* note 2 at 287-288; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87; Dennis (2007) *supra* note 3 at 847.

⁶ Schwikkard and Van der Merwe (2009) *supra* note 2 at 87; Zeffert and Paizes (2009) *supra* note 2 at 309-310; Schmidt (1998) *supra* note 2 at 429; Hoffman and Zeffert (1988) *supra* note 2 at 83-84; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 250.

⁷ Zeffert and Paizes (2009) *supra* note 2 at 311; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87-88.

⁸ Zeffert and Paizes (2009) *supra* note 2 at 310-311; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87-90; Keane (2006) *supra* note 2 at 552; Cross and Tapper (2007) *supra* note 2 at 566-567; Dennis (2007) *supra* note 3 at 847. See also Wigmore, JH “Evidence in Trials at common Law” (1978) at paragraph 1918 where he notes that the true essence of the opinion rule simply relates to the exclusion of supererogatory evidence. He notes: “It is not that there is any fault to find with the witness himself or the sufficiency of his sources of

consequently often difficult to distinguish between facts and opinion of such witness. The second exception relates to the opinion evidence presented by a witness who by way of skill, experience and competence is in a better position to draw inferences from the facts than the court due to the fact that the subject-matter requires skill, knowledge or expertise beyond the normal experience of the court.⁹ For purposes of this chapter, emphasis will fall on the second exception relating to expert evidence. One of the principle motivations for the exclusion of opinion evidence is predicated upon the premise of protecting the function of the trier of fact or judicial authority and entails that a witness should refrain from expressing opinion evidence on issues that the court itself has to decide upon and accordingly the witness should not “usurp” the function of the court. The latter principle is more commonly referred to within the law of evidence as the so-called “ultimate issue” principle.¹⁰ In *S v Harris*¹¹, Ogilvie Thomson JA indirectly encroached the ultimate issue rule by stating:¹²

“... 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 question which falls to be assessed is whether the ultimate issue rule should still be retained in our current rules of evidence. Within a climate of rapid

knowledge or the positiveness of his impression; but simply that his testimony otherwise unobjectionable, is not needed, is superfluous.”

⁹ *Ibid.* See also *S v Nangatuuala and Another* 1997 (4) SA 766 (SWA); *Gentiruco AG v Firestone SA (Pty) Ltd* 1972 (1) SA 589 (A) at 616 G-H.

¹⁰ Paizes and Zeffert (2009) *supra* note 2 at 310-314; Schwikkard and Van der Merwe (2009) *supra* note 2 at 88; Keane (2006) *supra* note 2 at 568-570; Cross and Tapper (2007) *supra* note 2 at 574-575; Delisle and Stuart (2001) *supra* note 2 at 679; Freckelton and Selby (2005) *supra* note 2 at 277; Dennis (2007) *supra* note 3 at 864-865; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 250-251.

¹¹ *S v Harris* 1965 (2) SA 340 (A).

¹² At 365 B-C. See also *S v September* 1996 (1) SACR 325 (A); Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 250-251.

developments in science and technology also with reference to the sciences of psychiatry and psychology, the “gap” between layman’s knowledge and expert knowledge is increasingly expanding. In the ultimate pursuit for truth and justice, various questions arise as to the admissibility, scientific reliability and validity of psychiatric and psychological evidence. Van Kampen illustrates the anomaly as follows:¹³

“Over many centuries, science has become pivotal to our understanding of (human) nature and its contribution to legal decision making processes has increased dramatically. But as the involvement of science itself, and various techniques based upon its insights grew, so did a number of problems related to the use of such knowledge by legal institutions.”

And further:

“The vast range of problems related to the use of (applied) scientific or otherwise specialised knowledge by legal institutions that have been identified over the years – and the manifest presence of some of these problems in more well-known miscarriages of justice – has made expert evidence one of the most hotly debated topics in legal literature.”

In chapter 2 the author addressed the controversy surrounding the need for expert evidence in support of the defence of non-pathological criminal incapacity also with reference to cases where expert evidence pertaining to the battered woman syndrome is advanced in support of non-pathological criminal incapacity. Upon closer scrutiny of the case law adhering to the traditional approach towards expert

¹³ Van Kampen, PTC “Expert Evidence Compared – Rules and Practices in the Dutch and American Criminal Justice System” (1998) at 4-5. See also Redmayne, M “Expert Evidence and Criminal Justice” (2001) at 36 where he states: “Fact finders need to analyse expert evidence and combine it with the other evidence that is presented to them; for their part, experts need to present their evidence in a manner that facilitates this task. These points are obvious, even banal. What is interesting is that their implementation is challenging, and even controversial.” See also Roberts, P “Science in the Criminal Process” (1994) *Oxford Journal of Legal Studies* 469 at 506 where it is stated: “... one must appreciate that forensic science is, in essence, science on the law’s terms. Although lawyers might look to science, with its popular reputation for “hard facts”, as an independent and legitimizing check on the pursuit of criminal justice, there is an important sense in which forensic science evidence is a mirror in which the criminal process admires its own reflection.”

evidence, various traces of the ultimate issue paradigm become evident.¹⁴ In chapter 2 the author in addition emphasised the lack of adequate statutory recognition of expert evidence in support of the defence of non-pathological criminal incapacity. Proper statutory recognition of expert evidence is, however, only one step towards the proper application of expert evidence in cases where the defence of criminal incapacity is raised. Obstacles such as the ultimate issue rule, reliability and validity further places a barrier on the acceptance of expert evidence which will have to be addressed. In chapter 3 the author indicated that even though expert evidence is statutorily provided for in cases of pathological criminal incapacity, the application thereof is often clouded and not coherent. The latter is further exacerbated by the divergent views of the behavioural sciences as opposed to the legal profession. Despite the necessity and pivotal role of expert evidence in cases where criminal capacity is in issue, courts frequently approach such evidence with great caution, scrutiny and scepticism. Melton *et al* encapsulate this dilemma by stating:¹⁵

“To some extent, this antipathy stems from the belief that mental health professionals too often try to answer legal questions for which there are no good behavioural science answers – or, worse, are merely selling their testimony to the highest bidder. But it also flows from the fact that even when clinicians have something useful to say and are eager to maintain their integrity, their message is often obscured or confused. Their reports are perceived as conclusory and filled with jargon; their testimony is viewed as hard to follow (on direct examination) and befuddled (on cross-examination).”

¹⁴ See chapter 2 *supra* paragraph 9.1 with reference to *S v Laubscher* 1988 (1) SA 163 (A) at 168 B-C; *S v Calitz* 1990 (1) SACR 119 (A); *S v Lesch* 1983 (1) SA 814 (EPD).

¹⁵ Melton, GB, Petrila, J, Poythress, NG and Slobogin, C “Psychological Evaluations for the Courts – A Handbook for Mental Health Professionals and Lawyers” (2007) at 577. See also Alan in Tredoux *et al* (2005) *supra* note 2 at 287-288 where it is stated: “Psychologists often insert their expertise into legal proceedings, either in the form of oral evidence, or as an affidavit. Unfortunately their offerings are often perceived to be of limited value by courts, and psychologists themselves often believe that the testimony they offer is misrepresented in court.” See also Blau, TH “The Psychologist as Expert Witness” (1998) at 2 where he quotes the words of Munsterberg who stated: “The lawyer and the judge and the jurymen are sure that they do not need the experimental psychologist. They do not wish to see that in this field pre-eminently applied experimental psychology has made strong strides ... They go on thinking that their legal instincts and their common sense supplies them with all that is needed and somewhat more; ...”

Dahl similarly refers to the ultimate issue problem and its impact on expert psychiatric evidence by stating:¹⁶

“One reason for resistance to the use of psychiatric knowledge by the law is lingering doubt about the scientific validity of psychiatry. However, legal decision-makers are also concerned that incorporation of psychiatric concepts into the criminal law will impair the ability of the law to achieve its policy objectives. They fear two developments: one, that psychiatrists will have increasing influence on ultimate legal determinations; and two, that the law will become dependent on concepts that belong to an outside discipline.”

In this chapter the author will assess the fundamental rules of evidence pertaining to expert evidence with an evaluation of the nature, scope, presentation and evaluation of expert evidence. The nature and scope of the forensic assessment process will also be the role of the forensic psychiatrist and psychologist within the realm of the presentation of expert evidence in support of the defence of criminal incapacity.¹⁷ The ultimate issue rule in conjunction with the various other controversies surrounding the presentation of expert evidence will be discussed,

¹⁶ Dahl, PR “Legal and Psychiatric concepts and the use of Psychiatric Evidence in Criminal Trials” (1985) *California Law Review* 411-442 at 411. See also Slovenko, R “Psychiatric Expert Testimony: Are the Criticisms Justified? (Part 1)” (1991) *Medicine and Law* at 1-29; Slovenko, R “Psychiatric Expert Testimony: Are the Criticisms Justified? (Part 2)” (1991) *Medicine and Law* 107-127; Ziskin, J “Coping with Psychiatric and Psychological Testimony” (1988) at 1-63.

¹⁷ For purposes of this study the role of expert evidence in support of the defence of criminal incapacity will only be assessed with reference to the role of psychiatrists and psychologists as these two professions are provided for within the framework of sections 77-79 of the Criminal Procedure Act 51 of 1977. Accordingly the role of social workers, criminologists and various other professions will not be addressed in this study. It is further important to note that this chapter will deal with the nature and scope of expert evidence and the rules pertaining to the admissibility of testimony presented by expert witnesses. As psychiatrists and psychologists will assume the roles of expert witnesses when called to testify in cases where the defence of criminal incapacity is raised, these rules will inadvertently apply to them. As such, reference to “expert witness” should be construed as reference to the psychiatrist or psychologist for purposes of this study within the paradigm of the defence of criminal incapacity. This chapter will accordingly address a *capita selecta* of principles pertaining to expert evidence which inadvertently also apply either directly or indirectly to the expert testimony of psychiatrists and psychologists in cases where the defence of criminal incapacity is advanced.

coupled with the competing disciplines of law and medicine and its impact on the proper presentation of expert evidence.

2 Constitutional foundation

“Whatever the system, it is surely fundamental that the truth in so far as it can be established should be established in what is regarded as a fair and therefore legitimate way.”¹⁸

An accused’s right to a fair trial is well established in terms of section 35(3) of the Bill of Rights of the Constitution.¹⁹ Section 35(3)(i) provides that every accused person has the right to a fair trial which includes the right to adduce and challenge evidence.²⁰ Within the framework of the defence of criminal incapacity and the presentation of expert evidence, this right of an accused person to adduce and challenge evidence and specifically expert evidence, becomes a vital tool in establishing the merits of the defence of criminal incapacity. The question which falls to be considered is whether our current rules of evidence pertaining to expert evidence adequately acknowledge and promote the fundamental right of an accused person to adduce and challenge evidence. In addition it has to be assessed whether the ultimate issue rule places unnecessary barriers on the proper presentation of expert evidence also within the realm of the defence of criminal incapacity. Inherent to the right to adduce and challenge evidence lays the necessity to cross-examine expert witnesses. The right to adduce and challenge evidence can be promoted both by calling witnesses and also by cross-examining of witnesses.²¹ In this chapter the fundamental right of an accused to adduce and challenge evidence will be assessed with the concomitant right to cross-examine expert witnesses on the backdrop of the defence of criminal incapacity.

¹⁸ Jörg, N, Field, S and Brants, C “Criminal Justice in Europe: A Comparative Study” (1995) at 42 as quoted in Meintjes-Van der Walt (2001) *SAJHR supra* note 2 at 301.

¹⁹ The Constitution of the Republic of South Africa, 1996. See chapter 2 *supra* paragraph 3.

²⁰ Currie, I and De Waal, J “The Bill of Rights Handbook” (2005) at 782; Devenish, GE “The South African Constitution” (2005) at 176-178. See also *Pennington v Minister of Justice* 1995 (3) BCLR 270 (C); *S v Matlabane* 1995 (8) BCLR 951 (B); Meintjes-Van der Walt (2001) *SAJHR supra* note 2 at 301-303.

²¹ Currie and De Waal (2005) *supra* note 20 at 779. See also Meintjes-Van der Walt (2001) *SAJHR* at 302-303. See also section 166 of the Criminal Procedure Act. This section will be discussed below.

3 The foundational principles of expert evidence

“In the lush pastures of the Common Law a number of sacred cows graze and no-one dares to cull them or even try to make them healthier. One answers to the name of “expert evidence” ... It is a scraggy animal, despised by many, yet its continued existence is essential for the proper administration of justice. Properly cared for it could provide good progeny but the breeding would have to be selective as some strains may not be worth encouraging.”²²

3.1 Relevance and the rules of expert evidence

In order to comprehend the role of the mental health professional with reference to psychiatrists and psychologists within the paradigm of the defence of criminal incapacity, an understanding of the basic and foundational principles of expert evidence becomes essential. It has already been indicated above that expert evidence represents one of the exceptions to the general rule against opinion evidence.²³ The opinion evidence of an expert will be deemed admissible if it is relevant in the sense that the expert by reason of specialised knowledge or skill is better qualified to draw an inference from the particular set of facts than the court itself.²⁴

²² Lawton, LJ “The Limitations of Expert Scientific Evidence” (1980) *Journal of Forensic Science* at 237 as quoted in Freckelton and Selby (2005) *supra* note 2 at 21.

²³ Zeffert and Paize (2009) *supra* note 2 at 310-312; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87-88; Meintjes-Van der Walt (2001) *supra* note 2 at 149; Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 343; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 288; Hoffmann and Zeffert (1988) *supra* note 2 at 83-86; Cross and Tapper (2007) *supra* note 2 at 566-567; Keane (2006) *supra* note 2 at 552-553. See also Du Toit *et al* (2007) *supra* note 2 at 24-17 where it is stated that it is incorrect to refer to expert evidence as an “exception” to the general “opinion-rule”. It is further stated that the opinion of an expert is admissible if relevant. For purposes of this discussion the phrase “exception” will, however, be utilized in order to differentiate “expert evidence” from other forms of “opinion evidence”.

²⁴ *Ibid.* See also Du Toit *et al* (2007) *supra* note 2 at 24-16A; *R v Vilbro & Another* 1957 (3) SA 223 (A) at 228 G; *Ruto Flour Mills Ltd v Adelson (1)* 1958 (4) SA 235 (T).

The evidence presented by mental health experts will be meaningless to the criminal justice system if it is not relevant to the issues before the court.²⁵ Relevance in this sense can be deemed as one of the core requirements governing the admissibility of expert evidence within the criminal justice system. Relevance generally relates to the “probative potential of an item of information to support or negate the existence of a fact or consequence (*factum probandum*).”²⁶ Paizes and Zeffert state that relevancy essentially relates to a matter of common sense and reason.²⁷ Section 210 of the Criminal Procedure Act reads as follows:²⁸

“No evidence as to any fact, matter or thing shall be admissible which is irrelevant or immaterial and which cannot conduce to prove or disprove any point or fact at issue in criminal proceedings.”

Du Toit *et al* similarly state that the relevance of an item of evidence entails its logical ability to show or indicate the material fact for which the evidence is adduced.²⁹ Hiemstra notes that evidence which contributes to the proof or disproof of a fact in dispute is relevant and embraces evidence that directly proves matters in issue as well as those from which proof of a point in issue can be properly deduced and consequently all other evidence is irrelevant.³⁰ Hiemstra further notes:³¹

²⁵ Meintjes-Van der Walt (2001) *supra* note 2 at 150; Paizes and Zeffert (2009) *supra* note 2 at 237-243. See also *S v Gakool* 1965 (3) SA 461 (N) at 4754; *R v Matthews & Others* 1960 (1) SA 752 (A) at 758 A.

²⁶ Meintjes-Van der Walt (2001) *supra* note 2 at 150. See also *R v Katz* 1946 AD 781 where Watermeyer, CJ held: “The word relevant means that any two facts to which it is applied are so related to each other that according to the common course of events one, either taken by itself, or in connection with other facts, proves or renders probable the past, present or future existence or non-existence of the other.”

²⁷ Paizes and Zeffert (2009) *supra* note 2 at 237.

²⁸ Criminal Procedure Act 51 of 1977; Hiemstra (2009) *supra* note 2 at 24-12; Du Toit *et al supra* note 2 at 24-12. See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 45. See also *DPP v Kilbourne* 1973 AC 729 at 756 where Lord Simon held: “Evidence is relevant if it is logically probative or disprobative of some matter which requires proof. I do not propose to analyse what is involved in ‘logical probativeness’ except to note that the term does not of itself express the element of experience which is so significant of its operation in law, and possibly elsewhere. It is sufficient to say ... that relevant evidence, is evidence which makes the matter which requires proof more or less probable.”

²⁹ Du Toit *et al supra* note 2 at 24-12. See also *R v Trupedo* 1920 AD 58 at 62.

³⁰ Hiemstra (2009) *supra* note 2 at 24-12.

³¹ *Ibid.*

“... not everything which is relevant is admissible or, as it is also sometimes put, not everything with evidential value is accepted as relevant. In principle the relevance of a fact is determined by the probative value it has regarding the facts in dispute; and the relevance of a fact determines the admissibility of evidence regarding that fact.”

The principle of relevance will inadvertently play a pivotal role in respect of the admissibility of expert psychiatric or psychological evidence in support of the defence of criminal incapacity. Merely adducing such testimony will not necessarily suffice to comply with the requirement of relevance. An opinion of a mental health expert may thus be rendered inadmissible due to the irrelevance thereof. Conversely, such opinion may be admitted if found to satisfy the prerequisite of relevance. Relevance at the end of the day is founded on “a mixture of common sense, logic and experience – and not rules of law.”³²

It is trite that mental health professionals will, in cases where criminal incapacity is raised as a defence, be better qualified than the trier of fact to assess whether an accused in fact lacked criminal capacity at the time of the offence. The admissibility of expert evidence by mental health professionals will, however, be subject to the foundational principles governing expert evidence. There are generally four rules of expert evidence which regulate the reception and admissibility of opinion testimony by experts:³³

- The first rule relates to the so-called “expertise rule” or “specialist” rule. This rule requires assessment as to whether the witness possess sufficient knowledge, skill or experience to render him or her an expert who can assist the trier of fact;
- The second rule is referred to as the “common knowledge rule” which entails an assessment as to whether the opinion sought from the witness relates to information beyond the ordinary or general knowledge of the court;

³² *Ibid.*

³³ Freckelton and Selby (2005) *supra* note 2 at 2-3; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 288-289; Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 343; Meintjes-Van der Walt (2001) *supra* note 2 at 147-170; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 238-249; Meintjes-Van der Walt (2000) *SACJ supra* note 2 at 771-790.

- The third rule is referred to as the “ultimate issue rule” in which case it has to be assessed as to whether the expert’s opinion will be “usurping” the function of the court;
- The fourth rule relates to the so-called “basis rule”. This rule requires an assessment as to whether the expert’s opinion is founded on matters within the expert’s own observation.

These rules of expert evidence will be discussed in more detail below as they play an essential role in respect of expert evidence in support of the defence of criminal incapacity.

3.2 The expertise rule

The opinion evidence of expert witnesses is only admissible in respect of matters calling for specialised skill, knowledge or expertise. Mental health professionals will accordingly have to indicate that they are in fact specialists in the relevant field and it is the function of the presiding officer to determine whether the witness possesses sufficient qualifications to enable him or her to assist the court.³⁴ In *Menday v Protea Assurance Co (Pty) Ltd*³⁵, Addleson J stated the following:³⁶

“However eminent an expert may be in a general field, he does not constitute an expert in a particular sphere unless by special study or experience he is qualified to express an opinion on that topic. The dangers of holding otherwise – of being overawed by a recital of degrees and diplomas – are obvious: the Court has then no way of being satisfied that it is not being blinded by pure “theory” untested by knowledge or practice. The expert must either himself have knowledge or experience in the special field on which he testifies (whatever general knowledge he may also have

³⁴ Zeffert and Paizes (2009) *supra* note 2 at 324; Dennis (2007) *supra* note 3 at 850; Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 343; Schmidt (1998) *supra* note 2 at 437-438; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 289; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 240-241; Du Toit *et al* (2007) *supra* note 2 at 24-16A-24-17; Hiemstra (2009) *supra* note 2 at 24-26. See also Schiffer, ME “Mental Disorder and the Criminal Trial Process” (1978) at 196-201.

³⁵ *Menday v Protea Assurance Co (Pty) Ltd* 1976 (1) SA 565 (E).

³⁶ At 569 E-G. See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 96-97.

in pure theory) or he must rely on knowledge or experience of experts other than themselves who are shown to be acceptable experts in that field.”

The mere fact that witnesses are mental health professionals does not render them experts in every area concerning mental health.³⁷ Alan notes that the mere fact that a person is a psychologist or even possesses a doctorate qualification in psychology, does not render the person an expert in the specific issue the court has to assess.³⁸ Brodsky, Caputo and Domino similarly reported that within the forensic climate the expertise of a psychologist with a doctorate degree is not always welcomed with respect and the expert will inadvertently face challenges aimed at his or her training, knowledge, methodology and opinions.³⁹ Conversely, a witness is not expected to possess the highest qualifications in the specific field.⁴⁰

According to Allan, there are three important considerations that play a role in evaluating the expert’s expertise with reference to the field of psychology:⁴¹

³⁷ Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 343; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 289. See also Macdonald, JM “Psychiatry and the Criminal – A guide to Psychiatric Examinations for the Criminal Courts” (1976) at 450 where he states: “It is a mistake to assume that a prominent psychiatrist well-known to the judge and attorney needs no introduction. A man fearful of a barking dog was told, “You know the proverb, a barking dog never bits”. He replied, “You know the proverb, I know the proverb, but does the dog?” See also Murphy, P “Murphy on Evidence” (2008) at 364-365.

³⁸ Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 289. See also Shuman, DW “Expertise in Law, Medicine, and Health Care” (2001) *Journal of Health Politics, Policy and Law* 267-290 at 272 where he notes: “When expert testimony is admissible on an issue, the requirements for admissibility under the traditional adversary approach focus predominantly on the qualifications of the expert, leaving scrutiny of the validity of the expert’s methods and procedures to the fact finder as part of its assessment of the appropriate weight to be accorded to the evidence in reaching a decision on the ultimate issues. The standard applied in assessing qualifications is a functional determination to which the trial judge is accorded significant discretion.”

³⁹ Bradsky, SL, Caputo, AA and Domino, ML “The Mental Health Professional in Court – Legal Issues, Research Foundations and Effective Testimony” in Van Dorsten, B (ed) “Forensic Psychology – From Classroom to Courtroom” (2002) 17-33 at 17-18. See also Arrigo, BA and Shipley, SL “Introduction to Forensic Psychology – Issues and Controversies in Law, Law Enforcement and Corrections” (2005) 36.

⁴⁰ Schmidt (1998) *supra* note 2 at 438; Freckelton and Selby (2005) *supra* note 2 at 24.

⁴¹ Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 289. See also the Health Professions Act 56 of 1974. Section 34 requires registration for practicing a profession in respect of which a professional board has been instituted. Section 37 deals with the specific functions of the psychologist. These were already discussed in chapter 1 above.

- It has to be ascertained whether the person acting as an expert witness is registered as a psychologist with the professional Board of Psychology of the Health Professions Council of South Africa. The requirement for registration as a psychologist entails an approved masters degree generally in either Arts (MA), Social Science (MSocSci) or Science (MSc).⁴²
- The category of psychology the psychologist specialised in and completed postgraduate studies has to be ascertained.
- The third factor relates to whether the knowledge, skill and expertise of the psychologist are such that they are relevant to the issue before the court.

Section 67(2) of the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act⁴³ in addition requires that a psychologist base his or her psycho-legal work on “appropriate knowledge of and competence in the areas underlying such work, including specialised knowledge concerning specific populations”. In the case of psychiatrists, registration with the Health Professions Council of South Africa as a specialist psychiatrist is essential and it is further crucial to determine the psychiatrist’s field of expertise.⁴⁴

In respect of the “expertise rule”, Meyer, Landis and Hays in addition note the following:⁴⁵

“Mental health experts, including psychologists, psychiatrists, and in some cases psychiatric social workers and nurses, are qualified for the same sorts and reasons. Jurors cannot collect, integrate, and interpret data on human behaviour and mental disorders, at least not in the sophisticated ways available to these professionals.”

⁴² *Ibid.*

⁴³ GNR 717 of 4 August 2006: “Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 chapter 7 – Psycholegal Activities” at 64.

⁴⁴ Kaliski in Kaliski (2006) *supra* note 2 “Appendix: Mental Health Practitioners – The Psychiatrist” 377-378. See also Macdonald (1976) *supra* note 37 at 451.

⁴⁵ Meyer, RG, Landis, ER and Hays, JR “Law for the Psychotherapist” (1988) at 222. See also Wells, G “Expert Psychological testimony: Empirical and Conceptual Analyses of Effects” (1986) *Law and Human Behavior* at 83.

Meyer, Landis and Hays suggest the following six criteria for establishing expertise:⁴⁶

- Education;
- Credentials;
- Relevant experience, including previous diagnostic and intervention experience;
- Research and publications;
- Knowledge and application of scientific principles;
- Use of specific tests, techniques and procedures;
- Prior court exposure as an expert.

Mental health professionals who act as expert witnesses are required to possess both theoretical as well as practical knowledge.⁴⁷ Theoretical knowledge will have to be combined with personal knowledge and professional, practical experience within the specific field.⁴⁸

Paizes and Zeffert submit that there is generally no hard and fast rule that an expert's knowledge must derive from personal experience rather than from reading, but the expert, however, should have sufficient experience to enable him or her to find reliable sources and views and estimate their value.⁴⁹ In *S v Van As*⁵⁰, Kirk-Cohen J distinguished two manifestations of expert evidence which could also be useful in terms of the expertise rule.⁵¹ The first manifestation of expert evidence relates to the situation where the expert expresses an opinion that is founded on the opinions of well-known authors or authority in the particular field. The second relates to an expert who conducts experiments and presents the results of such experiments to the court. In the latter instance it will generally be easier for courts to comprehend the evidence and render a decision based upon

⁴⁶ Meyer, Landis and Hays (1988) *supra* note 45 at 222-223; Melton *et al* (2007) *supra* note 2 at 589.

⁴⁷ Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 290-291; Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 344.

⁴⁸ *Ibid.*

⁴⁹ Zeffert and Paizes (2009) *supra* note 2 at 325; *S v Kimimbi* 1963 (3) SA 250 (CPD) at 252.

⁵⁰ *S v Van As* 1991 (2) SACR 74 (W).

⁵¹ At 86 H-J. See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 98.

such evidence as the expert is not merely expressing an opinion, but is also demonstrating the factual evidence upon which the opinion is founded. Practical experience will thus be crucial to add more probative value to the mental health expert's opinion.

In the ultimate analysis of assessing the presence or absence of appropriate expertise, the skill, knowledge, training and professional experience of the mental health expert should be the guiding principles and the experts will have to indicate that they have been trained in a specific discipline or have experience in the particular field rising above that of ordinary laymen.⁵²

3.3 The Common knowledge rule

The essential *rationale* behind the admission of expert evidence is predicated on the assumption that the expert as a result of specialised training, skill, knowledge or experience, is in a better position than the trier of fact to draw inferences from the facts. The question to be asked is whether the evidence presented by the expert will be “helpful” or to the “assistance” to the trier of fact in the sense that it can add to the existing knowledge of the trier of fact and thus provide assistance in the determination of the issues.⁵³ The expert evidence accordingly has to be

⁵² Verschoor, T, Calitz, FJW and Van Rensburg, PHJJ “Deskundige Getuienis” (1994) *Geneeskunde* 5-10 at 5; Gillmer, BT, Louw, DA and Verschoor, T “Forensic expertise: the psychological perspective” (1995) *SACJ* 259-270 at 259; Meintjes-Van der Walt (2001) *supra* note 2 at 155 state: “... in the rapidly developing world of science and technology, new and novel theories and techniques are constantly emerging. This area between the acknowledged accepted fields of expertise and cutting-edge experimentation has been aptly referred to as the “twilight zone” of expertise.” See also Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 243; Meintjes-Van der Walt (2003) *Journal of African Law supra* note 2 at 94-95.

⁵³ Meintjes-Van der Walt (2001) *supra* note 2 at 157; Meintjes-Van der Walt (23001) *THRHR supra* note 2 at 244-245; Du Toit *et al* (2007) *supra* note 2 at 24-16A-24-17; Hiemstra (2009) *supra* note 2 at 24-25; Zeffert and Paizes (2009) *supra* note 2 at 322-324; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87-88; Freckelton and Selby (2005) *supra* note 2 at 102-103; Davies, G, Hollin, C and Bull, R “Forensic Psychology” (2008) at 252-253; Sheldon, DH “From Normative to Positive Data: Expert Psychological Evidence Re-examined” (1991) *Criminal Law Review* 811-820 at 814-815; Lacoursiere, RB “Forensic Psychiatry: Less Typical Applications (1990) *Washburn Law Journal* 29-40 at 29; Howitt, D “Introduction to Forensic and Criminal psychology” (2002) at 5-6. See also *Holtzhausen v Roodt* 1997 (4) SA 766 (WLD) discussed below in this chapter. See also *S v Mkhize and Others* 1999 (1) SACR 256 (WLD) at 263 C-D where Boruchowitz J encapsulated the common knowledge rule and to a lesser extent, the expertise rule as discussed above by stating: “The need to receive expert evidence arises from the fact that the court, by reason of its lack of special knowledge and skill, is incapable of drawing properly reasoned inferences from the various images which are to be seen under the microscope. Because of the specialized nature of the investigation the

beyond the “common knowledge” of the court. Slovenko submits that the admissibility of expert evidence in this regard is founded on two “prongs” – the first “prong” requires the court to decide whether the witness whose expert testimony is presented, is in fact an expert within the specific scientific field and whether the witness is qualified as an expert to present evidence founded on scientific, technical or other specialised knowledge; the second “prong” requires the court to assess whether such evidence will be of “help” or assistance and the “helpfulness standard” as such requires a “valid connection to the pertinent inquiry as a precondition to admissibility”.⁵⁴ It follows that where the triers of fact can draw their own inferences without the assistance of an expert witness, the matter falling within their own experience or “common knowledge”, the opinion evidence will be deemed inadmissible.⁵⁵ In cases where criminal incapacity is raised as a defence and the mental state of the accused is at issue, the evidence of mental health professionals will be crucial and will inadvertently relate to concepts beyond the common knowledge of the trier of fact.⁵⁶ Gutheil and Appelbaum note the following in this regard.⁵⁷

court, with its untrained eye, is hardly in a position to itself, from its own observations, draw any conclusions and is thus dependent upon the opinion of skilled witnesses ...” See also *R v Morela* 1947 (3) SA 147 (A) at 153.

⁵⁴ Slovenko, R “Psychiatry in Law/Law in Psychiatry” (2002) at 44. See also Perlin, M “The Legal Status of the Psychologist in the Courtroom” (1977) *Journal of Psychiatry* 41-45 at 43 where it is noted that the answer to the question as to whether an opinion offered by an expert will aid the trier of fact in the search for truth will depend on the nature and extent of the witness’s knowledge. See also *Ruto Flour Mills Ltd v Adelson (1)* 1958 (4) SA 235 (T); *Gentiruco AG v Firestone SA (Pty) Ltd* 1972 (1) SA 589 (A) 616 H.

⁵⁵ Keane (2006) *supra* note 2 at 556; Freckelton and Selby (2005) *supra* note 2 at 102; Murphy (2008) *supra* note 2 at 370; Dennis (2007) *supra* note 2 at 850-851.

⁵⁶ Freckelton and Selby (2005) *supra* note 2 at 131; Murphy (2008) *supra* note 2 at 370; Sheldon (1991) *Criminal Law Review supra* note 45 at 814; Keane (2006) *supra* note 2 at 557; Gutheil and Appelbaum (2000) *supra* note 2 at 340-341. See also Alan and Meintjes-Van der Walt in Kaliski (ed)(2006) *supra* note 2 at 344; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 292. See also chapter 2 where the decisions of *S v Kok* 1998 (1) SACR 532 (N) and *S v Van der Sandt* 1998 (2) SACR 627 (W) were discussed where it was held that in cases where non-pathological criminal incapacity is raised as a defence, the court was itself in a position to assess whether the accused had criminal capacity at the time of the commission of the offence. It is submitted that due to the inherent complexity of the defence of criminal incapacity, the trier of fact will without doubt need expert evidence as to the mental state of the accused at the time of the offence, be it the defence of non-pathological or pathological criminal incapacity. The further possibility cannot be negated that an accused may rely on the defence of non-pathological criminal incapacity, but psychiatric assessment may later prove that the accused suffered from a pathological state at the time of the offence. Placing a “barrier” to expert testimony in such a case could have a prejudicial effect on the outcome of a case.

⁵⁷ Gutheil and Appelbaum (2000) *supra* note 2 at 340.

“In cases of alleged mental illness, however, the courts – abandoning their historic position that even a layperson can tell if someone is crazy or not – have turned more and more to mental health professionals for help in interpreting human behaviour.”

Pipkin in addition note that expert evidence is a well established way of educating the courts in fields which are beyond its knowledge or comprehension.⁵⁸ Pipkin states⁵⁹ that experts are used to bridge the gap between common knowledge and specialized knowledge, allowing (juries) to decide complex issues which they could not otherwise understand.

3.4 The Ultimate issue rule

Consider the following two opinions:

- (i) “Mr Jones is insane.”

As opposed to:

- (ii) “Mr Jones suffered from paranoid schizophrenia that, in my opinion to a reasonable degree of medical certainty, impaired his ability to appreciate the wrongfulness of his act or to act in accordance with an appreciation of the wrongfulness of his act.”

The two forms of opinion evidence which can be presented by mental health professionals as quoted above, encapsulates the salient features of the so-called “ultimate issue” rule in respect of expert evidence. In cases where mental health experts have to testify as to the mental state of the accused at the time of the commission of the offence, opinion (i) is regarded as an opinion on the “ultimate legal issue” which is regarded as an invasion of the legal arena and prohibited. Opinion (ii) is accordingly more preferable as the mental health expert refrains from expressing an opinion on the “ultimate issue” which is the lack or not of

⁵⁸ Pipkin (1989) *Law and Psychology Review supra* note 2 105-108 at 103.

⁵⁹ *Ibid.*

criminal capacity at the time of the offence which is regarded as a legal question and not a medical one. The viability of the ultimate issue doctrine is, however, questionable and presents several dilemmas in practice.

The ultimate issue rule generally provides that an expert witness may not be asked to provide opinion evidence concerning a matter which is regarded as an “ultimate issue” in a case.⁶⁰ The ultimate issue rule is founded upon the fear that the function of the trier of fact may be “usurped” by the expert’s exposition of expert evidence which deals with issues essential to the assessment of the case.⁶¹

Freckelton and Selby define “ultimate issue” as:⁶²

“... the central question which is the responsibility of the judge or jury to determine – an important issue of fact or law.”

Jackson, in addition, defines “ultimate issues” as:⁶³

“... material facts which must be proved by the prosecution beyond reasonable doubt before a defendant can be found guilty of a particular offence ...”

⁶⁰ Meintjes-Van der Walt (2001) *supra* note 2 at 164; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 250; Freckelton and Selby (2005) *supra* note 2 at 277; Schmidt, CWH and Rademeyer, H “Bewysreg” (2000) at 468; Zeffert and Paizes (2009) *supra* note 2 at 313-319; Schwikkard and Van der Merwe (2009) *supra* note 2 at 87-88; Alan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 345-346; Alan in Tredoux *et al* (eds) (2005) *supra* note 2 at 296; Slovenko, R “Commentary: Deceptions to the Rule on Ultimate Issue Testimony” (2006) *The Journal of the American Academy of Psychiatry and the Law* 22-25; Buchanan, A “Psychiatric Evidence on the ultimate issue” (2006) *The Journal of the American Academy of Psychiatry and the Law* 14-21; Melton *et al* (2007) *supra* note 2 at 600-605; Murphy (2008) *supra* note 2 at 368-369; Cross and Tapper (2007) *supra* note 2 at 574-575; Keane (2006) *supra* note 2 at 368-369; Schiffer, ME “Mental Disorder and the Criminal Trial Process” (1978) at 208-209.

⁶¹ *Ibid.* See also *S v Gouws* 1967 (4) SA 527 (E) at 528 D where Kotze J stated: “The prime function of an expert seems to me to guide the court to a correct decision on questions falling within his specialized field. His own decision should not, however, displace that of the tribunal which has to determine the issue to be tried.”

⁶² Freckelton and Selby (2005) *supra* note 2 at 277.

⁶³ Jackson, JD “The Ultimate Issue Rule: One Rule too many” (1984) *Crim LR* as quoted in Meintjes-Van der Walt (2001) *supra* note 2 at 164.

Within the realm of the defence of criminal incapacity, the ultimate issue will inadvertently be whether the accused lacked criminal capacity at the time of the commission of the offence, or phrased differently, was “insane”; or whether the accused is incompetent to stand trial. The ultimate issue doctrine is problematic for mental health professionals requested to provide an opinion on the mental state of an accused as it is often difficult to express an opinion without addressing the ultimate issue itself. Melton *et al* note that mental health professionals are often pressured to provide ultimate issue testimony.⁶⁴ The numerous pressures on mental health professionals include the following:⁶⁵

- The presumption on the part of legal professionals that such expert testimony is an essential part of the mental health expert’s presentation. In many instances the courts regard ultimate issue opinions as very important and often require conclusory testimony from the mental health professional;
- Economic factors often play a role in respect of mental health professionals in private practice who may feel that their “market value” will lessen if they are too rigid in resisting providing opinions and conclusions easily obtainable elsewhere;⁶⁶
- The structure and dynamics of the courtroom may also tempt the professional to address questions often beyond his or her expertise.⁶⁷

⁶⁴ Melton *et al* (2007) *supra* note 2 at 601.

⁶⁵ Melton *et al* (2007) *supra* note 2 at 601-602. See also Brodsky, SL and Poythress, NG “Expertise on the Witness stand: A Practitioner’s Guide” in Ewing, CP (ed) “Psychology, Psychiatry and the Law: A Clinical and Forensic Handbook” (1985) 389 at 407-408. See also Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 296. It is interesting to note that Melton *et al* (2007) *supra* note 2 at 601 in addition note that in a survey conducted as to the rated importance of certain aspects of mental health expert testimony, the findings in respect of opinion evidence on the ultimate legal issues was rated relatively high by both prosecutors as well as judges. See also Gilmer, BT, Louw, DA and Verschoor, T “Forensic Expertise: the psychological perspective” (1995) SACJ 259-270 at 264 where they note that more often than not evidence deemed as invading on ultimate legal issues which is regarded as “juristically inappropriate” is regarded by judges to retain some of the highest probative value.

⁶⁶ See also Halleck (1980) *supra* note 2 at 214 where he notes: “I have on a number of occasions offered to go to court in insanity cases and testify as to the nature of the offender’s illness and as to how it may have influenced his criminal behavior, but have indicated that I could not make conclusory statements as to the offender’s responsibility under any standard of insanity. No attorney has accepted my offer, primarily because they assume that if the opposing side employs a psychiatrist who does make a conclusory statement, that psychiatrist’s testimony will carry more weight than mine and will prevail.”

⁶⁷ See also Brodsky (1999) *supra* note 2 at 178 where he quotes the words of Dr Joe Dixon who was asked to testify as to the ultimate opinion with regards to the mental state of an accused: “Several years ago, when I was a new forensic “expert”, I had evaluated the defendant in a felony case and was on the stand nearing the end of my cross-examination by the defense

- Mental health professionals are often prepared to provide ultimate issue testimony due to the fact that they believe that there is no ethical or legal prohibition against doing so.

Melton *et al* encapsulate the clash between law and medicine in respect of the ultimate legal issue as follows:⁶⁸

“On the question of the ultimate legal issue, the relationship between the law and the mental health sciences invokes the analogy of a couple in psychotherapy who are locked in an overly dependent relationship. The legal system resists dealing with problems of its own by demanding that mental health professionals accept responsibility for them, conferring special status as an inducement. For their part, mental health professionals experience an increasing awareness of the unreasonable demands being made, but are unsure how to break the bond. Although both feel ambivalence, it is a relationship with old roots and considerable inertia.”

In principle there are two approaches which could be followed in respect of the ultimate issue rule. On the one hand it could be argued that the ultimate issue rule serves the legitimate purpose of protecting the function of the trier of fact in prohibiting the mental health expert from expressing an opinion on the ultimate issue or as is often stated, “usurping” the function of the court. In this sense the mental health professional should refrain from expressing opinions on the ultimate issue and should stay within the boundaries of his or her field of expertise. On the other hand the question arises as to whether the ultimate issue rule serves any purpose. Melton *et al* advocate in favour of an approach by which mental health professionals should “resist the ultimate issue question”.⁶⁹ In terms of this

attorney in this bench trial. The courtroom was crowded, the judge was attentive, and, thus, the questioning by both attorneys had been on point and knowledgeable. The defense attorney then asked me for an ultimate issue opinion. “So, Doctor, you are telling this court that Mr Smith was insane at the time of this offense?” I quickly deferred, and began to explain such conclusion was the prerogative and province exclusively of the court. The judge interrupted me, and said: “No that’s quite all right, Doctor, please answer the question.”

⁶⁸ Melton *et al* (2007) *supra* note 2 at 605.

⁶⁹ Melton *et al* (2007) *supra* note 2 at 603-604. See also Brodsky (1999) *supra* note 2 at 182 where he states that ultimate issue questions are legal in nature and beyond the expertise of the mental health professional.

approach mental health professionals should refrain from presenting conclusory opinions which do not fall within their professional competence.⁷⁰ Melton *et al* state that although mental health professionals have a vast amount of expertise in their particular fields of specialisation, they do not have the necessary expertise to render ultimate legal judgments such as whether an accused person is incompetent or insane as these judgments are "... judgments that involve moral values and the weighing of competing social interests".⁷¹ Gutheil states that mental health experts should refrain from stating an opinion on the ultimate issue such as whether the accused is "insane" or not, but should rather present an opinion as to whether an accused with a reasonable degree of medical certainty, lacked capacity to appreciate the wrongfulness of his conduct, or, in line with the capacity test in South Africa, lacked the capacity to act in accordance with such appreciation.⁷² Expert evidence in the latter fashion will consequently avoid the so-called "battle of the experts" while enhancing the trier of fact's understanding of the clinical data.⁷³ It is, however, often difficult for mental health professionals not to answer the ultimate issue when presenting their opinion. The question which falls to be assessed is whether there is a need for the perpetuation of the ultimate issue rule. Should the opinion of a mental health professional not rather be judged according to its relevance? A decision which is of relevance in this regard is *Holtzhauzen v Roodt*.⁷⁴ The salient facts of this decision were briefly as follows.

The plaintiff sued the defendant for defamation arising from reports she made to her mother and allegedly her close friend and sisters consisting of a statement that she had been raped by the plaintiff. The defendant consequently gave notice in terms of Rule 39(9) of the Uniform Rules of Court of his intention to call two expert witnesses, Mr Wilkinson and Ms Breslin. Mr Wilkinson was a qualified clinical

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² Gutheil, TG "Assessment of Mental State at the Time of the Criminal Offense: The Forensic Examination" in Simon, RI and Shuman, DW (eds) "Retrospective Assessment of Mental States in Litigation: Predicting the Past" (2002) at 94; Melton *et al* (2007) *supra* note 2 at 604.

⁷³ *Ibid.*

⁷⁴ *Holtzhauzen v Roodt* 1997 (4) SA 766 (WLD). See also Du Toit *et al* (2007) *supra* note 2 at 24-16B; Hiemstra (2009) *supra* note 2 at 24-27; Zeffert and Paizes (2009) *supra* note 2 at 317; Schwikkard and Van der Merwe (2009) *supra* note 2 at 94-96; Schmidt, CWH and Rademeyer, H "Bewysreg" (2000) at 468; Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 345-346. See also *S v Kleynhans* 2005 (2) SACR 582 (WLD) at 585 A-G where Satchwell J again reaffirms the principles pertaining to expert evidence as enunciated in *Holtzhauzen v Roodt supra*.

psychologist and a member of the South African Society of Clinical Hypnosis; and Ms Breslin had a master's degree in social work and was the clinical supervisor of "People Opposing Woman Abuse" which dealt with the counselling of women who had been raped or who were in abusive relationships. Mr Wilkinson's testimony was to the effect that the defendant had consulted him on a number of occasions and had told him that she had been raped by the plaintiff and, furthermore, that she had also done so twice whilst under hypnosis during hypnotherapy sessions. Mr Wilkinson's opinion further stated that the defendant was telling the truth about the relevant incident. Ms Breslin's testimony stated that women who had been raped would not often reveal the incident to third parties immediately after it had occurred and that it was common for such victims to exhibit radical changes in behaviour. The plaintiff opposed the admission of the evidence of Mr Wilkinson and Ms Breslin on the basis that Mr Wilkinson's evidence usurped the function of the court and amounted to evidence of the content of a previous consistent statement; and further that Ms Breslin's evidence was of a general nature as she had had no consultation or discussion with the defendant and accordingly that the evidence was irrelevant. Before dealing with the remarks made by Satchwell J as to the relevance of each of the experts' opinions, it is necessary to look at the findings rendered in respect of expert evidence and the admissibility thereof. Satchwell J held the following in respect of expert evidence:⁷⁵

- The expert witness must be called to give evidence on matters calling for specialised skill or knowledge. The court will have to determine whether the subject of enquiry involves issues calling for specialised skill or knowledge. Evidence of opinion on matters which do not call for expertise is excluded as it does not help the court. At best, it is superfluous and, at worst, it could be a cause of confusion.⁷⁶
- The courts are accustomed to receiving the evidence of psychologists and psychiatrist, particularly in criminal courts. However, the expertise of the witness should not be elevated to such heights that sight is lost of the court's

⁷⁵ At 772 B-773 C. See also Hiemstra (2009) *supra* note 2 at 24-27.

⁷⁶ At 772 C-D. This *dictum* could also have been placed under the heading of the "common knowledge rule" as discussed above.

own capabilities and responsibilities in drawing inferences from the evidence.⁷⁷

- The witness must be a qualified expert. It is for the judge to determine whether the witness has undergone a course of special study or has experience or skill as will render him or her an expert in a particular field. It is not essential for the expertise to have been acquired professionally.⁷⁸
- The facts upon which the expert opinion is based must be proved by admissible evidence. Such facts either fall within the personal knowledge of the expert or form the basis of facts proved by others. If the particular expert has observed them, then the expert must testify as to their existence. The expert must further provide criteria for testing the accuracy as well as the objectivity of his or her conclusion and the court must be informed of the basis upon which the opinion is based. Due to the fact that the testimony of an expert will carry more weight, higher standards of accuracy and objectivity should be required.⁷⁹
- The guidance offered by the expert must be sufficiently relevant to the matter in issue which is to be determined by the court.⁸⁰
- Opinion evidence must not usurp the function of the court. The witness is not permitted to give an opinion on the legal or general merits of the case. The evidence of the opinion of the expert witness should not be presented on the ultimate issue. The expert should not be required to answer questions which the court has to decide.⁸¹

The main issue in this case related to the relevance and admissibility of the expert opinions of Mr Wilkinson and Ms Breslin. With regards to Mr Wilkinson's testimony, Satchwell J held that it was not relevant for a number of reasons, of which the most important are the following:

- The greatest part of the evidence of Mr Wilkinson was to refer the court to consultations which he had with the defendant during which she made

⁷⁷ At 772 E-G. See also *S v Kalogoropoulos* 1993 (1) SACR 12 (A) at 22 D-E.

⁷⁸ At 772 H.

⁷⁹ At 772 I-773 B.

⁸⁰ At 773 B.

⁸¹ At 773 C.

particular statements to him. The only reason for the advancement of these statements was to indicate consistency in the statements made by the defendant prior to her giving evidence in court. Satchwell J held that these statements were superfluous.⁸²

- The conclusion expressed by Mr Wilkinson displaced the value judgment of the court.⁸³ Satchwell J in addition held:
“It is required of this court to make certain determinations on its own on an assessment and on an evaluation of all the evidence that has been placed before the court and not just on the version as presented by the defendant.”⁸⁴
- It is an established principle that litigants should have their disputes resolved by judges and not by witnesses.⁸⁵ Satchwell J further held:⁸⁶
“If the Wilkinson’s of the world are too readily allowed to give their opinions on the subject-matter of litigation, then this would lead to the balancing of opinion as between witnesses. This would tend to shift responsibility from the Bench to the witness-box.”
- The evidence to be presented by Mr Wilkinson regarding the hypnosis and the conditions under which the statements were made by the defendant usurped the judgment of the court.⁸⁷

In respect of Ms Breslin’s evidence Satchwell J held that the guiding criteria in the assessment of relevance in respect of Ms Breslin’s evidence were whether it was “helpful” and “of assistance to the court”.⁸⁸ It was further held that the test with regard to the admissibility of expert evidence was whether a court, by reason of its lack of special knowledge and skill, was not sufficiently informed to enable it to venture the task of drawing properly reasoned inferences from the facts established by the evidence and consequently expert opinion will be admitted if such expert is by reason of special knowledge or skill better equipped than the court to advance, reject and comment on certain inferences in order to assist the

⁸² At 774 C-D.

⁸³ At 774 F.

⁸⁴ At 774 G-H.

⁸⁵ At 774 H-I.

⁸⁶ At 774 I-J.

⁸⁷ At 775 A.

⁸⁸ At 776 G-H.

court.⁸⁹ Satchwell J held that the rape of a woman is an experience of utmost intimacy and that the ability of a judicial officer to fully comprehend the “kaleidoscope of emotion and experience of both rapist and rape survivor is extremely limited”.⁹⁰ Satchwell J in addition held that it would be unwise for a judicial officer lacking special knowledge and skill to draw inferences from facts which have been proved by evidence in the absence of granting an expert in the field the opportunity to provide guidance on the specific aspect.⁹¹ Expert evidence could provide guidance as to why the rape victim failed to immediately (or at the first possible opportunity) report the rape.⁹² Satchwell J accordingly held that the evidence of Ms Breslin was admissible but stated the following:⁹³

“At the end of the day, however, I must stress that the value which I will attach to such evidence will fall to be assessed in the light of all the evidence before the court; that is the evidence of the defendant, of the plaintiff and his wife, of their son and nephew, of the defendant’s mother and her sisters. The guidance and opinion of Ms Breslin will merely be one pointer of assistance. It remains for the court to determine the probative value of Breslin’s evidence and in what manner and to what extent it is of use in understanding the facts before the court.”

If one were to reflect on the *Holtzhausen* decision it becomes clear that the evidence of the experts was assessed as to its admissibility on the backdrop of the basic tenet in the law of evidence – its relevance and helpfulness. It is unfortunate that the ultimate issue rule was once again reaffirmed. It is clear that the evidence of Mr Wilkinson was irrelevant. His evidence failed the threshold test of relevance and on that basis it was held inadmissible. It could thus be argued that the argument of Mr Wilkinson “usurping” the function of the court was unnecessary and superfluous which results in questions arising as to the viability of this rule. Despite the fact that the *Holtzhausen* decision was a civil hearing, the principles

⁸⁹ At 777 H-J.

⁹⁰ At 778 F-H.

⁹¹ At 778 I-J.

⁹² At 778 I-779 C.

⁹³ At 779 C-E.

enunciated therein can also be applicable to the presentation of expert evidence in cases where criminal incapacity is raised as a defence.

Zeffert and Paizes correctly state that the *Holtzhauzen* decision provides a good example of when the opinion of an expert witness is provided on the issue which the court ultimately has to assess.⁹⁴ Zeffert and Paizes⁹⁵ correctly note that it is unfortunate that the court, while, rightly basing its assessment on considerations of relevancy and achieving the correct result, resorted to the meaningless expression of “usurping the function of the court” which, as has been submitted, may obfuscate the fact that the court in assessing whether to accept expert opinion on an ultimate issue, is concerned with a flexible and practical concept that expresses “the need for relevance”.⁹⁶

The ultimate issue rule and consequently the rule that an expert witness should not usurp the function of the court has been described by Wigmore as a “mere bit of empty rhetoric”.⁹⁷ Wigmore correctly notes that there is no reason for such rule as the witness is not attempting to “usurp” the function of the tribunal of fact as he or she is merely offering a portion of testimony which could still be rejected in favour of an alternative view.⁹⁸ With regard to psychiatric testimony on the ultimate issue, Schiffer describes the rule as “an artificial and functionless rule of semantics”.⁹⁹ Within the South African legal system where there is no jury system

⁹⁴ Zeffert and Paizes (2009) *supra* note 2 at 318; Schwikkard and Van der Merwe (2009) *supra* note 2 at 88-89. See also *DPP v A and BC Chewing Gum Co Ltd* 1968 AC 159 at 164 where Lord Parker held: “... I cannot help feeling that with the advance of science more and more inroads have been made into the old common law principles. Those who practice in the criminal courts see everyday cases of experts being called on the question of diminished responsibility and although technically the final question “Do you think he was suffering from diminished responsibility” is strictly inadmissible, it is allowed time and again without any objection.”

⁹⁵ *Ibid.*

⁹⁶ Emphasis added.

⁹⁷ Wigmore, JH “Evidence in Trials at Common Law” (1978) paragraph 1920 at p 18-19.

⁹⁸ *Ibid.* See also *Gentiruco AG v Firestone SA (Pty) Ltd* 1972 (1) SA 589 (A) at 616 E-H.

⁹⁹ Schiffer, ME “Mental Disorder and the Criminal Process” (1978) at 214 and also at 199 where he states: “Although the phrases “usurping the function of the jury” or “invading the province of the jury” are bandied about widely today in the context of expert opinion, it may be doubted whether they accurately describe the situations to which they are commonly applied. When such label is affixed to the expression by an expert witness of an opinion on an “ultimate issue” which the jury are to decide, it is submitted that the description is inaccurate. If the expert is qualified in his field, the implication is that the opinion he is expressing is one which the triers of fact could not themselves have formulated; otherwise the expert wouldn’t be there in the first place. So when a psychiatrist expresses his opinion that an accused was insane at

anymore, it is submitted that the ultimate issue rule is redundant and superfluous. Expert evidence from psychiatrists and psychologists should be received or rejected on the basis of its relevance and helpfulness.

Meintjes-Van der Walt correctly state that even where expert evidence is allowed on the ultimate issue, it remains evidence to be weighed by the trier of fact and accordingly the admission of such evidence does not imply reliance on such evidence.¹⁰⁰ Expert opinion evidence should be judged on the basis of its relevance to the issues before the court and whether it can adequately assist the trier of fact in the assessment of the relevant issues. It could further be argued that mental health professionals, taking into consideration the boundaries of their own professional expertise, should be allowed to express their opinions liberally with regards to the findings as to the mental state of an accused person. At the end of the day it remains within judicial discretion to determine the appropriate weight to be accorded to such evidence. In *Ruto Flour Mills Ltd v Adelson (1)*¹⁰¹, Boshoff J held the following:¹⁰²

“An expert’s opinion is received because and whenever his skill is greater than the court’s ... The fact that an expert expresses an opinion on a matter which the court has to decide does not, in itself, make the evidence inadmissible ... where the issue involves other elements besides purely scientific, the expert must confine himself to the latter and must not give his opinion upon the legal or general merits of the case. Where, however, the issue is substantially one of science or skill merely, the expert may, if he has himself observed the facts, be asked the very question which the jury have to decide.”

This quotation could also be applied to the sciences of psychiatry and psychology. From a psychiatric perspective, Halleck notes that psychiatric testimony is generally required for purposes of providing facts of an accused’s mental illness;

the time he committed an act, he is lending his special knowledge to the jury to aid them in performing their function.”

¹⁰⁰ Meintjes-Van der Walt (2001) *supra* note 2 at 166; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 251-252.

¹⁰¹ *Ruto Flour Mills Ltd v Adelson* 1958 (4) SA 235 (TPD).

¹⁰² At 237 A-F.

to provide opinions relating to the nature of that illness; and to provide opinions as to whether the individual's illness was of such a nature to render him or her legally insane.¹⁰³ Halleck suggests that it is the third task which is more often than not, problematic as the process of converting clinical data into opinions as to how mental illness renders an individual legally insane and negating criminal responsibility, is a task for which a psychiatrist has "no training, no science, and no theories to guide him".¹⁰⁴ The cornerstone for the admission of such testimony should be relevance and helpfulness and not whether the witness addresses the ultimate issue. Slovenko correctly states that, similar to other forms of evidence, the trier of fact retains a discretion to exclude expert evidence if it is established that its probative value is substantially outweighed by its prejudicial effect or if its admission would confuse the issues, result in a delay of the proceedings or waste of judicial resources.¹⁰⁵ Slovenko in addition states:¹⁰⁶

"Ultimately, the rule simply ignores the principle that the touchstone in the law of expert evidence is helpfulness."

Gilmer, Louw and Verschoor submit that there are principally two motivations why mental health experts should refrain from providing opinions on ultimate legal issues – the first reason relates to the ethical dilemma of purporting to be scientific where there are no bases for such pretension. The second reason relates to

¹⁰³ Halleck (1980) *supra* note 2 at 213.

¹⁰⁴ *Ibid.*

¹⁰⁵ Slovenko, R "Commentary: Deceptions to the Rule on Ultimate Issue Testimony" (2006) *Journal of American Academy of Psychiatry and the Law* 22 at 25.

¹⁰⁶ *Ibid.* See also Freckelton and Selby (2005) *supra* note 2 at 294-295 where they note proposed law reform in New Zealand in the form of legislation, the New Zealand Law Commission recommended that the term "expert" be defined as a "person with specialized knowledge or skill based upon training, study or experience" and that expert evidence "is evidence offered by a properly qualified expert that is within the expert's field of expertise". Most importantly the Commission recommended that opinion evidence should not be ruled inadmissible by the mere fact that it deals or addresses an ultimate issue. See also Roger, R, Bagby, RM and Chow, MMK "Psychiatrists and the Parameters of Expert Testimony" (1992) *International Journal of Law and Psychiatry* at 387-396 at 387 where they note: "The effects on judges and juries of how expert testimony is presented have gone largely unnoticed in the professional literature. One notable exception has been the barrage of criticism levied at mental health experts for their overreaching testimony in insanity trials. A particularly contentious issue is whether conclusory opinions on the matter of insanity "invade the province of the jury" by unduly influencing jurors' perceptions and subsequent verdict."

instances where the expert by doing so “usurps” the function of the court.¹⁰⁷ Gilmer, Louw and Verschoor note that a court may admit whatever evidence it deems fit in a specific case, weigh the probative value thereof and assume responsibility for the result which follows.¹⁰⁸ Where an expert, however, seeks to express an opinion beyond that arising from knowledge, training and expertise, the expert will cease in providing an expert opinion and venture into providing “an illegitimate opinion as a person who happens to be an expert in a non-relevant field”.¹⁰⁹ According to Gilmer, Louw and Verschoor the question as to whether a witness is “usurping” the function of the court, is in principle the court’s concern and they state the following:¹¹⁰

“The expert’s concern is to remain within the generally accepted terrain of that discipline and to follow the court’s direction as to the questions the court desires be answered.”

Mental health professionals should be permitted to testify as to their clinical findings in respect of an accused. Whether the opinion testimony is couched in terminology of a conclusory nature should be of less concern and should yield to the greater need for assessing the mental state of the accused at the time of the offence as comprehensively and thoroughly as possible.

3.5 The Basis rule

The essential value of a psychiatric or psychological opinion is dependent on the basis upon which it is founded. The basis rule entails that expert witnesses must state the facts or reasons upon which their opinions are founded.¹¹¹ One of the

¹⁰⁷ Gillmer, BT, Louw, DA and Verschoor, T “Forensic Expertise: the psychological perspective” (1995) SACJ 249-270 at 268. See also Kenny, A “The psychiatric expert in court” (1984) *Psychological Medicine* at 291.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ Meintjes-Van der Walt (2001) *supra* note 2 at 166; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 252; Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 346; Schiffer (1978) *supra* note 2 at 201; Schmidt (2000) *supra* note 2 at 466; Allan in Tredoux *et al* (2005) *supra* note 2 at 294-295; Keane (2006) *supra* note 2 at 565-566; Zeffert and Paizes (2009) *supra* note 2 at 325-326; Freckelton and Selby (2005) *supra* note 2 at 209; Schwikkard and Van der Merwe (2009) *supra* note 2 at 97-99.

most authoritative expositions of the basis rule was expressed by Lawton LJ in the case of *R v Turner*¹¹² where it was held:¹¹³

“It is not for this court to instruct psychiatrists how to draft their reports, but those who call psychiatrists as witnesses should remember that the facts upon which they base their opinions must be proved by admissible evidence. This elementary principle is frequently overlooked.”

In *Coopers (South Africa) (Pty) Ltd v Deutche Gesellschaft für Schädlingsbekämpfung Mbh*¹¹⁴ Wessels JA similarly described the basis rule as follows:¹¹⁵

“... an expert’s opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some of her competent witnesses. Except possibly where it is not controverted, an expert’s bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, is disclosed by the expert.”

And further:¹¹⁶

¹¹² *R v Turner* (1975) 1 QB 834.

¹¹³ At 834. See also Freckelton and Selby (2005) *supra* note 2 at 213.

¹¹⁴ *Coopers (South Africa) (Pty) Ltd v Deutche Gesellschaft für Schädlingsbekämpfung Mbh* 1976 (3) SA 352 (A). See also Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 346; Meintjes-Van der Walt (2001) *supra* note 2 at 166-167; Schmidt (2000) *supra* note 2 at 467; Schwikkard and Van der Merwe (2009) *supra* note 2 at 97.

¹¹⁵ At 371 F-H. See also *R v Jacobs* 1940 TPD 142 at 146 where Rowbottom J held: “... it is held at the greatest importance that the value of the opinion should be capable of being tested and unless the expert states the grounds upon which he bases his opinion, it is not possible to test its correctness so as to form a proper judgment upon it.”

¹¹⁶ At 371 H-372 A. See also the decision of *R v Noll* (1999) 3 VR 704, VSCA 164 at 3 where Ormiston JA held: “As a matter of principle, as exemplified by the authorities, experts can speak of many matters with authority if their training and experience entitle them to do so, notwithstanding that they cannot describe in detail the basis of knowledge in related areas. Professional people in the guise of experts can no longer be polymaths they must, in this modern era, rely on others to provide much of their acquired expertise. Their particular talent is that they know where to go to acquire that knowledge in a reliable form.” See also Freckelton and Selby (2005) *supra* note 2 at 210.

“Where the process of reasoning is not simply a matter of ordinary logic, but involves, for example, the application of scientific principles, it will ordinarily also be necessary to set out the reasoning process in summarised form.”

Meintjes-Van der Walt submits that the basis rule is usually not deemed as an admissibility rule of expert evidence, but is rather taken into consideration during evaluation of expert evidence.¹¹⁷ The issue as to admissibility comes into play due to the practice of expert witnesses to provide opinion evidence on information or data provided by others and consequently these experts employ hearsay to a certain extent in forming their opinions.¹¹⁸ The problem that arises is that if the rule against hearsay evidence is applied strictly, an expert will be prevented from providing his or her expert opinion due to the fact that his or her inferences and conclusions are often governed by knowledge acquired during the course of his or her training, professional practice as well as information acquired through reading or which he or she heard from others who possess the specialised knowledge.¹¹⁹

¹¹⁷ Meintjes-Van der Walt (2001) *supra* note 2 at 167; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 252; Schwikkard and Van der Merwe (2009) *supra* note 2 at 97; Freckelton and Selby (2005) *supra* note 2 at 210.

¹¹⁸ *Ibid.*

¹¹⁹ Meintjes-Van der Walt (2001) *supra* note 2 at 167; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 253; Schwikkard and Van der Merwe (2009) *supra* note 2 at 100. For purposes of this study hearsay evidence will not be addressed but it suffices to note that matters relating to hearsay evidence are regulated in terms of section 3 of the Law of Evidence Amendment Act 45 of 1988. Section 3(4) defines hearsay evidence as: “... evidence, whether oral or in writing the probative value of which depends upon the credibility of any person other than the person giving such evidence.” Section 3 further provides the following in respect of hearsay evidence: “(1) Subject to the provisions of any other law, hearsay evidence shall not be admitted as evidence at criminal or civil proceedings, unless – (a) each party against whom the evidence is to be adduced agrees to the admission thereof as evidence at such proceedings; (b) the person upon whose credibility the probative value of such evidence depends, himself testifies at such proceedings; or (c) the court having regard to – (i) the nature of the proceedings; (ii) the nature of the evidence; (iii) the purpose for which the evidence is tendered; (iv) the probative value of the evidence; (v) the reason why the evidence is not given by the person upon whose credibility the probative value of such evidence depends; (vi) any prejudice to a party which the admission of such evidence might entail; and (vii) any other factor which should in the opinion of the court be taken into account, is of the opinion that such evidence should be admitted in the interests of justice. (2) The provisions of subsection (1) shall not render admissible any evidence which is inadmissible on any ground other than that such evidence is hearsay evidence. (3) Hearsay evidence may be provisionally admitted in terms of subsection (1)(b) if the court is informed that the person upon whose credibility the probative value of such evidence depends, will himself testify in such proceedings: Provided that if such person does not later testify in such proceedings, the hearsay evidence shall be left out of account unless the hearsay evidence is admitted in terms of paragraph (a) of subsection (1) or is admitted by the court in terms of paragraph (c) of that subsection.” See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 269-284; Pattenden, R “Expert Opinion Evidence Based on Hearsay” (1982) *The Criminal Law Review* at 85-96.

Meintjes-Van der Walt indicates that as a result of the logistical dilemmas which would arise if every original source is to be called as a witness, the hearsay rule has been relaxed and accordingly where expert opinion evidence is presented and all its bases have not been proved to the court, the rule has developed that such basis material must be proved by way of admissible evidence.¹²⁰ An expert witness may therefore rely on information which would technically amount to hearsay evidence as a result of the necessity thereof in practice due to the fact that scientific issues frequently entail reliance upon data and information advanced by others.¹²¹ In *S v Kimimbi*¹²² Watermeyer J held the following:¹²³

“No one professional man can know from personal observations more than a minute fraction of the data which he must every day treat as working truths. Hence a reliance on the reported data of fellow scientists learned by perusing their reports in books and journals. The law must and does accept this kind of knowledge from scientific men ... to reject a professional physician or mathematician because the fact or some of the facts to which he testifies are known to him only upon the authority of others, would be to ignore the accepted methods of professional work and to insist on impossible standards.”

Expert witnesses relying on information espoused in textbooks written by others who are not called as witnesses, will not make use of hearsay and such evidence will generally be admissible provided that the requirements as enunciated in

¹²⁰ Meintjes-Van der Walt (2001) *supra* note 2 at 167; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 253; Schwikkard and Van der Merwe (2009) *supra* note 2 at 100; Schmidt (2000) *supra* note 2 at 466.

¹²¹ Zeffert and Paizes (2009) *supra* note 2 at 325; Schwikkard and Van der Merwe (2009) *supra* note 2 at 100.

¹²² *S v Kimimbi* 1963 (3) SA 250 (CPD). See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 100-101; Zeffert and Paizes (2009) *supra* note 2 at 325. See also Moenssens, AA, Moses, RE and Inbau, FE “Scientific Evidence in Criminal Cases” (1973) at 86-87 where it is noted: “Technically, the diagnostic opinion of the psychiatrist is required by the hearsay rule of evidence to be based upon his own findings rather than those of third parties. This restriction is highly questionable since much of the information that a psychiatrist normally relies upon in forming an opinion is derived from out-of-court statements, medical reports and other sources deemed hearsay by the law ... As a matter of practice, many courts informally carve out an exception to the hearsay rule and allow the defense psychiatrist to testify to an opinion based in part on hearsay. Such statements may also be permitted without the hearsay rule or as exceptions to it on the ground that the truth or falsity of the statements is not in issue, but rather that the out-of-court statements served only as a basis of the expert’s opinion.

¹²³ At 251 H-252 A.

*Menday v Protea Assurance Co Ltd*¹²⁴, are complied with. These are the following:¹²⁵

- Firstly, the expert must by virtue of his or her own training be able to affirm the correctness of the statements in the particular book;
- Secondly, the work or publication must be reliable in the sense that it has been written by an individual with an established reputation or proved experience in that field.

Addleson J in addition held:¹²⁶

“... an expert with purely theoretical knowledge cannot in my view support his opinion in a special field (of which he has no personal experience) by referring to passages in a work which has itself not been shown to be authoritative. Again the dangers of holding the contrary are obvious.”

In *S v Jones*¹²⁷, Van Reenen J held that due to the fact that opinions expressed in textbooks do not amount to evidence *per se*, and strictly amount to hearsay, a court may not rely on them unless confirmed by an expert under oath.¹²⁸ Hiemstra also indicates that books and publications of highly acclaimed experts, who are acknowledged within the professional field may be used only by an individual who is also an expert provided that the witness establishes a foundation by expressing

¹²⁴ *Menday v Protea Assurance Co Ltd* 1976 (1) SA 565 (ECD).

¹²⁵ At 569 H. See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 100-101; Zeffert and Paizes (2009) *supra* note 2 at 325.

¹²⁶ *Ibid.* See also Feckelton and Selby (2005) *supra* note 2 at 216-217 where they discuss the decision of *R v Abadom* (1983) 1 WLR 126 at 131, 1 ALL ER 364 at 369, 76 *Crim App R* 48 at 53 where it was held: “Where an expert relies on the existence of some fact which is basic to the question on which he is asked to express his opinion, that fact must be proved by admissible evidence ... where the existence or non-existence of some fact is in issue, a report made by an expert who is not called as a witness is not admissible as evidence of that fact merely by the production of the report, even though it was made by an expert. These, however, are in our judgment the limits of the hearsay rule in relation to evidence of opinion given by experts, both in principle and on the authorities ... Once the primary facts on which their opinion is based have been proved by admissible evidence, they are entitled to draw on the work of others as part of the process of arriving at their conclusions. However, when they have done so, they should refer to the material in their evidence so that the cogency and the probative value of their conclusion can be tested and evaluated by reference to it ...” See also Meintjes-Van der Walt (2001) *THRHR supra* note 2 a 253.

¹²⁷ *S v Jones* 2004 (1) SACR 420 (CPD).

¹²⁸ At 427 c-d. See also *S v Collop* 1981 (1) SA 150 (A) at 167 B; Zeffert and Paizes (2009) *supra* note 2 at 326.

his or her own professional knowledge and experience, whereafter additional supporting authority may be quoted.¹²⁹ In terms of cross-examination, books and writings may be presented to an expert and if the expert acknowledges the authority of the work, the expert may be asked whether he or she agrees with the views enunciated therein and if he or she does, such passages will also become part of the expert evidence.¹³⁰ Other passages from the same publications are not regarded as evidence and may not be used by the court.¹³¹

Allan notes that there are various sources of information an expert can utilize to form an opinion, which include:¹³²

- Psychologists can provide an expert opinion as to statements made by their clients pertaining to specific symptoms provided it is not presented as evidence of the truth of what is contended, but rather to assess the accused's state of mind. Evidence of this nature is only provided to prove the existence of specific symptoms and does not serve as evidence of how they were caused, and if the source of evidence is discredited, the opinion of the expert will become valueless;
- Accumulated professional knowledge;
- Notes or reports of mental health professionals who treated or assessed the individual;
- Articles, research papers, professional literature or written material published by peers in scientific journals, provided the experts has adequate experience to enable them to identify reliable and proper sources of information. The personal assessment in the general subject must enable them to estimate the viability of the views expressed. There must be no alternative means of obtaining the specific information;
- Relevant research, tests or experiments, provided that such information forms part of the general body of knowledge falling within the field of

¹²⁹ Hiemstra (2009) *supra* note 2 at 24-26.

¹³⁰ *Ibid.*

¹³¹ *Ibid.* See also *R v Mofokeng* 1928 (AD) 132 at 136, where a conviction was set aside where reliance was placed on a passage which was not presented to the expert witness during trial and which was in conflict with the expert's opinion.

¹³² Allan in *Tredoux et al* (2005) *supra* note 2 at 294-295; Meintjes-Van der Walt (2003) *Journal of African Law* 88-106.

expertise of the experts which is related to their own research or practical work.

One of the most important aspects of the basis rule entails that the expert must provide valid and sound reasons for his or her opinion. The latter will increase the probative value of the opinion and also establish a sound foundation for it. In *S v Ramgobin and Ohters*¹³³, Milner JP held that an expert must be able to provide detailed reasons for his or her conclusions together with an accurate account of the assessments conducted for the purpose of arriving at such conclusions.¹³⁴ It was further held that such conclusions do not always necessarily have to be propounded in the form of a written report and accordingly experts are permitted to refresh their memories, reports and notes.¹³⁵ It is essential that expert evidence should be connected to the facts of the case and not amount to mere abstract theory or a bald statement of opinion unrelated to the circumstances or facts of the case.¹³⁶ Similarly, expert opinion will be deemed inadmissible if it is founded on a hypothetical situation which proves to be inconsistent with the proven facts.¹³⁷ It is further important that an expert opinion should be that of the expert and not counsel's interpretation presented to the expert witness.¹³⁸ A Court of Appeal retains the same capacity as the trial court to evaluate the reasoning of an expert opinion.¹³⁹

It is pivotal that expert witnesses clearly and coherently state the reasons and facts upon which their opinion is based. In cases where the defence of criminal incapacity is invoked, this rule will inadvertently be applicable to psychiatrists and

¹³³ *S v Ramgobin and Others* 1986 (4) SA 117 (NPD).

¹³⁴ At 146 E-G.

¹³⁵ *Ibid.* See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 97.

¹³⁶ This principle has already been addressed in chapter 3 *supra* with reference to the cases of *S v Mngomezulu* 1972 (1) SA 797 (A) and *S v Laubscher* 1979 (3) SA 47 (A) at 60 C, 62 A-B. See also Schmidt (2000) *supra* note 2 at 466; Schwikkard and Van der Merwe (2009) *supra* note 2 at 99; *S v Mkhole* 1990 (1) SACR 95 (A) at 100 C-D; *S v Boyce* 1990 (1) SACR 13 (T) at 19; Zeffert and Paizes (2009) *supra* note 2 at 326-327. See also Strauss, SA "Doctor, patient and the Law – A selection of practical issues" (1991) at 131. See also *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MbH* 1976 (3) SA 352 (A) at 371 F-H.

¹³⁷ Schwikkard and Van der Merwe (2009) *supra* note 2 at 99; *S v Mngomezulu* 1972 (1) SA 797 (A).

¹³⁸ *Ibid.*

¹³⁹ Schwikkard and Van der Merwe (2009) *supra* note 2 at 100. See also *Stock v Stock* 1981 (3) SA 1280 (A) at 1296 F.

psychologists. Within an era of constitutionalism, it is doubtful whether an accused or his or her legal representative or even the court will be able to adequately challenge an opinion if such basis for the opinion is absent.¹⁴⁰ The constitutional right of an accused to a fair trial with reference to the right to adduce and challenge evidence will thus be jeopardised where opinion evidence by a mental health expert is not sufficiently motivated and such evidence should be inadmissible against an accused. Meintjes-Van der Walt correctly submits that stating the basis for an expert's opinion is pivotal to the judicial decision-making process:

“... as without stating the facts or data upon which such opinions are based, their bold statements provide no means of accountability.”¹⁴¹

4 The probative value and weight of expert evidence

One of the most problematic areas pertaining to expert evidence relates to the assessment of its probative value. As it is difficult, if not impossible, to formulate set criteria or rules for determining probative value, the task of assessing probative value will fall upon the trier of fact. The problem of assessing probative value is further exacerbated if there are divergent opinions within the medical field itself. Zeffert and Paizes note that the court often does not have any means in terms of which to test the expert's conclusions and if consequently there is a conflict of expert evidence on issues where the motivations for the opinion is beyond the grasp of the trier of fact, it may have to resort to doubtful criteria such as the rival witness's reputation and experience.¹⁴² Zeffert and Paizes state that the resolution

¹⁴⁰ See also Schmidt (2000) *supra* note 2 at 467. See also *S v Williams* 1985 (1) SA 750 (C) at 752-753 where Aaron AJ held that the requirement that reasons be advanced for inferences of expert witnesses generally relate more to the weight accorded to the evidence, than to its admissibility. Zeffert and Paizes (2009) *supra* note 2 at 328, however, correctly note that often a failure to provide reasons may deprive an opinion of any weight and accordingly such opinion will lack any probative value and will be irrelevant and consequently inadmissible.

¹⁴¹ Meintjes-Van der Walt (2001) *supra* note 2 at 170-171; Meintjes-Van der Walt (2001) *THRHR supra* note 2 at 255. See also Zeffert and Paizes (2009) *supra* note 2 at 326.

¹⁴² Zeffert and Paizes (2009) *supra* note 2 at 328. See also *S v Malindi* 1983 (4) SA 99 (TPD) at 104 H-105 A where this approach was encroached by Le Roux J. See also Hoffmann and Zeffert (1988) *supra* note 2 at 103-104; Schmidt (2000) *supra* note 2 at 470. See also Crous, AJ “Die beslegtingsproblematiek in gevalle van mediese wanpraktykgeskille” (1996) *THRHR* at 22-33 at 24-25 where it is stated: “Die primêre taak van ‘n deskundige is om aan die hof leiding te gee om ‘n juiste beslissing te maak ten opsigte van vrae wat binne sy

of such conflict will generally not be reliant on credibility, but rather on the inherent reasoning behind it. They submit the following:¹⁴³

“A court which relies upon an expert’s opinion is therefore, to a greater or lesser extent, at times taking a step in the dark – something which should be done, if ever at all – only with considerable caution. But usually, the determination ..., depends on the examination of the opinions and the analysis of the reasoning behind them.”

A landmark decision where the Supreme Court of Appeal authoritatively dealt with the approach to be followed in respect of considerations applicable in the assessment of expert medical evidence, is the decision of *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*¹⁴⁴. Although this decision dealt with medical negligence and was not a criminal matter relating to the defence of criminal incapacity, the guidelines enunciated therein for the assessment of expert medical evidence can nevertheless also be made applicable to the presentation of expert evidence in cases where the defence of criminal incapacity is raised.¹⁴⁵ The Supreme Court of Appeal held that it is essential in the evaluation of expert evidence to determine whether and to what extent the opinions advanced are

gespesialiseerde veld ontstaan; sy persoonlike bevinding dien nie as plaasvervanger vir die bevinding van die hof wat tot ‘n beslissing moet kom oor die aangeleentheid voor hom nie.”

¹⁴³ Zeffert and Paizes (2009) *supra* note 2 at 328.

¹⁴⁴ *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA). See also Carstens, PA and Pearmain, D “Foundational Principles of South African Medical Law” (2007) at 784-791.

¹⁴⁵ As medical negligence falls beyond the scope of this study, the facts and decision of *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA) will not be addressed and the emphasis will be placed solely on the Supreme Court of Appeal’s approach towards the assessment of expert medical evidence. For an in depth discussion of the facts and decision of this case see Carstens (2002) *THRHR supra* note 2 at 430; Carstens and Pearmain (2007) *supra* note 2 at 784-791. See also Carstens, PA “Nalatigheid en Verskillende gedagterigtings (“schools of opinion”) Binne die mediese praktyk – *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W)” *THRHR* at 673; *Castell v De Greeff* 1994 (4) SA 408 (CPD) at 426 H-J where Ackermann J held: “Expert medical evidence would be relevant to determine what risks inherent in or are the result of particular treatment (surgical or otherwise) and might also have a bearing on their materiality but, in the words of the Supreme Court of Canada in *Reibl v Hughes* ... ‘this is not a question that is to be concluded on the basis of expert medical evidence alone’ – ‘The ultimate question’, ... is ‘whether (the defendant’s conduct) conforms to the standard of reasonable care demanded by the Law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.’” This decision illustrates the approach followed in cases of medical negligence. See also *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (WLD).

founded on logical reasons.¹⁴⁶ It was further held, albeit with reference to medical negligence, that a court is not bound to absolve a defendant from liability for allegedly negligent medical intervention just because evidence of expert opinion, albeit genuinely held, is that the conduct in issue accorded with sound practice.¹⁴⁷ The court must further be satisfied that such opinion had a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion. If a body of professional opinion overlooks an obvious risk which could have been guarded against, it will not be reasonable, even if almost universally held.¹⁴⁸ The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence, and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide the benchmark by reference to which the defendant's conduct fails to be assessed.¹⁴⁹ It was also held that expert scientific witnesses tend to assess likelihood in terms of scientific certainty.¹⁵⁰ It is clear that the assessment of the probative value of expert evidence is a difficult task. It is essential, where conflicting medical opinions are advanced, to weigh each portion of expert evidence carefully.¹⁵¹ In cases where criminal incapacity is raised as a defence,

¹⁴⁶ At 1200 I-J. See also Carstens (2002) *THRHR supra* note 2 at 433; Carstens and Pearmain (2007) *supra* at 86.

¹⁴⁷ At 1201 A-B. See also Carstens (2002) *THRHR supra* note 2 at 433; Carstens and Pearmain (2007) *supra* 861. See also *Van Wyk v Lewis* 1924 (AD) 438 at 447-448 where Innes CJ held: "The testimony of experienced members of the (medical) profession is of the greatest value in questions of this kind. But the decision of what is reasonable under the circumstances is for the court; it will pay high regard to the views of the profession, but is not bound to adopt them."

¹⁴⁸ *Ibid.*

¹⁴⁹ At 1201 D-E. See also Carstens (2002) *THRHR supra* note 2 at 433; Carstens and Pearmain (2007) *supra* note 2 at 862.

¹⁵⁰ At 1201 E-F. See also *Dingley v The Chief Constable, Strathclyde Police* 2000 SC (HL) 77 at 89 D-E where House of Lords held: "(o)ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been provided or disproved." See also Carstens (2002) *THRHR supra* note 2 at 433. See also *Bolitho v City and Hackney Health Authority* 1998 AC 232 (HL). See also Zeffert and Paizes (2009) *supra* note 2 at 329.

¹⁵¹ See also Carstens and Pearmain (2007) *supra* note 2 at 790-791 where Carstens advances several points of criticism in respect of the decision in *Michael v Linksfield Park Clinic (Pty) Ltd supra*. Carstens submits that the analysis of the nature of expert evidence in relation to the test for medical negligence is problematic in respect of the context in which it is applied and submits that the latter is "somewhat clouded". Carstens in addition notes that the latter is also evident with regards to the court's assessment of conflicting schools of thought in medical

this principle will require the balancing of expert opinion advanced by both the prosecution and defence in order to derive at a sound decision as to the accused's mental state at the time of the offence. Barlow encapsulates the dilemma in respect of the probative value of expert evidence by stating:¹⁵²

“The question arises as to what regard the courts must pay to medical opinion. Must the courts make medical men the final judges ... or must they decide questions involving medical theory and dispute? ... The difficulty that faces the legal man is, however, that of judging upon the correctness of work that is highly skilled and beyond his providence. The practice of our courts has been to weigh up carefully the medical evidence presented to it by both sides but to keep the final decision in their own hands.”

In *Louwrens v Oldwage*¹⁵³, the Supreme Court of Appeal overturned a judgment of the court *a quo* where the latter rejected the evidence of the defendant's experts in favour of the plaintiff's experts without providing reasons for doing so.¹⁵⁴ It was held that on a proper approach, the choice of or preference of one version over the

practice. According to Carstens the court correctly found that it must be satisfied that the medical opinion advanced should have a logical basis, but the court, however, held, albeit in respect of medical negligence, that a defendant can be held liable if the supporting body of expert evidence is not capable of withstanding logical analysis and is therefore not reasonable. Carstens submits that the court's indication that logic is indicative of reasonableness or, put differently, that the absence of logic is indicative of unreasonableness is problematic. Carstens submits that expert's medical opinion founded on logic is not necessarily indicative of reasonableness. Carstens notes: “Logic refers to process of reasoning/rationality based on scientific or deductive cause and effect. Therefore a given result or inference is either logical or illogical. Reasonableness on the other hand is a value judgment indicative of or based on an accepted standard or norm while it is true that logic more often than not is an integral part of reasonableness, it does not necessarily follow that logic can be equated to reasonableness.” See also Carstens (2002) *THRHR supra* note 2 at 434-435.

¹⁵² Barlow, TB “Medical Negligence Resulting in Death” (1948) *THRHR* 173-190 at 178. See also the approach followed in *Webb v Isaacs* 1915 EDL 273; *Coppen v Impey* 1916 CPD 309 in respect of medical negligence cases.

¹⁵³ *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

¹⁵⁴ It is to be noted that this decision also dealt with medical negligence but is discussed within the scope of this study for the sole purpose of exhibiting the Supreme Court of Appeal's approach to expert evidence. The salient facts of the decision were that the plaintiff was successful in the High Court in his action for damages for the negligent performance upon him of a surgical procedure by the defendant. The plaintiff's success was based on a resolution in his favour of the essential dispute of fact between the parties, with the court preferring the evidence of the plaintiff and his expert witness to the evidence of the defendant and his expert witness but without providing reasons for its preference. The Supreme Court of Appeal, however, held that the evidence of the defendant and his expert was to be accepted and the evidence of the plaintiff and his expert was to be rejected (see paragraph (18) at 170 C-E of the judgment).

other ought to be preceded by an evaluation and assessment of the credibility of the relevant witness, their reliability and the probabilities.¹⁵⁵ It was in addition held that the uncritical acceptance of the plaintiff's expert evidence and the rejection of the defendant's expert witnesses fall short of the general standard.¹⁵⁶ The Supreme Court of Appeal reiterated that it was required of the trial Judge to determine to what extent the opinions advanced by the various experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in the light of probabilities.¹⁵⁷ According to Carstens and Pearmain, the probative value of expert medical evidence is dependent upon the qualifications, skill and degree of expertise of the expert witness and also the ability of the court to evaluate this testimony.¹⁵⁸ Expert medical testimony will often be so technical in nature that the court will find it difficult to reach reliable conclusions on its own, especially where there are conflicting opinions.¹⁵⁹ It is submitted that the approach suggested in the *Michael v Linksfeld Park Clinic (Pty) Ltd* decision, subsequently reaffirmed in *Holtzhauzen v Roodt*, provides a useful approach to follow in assessing the probative value of expert medical testimony which could inadvertently apply to cases where the defence of criminal incapacity is raised.

Carstens notes that where there are conflicting expert opinions or different schools of thought within the medical profession, even a conflicting and minority school of thought or expert opinion will be acceptable, subject to the fact that such opinion is in line with what is deemed to be reasonable within a specific branch of the medical profession.¹⁶⁰ It is clear that the probative value of expert evidence is inherently affected when there are divergent and conflicting medical opinions advanced. The latter is also often referred to as the "battle of the experts". Gutheil and Appelbaum indicate that the latter is precisely why mental health professionals often abstain from courtroom proceedings as this "battle of the experts" creates the impression that expert opinion is available to the "highest bidder" with an

¹⁵⁵ At 167 H-J.

¹⁵⁶ At 175 G-I.

¹⁵⁷ At 175 H-J. See also Carstens and Pearmain (2007) *supra* note 2 at 862.

¹⁵⁸ Carstens and Pearmain (2007) *supra* note 2 at 861.

¹⁵⁹ *Ibid.*

¹⁶⁰ Carstens (2002) *THRHR supra* note 2 at 435. See also Gutheil and Appelbaum (2000) *supra* note 2 at 34.

absence of knowledge on which their opinions are based.¹⁶¹ Schiffer notes that one of the main reasons psychiatrists disagree is more often than not, not related to the technical medical questions, but rather to the specific questions the law presented to them.¹⁶² Psychiatrists are pressured in expressing opinions beyond their fields of expertise.¹⁶³ Schiffer states:¹⁶⁴

“Because both psychiatrists A and B have diagnosed the accused as a psychopathic personality, does it follow that they will agree on whether or not the accused “knew that an act or omission was wrong?” Often the psychiatrist’s capacity for answering such questions is no better than that of the average layman; for the tools he must use in making the decision are not the tools of his profession, but rather the personalized values and morality he possesses as a private citizen.”

It is submitted that mental health professionals should be required to provide expert testimony which remains within the boundaries of their respective fields of expertise. It is essential that law and medicine acknowledge the boundaries of their respective professions. Allan and Meintjes-Van der Walt suggest the following considerations to be taken into account when according appropriate weight to expert testimony:¹⁶⁵

- Whether the expert was competent to perform the required assessments and test and to adequately evaluate the results thereof;
- Whether the expert was a credible witness taking into consideration the methods employed to collect data, the thoroughness of the investigations; and whether the expert was honest in providing his or her presentation of the facts and opinions;

¹⁶¹ Gutheil and Appelbaum (2000) *supra* note 2 at 34. See also Slovenko, R “Psychiatric Expert Testimony: Are the criticisms Justified? (Part 2)” (1991) *Medicine and Law* 107-127 at 113.

¹⁶² Schiffer (1978) *supra* note 2 at 216.

¹⁶³ *Ibid.* See also Slovenko (1991) *Medicine and Law supra* note 161 at 113.

¹⁶⁴ *Ibid.* See also Slovenko (1991) *Medicine and Law supra* note 161 at 114 where it is similarly noted: “And who has the task of translating psychobabble into legal babble? In humility, a number of psychiatrists when testifying say that “insanity”, “mental illness” or “mental disease” as used in law is a legal concept ... while other experts talk in the language of their discipline (for example, what is lung disease?), but the psychiatrist is obliged to talk in legal language.”

¹⁶⁵ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 352.

- Whether the opinion is causally connected to the facts of the case;
- The credibility of the facts on which the expert's opinion is founded and consequently if the source is discredited in court it will lessen the value of any opinion based on the facts provided by the source;
- Where two experts provide mutually exclusive opinions, courts will propose to reconcile the two opinions taking into consideration the full circumspection of the evidence and the probabilities as they view them.¹⁶⁶

When a court is confronted with conflicting medical opinions, one of the main considerations in the assessment of probative value should relate to the basis and reasons upon which such opinion is advanced. It is pivotal, however, that the opinion evidence on both sides be evaluated and considered on an equal footing. When a portion of expert evidence is accepted in favour of another portion or even when one side's expert opinion is accepted and the other side's rejected, the court should provide sound and logical reasons for doing so. When a court is forced to decide between conflicting opinions the court will be in the same position as when it has to assess the probative value of a single expert witness. The court will have to consider the expert's qualifications, his or her overall credibility as a witness and the extent to which his or her evidence was founded on a firm basis.

5 The presentation and evaluation of expert evidence

5.1 Adversarial *versus* Inquisitorial systems of justice

The mental health professional encountering the legal system, is confronted with a completely different context than that of clinical practice. The mental health expert called upon to testify in criminal proceedings, and thus in cases of criminal incapacity, will be faced with either the adversarial or inquisitorial system of criminal procedure. In order to fully comprehend the role of the mental health expert and the consequent role of the expert testimony presented by such expert, a brief elaboration of the essential differences between these two systems is required. The essential characteristics will be discussed below.

¹⁶⁶ See also *Botha v Minister of Transport* 1956 (4) SA 375 (W) at 378 B-E.

- **The adversarial system**

The adversarial system is uniquely described as a contest between two parties in the search to resolve a dispute before a passive and impartial presiding officer.¹⁶⁷ In the adversarial system much emphasis is placed on the presentation of oral evidence. Meintjes-Van der Walt indicates that the emphasis on oral evidence as opposed to written statements can be traced to the fact that within the adversarial model, the verbal confrontation between the witness and the cross-examiner is regarded as the most effective means to test the version of the witness.¹⁶⁸ In addition to the latter, the cross-examination of witnesses is pivotal as it is presumed that truth can be ascertained more sufficiently when parties introduce their evidence within a process which guarantees cross-examination.¹⁶⁹ Within the adversarial system, the presiding officer remains mainly passive and his or her role is to listen to the evidence which is presented by both parties and consequently render a decision and in this sense he or she is often described as an “umpire”¹⁷⁰. The presiding officer may, however, intervene when necessary in order to ensure that the trial proceeds speedily and effectively and as such he or she has the authority to pose additional questions to witnesses and also to call witnesses who have not been called by either party but who can nevertheless assist the court in the assessment of the issues.¹⁷¹ Within the adversarial context, each party is responsible for seeking evidence in support of their respective arguments and this principle is often referred to as the “contest” or “battle” theory where each party has to prove its own case and the judge remains impartial and

¹⁶⁷ Meintjes-Van der Walt (2001) *supra* note 2 at 40; Schwikkard and Van der Merwe (2009) *supra* note 2 at 9; Gutheil and Appelbaum (2000) *supra* note 2 at 34; Gillmer, BT, Louw, DA and Verschoor, T “Forensic expertise: the psychological perspective” (1995) *SACJ* at 259-270 at 262; Memon *et al* (2003) *supra* note 2 at 170-171; Chaplow, DG, Peters, JL and Kydd, RR “The Expert Witness in Forensic Psychiatry” (1992) *Aust NZJ Psychiatry* 624-630 at 626.

¹⁶⁸ Meintjes-Van der Walt (2001) *supra* note 2 at 41. See also Schwikkard and Van der Merwe (2009) *supra* note 2 at 9-10.

¹⁶⁹ *Ibid.*

¹⁷⁰ Meintjes-Van der Walt (2001) *supra* note 2 at 42.

¹⁷¹ Meintjes-Van der Walt (2001) *supra* note 2 at 43. See also section 186 of the Criminal Procedure Act 51 of 1977 which provides that a court “shall” *subpoena* and examine any person if his evidence proves “essential to the just decision of the case”.

ensures that the “rules of the game are observed”.¹⁷² The adversarial model is further epitomised by an extensive law of evidence with stringent rules in respect of the admissibility and exclusion of evidence.¹⁷³ For the mental health professional the adversarial system will be somewhat different from clinical practice. Gutheil, Bursztajn, Brodsky and Alexander note that within mental health care, ambiguity is generally the rule rather than the exception and this ambiguity is often used as a tool and truth “... appears to be measured against an absolute standard based upon empirical observations and consensus within the scientific community.”¹⁷⁴ Gutheil *et al* contrast the adversarial model with clinical practice and state:¹⁷⁵

“The adversarial system of the law is quite different. Its search for truth is procedural, rather than empirical, based upon the notion that each party to a dispute should argue the case from that party’s perspective and present what evidence it has, with truth determined by a neutral trier of fact according to the groundwork of rules. The law is primarily deontological – its “rightness” depends upon the extent to which proper procedures are followed in reaching the result, not whether the result provides the most good for the most people.”

South Africa, in principle, follows the adversarial system.¹⁷⁶ Schwikkard and Van der Merwe indicate that the criticisms levelled towards the adversarial system mainly comprise the following:¹⁷⁷

- The adversarial system presupposes a measure of equality between the parties;

¹⁷² Meintjes-Van der Walt (2001) *supra* note 2 at 44. See also Slovenko, R “Psychiatry in Law/Law in Psychiatry” (2002) at 4 where he states: “The adversary proceeding requires that lawyers, like gladiators, carry out their task in a fair or sporting manner.”

¹⁷³ *Ibid.*

¹⁷⁴ Gutheil, TG, Bursztajn, HJ, Brodsky, A and Alexander, U “Decision Making in Psychiatry and Law” (1991) at 174-175 (hereafter Gutheil *et al*).

¹⁷⁵ *Ibid.* See also Slovenko (2002) *supra* note 2 at 4 where he states that physicians are generally trained to search for medical truth whereas legal professionals are trained to represent any point of view.

¹⁷⁶ Meintjes-Van der Walt (2001) *supra* note 2 at 39.

¹⁷⁷ Schwikkard and Van der Merwe (2009) *supra* note 2 at 9-10.

- The underlying principle that the parties are involved in a legal contest may create conflict which does not necessarily resolve the issues;
 - The outcome of the case to a large extent is dependent on the experience and capabilities of the cross-examiner;
 - The partisan manner by which the parties are allowed to present evidence as well as the limited capacity of the trier of fact to intervene and call witnesses may promote procedural truth at the cost of material truth.
- **The inquisitorial system**

In contrast to the adversarial system, the presiding officer in the inquisitorial system assumes an active role based on the predisposition that the trial is not a contest between two parties but rather an assessment in search of material truth.¹⁷⁸ In terms of the inquisitorial system, emphasis is not placed on oral presentation of evidence or the practice of cross-examination and consequently the distinction between examination in chief and cross-examination is relatively rare.¹⁷⁹ Within the inquisitorial model the presiding officer actively participates in the trial by questioning witnesses as well as the accused and he or she is not bound by the evidence presented by the parties but can ensure that all relevant information be assessed and presented at trial.¹⁸⁰ Whereas quality of proof is the ultimate aim of the adversarial system, the search for truth is strived at in terms of the inquisitorial system.¹⁸¹ The rules of evidence are generally more relaxed and less stringent in terms of the inquisitorial system with the focus falling on the value to be attached to the evidence.¹⁸²

¹⁷⁸ Schwikkard and Van der Merwe (2009) *supra* note 2 at 10; Meintjes-Van der Walt (2001) *supra* note 2 at 42-44; Gillmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 262.

¹⁷⁹ *Ibid.*

¹⁸⁰ *Ibid.*

¹⁸¹ Gillmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 262.

¹⁸² See Meintjes-Van der Walt (2001) *supra* note 2 at 45 and also 47 where she provides a helpful synopsis of the distinctions between the adversarial and inquisitorial systems:

Adversarial system

Inquisitorial system

The distinction between adversarial and inquisitorial systems are discussed as the specific system which is followed will inadvertently affect the role of the expert witness as well as the probative value attached to such expert evidence. As South Africa in principle follows an adversarial system, aspects such as pre-trial disclosure and cross-examination of expert witnesses become important and will be discussed below. It is apparent that from an inquisitorial point of view, the rules pertaining to expert evidence will be less stringent than in the case of the adversarial model. A question to be posed is whether the value of expert evidence will not receive better recognition in terms of a more inquisitorial model of evidence.

5.2 The role of the expert

The mental health expert witness has numerous roles to portray when engaging in the legal process and consequently also when testifying in support of the defence of criminal incapacity. Gutheil and Simon encapsulate the role of the forensic mental health expert under the labels of consultant, businessperson, teacher or

-
- | | |
|---|--|
| <ul style="list-style-type: none"> • Court decisions are an important source of law • <i>Stare decisis</i> for continuity • Elaborate decisions to be followed • Control as exercised by courts over investigations is retrospective by means of rules of evidence • Judicial passivity • Parties responsible for obtaining and presenting evidence • Accused pleads guilty/not guilty • Decision founded entirely upon material adduced by parties • Oral evidence, with cross-examination the primary test for reliability of testimony • No inference of guilty from accused's silence • Little disclosure of defence case before trial • Trial as the site of contest • Institutional trust reposed in dialectic of parties and finder of fact | <ul style="list-style-type: none"> • Legislation is usually the important source of law • No <i>stare decisis</i> • Brief decisions, not creating precedent although superior court decisions are often followed in practice • Contemporaneous judicial control of investigation in accordance with code of criminal procedure • Judicial activity • Court has power to obtain evidence • Accused not required to plead • Decision can be based upon any material lawfully available to the court • Generally written evidence is preferred above oral evidence • Inference of guilty from accused's silence may legitimately be made • Full disclosure of prosecution and defence cases prior to trial • Trial as verification of dossier • Institutional trust reposed in state officials |
|---|--|

educator, advocate, witness and performer.¹⁸³ The most prominent of these roles will be discussed below.

- **Consultant**

The expert witness typically functions as a consultant from the very outset of being retained by the instructing attorney and as such the expert provides consultation on aspects pertaining to psychiatry.¹⁸⁴ Gutheil and Simon note that a consulting witness should be distinguished from a testifying witness – a testifying witness is typically one who is required to be available to testify should a case proceed to trial and such expert's objective opinion may be received by means of discovery mechanisms such as reports and interrogatories.¹⁸⁵ A consulting expert witness participates behind the scenes in a more partisan fashion and provides advice on various areas such as case strategy, weaknesses of the other side's case and accordingly the views of such experts are protected from discovery.¹⁸⁶ The consultative role of the expert witness further entails consultation pertaining to the opening statement and closing arguments of the case.¹⁸⁷

- **Educator**

Expert witness practice to a great extent entails educating or teaching. This role is portrayed in two distinct phases:¹⁸⁸

- Firstly the expert witness teaches the legal professionals as to important psychiatric aspects of the case; the specific contributions psychiatry can make to the case; the strengths and weaknesses of the case and also that which the expert witness can state regarding the issues of the case to a reasonable degree of medical certainty.

¹⁸³ Gutheil, TG and Simon, RI "Mastering Forensic Psychiatric Practice – Advanced Strategies for the Expert Witness" (2002) at 3-9.

¹⁸⁴ *Ibid.*

¹⁸⁵ Gutheil and Simon (2002) *supra* note 183 at 4.

¹⁸⁶ *Ibid.* See also Gillmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 263.

¹⁸⁷ Gutheil and Simon (2002) *supra* note 183 at 5. See also Bond, C, Solon, M, Harper, P and Davies, G "The expert witness – A Practical Guide" (2007) at 67-68.

¹⁸⁸ *Ibid.*

- Secondly the expert witness teaches the court regarding psychiatric issues. This phase will typically entail the translation and explanation of psychiatric terminology in terms of lay language to make these more comprehensible.

According to Camper and Lottis, proponents of the educator approach believe that the expert witness should follow the stance of the objective scientist in presenting expert evidence and as such the expert's function is to educate the court on matters relevant to the issues.¹⁸⁹ Meintjes-Van der Walt correctly asserts that legal education in respect of expert evidence in general as well as the different areas of evidence can contribute in making the judicial field more comprehensible.¹⁹⁰ Meintjes-Van der Walt notes:¹⁹¹

“It is an understanding of the nature of expert evidence and particularly scientific knowledge that informs the way in which the legal process responds to this kind of evidence ... knowledge of the different theories, as well as the way in which the law views science, is crucial to participants in the legal process when scientific evidence is introduced.”

- **Advocate**

The role of the expert witness is also often conveyed as that of the persuader or, stated differently, the advocate. Gutheil and Simon note that it should be borne in mind that an expert, after assessment and evaluation of various data and application of training and experience, may ethically state his or her opinion persuasively but this function should be distinguished from advocacy for the side of the case that retains the expert, as this is the function of the legal professional.¹⁹² Adherents to the advocacy paradigm take the view that an expert is compelled by the very nature of testifying to take a stance in respect of the issues before the court and to only focus on evidence supportive of such stance and as such the “selectivity in the presentation of evidence is determined, in part,

¹⁸⁹ Camper, PM and Lottis, EF “The Role of Psychologists as Expert Witnesses in the Courtroom: No More Daniels in the Lions Den” (1985) *Law and Psychology Review* 1-13 at 3.

¹⁹⁰ Meintjes-Van der Walt (2003) *Journal of African Law supra* note 2 at 91.

¹⁹¹ *Ibid.*

¹⁹² Simon and Gutheil (2002) *supra* note 183 at 5.

by the consequences of advocating that particular position in the case of trial.”¹⁹³
The advocacy role has been subjected to criticism in that it promotes the so-called
“battles of the experts”.¹⁹⁴

Gudjonsson and Howard ascribe the clinical, experimental, actuarial and advisory role to forensic psychology.¹⁹⁵ The clinical role typically relates to those issues of evidence where the mental abnormality of one of the parties becomes relevant to the legal issue and concerns the mental state of the particular client.¹⁹⁶ In terms of the experimental role, applied and academic psychologists are able to construct unique, innovative experiments which relate directly to some of the questions that the forensic psychologist has translated from the legal professional’s original request.¹⁹⁷ The actuarial role is one in which the forensic psychologist provides evidence with regards to the probability of certain events and such information is gathered in two ways: by means of conducting a search of literature where such data is most likely reported and also by means of fieldwork.¹⁹⁸ The advisory rule entails the process in terms of which the evidence given by other psychologists is evaluated and consequently counsel or the court is advised concerning its strengths and weaknesses.¹⁹⁹ In respect of assessing the essential roles of the various mental health professionals, it becomes crucial to distinguish between the

¹⁹³ Camper and Lottis (1985) *supra* note 189 at 4-5.

¹⁹⁴ *Ibid.* For an alternative view in support of the advocacy role see also Diamond, BL “The psychiatrist as advocate” (1973) *The Journal of Psychiatry and Law* at 5-21 where it is stated that an expert witness will invariably act as an advocate, either willingly or unwillingly and accordingly to accept the advocate role and to pursue such role will be ethical if performed without deceit. Diamond specifically notes (at 7): “The problem is that the expert witness who believes in his non-advocacy stance, in the impartiality of his opinions, may in fact be a potent advocate, and yet be entirely unaware of what he is advocating as well as the consequences of his advocacy. It is true that the psychiatrist who admits to himself his advocacy position may not be fully aware of all he is advocating or of all the consequences of his position. But, at least his less self-deluding posture permits further inquiry, of further self-knowledgeable, and greater understanding of both his own role and that of the social institutions in which he is engaged.” And further (at 8): “However the psychiatrist’s advocacy inevitably involves effects which go far beyond the destiny of the individual defendant or plaintiff. Here we are concerned with the impact of expert testimony upon the law itself; upon society’s attitude toward the mentally ill; and upon social policies which determine the fate of large numbers of other individuals.”

¹⁹⁵ Gudjonsson, GH and Howard, LRC “Forensic Psychology – A guide to practice” (1998) at 68-78; Gilmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 262-263.

¹⁹⁶ Gudjonsson and Howard (1998) *supra* note 195 at 68-69.

¹⁹⁷ Gudjonsson and Howard (1998) *supra* note 195 at 70-71.

¹⁹⁸ Gudjonsson and Howard (1998) *supra* at 72; Gilmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 263.

¹⁹⁹ Gudjonssen and Howard (1998) *supra* note 195 at 73-75; Gilmer, Louw and Verschoor (1995) *SACJ supra* note 167 at 263.

forensic psychologist and forensic psychiatrist and the approaches followed by these two professions respectively. From the outset it should be noted that the main role of the forensic psychiatrist entails a mental status examination of individuals presumed to be suffering from mental illness.²⁰⁰ Forensic psychology, on the other hand, relates to the collection, assessment and presentation of evidence for judicial purposes.²⁰¹ According to Grisso, there are four essential differences between psychiatrists and psychologists, which are the following:²⁰²

Psychiatry	Psychology
Content	
<ul style="list-style-type: none"> Psychiatrists are trained to primarily deal with biological, medical as well as psychopharmacological issues. 	<ul style="list-style-type: none"> Psychologists are trained to assess issues which go beyond mental disorder such as describing an individual's functional abilities, personality, behaviour and coping methods.
Methods	
<ul style="list-style-type: none"> Psychiatrists rely primarily on interviews and observation to conduct their assessment. 	<ul style="list-style-type: none"> Psychologists use standardised and qualitative assessment techniques in addition to interviews.
Epistemological differences	
<ul style="list-style-type: none"> Psychiatrists base their research on observations of large clinical samples. 	<ul style="list-style-type: none"> Psychologists primarily conduct controlled and circumscribed experiments.
Mentoring systems	

²⁰⁰ Gudjonssen and Howard (1998) *supra* note 195 at 75. See also Faulk, M "Basic Forensic Psychiatry" (1994) at 1-3; Gunn, J and Taylor, PJ "Forensic Psychiatry – Clinical, Legal and Ethical Issues" (1993) at 1-2; Sadock, BJ and Sadock, VA "Kaplan & Sadock's Synopsis of Psychiatry" (2003) at 1351-1352; Freckelton, I and Selby, H "Expert Evidence in Criminal Law" (1999) at 363-366.

²⁰¹ Gudjonssen and Howard (1998) *supra* note 195 at 75-76; Sales, BD and Elwork, A "Issues in Training Forensic Psychologists" in Cooke, G (ed) "The Role of the Forensic Psychologist" (1980) at 20-22; Davies, G Hollin, C and Bull, R "Forensic Psychology" (2008) at xiii-xvi; Howitt, D "Introduction to Forensic and Criminal Psychology" (2006) at 1-7.

²⁰² Grisso, T "The differences between forensic psychiatry and forensic psychology" (1993) *Bulletin of the American Academy of Psychiatry and Law* at 133-145 as discussed in Gudjonssen and Howard (1998) *supra* note 195 at 76-77.

<ul style="list-style-type: none"> • Forensic psychiatric training frequently makes use of teaching hospital departments and residency training. 	<ul style="list-style-type: none"> • Graduate training programmes in psychology are premised within the various psychology departments of universities.
---	--

It is crucial to comprehend the differences between forensic psychiatry and psychology in order to accord the appropriate roles to each mental health professional specifically with reference to the defence of criminal incapacity.²⁰³ It is to be noted that the current section 79 of the Criminal Procedure Act only makes mention of the clinical psychologist and further leaves the appointment of such expert to the court's discretion.²⁰⁴ A question to be asked is whether provision should not expressly be made for forensic psychology or adequate training in such profession? For purposes of the defence of criminal incapacity it is submitted that the specific section should expressly provide for the expertise of a forensic psychologist. It has already been illustrated in chapter 1 that there are specific differences between clinical as opposed to forensic psychology and retaining the correct expert could accordingly add probative value to the opinion of the expert.

5.3 Pre-trial consultations and disclosure

Procedural mechanisms are often underestimated for its value in the adjudication of issues within a criminal trial and also consequently with reference to the defence of criminal incapacity, entail pre-trial meetings and disclosure. Meintjes-Van der Walt correctly notes that pre-trial investigative procedures can prove to be pivotal in the assessment of the ultimate admissibility, reliability and the weight accorded to expert evidence.²⁰⁵ Pre-trial measures afford both the prosecution as well as the defence an adequate opportunity to prepare their cases. Prosecution disclosure of expert evidence is, as a general rule, firmly established whilst the

²⁰³ See Gudjonsson and Howard (1998) *supra* note 167 at 77 where it is noted: "The main implication of the differences between psychologists and psychiatrists is that they have different skills and apply different methods to the assessment, which when used jointly can be employed to the maximum benefit of the case."

²⁰⁴ See section 79(2)(b)(iv) of the Criminal Procedure Act 51 of 1977.

²⁰⁵ Meintjes-Van der Walt (2001) *supra* note 2 at 86; Meintjes-Van der Walt (2003) *Journal of African Law supra* note 2 at 94; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 309.

same is not true for defence disclosure of expert evidence.²⁰⁶ Pre-trial disclosure of expert evidence by the prosecution provides a means in terms of which the defence is empowered to sufficiently answer to the case and as such adequately challenge evidence.²⁰⁷ Meintjes-Van der Walt submits, and the researcher concurs with such submission, that there should be reciprocal disclosure within the ambit of expert evidence.²⁰⁸ Such disclosure will not conflict with an accused's right to remain silent or his or her privilege against self-incrimination and, because disclosure of expert evidence to be adduced during the trial will most likely entail evidence in favour of the accused, such disclosure will not be self-incriminating.²⁰⁹ According to Meintjes-Van der Walt, the only disadvantage associated with defence disclosure of expert evidence is that the defence will most probably lose the tactical measure of surprise which is associated with "trial by ambush".²¹⁰

Meintjes-Van der Walt notes that insufficient pre-trial disclosure will result in the curtailment of defence counsel's trial preparation and will further severely prejudice the attainment of justice within the criminal justice system.²¹¹ The reciprocal process of disclosure can best be achieved by means of a pre-trial meeting or consultation of the prosecution, defence and their experts.²¹² During these consultations the various experts could discuss their respective assessments and conclusions and further identify the specific areas they have consensus on as well as the areas where there is a difference of opinion.²¹³ The

²⁰⁶ Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 309; Meintjes-Van der Walt (2003) *SACJ supra* note 2 at 3; Meintjes-Van der Walt (2001) *supra* note 2 at 109.

²⁰⁷ Meintjes-Van der Walt (2001) *supra* note 2 at 106.

²⁰⁸ Disclosure within the field of expert evidence. Full defence disclosure will not be addressed in this study. See Meintjes-Van der Walt (2003) *SACJ supra* note 2 at 361. See also Diamond, BL "The Psychiatric Expert Witness – Hones: Advocate or "Hired Gun" in Rosner, R and Weinstock, R "Ethical Practice in Psychiatry and the Law" (1990) at 81 where it is stated that there should be complete disclosure in order to facilitate an effective, credible, and righteous defence.

²⁰⁹ Meintjes-Van der Walt (2003) *SACJ supra* note 2 at 361.

²¹⁰ *Ibid.*

²¹¹ Meintjes-Van der Walt (2001) *supra* note 2 at 115.

²¹² Meintjes-Van der Walt (2001) *supra* note 2 at 116-117; Meintjes-Van der Walt (2000) *CILSA supra* note 2 at 369.

²¹³ *Ibid.* See also *S v Huma* (1) 1995 (2) SACR 407 (W) at 410 J-411 A where Claassen J held: "I would like to commend to them the possibility of comparing one another's finding so as to come to a joint finding, if at all possible I would commend to the experts in this particular case the procedure adopted in civil cases, where the experts meet in advance of the trial so as to indicate where they agree and disagree. Such co-operation between experts of opposing sides generally results in saving of time and costs." See also Meintjes-Van der Walt (1996) *SACJ supra* note 2 at 366.

result of pre-trial meetings would in effect be that the defence would also have to disclose expert information intended to be used during the trial. Pre-trial consultations will result in only leaving the disputed issues for trial. Allan suggests the following issues which should be addressed during pre-trial conferences:²¹⁴

- The psychologist's qualifications and the accuracy thereof should be assessed;
- Legal professionals should enunciate the theory of the case as well as possible strategies of the opposing side;
- Psychologists should present an honest and accurate account of the opinions of such experts as may have been retained by the other side;
- Possible strategies for evidence in chief should be constructed and legal professionals should advise psychologists as to possible questions which could be posed but not the answers to these questions;
- Legal professionals and psychologists should objectively and critically assess the written report to determine its weaknesses and these weaknesses should ideally be addressed during the examination in chief;
- Expert witnesses should anticipate possible facts which may be used to contradict their opinions and plan strategies in respect of these facts with an opinion. The latter could be achieved by indicating that the conflicting evidence is irrelevant;
- Legal professionals can anticipate possible questions that will be asked in cross-examination but should refrain from coaching witnesses and accordingly telling them what answers to provide to questions;
- Legal professionals should ascertain what the expert witness's view is on ultimate issue questions;
- The court procedure and etiquette should be explained to the psychologist or expert witness;
- The expert witness should, if necessary, be instructed to remain in court to hear other witnesses.

²¹⁴ Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 309-310. Although the learned author refers specifically to psychology, it is submitted that these issues could equally apply to the field of psychiatry.

Meintjes-Van der Walt²¹⁵ in respect of the necessity for pre-trial consultation and disclosure states that reciprocal disclosure of expert evidence should be construed as a method of assisting the court within the adversarial climate by means of the proper presentation and competent challenge of expert evidence, thereby reducing the obfuscating effect that “trial by ambush” can have.

5.4 Oral *versus* documentary evidence

Within our current system of evidence, there is generally a preference for oral evidence as opposed to documentary evidence. Section 161 of the Criminal Procedure Act clearly states:²¹⁶

“(1) A witness at criminal proceedings shall, except where this Act or any other law expressly provides otherwise, give his evidence *viva voce*.

(2) In this section the expression ‘*viva voce*’ shall, in the case of a deaf and dumb witness, be deemed to include gesture language and, in the case of a witness under the age of eighteen years, be deemed to include demonstrations, gestures or any other form of non-verbal expression.”

An expert witness, whether for the prosecution or the defence, will be deemed a “witness” and will have to comply with this section. The underlying premise for the preference of oral testimony could be traced mainly to the fact that within an adversarial trial, the verbal interaction between the witness and the cross-examiner is deemed as the most efficient means of testing the witness’s testimony.²¹⁷ Other reasons for the preference of oral evidence include the fact that the trier of fact is afforded the opportunity to observe the demeanour of the witness which can provide a basis for deductions relating to credibility; and further that taking the oath in an open court will emphasise to the witness the importance of speaking the truth.²¹⁸ Inquisitorial systems, on the other hand, place much reliance on documentary evidence. There are, however, exceptions to the general

²¹⁵ Meintjes-Van der Walt (2001) *supra* note 2 at 119.

²¹⁶ The Criminal Procedure Act 51 of 1977.

²¹⁷ Meintjes-Van der Walt (2001) *Stell LR supra* note 2 at 285; Meintjes-Van der Walt (2001) *supra* note 2 at 123.

²¹⁸ *Ibid.*

rule that a witness should provide oral evidence. Section 212(4)(a) is one such example and provides for the presentation and use of affidavits and certificates as a means of adducing expert evidence and reads as follows:²¹⁹

“Whenever any fact established by any examination or process requiring any skill in biology, chemistry, physics, astronomy, geography, anatomy, human behavioural sciences, any branch of pathology or in toxicology or in the identification of finger-prints or palm-prints, is or may become relevant to the issue at criminal proceedings, a document purporting to be an affidavit made by a person who in that affidavit alleges that he or she is in the service of the State or of a provincial administration or is in the service of or is attached to the South African Institute for Medical Research or any university in the Republic or any other body designated by the Minister for the purposes of this subsection by notice in the Gazette, and that he or she has established such fact by means of such an examination or process, shall, upon its mere production at such proceedings be *prima facie* proof of such fact: Provided that the person who may make such affidavit may, in any case in which skill is required in chemistry, anatomy or pathology, issue a certificate in lieu of such affidavit, in which event the provisions of this paragraph shall *mutatis mutandis* apply with reference to such certificate: Provided further that if such affidavit or certificate contains an opinion, such affidavit or certificate shall be *prima facie* proof of that opinion if –

- (i) the expertise of the declaring, and
- (ii) the grounds on which the opinion is based

can be determined from the affidavit or certificate.”

This section is important as it could also pertain to the testimony by psychiatrists and psychologists as it specifically refers to “human behavioural sciences”. The mere production of the said affidavit will provide *prima facie* proof of the facts enunciated therein.²²⁰ It is thus of relevance to note that although oral evidence is

²¹⁹ Meintjes-Van der Walt (2001) *Stell LR supra* note 2 at 287-288; Meintjes-Van der Walt (2001) *supra* note 2 at 123-127.

²²⁰ Meintjes-Van der Walt (2001) *Stell LR supra* note 2 at 288. In *S v Veldthuizen* 1982 (3) SA 413 (A) at 416 Diemont JA held that *prima facie* evidence entails: “... that the judicial officer

preferred within the adversarial system in South Africa, documentary evidence can be introduced in exceptional circumstances.²²¹

5.5 Cross-examination of expert witnesses

“Testifying in court is lecturing under combat conditions.”²²²

“If all witnesses had the honesty and intelligence to come forward and scrupulously follow the letter as well as the spirit of the oath, ‘to tell the truth, the whole truth, and nothing but the truth’, and if all advocates on either side had the necessary intelligence and were similarly sworn to develop the whole truth and nothing but the truth, of course there would be no occasion for cross-examination and the occupation of the cross-examiner would be gone. But as yet no substitute has ever been found for cross-examination as a means of separating truth from falsehood, and of reducing exaggerated statements to their true dimensions.”²²³

One of the most effective ways of testing the validity and reliability of expert evidence is by means of cross-examination of the expert witness. The art of cross-

will accept the evidence as *prima facie* proof of the issue and in the absence of other credible evidence, that evidence will become conclusive proof.”

²²¹ See also section 34 of the Civil Proceedings Evidence Act 25 of 1965 which has been incorporated into the Criminal Procedure Act by virtue of section 222 as discussed in Meintjes-Van der Walt (2001) *Stell LR supra* note 2 at 289-290 for a further example of where statements of an expert can be admissible provided the requirements of the said section were complied with. See also section 213 of the Criminal Procedure Act which provides that written statements can be handed in as evidence if the parties consent thereto. It will be admissible as evidence by the mere submission thereof if no objection is made.

²²² Tanay, E as quoted in Gutheil, TG and Simon, RI “Mastering forensic Psychiatric Practice – Advanced Strategies for the Expert Witness” (2002) at 93.

²²³ Wellman, FL as quoted in Engelbrecht, J “The Art of Cross-Examination” (1975) *The Magistrate* at 54. For purposes of the current study, emphasis will fall on the cross-examination of expert witnesses in particular and as such the practice of cross-examination in general will not be addressed comprehensively. See also section 166 of the Criminal Procedure Act 51 of 1977 which specifically provides for the cross-examination of witnesses whether for the prosecution, defence or in duty of the court. The latter section reads as follows: “(1) An accused may cross-examine any witness called on behalf of the prosecution at criminal proceedings or any co-accused who testifies at criminal proceedings or any witness called on behalf of such co-accused at criminal proceedings, and the prosecutor may cross-examine any witness, including an accused, called on behalf of the defence at criminal proceedings, and a witness called at such proceedings on behalf of the prosecution may be re-examined by the prosecutor on any matter raised during the cross-examination of that witness, and a witness called on behalf of the defence at such proceedings may likewise be re-examined by the accused. (2) The prosecutor and the accused may, with leave of the court, examine or cross-examine any witness called by the court at criminal proceedings.”

examination and the success thereof to a large extent depends on the skill and experience of the cross-examiner. Within the paradigm of the defence of criminal incapacity, the prosecution as well as the defence will seek to challenge the opposing side's expert witnesses by means of cross-examination. In general, the rules of evidence pertaining to the cross-examination of an expert witness and that of ordinary witnesses are the same.²²⁴ Morris distinctly defines the objectives of cross-examination as follows.²²⁵

- To elicit facts favourable to your case;
- To elicit facts which may be utilised to cross-examine other witnesses;
- To show that adverse evidence is unacceptable;
- To show that the witness is not credible;
- To put your case to the witness so that it may be known and commented upon.

It is important to further distinguish between matters of scientific facts and matters of opinion as experts rarely differ on matters of scientific facts whilst differences on opinion are common practice.²²⁶ According to Morris, there are five basic methods of cross-examination, which are the following:²²⁷

- Compare the evidence with established or clearly proven facts;
- Test the evidence for incongruities of fact, or more usefully, of conduct;

²²⁴ Engelbrecht, J "Cross-examining expert witnesses" (1982) *De Rebus* at 556; Allan in Tredoux *et al* (eds) *supra* note 2 at 313.

²²⁵ Mullins, J and Da Silva, C "Morris – Technique in Litigation" (2010) 6th ed at 220-221; Morris, E "Technique in Litigation" (2003) at 202; Wrottesley "On the Examination of witness" as quoted in Morris *supra* similarly described the object of cross-examination as follows: "The objects of cross-examination are three in number. The first is to elicit something in your favour; the second is to weaken the force of what the witness has said against you; and the third is to show that from his present demeanour or from his past life he is unworthy of belief and thus weakens or destroys the force of his testimony." See also Engelbrecht (1975) *The Magistrate supra* note 223 at 53. See also Meintjes-Van der Walt, L "Cross-examination of expert witnesses" (2001) *De Rebus* 22-25 at 23 where she states: "The objectives of cross-examination are to elicit information that is favourable to the cross-examiner and to cast doubt on the accuracy of the evidence given by the witness being cross-examined." See also Davies, Hollin and Bull (2008) *supra* at 165-166. See also Melton *et al* (2007) *supra* note 2 at 592-595; Wolmarans (1986) *supra* note 2 at 47-49; Zeffert and Paizes (2009) *supra* note 2 at 906-927; Bond, C, Solon, M and Harper, P "The Expert Witness in Court – A Practical Guide" (1999) at 112-115; Meintjes-Van der Walt, L "Eyewitness evidence and eyewitness science: Whether twain shall merit" (2009) *SACJ* 305 at 322-324.

²²⁶ Engelbrecht (1982) *De Rebus supra* note 224 at 556.

²²⁷ Morris (2003) *supra* note 225 at 203.

- Test the evidence on the backdrop of common sense or reason;
- Test the evidence within the context of what the state of mind of the witness was or would have been at the time;
- Test the witness on collateral issue.

These principles will inadvertently also apply to the cross-examination of psychiatrists and psychologists where the defence of criminal incapacity is raised. Research pertaining to the cross-examination of expert witnesses enunciates the following basic guidelines to follow during the cross-examination of an expert witness:

- It is important to assess the expert's qualifications, experience and capabilities in order to determine whether he or she is in fact an expert with specialized knowledge.²²⁸ Engelbrecht notes in this regard.²²⁹

“When the expertise of an expert witness is attacked, especially his standing in the profession, it is submitted that the cross-examiner should satisfy himself not only that the imputation is well founded but also that the answers would or might materially affect the credibility of the witness.”

Meintjes-Van der Walt in addition notes that expert evidence can be challenged by indicating that the expert does not possess the necessary expertise to provide an opinion on a specific point, or that even though the expert has the required qualifications, he or she lacks the necessary experience and accordingly less weight should be attached to his or her opinion.²³⁰ Engelbrecht²³¹ in addition notes that the entire effect of the testimony of an expert witness can also be eliminated by putting the witness to test at the trial in respect of his qualifications, his experience and his ability and discrimination as an expert and a “failure to meet the test renders his evidence nugatory”.

²²⁸ Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313; Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 350-351; Mullins and Da Silva (2010) *Supra* note 225 at 280.

²²⁹ Engelbrecht (1982) *De Rebus supra* note 224 at 556; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313.

²³⁰ Meintjes-Van der Walt (2001) *De Rebus supra* at 23.

²³¹ Engelbrecht (1975) *supra* note 223 at 58.

- Test and challenge the objectivity and credibility of the expert witness.²³² In this regard the evidence of the expert witness can be compared with the opinions of other experts in the field in order to assess the thoroughness of the assessments undertaken by the expert and the reliability and validity of such methods.²³³
- Evaluate and challenge the relevance and scientific credibility of the expert evidence as well as the reliability and validity of specific diagnoses, diagnostic methods and theories.²³⁴
- It is pivotal to assess and challenge the accuracy of the factual basis which constitutes the foundation of the witness's opinion.²³⁵ An expert's opinion can be founded upon data, facts, tests or other observations generally accepted within the expert's field of expertise and the cross-examiner needs to test the validity of these bases.²³⁶ The cross-examiner needs to assess whether the methodology and processes that were followed complied with adequate procedures in order to ensure accuracy and validity.²³⁷
- Morris notes that cross-examination will proceed "on lines of pure logic or scientific analysis" and further states that one will ascertain which factors the witness has taken into consideration in arriving at his or her opinion and once an error in the premises is established, if it can be established, the inquiry relates to how far that error bears upon the result.²³⁸ Morris in addition notes: "The next attack, assuming the failure of the previous one suggested, is on

²³² Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313.

²³³ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 351; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313. See also *S v Lamprecht* 1977 (1) SA 246 (E).

²³⁴ Allan in Tredoux *et al* (eds) 2005) *supra* note 2 at 313.

²³⁵ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 351; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313. See also Halleck, S "Law in the Practice of Psychiatry – A Handbook for Clinicians" (1980) at 202-203.

²³⁶ Meintjes-Van der Walt (2001) *De Rebus supra* note 2 at 23.

²³⁷ *Ibid.*

²³⁸ Morris (2003) *supra* note 224 at 251; Engelbrecht (1975) *supra* note 224 at 58; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 313-314.

the justification for drawing an inference or forming an opinion as the witness has done.”²³⁹

- Expert witnesses should at all times be treated in a courteous and fair manner and it is incumbent upon a presiding officer to ensure that a fair cross-examination is conducted.²⁴⁰ Snyman J made the following observations in this regard in *S v Azov*²⁴¹ where it was noted:²⁴²

“I think it must be made clear to him, and perhaps to others, that witnesses who come into court, ... are entitled to the ordinary courtesy one extends to decent people.”

- Cross-examination should not be aimed at wearing down the witness in order to facilitate answers favourable to the cross-examiner as a result of fatigue.²⁴³
- Cross-examination should not be rendered in order to obscure the truth and there should be no misrepresentation to a witness as to what he himself testified as a basis for an attack upon the witness.²⁴⁴
- Morris states that one of the most important points to ponder when cross-examining expert witnesses is “the essence of the matter”.²⁴⁵

²³⁹ *Ibid.*

²⁴⁰ Engelbrecht (1982) *De Rebus supra* note 224 at 556; Morris (2003) *supra* note 225 at 215.

²⁴¹ *S v Azov* 1974 (1) SA 808 (T); Zeffert and Paizes (2009) *supra* note 2 at 211.

²⁴² At 810-811. See also *S v Van Lill* 1969 (2) PH H 219 (T); *S v Makaula* 1964 (2) SA 575 (E).

²⁴³ Engelbrecht (1982) *De Rebus supra* note 224 at 556. See also Verschoor and Van Rensburg (1994) *supra* note 2 at 6; Bromberg, W “Psychiatrists in Court – The Psychiatrists View” (1969) at 50 where it is stated: “Courtroom tactics represent one of the Games People Play, perhaps the cause of justice would be better served if both sides renounce the game and carry out the testimony and cross-examination in a spirit of calm assertion and equally calm inquiry.”

²⁴⁴ *Ibid.* Engelbrecht (1982) *De Rebus supra* note 224 at 556-557 in addition notes: “While it’s perfectly permissible to test a witness’s version of events by ascertaining the details thereof and then by interrogating him about them, one ought not in cross-examination so to frame one’s questions that they appear as statements of fact to which others will depose when in truth the “facts” in question are not part of one’s case and no evidence is intended to be led thereon.” See also *S v Kubeka* 1982 (1) SA 534 (W).

²⁴⁵ Mullins and Da Silva (2010) *supra* note 225 at 281; Morris (2003) *supra* note 225 at 251.

It is apparent that the cross-examination of expert witnesses constitutes a vital tool in order to test the veracity, credibility, reliability and probative value of expert evidence. The use of this “tool” is, however, dependent on the skills, training and experience of the cross-examiner. Cross-examination is further an inherent feature of the right of an accused to a fair trial and more pertinently the right to adduce and challenge evidence as espoused in section 35(3)(i) of the Bill of Rights in the Constitution.²⁴⁶

6 Ethical issues pertaining to the forensic assessment conducted by experts

6.1 Bias and the so-called “hired guns”

Within the climate of an adversarial system of justice, a natural consequence of such system is that each party will propose to retain expert witnesses most favourable and supportive to their respective cases. Expert witnesses are, however, consultants of the court and should strive to be as impartial and unbiased as possible. Some experts are often labelled as “hired guns” due to the fact that they are willing to express an opinion requested by the legal professional regardless of whether such opinion is objectively speaking, the correct one.²⁴⁷ Diamond defines the so-called “hired gun” as one who knowingly gives false or misleading testimony by intentionally violating the oath with the underlying motive for doing so usually being money; but often there are also other reasons such as desire for publicity, to bolster self-esteem, to please attorneys or to further some personal endeavour.²⁴⁸

²⁴⁶ Constitution of the Republic of South Africa, 1996. See also Meintjes-Van der Walt (2001) *supra* note 2 at 192 where the practice of cross-examination is questioned as an appropriate measure for asserting the truth. See also Meintjes-Van der Walt (2001) *SAJHR supra* note 2 at 308-312.

²⁴⁷ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 353; Meintjes-Van der Walt (2001) *supra* note 2 at 134-136; Memon, A, Vrij, A and Bull, R “Psychology and Law – Truthfulness, Accuracy and Credibility” (2003) at 178.

²⁴⁸ Diamond, BL “The Psychiatric Expert Witness – Honest Advocate or “Hired Gun” in Rosner, R and Weinstock, R “Ethical Practice in Psychiatry and the Law” (1990) 75 at 76-77. See also Weinstein, HC “The Impartial Expert – Myth or Reality” in Rosner and Weinstock (eds) (1990) *supra* at 117-128; Slovenko, R “The Role of the (Psychiatric) Expert in the Judicial Process” in Rosner and Weinstock (eds) (1990) *supra* at 85-105 specifically at 86 where it is noted: “Quite often, lawyers crudely accuse their opponents of “buying” experts, and call them “hired guns”. Actually there is nothing unethical about hiring those with favorable opinions, as long as the

It is often difficult to disseminate whether an expert is a “hired gun” or whether he or she is merely very favourable to his or her side’s case. The “hired gun” effect is a very unfortunate consequence of the presentation of expert evidence and does injustice to the principle of a fair and just trial. Allan and Meintjes-Van der Walt correctly assert that it is often difficult for experts to be completely impartial as a result of various factors which include the following:²⁴⁹

- Legal professionals will inadvertently select an expert who supports the case they want to present to the court. As such the expert will begin to identify with the client. Meintjes-Van der Walt in addition notes that such bias may be completely unconscious as numerous sources suggest that simply being placed in the role of an adversary witness will result in testimony which is biased in favour of the party for whom it is provided and consequently an expert witness may therefore be honest yet biased.²⁵⁰
- The fact that some experts are paid often creates the impression of bias and even though experts will deny this factor impacting on their impartiality, receiving remuneration will often make it difficult for the expert to remain neutral especially if the particular expert is dependent financially on the income generated by means of acting as an expert witness.
- As legal professionals are ethically obliged to present their clients’ case as positively as possible they will inadvertently be selective in respect of the information they provide to the expert so as to strengthen their case as much as possible. In this sense it is pivotal that experts assess all information critically in order to ensure that their observations are not clouded.

lawyers do not ask the expert to fabricate or falsify.” See also Slovenko, R “The lawyer and the forensic expert: Boundaries of Ethical practice” (1987) *Behavioral Sciences and Law* at 119.

²⁴⁹ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 353-354.

²⁵⁰ Meintjes-Van der Walt (2001) *supra* note 2 at 136. See also Wolmarans (1986) *supra* note 2 at 62 where it is noted that some motivating or causal factors towards biased experts are the fact that the expert would not be in the witness box if he or she did not support their side’s view; the instructions received could have been one-sided or incomplete, the expert’s own preparations could have been superficial; the nature of the legal process often renders it impossible to provide a scientific and objective opinion; the atmosphere in court is often unsound and distressing; inadequate knowledge can often lead to unconscious bias.

- The most problematic form of bias occurs when experts allow their own ideology, morality or theories to influence their opinions.

It is essential that expert witnesses realise that they are witnesses providing evidence based on their honest opinion, knowledge as well as admissible facts.²⁵¹

There are no hard and fast rule to combat the “hired gun” problem but it remains trite that this practice severely corrupts the legal process and should be curbed as much as possible. Diamond indicates that a combination of measures by both the legal and psychiatric communities could reduce this problem with due regard to the following guidelines:²⁵²

- Proper recognition of the boundaries of legitimate psychiatric expertise should be established within the forensic psychiatric community;
- More stringent standards for the qualification of experts should be required and adopted by courts as well as legislatures;
- It should be required that the expert be knowledgeable pertaining to the scientific literature on the subject at issue. Diamond encapsulates the latter by stating:²⁵³

“The logic of science, rather than the logic of the law, should be the required standard for the expert’s testimony. Total disclosure is mandatory in the logic of science.”

- Mere reliance on the “battle of the experts” in order to expose unscientific, irrational or dishonest expert evidence is not sufficient and as such the presiding officer should take responsibility for establishing criteria for expertise and should exclude evidence that fails to meet the yardstick for appropriate standards of expertise.

²⁵¹ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 354; Meintjes-Van der Walt (2001) *supra* note 2 at 136. See also Memon, Vrij and Bull (2003) *supra* at 178 where it is noted that during a survey conducted pertaining to the effectiveness of expert testimony, it was revealed that experts who were highly paid for their testimony were viewed by jurors as “hired guns” and were held less credible and effective. The moderately paid expert from a less well-known institution was deemed as someone who was testifying merely as a result of his expertise in a particular area. See also Gutmacher, MS “The Role of Psychiatry in Law” (1968) at 87-91.

²⁵² Diamond in Rosner and Weinstock (eds) (1990) *supra* note 247 at 81-83.

²⁵³ Diamond in Rosner and Weinstock (eds) (1990) *supra* note 247 at 83.

- The law should put an end to its quest for certainty as well as its belief that certainty can be obtained by means of science as scientific knowledge is always approximate and subject to change and as such there is a degree of doubt as to every scientific conclusion.
- The role of the expert witness within the adversarial process should be exposed to the trier of fact.
- Professional organizations should play a more active role in establishing guidelines, ethical standards and also in exposing and disciplining members of their respective professions who abuse the legal principle of expert testimony. Diamond in addition note:²⁵⁴

“To avoid the discrediting of both law and psychiatry, the courts and bar associations must take the responsibility for control of the lawyers who wilfully encourage irresponsible expertise and the psychiatric organizations must accept responsibility for the exposure and discipline of their professionals who give unethical and dishonest testimony. The “hired gun” violates his oath as a witness to tell the truth, the whole truth, and nothing but the truth, and therefore cannot be tolerated in our system of justice.”

The defence of criminal incapacity is a complex and controversial defence. In the ultimate search for truth and the assessment of the merits of this defence, it is pivotal that mental health experts provide their opinion free of bias and impartial. Although it is difficult to formulate set rules to achieve such goal, the criteria above could provide a contextual framework toward the abolition of the “hired guns” and the proper practice of the presentation of expert testimony.

6.2 Dual relationships

Mental health professionals are often confronted with the ethical dilemma of being requested to serve as an expert witness whilst at the same instance acting as a treating clinician for the specific client or in the case of criminal incapacity, the accused. The Health Professions Council of South Africa (HPCSA) as well as the Society of Psychiatrists of South Africa (SASOP) has recommended that treating

²⁵⁴ Diamond in Rosner and Weinstock (eds) (1990) *supra* note 247 at 84.

therapists should not endeavour psycholegal assessments for their own clients.²⁵⁵ The ethical conflict of serving both as a treating therapist as well as an expert witness, emanates from the essential differences in pragmatic approaches between these two relationships. Strassburger, Gutheil and Bradsky assert the following with respect to the difference between these two relationships:²⁵⁶

“The process of psychotherapy is a search for meaning more than for facts. In other words, it may be conceived of more as a search for narrative truth ... than for historical truth. Whereas the forensic examiner is sceptical, questioning even plausible assertions for purposes of evaluation, the therapist may be deliberately credulous, provisionally “believing” even implausible assertions for therapeutic purposes. The therapist accepts the patient’s narrative as representing an inner, personal reality, albeit coloured by biases and misperceptions.”

In chapter 1, the fundamental differences between a therapeutic *versus* a forensic relationship were discussed and will not be repeated here.²⁵⁷ For purposes of this discussion it is, however, important to elaborate on the differences between these two relationships in order to clarify the ethical problem of assuming dual relationships.

According to Strassburger, Gutheil and Bradsky, clinical and forensic assessments are further dissimilar in the following respects:²⁵⁸

²⁵⁵ Zabow, T and Kaliski, S “Ethical Considerations” in Kaliski (eds) (2006) *supra* note 2 at 361. See also the “Rules of Conduct Pertaining Specifically to the Profession of Psychology as contained in the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 GNR 717 of 4 August 2006 at paragraph 71 which reads as follows: “Conflicting roles – (1) A psychologist shall avoid performing multiple and potentially conflicting roles in psycho-legal matters.”

²⁵⁶ Strassburger, LH, Gutheil, TG and Brodsky, A “On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness” (1997) *American Journal of Psychiatry* 448-456 at 451. See also Campbell, TW “Psychotherapy with children of divorce: the pitfalls of triangulated relationships” (1992) *Psychotherapy* 646-52 where it is noted that often therapists find it difficult to competently evaluate their clients as the therapeutic alliance between the client and therapist reduces the therapist’s objectivity. Conversely, evaluators will find it problematic to act therapeutically to the subjects of their evaluations. (As discussed in Slovenko, R “On a Therapist Serving as Expert Witness” (2002) *Journal of American Academy of Psychiatry* 10-13 at 10).

²⁵⁷ See chapter 1 *supra* at paragraph 2-10.

²⁵⁸ Strassburger, Gutheil and Brodsky (1997) *supra* note 256 at 450-453. See also Melton *et al* (2007) *supra* note 2 at 43-47; Stone, AA “Revisiting the Parable: truth without consequences”

- The treating clinician typically follows a psychodynamic approach whereas the forensic mental health expert's view is more descriptive. Strassburger, Gutheil and Brodsky encapsulate the latter by stating:²⁵⁹

“Whereas the treating clinician looks out from within, the forensic expert, who must adhere to an ethical standard of objectivity, looks in from outside.”

- Within the clinical context of treatment, the ultimate goal is psychological in the sense of benefiting the patient promoting healing and widening the level of individual awareness, responsibility and self-sustainability. Conversely, within the forensic context the ultimate goal is the social one of benefiting the society by promoting the resolution of cases by means of the adversarial system of justice.
- Within the treatment relationship, the psychotherapist attempts to form an alliance with that part of the patient which strives to change and move away from psychopathological symptoms and resume healthy adaptations. The forensic evaluator will seek an alliance with that part of the evaluatee seeking exculpation and exoneration from either criminal responsibility or avoidance of responsibility by means of a finding of incompetence. In this sense the forensic evaluator's approach epitomises psychopathology whereas the psychotherapist adheres to an approach of normalization.
- Therapeutic relationships is characterised by empathy, whereas forensic relationships limits the use of empathy as it could lead to “*quasi* therapeutic” interaction resulting in the evaluatee being disappointed by consequent report of the evaluator if unfavourable to the evaluatee.

(1994) *International Journal of Law and Psychiatry* 79-97; Appelbaum, PS “The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm” (1990) *International Journal of Law and Psychiatry* 249-259; Rappeport, JR “Differences between forensic and general psychiatrists” (1982) *American Journal of Psychiatry* at 331-334.

²⁵⁹ *Ibid.*

- Therapeutic assessments are less dependent on collateral sources of information whereas forensic assessments frequently require meticulous assessment of multiple sources of information.
- Psychotherapists and forensic mental health professionals further approach individuals with divergent interviewing methodologies.
- Forensic assessment are usually characterised by time constraints and a sense of urgency which does not prevail in clinical settings.

Miller notes that the potential for conflating the roles of evaluator and treater is generally reduced in criminal matters as opposed to civil trials as a result of the fact that the adversarial system is better comprehended by accused persons than by civil litigants.²⁶⁰ In addition, the professional boundaries of the relationship with an accused are usually more specified, allowing the mental health expert from the outset to inform the examinee as to the nature and scope of the evaluation.²⁶¹ The ethical dilemma of assuming a dual relationship can also differ in respect of the order of assumption of the roles. Miller notes that the most problematic situation occurs when in an ongoing relationship primarily based on treatment the psychotherapist is called to provide an expert opinion in respect of the patient.²⁶² Within the forensic paradigm, however, the assessment for competency to stand trial or criminal responsibility often precedes treatment.²⁶³ It is submitted, regardless of the order of assumption of roles, that a mental health expert who was the treating clinician of an accused should not act as an expert witness in a criminal trial, and *vice versa*, a forensic examiner who assessed an accused for purposes of criminal capacity should not later assume a therapeutic relationship with such accused. Slovenko encapsulates the ethical dilemma of dual relationships by stating that testifying contradicts the therapeutic role and even though therapy may be formally terminated, therapy inadvertently never ends – as

²⁶⁰ Miller, RD “Ethical Issues Involved in the Dual Role of Treater and Evaluator” in Rosner and Weinstock (1990) *supra* note 2 at 132.

²⁶¹ *Ibid.*

²⁶² *Ibid.*

²⁶³ *Ibid.*

it is in the mind, resulting in the transference always being there and accordingly “the roles of healer and examiner get confused”.²⁶⁴

Slovenko also notes that assuming conflicting therapeutic and forensic relationships promotes the risk that expert witnesses will be more concerned with the outcome of the case than the accuracy of their evidence.²⁶⁵ The researcher concedes with the statement by Strassburger, Gutheil and Bradsky where they state:²⁶⁶

“Notwithstanding the growing pressures from the complex clinical/legal marketplace to perform simultaneously in multiple roles, two heads are better than one only if they really are two distinct heads, each wearing its own hat.”

Assuming dual relationships should be avoided by mental health professionals at all costs. Role conflict in being both an evaluator as well as a treater negatively impacts on a therapeutic relationship and within the forensic context, such conflict will lead to bias which inadvertently will affect the probative value of the forensic expert’s evidence, making the search for truth more controversial and problematic. It is notable that the Health Professions Council of South Africa recommends that treating clinicians should refer to other mental health professionals whenever their patients need a psycholegal evaluation.²⁶⁷

²⁶⁴ Slovenko, R “Psychotherapy and Confidentiality – Testimonial Privileged Communication, Breach of Confidentiality and Reporting Duties” (1998) at 527.

²⁶⁵ Slovenko, R “Psychiatry in Law/Law in Psychiatry” (2002) at 8-9. See also Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 355; Zabow and Kaliski in Kaliski (ed) (2006) *supra* note 2 at 361; Allan in Tredoux *et al* (eds) (2005) *supra* note 2 at 307. See also Cohen, A and Malcolm, C “Psychological assessment for the Courts” in Tredoux *et al* (eds) (2005) *supra* note 2 at 70. See also Shapiro, DL “Forensic Psychological Assessment – An Integrative Approach” (1991) at 235 where the problem of dual relationships is encapsulated as follows: “From the point of view of professional ethics, an important point to be made is that one cannot be an effective therapist, in terms of helping the patient deal with his or here difficulties, if one has also been involved in doing a comprehensive forensic evaluation of that individual if one has done a comprehensive assessment, interviewed many witnesses, reviewed many reports, and assessed the possibilities of malingering or secondary gain, then one in a sense “knows too much” to be of assistance to the patient and to maintain the “free-floating attention” necessary to truly help that patient unravel his or her personal difficulties.”

²⁶⁶ Strassburger, Gutheil and Bradsky (1997) *supra* note 256 at 455. See also Appelbaum (1990) *International Journal of Law and Psychiatry supra* at 258.

²⁶⁷ Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 355.

6.3 Confidentiality

“All that may come to my knowledge in the exercise of my profession or outside of my profession or in the daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.”
(Hippocrates)

Confidentiality represents another domain where forensic and therapeutic assessments differ. Within the traditional clinical or therapeutic setting, patients reveal intimate and private details about themselves to their doctors or psychotherapists with the reasonable expectation that such information will not be divulged to others. Within the clinical context confidentiality constitutes an implied agreement that the psychotherapist will not divulge the information acquired to third parties and as such there is a professional duty on the mental health professional to adhere to confidentiality. Failure of this duty could result in an action for invasion of privacy, defamation or even breach of contract.²⁶⁸

Within the forensic assessment context, especially when the defence of criminal incapacity is raised, the principles pertaining to confidentiality are less operative and applicable. The forensic relationship as such does not provide for a confidentiality clause and accordingly all information can be divulged as far as it is relevant in the enquiry into the accused’s mental state.²⁶⁹ Despite the reality that

²⁶⁸ Zabow and Kaliski in Kaliski (ed) (2006) *supra* note 2 at 362; Slovenko (2002) *supra* at 75; Carstens and Pearmain (2007) *supra* note 2 at 943-952; Kaplan and Sadock (2003) *supra* at 1369-1370. Section 14 of the Constitution of the Republic of South Africa, 1996 as stated in chapters 2 and 3 respectively provides that everyone has the right to privacy which includes the right not to have the privacy of their communications infringed. It is further interesting to note that the ethical guidelines of the Health Professions Council of South Africa (HPCSA) pertaining to “Confidentiality: Protecting and Providing Information” 30 May 2007 provides that a practitioner may only divulge information regarding patients amongst others if it is done in terms of statutory provisions; at the instruction of the court; in the public interest; or with the express consent of the patient. The guidelines further provide that patients have the right to expect that information regarding them will be held in confidence by health care practitioners (4.1). See also Strassburger, Gutheil and Bradsky (1997) *American Journal of Psychiatry supra* note 256 at 454; Gutheil and Appelbaum (2000) *supra* at 1-18; Slovenko, R “Psychotherapy, Confidentiality and Privileged Communication” (1966) at 18-20, 53-92; Simon, RI “Clinical Psychiatry and the Law” (1987) at 132-161.

²⁶⁹ Cohen and Malcolm in Tredoux *et al* (eds) (2005) *supra* note 2 at 73; Zabow and Kaliski in Kaliski (ed) (2006) *supra* note 2 at 363. It is notable that the Promotion of Access to Information Act 2 of 2000 defines “Personal Information” as: “...information about an identifiable individual, including, but not limited to - (a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age,

forensic assessment does not create fiduciary relationships, it is still essential that the forensic expert act ethically and as such timeously inform the examinee that the usual doctor-patient rules do not apply.²⁷⁰ Every evaluation should accordingly be preceded with a cautionary warning providing for the following:²⁷¹

- A clear exposition regarding why the expert has been retained;
- A statement providing that the contents and subsequent results of the assessment are not confidential;
- That the assessment does not entail treatment and as such the usual advantages of a therapeutic relationship do not apply;
- That the examinee need not answer questions.

It is thus clear that the ordinary principles relating to confidentiality of communications do not apply in its strict sense within the ambit of forensic assessments. In chapter 2 and 3 it was further noted that in terms of section 79(7) of the Criminal Procedure Act, statements by the accused during the enquiry into his or her criminal incapacity may be admissible provided that it is relevant to the

physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the individual; ..." It is further stated in section 7 of the Act that the provisions of the Act do not apply to records required for criminal or civil proceedings after the commencement of the proceedings. Section 7 provides as follows: "(1) This Act does not apply to a record of a public body or a private body if - (a) that record is requested for the purpose of criminal or civil proceedings; (b) so requested after the commencement of such criminal or civil proceedings, as the case may be; and (c) the production of or access to that record for the purpose referred to in paragraph (a) is provided for in any other law. (2) Any record obtained in a manner that contravenes subsection (1) is not admissible as evidence in the criminal or civil proceedings referred to in that subsection unless the exclusion of such record by the court in question would, in its opinion, be detrimental to the interests of justice." Accordingly within a criminal proceeding where the defence of criminal incapacity is raised, the Promotion of Access to Information Act, 2000 will not apply in respect of records requested provided that the proceedings have commenced.

²⁷⁰ Zabow and Kaliski in Kaliski (ed) (2006) *supra* note 2 at 374. See also Slovenko, R "Psychotherapy and Confidentiality – Testimonial Privileged Communication, Breach of Confidentiality and Reporting Duties" (1998) at 154-155 where he states: "In the case of a defendant who asserts a defense of insanity ... the prevailing law is that he cannot claim possible self-incrimination with respect to psychiatric evidence, be it by a treating or examining psychiatrist. ... By pleading and offering evidence of insanity, the accused puts his mental state in issue, and thus waives any psychotherapist-patient privilege; his medical or psychiatric history is open to the prosecution ..."; Shapiro, DL "Forensic Psychological Assessment – An Integrative Approach" (1991) at 202-203; Gutheil, TG "Psychiatric Expert Witnesses in the New Millennium" (2006) *Psychiatric Clin North America* at 829-830; Gudjonsson, GH and Howard, LRC "Forensic Psychology – A Guide to Practice" (1998) at 48.

²⁷¹ Sadoff, RL "Ethical Issues in Forensic Psychiatry" in Rosner and Weinstock (1990) *supra* at 164-165; Cohen and Malcolm in Tredoux *et al* (eds) (2005) *supra* note 2 at 73; Zabow and Kaliski in Kaliski (ed) (2006) *supra* note 2 at 374. See also Zabow, T "Forensic Psychiatry" in Dada, MA and McQuoid-Mason, DJ "Introduction to Medico-Legal Practice" (2001) at 111.

assessment and determination of the accused's mental state. Reasonableness and fairness dictates, however, that the accused be informed that communications conducted during the psycholegal assessment will not be confidential as the interests involved are not restricted to the individual solely, but also extends to the society and public and accordingly such information could very well be submitted to a court as evidence resulting in the accused's privacy becoming public domain.²⁷² Slovenko interestingly notes that the evidential value of forensic expert testimony is often stronger than the value of therapist-expert testimony due to the fact that a psychiatrist appointed to conduct an examination obtains in a few hours (without a promise of confidentiality) more information pertaining to the legal issues than a treating psychiatrist, as the examiner conducts an interview with the relevant legal issues directly in mind, whereas in therapy, the subject may be "diluted with fantasy and association".²⁷³

7 The forensic report

The findings of the forensic assessment conducted by the forensic mental health professional are essentially enumerated and explained in the forensic report. The forensic report represents one of the essential roles of the forensic examiner who conducted the forensic assessment for purposes of the criminal capacity enquiry. The forensic report differs markedly from the traditional therapist's report as it is addressed to a different audience – a "non-medical" audience, where no assumptions can be made as to the degree of comprehension of medical terminology and mental health constructs.²⁷⁴ On the other hand, the classic therapist's report is addressed to a medical audience including treating professionals who are educated and experienced to understand the relevance of symptoms or specific findings.²⁷⁵ The forensic report is further of importance as it generally represents the forensic mental health expert's bases for his or her opinion which in turn denotes the "basis-rule" of expert evidence as discussed

²⁷² See Kaliski, S, Allan, A and Meintjes-Van der Walt, L "Writing a psycholegal report" in Kaliski (ed) (2006) *supra* note 2 at 339.

²⁷³ Slovenko, R "Psychotherapy and Confidentiality – Testimonial Privileged Communication, Breach of Confidentiality and Reporting Duties" (1998) at 537.

²⁷⁴ "The Mental Health Professional and the Legal System" (1991) issued by the Group for the Advancement of Psychiatry at 93.

²⁷⁵ *Ibid.*

earlier in this chapter. According to Melton *et al*, the purpose of a forensic report is threefold:²⁷⁶

- It represents a professional record stating that an evaluation has been conducted and as such the nature of the assessment and assessment methods used during the evaluation are summarized and documented;
- In drafting a report, the mental health professional is obliged to organise data gathered from various sources and to weigh such information and as such the mental health expert is better equipped to prepare and rehearse for purposes of any direct and cross-examination evidence to be given;
- A further function of the report is to allow disposition without formal proceedings.

The rules for writing forensic reports are not set in stone. There are, however, certain basic guidelines applicable within most contexts. These guidelines will be enunciated below.

7.1 Content of the forensic report

The forensic report will contain a wide range of information collated from various sources. The most important are the following:

7.1.1 Reason for referral

It is pivotal from the outset to identify the reason for referral. As indicated in chapter 2 and 3, section 79 of the Criminal Procedure Act makes provision for the referral of an accused for psychiatric observation and requires reports from the psychiatrist appointed by the head of the Mental Health Institution to conduct the enquiry and in cases of serious violence, by a panel of up to two psychiatrists and a clinical psychologist. The assessment can either relate to assessing competency

²⁷⁶ Melton *et al* (2007) *supra* note 2 at 583. See also Hess, K and Weiner, IB “The Handbook of Forensic Psychology” (1999) at 508.

to stand trial, criminal capacity, or both and also for any other reason and as such the reason for referral should be clearly stated.²⁷⁷

7.1.2 Collateral data and sources of information

In this section the mental health professional would identify and summarise sources of information other than the individual who is evaluated, including interviews with other parties, statements made by the evaluatee and other documents perused during the course of the examination.²⁷⁸

7.1.3 Personal background information

This section will include historical information pertaining to the evaluatee relevant to the assessment. The nature of the referral will dictate whether to focus on the accused's current mental state as is required in terms of competency to stand trial assessments, or a historical disposition of psychiatric illness which could be relevant for purposes of assessing criminal capacity.²⁷⁹ Gunn and Taylor note that the previous psychiatric history of an accused will be of major importance and detail should be provided relating to previous episodes of mental disorder.²⁸⁰ Additional information will include previous history and family history and also previous criminal convictions.²⁸¹

²⁷⁷ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 332; Melton *et al* (2007) *supra* note 2 at 583; "The Mental Health Professional and the Legal System" (1991) *supra* note 274 at 93; Gudjonssen, GH and Howard, LRC "Forensic Psychology – A guide to Practice" (1998) at 191; Faulk, M "Basic Forensic Psychiatry" (1994) at 289.

²⁷⁸ Cohen and Malcolm in Tredoux *et al* (eds) *supra* note 2 at 79; Melton *et al* (2007) *supra* note 2 at 584; "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 94; Hess and Weiner (1999) *supra* note 276 at 514. See also Rubin, JG "The Psychiatric Report" in Allan, RC, Foster, EZ and Rubin, JG (eds) "Readings in Law and Psychiatry" (1968) at 69-72.

²⁷⁹ Melton *et al* (2007) *supra* note 2 at 584; "Mental Health Professional and the Legal System" (1991) *supra* note 273 at 94-95; Faulk (1994) *supra* note 274 at 289.

²⁸⁰ Gunn, J and Taylor, PJ "Forensic Psychiatry – Clinical, Legal and Ethical Issues" (1993) at 839. See also "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 95-96.

²⁸¹ *Ibid.*

7.1.4 Mental status examination, clinical findings and the psychiatric diagnosis

In this part of the assessment, the clinical observations will be noted and should provide clear descriptions of the evaluatee's behaviour and statements made by him or her.²⁸² It is important that the expert separates the process of description or observation and the inferences which can be deducted therefrom.²⁸³ The psychological tests performed should be reported and a complete test report should be annexed to the final report.²⁸⁴ The ultimate psychiatric diagnosis is pivotal to the forensic report due to the fact that forensic reports are aimed at specific legal tests which are dependent on the existence or presence of mental disorder or mental defect.²⁸⁵ Kaliski, Allan and Meintjes-Van der Walt advise that the forensic report should deal separately with the accused's current mental state as opposed to the retrospective mental state at the time of the alleged offence.²⁸⁶ The psychiatric diagnosis should refer to the diagnostic criteria espoused in the DSM-IVTR or the ICD-10 manuals and the expert should ensure that all the relevant criteria for a specific diagnosis are identified in the report. If reliance is placed on diagnoses falling outside the ambit of the DSM-IV or the ICD-10, such fact should be mentioned.²⁸⁷

7.1.5 The forensic opinion

The most crucial section of the report will relate to the mental health expert's deductive reasoning canvassed in the opinion section. Melton *et al* notes the following in this regard:²⁸⁸

²⁸² Melton *et al* (2007) *supra* note 2 at 584; "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 96; Gudjonssen and Howard (1998) *supra* note 195 at 191.

²⁸³ "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 96-97; Gudjonssen and Howard (1998) *supra* note 195 at 191.

²⁸⁴ "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 97; Melton *et al* (2007) *supra* note 2 at 584.

²⁸⁵ "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 97-98; Hess and Weiner (1999) *supra* at 517.

²⁸⁶ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 333.

²⁸⁷ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 333; Melton *et al* *supra* note 2 at 584; "Mental Health Professional and the Legal System" (1991) *supra* note 274 at 98.

²⁸⁸ Melton *et al* (2007) *supra* note 2 at 584.

“In this section, the examiner would draw on information reported in the previous sections and integrate the data, using a logical or theoretical theme to indicate the possible relevance of the clinical material to the legal issue being decided.”

Gunn and Taylor note that it is advisable to restrict the opinion to a coincidental assessment of the accused’s mental state and the alleged offence without expressly presuming causality.²⁸⁹ Hess and Weiner state:²⁹⁰

“... relative statements about people usually create fewer difficulties for forensic consultants than absolute statements ...statements about persons examined in forensic cases that are couched in terms of conditions they are more or less likely to have, behaviour they probably showed in the past or will be inclined to show in the future, and reasonable alternative implications of both for the legal issues in a case will typically stand the consultant in good stead.”

The process of reasoning behind the opinion should be clearly explained and the opinion should be expressed with reasonable medical certainty.²⁹¹ Conclusory statements should be refrained from and the mental health professional should guard against venturing outside his or her field of expertise.²⁹² The opinion should contain findings relating to whether the accused is fit to stand trial or whether he or she had the capacity to appreciate the wrongfulness of his or her conduct and to act in accordance with such appreciation. The prognosis of the accused in respect of further management and/or treatment should also be included.²⁹³

7.2 Style and structure of the forensic report

²⁸⁹ Gunn and Taylor (1993) *supra* note 200 at 840.

²⁹⁰ Hess and Weiner (1999) *supra* note 276 at 518.

²⁹¹ “Mental Health Professional and the Legal System” (1991) *supra* note 274 at 98-99; Gudjonnsen and Howard (1998) *supra* note 195 at 191.

²⁹² Gunn and Taylor (1993) *supra* note 200 at 840-841; “Mental Health Professional and the Legal System” (1991) *supra* note 274 at 98; Faulk (1994) *supra* note 200 at 297.

²⁹³ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 333; Gunn and Taylor (1993) *supra* note 200 at 846-847; Faulk (1994) *supra* note 200 at 296; Hess and Weiner (1999) *supra* note 276 at 512-513; Cohen and Malcolm in Tredoux *et al* (eds) *supra* note 2 at 79-80.

The following principles are important in respect of the structure of forensic reports:

- It should be borne in mind that the forensic report is not a “case presentation” and as such constitutes the presentation of psychiatric information for a non-psychiatric purpose.²⁹⁴
- Clarity is pivotal in respect of the forensic report.²⁹⁵ Hess and Weiner indicate that mental health experts should state their findings and conclusions in ordinary English and limit the use of technical “jargon”.²⁹⁶
- It is important to avoid over as well as under inclusiveness of information in the forensic report. Melton *et al* note in this regard that there is, on the one hand, the school of thought who advocates reports which tend to be brief and conclusive, whilst on the other hand, there is the school of thought encouraging lengthy, overly detailed reports.²⁹⁷ The problem with the first type is that it is often not efficient, whilst the latter is often not properly understood and frequently include irrelevant information leading to the inference of lack of certainty.²⁹⁸ Kaliski, Allan and Meintjes-Van der Walt note that courts tend to prefer brevity with the exception that if issues get more complex, the report will generally be longer.²⁹⁹ Somewhere between these two extremes the mental health expert should strive to be as concise as possible without omitting crucial information relevant in the determination of the factual issues.

²⁹⁴ Gunn and Taylor (1993) *supra* note 200 at 837.

²⁹⁵ Gunn and Taylor (1993) *supra* note 200 at 837; Hess and Weiner (1999) *supra* note 2 at 514-515.

²⁹⁶ *Ibid.* See also Melton *et al* (2007) *supra* note 2 at 586. See also Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 341 where they note: “Many reports consist of long sentences, sprinkled with complicated terms, and few attempts to break the text into comfortable paragraphs. Simple, direct language should always be a priority.” See also Gudjonssen and Howard (1998) *supra* note 191 at 193.

²⁹⁷ Melton *et al* (2007) *supra* note 2 at 585-586; Gudjonssen and Howard (1998) *supra* note 195 at 292; Gunn and Taylor (1993) *supra* note 200 at 837.

²⁹⁸ *Ibid.*

²⁹⁹ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 330-331. See also Cohen and Malcolm in Tredoux *et al* (eds) (2005) *supra* note 2 at 80.

- Complex technical terminology should not be utilised and if it is necessary to use them, definitions and explanations should be provided.³⁰⁰
- Only facts and opinions that can be defended under cross-examination should be stated in a report.³⁰¹
- The report should be compiled with constant reference to the limits of the psychiatric role.³⁰²
- As soon as the report of the mental health professional is submitted to court, it ceases to be confidential.³⁰³
- Mental health professionals should remain within the ambit of the referral question and should address issues required in terms of the referral and avoid opinions on issues that have not been raised.³⁰⁴
- Forensic reports should ideally be written in an informative way in order to educate the non-expert.³⁰⁵

The forensic report forms an essential part of the mental health expert's role also with reference to the report by the panel of experts as required in terms of Section 79 of the Criminal Procedure Act pertaining to competency to stand trial and the defence of criminal incapacity. The forensic report should clearly and as concisely as possible set out details of all the relevant facts the mental health expert relied on to form an opinion. The important issues have to be assessed relevantly, precisely and in a manner comprehensible to other professionals.³⁰⁶

³⁰⁰ Gunn and Taylor (1993) *supra* note 200 at 837; Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 330.

³⁰¹ Gunn and Taylor (1993) *supra* note 200 at 837.

³⁰² Gunn and Taylor (1993) *supra* note 200 at 838.

³⁰³ *Ibid.*

³⁰⁴ Melton *et al* (2007) *supra* note 2 at 585; Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 330.

³⁰⁵ Hess and Weiner (1999) *supra* note 2 at 516; Faulk (1994) *supra* note 200 at 292; Gunn and Taylor (1993) *supra* note 200 at 837.

³⁰⁶ Kaliski, Allan and Meintjes-Van der Walt in Kaliski (ed) (2006) *supra* note 2 at 341. See also "The Mental Health Professional and the Legal System" (1991) *supra* note 274 at 100 where it is noted: "Forensic reports should be realistic as well as objective. The quality of one's

8 A draft ethical code for mental health professionals serving as expert witnesses

Meintjes-Van der Walt suggests that expert witnesses in criminal trials should submit to a code of ethics when serving as expert witnesses as it will not only limit bias and partisanship, but will also enhance the reliability of the expert opinion.³⁰⁷ As such the expert's written report should constitute the foundation of oral evidence and should be disclosed to the other side prior to the trial and will generally follow the following principles:³⁰⁸

- The expert's written report should provide details of the expert's qualifications as well as the literature or other material used in making the report.
- Attached to the expert report, or a summary thereof, should be the following:
 - All instructions (both original and supplementary and an indication whether written or oral) provided to the expert which defines the scope of the report;
 - The facts, matters and assumptions upon which the report is predicated; and

thinking as a practitioner is reflected in the report. A precise, lucid document conveys a sense of clear thinking and increases the likelihood that it will be used. A diffuse, vague report suggests fuzzy thinking and is easily discounted."

³⁰⁷ Meintjes-Van der Walt (2001) *supra* note 2 at 230-232; Meintjes-Van der Walt (2003) *Journal of African Law supra* note 2 at 99. See also the decision of *National Justice Cia Naviera SA v Prudential Assurance Co Ltd, The Ikarian Reefer* (1993) Lloyd's Rep 68 at 81-82 where the duties of experts were enunciated as follows (albeit with reference to civil cases it could be useful in criminal matters): "(1) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation. (2) An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters the High Court should never assume the role of an advocate. (3) An expert witness should state the facts or assumptions upon which his conclusion is based. He should not omit to consider material facts which could detract from his concluded opinion. (4) An expert witness should make it clear when a particular question or issue falls outside his expertise. (5) If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one..." See also Henderson, A "An Independent Product – The role of expert evidence in the preparation and presentation of High Court cases involving allegations of (professional) negligence" (1997) *De Rebus* at 63-65.

³⁰⁸ Meintjes-Van der Walt (2001) *supra* note 2 at 230-232.

- The documents and other materials which the expert has been instructed to consider.
- The expert opinion should be clearly and fully presented.
- The report should mention all the tests or experiments used by the expert and which data the expert used in compiling the report.
- The expert should provide reasons for each opinion and conclusion drawn.
- Where the expert's opinion is not sufficiently researched due to the fact that the expert considers that insufficient data is available, or for any other reason, this fact must be stated with an indication that the opinion is no more than a provisional one.
- Where the expert witness who has prepared a report takes the view that it might be incomplete or inaccurate without some qualification, such qualification must be stated in the report.
- The expert should make it clear when a particular question or issue falls beyond his or her field of expertise.
- Where the expert's report refers to photographs, plans, calculations, analyses, measurements, survey reports or other extrinsic evidence these must be conveyed to the defence/prosecution when disclosure takes place.

Meintjes-Van der Walt suggests the inclusion of a declaration in the report which should provide for the following:³⁰⁹

"I DECLARE THAT:

³⁰⁹ *Ibid.*

- (i) I understand that my over-riding duty in written reports and giving evidence is to assist the court on matters relevant to my area of expertise.
- (ii) I have endeavoured in my reports and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated which I have been asked to address.
- (iii) I have endeavoured to include in my report those matters which I have knowledge of or of which I had been made aware of which adversely affect the validity of my opinion.
- (iv) I have indicated the sources of all information I have used and all tests and experiments I have performed.
- (v) I have not without forming an independent view included or excluded anything which has been suggested to me by others.
- (vi) I will notify those instructing me immediately and confirm in writing if for any reason my existing report requires any correction, qualification or amplification.
- (vii) I understand that:
 - (a) my report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under oath or affirmation;
 - (b) I may be cross-examined on my report by a cross-examiner assisted by an expert;
 - (c) I am likely to be the subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standards set out above.
- (viii) I confirm that I have not entered into any arrangement where reimbursement is in any way dependent on the outcome of the case.”

The author supports the view of a draft ethical code for expert witnesses which will inadvertently apply to mental health professionals providing expert evidence in support of the defence of criminal incapacity. Such ethical code will contribute towards creating a sense of certainty for the mental health professional whilst at

the same instance adding value to the scientific reliability and validity of the expert opinion.

9 Conclusion

In this chapter the author addressed the specific nature and scope of the rules of expert evidence as they would pertain to mental health experts testifying in support of the defence of criminal incapacity. Specific practical as well as ethical considerations applicable within the forensic context were also addressed. The following conclusions can be drawn from the research presented in this chapter:

- The rules of expert evidence, as they currently stand, are essential in respect of the role and probative value of expert evidence and should as such be codified in a proper manner so as to create legal certainty.
- In the absence of a jury system, the ultimate issue doctrine is redundant and should be abolished. Expert evidence should be judged on the basis of its relevance and not the alleged conclusory status of the opinion presented.
- The assessment of the probative value of expert evidence remains a complex and intrinsic function of a court where various aspects play a role of which the most important are the expert's qualifications, credibility as a witness, the basis for the expert opinion and the probabilities of the case.
- Pre-trial consultations and disclosure play a vital role in the assessment of the admissibility and reliability of expert evidence and the assurance of a fair trial.
- The cross-examination of expert witnesses within the adversarial context constitutes a vital tool in order to challenge the veracity, credibility, reliability and probative value of expert evidence.

- Mental health experts should strive in providing their opinion in an impartial manner without bias with the concomitant alleviation of the “hired guns”.
- Mental health experts should at all costs refrain from assuming dual relationships as treater and evaluator and accordingly a treating clinician should not act as a forensic expert witness and *vice versa*.
- Accused persons should be made aware that the traditional principles pertaining to confidentiality will not apply or be less stringent within the scope of the forensic evaluation. This information should already from the outset of the forensic interview be stated to the accused.
- The forensic report fulfils an essential part of the function of the forensic mental health expert and it is pivotal that due regard be given to the correct content, length, format and style of such report.
- A draft ethical code for mental health professionals could be a useful step in providing guidelines, which are to a certain extent codified, to mental health professionals acting as expert witnesses.

In the following chapter the author will assess aspects pertaining to the presentation of expert evidence in the United States of America in order to illustrate areas where South Africa is in need of reform in respect of the rules pertaining to expert evidence as well as the legal status in respect of forensic mental health professionals specifically.

“An experienced judge places no confidence in an oath; he has seen it so often prostituted to the ends of falsehood. His whole attention is directed to the nature of the testimony; he scrutinises the witness, examines his tones, his air, the simplicity of his language; or his embarrassment, his variations; his agreement with himself and with others; he has marks by which to judge the probity of the witness.”³¹⁰

³¹⁰ Bentham, A “Treatise on Judicial Evidence” (1925) as quoted in Freckelton and Selby (2005) *supra* note 2 at 327.

CHAPTER 5

MASTERING FORENSIC EXPERT EVIDENCE: REFLECTIONS FROM THE UNITED STATES OF AMERICA

“(F)or the limits to which our thoughts are confined, are small in respect of the vast extent of Nature itself; some parts of it are too large to be comprehended and some too little to be perceived, and from thence it must follow that not having a full sensation of the object; we must be very lame and imperfect in our conceptions about it, and in all the propositions which we build upon it; hence we often take the shadow of things for the substance, small appearances for good similitudes, similitudes for definitions; and even many of those which we think to be the most solid definitions are rather expressions of our misguided apprehension than of the true nature of the things themselves.”¹

1 Introduction

Law and medicine both represent two major scientific enterprises, each supporting its own distinctive and often disparate phenomena. On face value it would seem as though these two scientific discourses are different in respect of the points of view of each profession, professional ideologies and content. Upon closer scrutiny there are various similarities between these two sciences. Weisstub correctly asserts that there are various affinities between law and medicine: they both entail wide discretion in fashioning their respective discourses; they both lack certainty when compared with scientific data found in the hard sciences and they are both central to those values and goals within our society that address the control of deviancy.² Weisstub in addition notes:³

¹ Hooke, R (1667) as quoted in Kiely, T “Forensic Evidence: Science and the Criminal Law” (2001) at 1.

² Weisstub, DN “Law and Psychiatry in the Canadian Context – cases, notes and materials” (1980) at vii. See also Brody, BA and Engelbrecht, HT “Mental Illness: Law and Public Policy” (1979) at ix, where it is noted:

“Medicine and the law are two major social institutions, each supporting various and often quite disparate practices. It is frequently unclear where certain practices fall – whether they are truly medical or really legal endeavors, whether they are attempts to cure or care for persons with diseases, or attempts to punish criminals and rectify harms. Indeed, the practices intertwine in

“Although psychiatry is arguably as uncertain in its predictions and diagnoses as law is in its interpretation of jurisprudence and prediction of legal outcomes in producing theoretical justifications of their projects, both of these groups attempt to model themselves after scientific paradigms of discovery and application.”

Law and medicine have another common characteristic – they are both inexact sciences in search of truth and vindication. Within the context of the defence of criminal incapacity, law needs medicine to explain human behaviour. Weisstub encapsulates the latter by stating:⁴

“Each needs the other in effect to survive, to respond meaningfully to scientific advances in knowledge, and to take responsibility where science can give no answers”.

Law is not set in stone. It constitutes an evolving science amenable to the changing values and needs of society. Criminal incapacity is probably one of the most complex and controversial defences within our current criminal justice system.

In Chapters 2 and 3 it was illustrated that one of the main problems associated with the defence of criminal incapacity relates to the problematic dialogue between law and medicine, whenever this defence is raised. In Chapter 4 the author addressed the evidential anomalies associated with criminal incapacity with specific emphasis on the lack of a codified system of evidence in respect of expert evidence by mental health professionals.

One of the greatest problems associated with the defence of criminal incapacity lies in the proof thereof. No matter how well this defence is formulated within the

endeavors that bridge these major social institutions, where legal concerns for rectifying harms and medical concerns for cure and care are joined, as in the case of much public policy bearing on the mentally ill.”

³ Weisstub (1980) *supra* note 2 at vii. See also Halleck, SL “Law in the Practice of Psychiatry – A Handbook for Clinicians” (1980) at 1-10.

⁴ Weisstub (1980) *supra* note 2 at xi.

framework of the substantive criminal law, it will have limited value if not coupled with appropriate procedures or guidelines aimed at enhancing the application of this defence. At the heart of the application of this defence is the mental health professional who is requested to provide an expert opinion as to either the accused's competency to stand trial or his or her mental state at the time of the offence. The rules pertaining to expert evidence in South Africa are common law orientated.

The question which falls to be assessed is whether a codified system of expert evidence will not aid in enhancing a more helpful dialogue between law and medicine whenever the defence of criminal incapacity is raised. It is impossible to formulate a set criteria or model framework for expert evidence in cases of criminal incapacity as each case will be assessed on its own merits. Guidelines or some form of codification of the rules pertaining to expert evidence by mental health professionals in cases of criminal incapacity will, however, assist in determining the yardstick by which expertise should be assessed and will also assist in determining the boundaries, reliability and validity of expert testimony by mental health professionals. It is trite that whenever solutions to problem areas in law cannot be found within the framework of national law, it is useful to reflect on foreign law in search for the appropriate remedies. In this chapter the author has selected as comparator country the United States of America.⁵ The rationale for

⁵ Melton, GB; Petrila, J; Poythress, NG and Slabogin, C "Psychological Evaluations for the Courts – A Handbook for Mental Health Professionals and Lawyers" (2007) at 3-24, 86-100 (hereafter "Melton *et al*"); Freckelton, I and Selby, H "Expert Evidence – Law, Practice, Procedure and Advocacy" (2005) at 21-59, 61-89, 293-294, 863-869; Graham, MH "Handbook of Federal Evidence" (1991) at 600-697; Graham, MH "Federal Rules of Evidence" (1981) at 198-217; Arrigo, A "Punishing the mentally ill – A Critical Analysis of Law and Psychiatry" (2002) at 127-144; Wright, F; Bahn, C and Rieber, RW "Forensic Psychology and Psychiatry" (1980) at 33-35; Meyer, RG; Landis, ER and Hays, JR "Law for the Psychotherapist" (1988) at 220-224; Slovenko, R "Psychiatry and Criminal Culpability" (1995) at 133-150; Ziskin, J "Coping with Psychiatric and Psychological Testimony" (1980) at 64-82; Sales, BD and Shuman, DW "Experts in Court: Reconciling Law, Science and Professional Knowledge" (2005) at 13-96; Blau, TH "The Psychologist as Expert Witness" (1998) at 29-61; Slovenko, R "Psychiatry in Law/Law in Psychiatry" (2002) at 43-64; Guttmacher, MS "The Role of Psychiatry in Law" (1968) at 74-86; Gold, L "Evidence: A Structural Approach" (2004) at 491-534; Brodsky, SL "The Expert Witness: more maxims and Guidelines for testifying in court" (1999) at 31-35; Patterson, D "Challenges to Expert Testimony Pre- and Post – Daubert" in Linder, RK and Mitchel, GN "Challenging Expert Witness Testimony" (2000) at 1-49; Shapiro, DL "Criminal Responsibility Evaluations – A manual for Practice" (1999) at 1-28; Kiely, TF "Forensic Evidence: Science and the Criminal Law" (2001) at 1-18; Rothstein, PF, Raede, MS and Crump, D "Evidence: Cases, Materials and Problems" (2006) at 321-370, 377-462; Van Kampen, PTC "Expert Evidence Compared – Rules in the Dutch and American Criminal

Justice System” (1998) at 188-201; Faigman, D: “Expert Evidence: The Rules and Rationality the Law Applies (or should Apply) to Psychological Expertise” in Carson, D and Bull, R “Handbook of Psychology in Legal Contexts” (2003) at 367-400; Sales, BD and Shuman, DW “Science, Experts and Law: Reflections on the Past and the Future” in Constanzo, M; Krauss, D and Pezdek, K “Expert Psychological Testimony for the Courts” (2007) at 9-30; Gutheil, TG, Bursztajn, HJ, Brodsky, A and Alexander, V “Decision-Making in Psychiatry and the Law” (1991) at 171-188; Wigmore, JH “Evidence in Trials at Common Law” (1978) at 1-41; Slovenko, R “Psychiatric Expert Testimony: Are the Criticisms Justified? (Part 1) (1991) *Medicine and Law* at 1-29; Slovenko, R “Psychiatric Expert Testimony: Are the Criticisms Justified? (Part 2)” (1991) *Medicine and Law* at 107-127; Bloom, JD, Williams, MH and Bigelow, DA “The Forensic Psychiatric System in the United States” (2000) *International Journal of Law and Psychiatry* at 605-613; Morse, S “Speciality Guidelines for Forensic Psychologists” (1991) *Law and Human Behaviour* at 655-665; Gutheil, TG and Bursztajn, H “Avoiding *Ipse dixit* mislabelling: Post-Daubert Approaches to Expert Clinical Opinions” accessed at <http://www.forensic-psych.com/articles/artAvoidIpsedixit.php> [accessed on 2007/03/28] at 1-7; Slovenko, R “On a Therapist Serving as a Witness” (2002) *Journal of American Academy of Psychiatry and the Law* at 10-13; Slovenko, R “Commentary: Deceptions to the Rule on Ultimate Issue Testimony” (2006) *Journal of the American Academy of Psychiatry and the Law* at 22-25; Black, B; Ayala, FJ and Salfron-Brinks, C “Science and the Law in the Wake of Daubert: A New Search for Scientific Knowledge” (1994) *Texas Law Review* at 715-802; Pipkin, WE “Expert Opinion Testimony: Experts, Where Did they come from and Why are they there?” (1989) *Law and Psychology Review* at 103-118; Cochrane, G “logy, Expert Testimony and the Law” (2001) *Washington State Bar Review* at 24-32; Gutheil, TG “Psychiatrists as Expert Witnesses” (2004) *American Journal of Psychiatry* at 2141; Kastenber, MJE “A Three-Dimensional Model for the Use of Expert Psychiatric and Psychological Evidence in the False Confession Defenses Before the Trier of Fact” (2003) *Seattle University Law Review* at 785-805; Reid, J “Criminal Insanity and Psychiatric Evidence: The Challenge of Blocker” (1962) *Howard Law Journal* at 1-14; Bloom, JD and Rogers, JL “The Legal Basis of Forensic Psychiatry: Statutorily Mandated Psychiatric Diagnoses” (1987) *American Journal of Psychiatry* at 847-853; Lipkin, RJ “Free Will, Responsibility and the Promise of Forensic Psychiatry” (1990) *International Journal of Law and Psychiatry* at 331-359; Gorman, WF “Are there Impartial Expert Psychiatric Witnesses” (1983) at 379-382; Dahl, PR “Legal and Psychiatric Concepts and the Use of Psychiatric Evidence in Criminal Trials” (1985) *Calif.L.R* at 411-442; Rogers, R; Bagby, RM and Chow, MK “Psychiatrists and the Parameters of Expert Testimony” (1992) *International Journal of Law and Psychiatry* at 387-396; Marwick, C “What Constitutes an Expert Witness” (1993) *Journal of the American Medical Association* at 2057; Bromberg, W “Psychiatrists in Court: The Psychiatrist’s View” (1969) *American Journal of Psychiatry* at 1343-1347; Slovenko, R “Expert Testimony: Use and Abuse” (1993) *Medicine and Law* at 627-641; Moriarty, JC (ed) “The Rule of Mental Illness in Criminal Trials – The Insanity Defense: The American Developments” (2001) at 1-124; Appelbaum, PS “The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm” (1990) *International Journal of Psychiatry* at 249-259; Perlin, ML “The Legal Status of the Psychologist in the Courtroom” (1977) at 41-45; Gutheil, TG “Psychiatric Expert Witnesses in the New Millennium” (2006) at 823-832; Slovenko, R “A history of the intermix of psychiatry and law” (2004) *The Journal of Psychiatry and Law* at 561-592; Buchanan, A “Psychiatric Evidence on the Ultimate Issue” (2006) *The Journal of the American Academy of Psychiatry and the Law* at 14-21; Cohen, D “Punishing the Insane: Restriction of Expert Psychiatric Testimony by Federal Rule of Evidence 704(b)” (1988) *University of Florida Law Review* at 541-561; Sparks, J “Admissibility of Expert Psychological Evidence in the Federal Courts” (1995) *Arizona State Law Journal* at 1315-1333; Wallace, D “The Syndrome Syndrome: Problems Concerning the Admissibility of Expert Testimony on Psychological Profiles” (1985) at 1035-1058; Imwinkelried, EJ “The Standard for Admitting Scientific Evidence: A critique from the Perspective of Juror Psychology” (1983) at 554-571; Trowbridge, BC “The Admissibility of Expert Testimony in Washington on Post Traumatic Stress Disorder and Related Trauma Syndromes: Avoiding the Battle of the Experts by Restoring the Use of Objective Psychological Testimony in the Courtroom” (2003) *Seattle University Law Review* at 453-523; Slobogin, C “Psychiatric Evidence in Criminal Trials: To Junk or not to Junk?” (1998) *William and Mary Law Review* at 1-56; Smith, KT “The Psychiatry Expert in the Criminal Trial: Are Bifurcation and the Rules

selecting the United States of America as comparator country include the following:

- The Federal Rules of Evidence could provide a useful framework towards a codification of the rules pertaining to opinion evidence with specific reference to expert evidence in South Africa;
- The decision of *Daubert v Merrell Dow Pharmaceuticals*⁶ and the principles enunciated therein could assist towards setting a yardstick by which reliability and validity of expert opinions can be assessed;
- Advanced research exists in the United States of America pertaining to the topic of expert evidence by mental health professionals in cases where the mental state of the accused is an issue;⁷
- The DSM-IV-TR which constitutes the main source of reference for purposes of ascertaining diagnostic criteria for the assessment of mental illness is drafted by the American Psychiatric Association;⁸
- The ethical code and guidelines for forensic psychiatrists and psychologists could be usefully applied within the South African context.

The abovementioned principles will form the cornerstones of this chapter in order to reflect on aspects within the American system which can be sufficiently applied within the South African context to areas where there is a need for development and improvement.

2 Mode of discussion

Concerning Opinion Testimony on Ultimate Issues Constitutionally Compatible?" (1987) *Marquette Law Review* at 493-533; Conley, WM "Restricting the Admission of Psychiatric Testimony on Defendant's Mental State: Wisconsin's Steel-curtain" (1981) *Wisconsin's Law Review* at 733-789; Harris, DA "Ake Revisited: Expert Psychiatric Witnesses Remain Beyond Reach for the Indigent" (1990) *North Carolina Law Review* at 763-783; Murphy, JP "Expert Witnesses at Trial: Where are the Ethics" (2000) *Georgetown Journal of Ethics* at 217-239; Gutheil, TG and Simon, RI "Mastering Forensic Psychiatric Practice – Advanced Strategies for the Expert Witness" (2002) at 113-140; During the course of this chapter the author will in respect of selected issues refer to the "jury" – this is merely for reference purposes within the framework of the American system and for purposes of clarity and comprehension. Similarly, the word "defendant" will often be used which denotes "accused" as is the position in South Africa.

⁶ *Daubert v Merrell Dow Pharmaceuticals* 509 US 579 (1993).

⁷ See note 5 *supra*.

⁸ See Chapter 3 *supra* where the DSM-IV-TR was comprehensively discussed.

In this chapter a *capita selecta* of principles pertaining to expert evidence as propounded in the Federal Rules of Evidence in the United States of America will be addressed. These principles will be evaluated on the backdrop of the format espoused in Chapter 4 in respect of the rules of expert evidence. This will be done to indicate the utility of a codified system of rules of expert evidence as opposed to the common law position prevailing in South Africa.

In addition thereto the ethical guidelines pertaining to forensic psychology and psychiatry prevailing in the United States of America will be addressed. This chapter should by no means be construed as an all encompassing exposition of the law and consequently the law of evidence in the United States of America. Selected issues will be assessed to illustrate possible areas where the South African system can be improved and developed in streamlining the application of the defence of criminal incapacity in South Africa.

3 Constitutional foundation

It remains trite that no topic or discussion can be embarked upon without references to the constitutional relevance and premise thereof. In Chapters 2 and 3 the constitutional relevance of the current study was extensively discussed and will not be repeated in this chapter.

For purposes of this chapter, Section 39 of the Bill of Rights of the Constitution is of importance.⁹ Section 39, which deals with the interpretation of the Bill of Rights, reads as follows:

- ”39. (1) When interpreting the Bill of Rights, a court, tribunal or forum
- (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
 - (b) must consider international law; and
 - (c) may consider foreign law

⁹ Constitution of the Republic of South Africa, 1996.

- (2) When interpreting any legislation and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.
- (3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognized or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.”

Section 39(1) accordingly requires that when interpreting the Bill of Rights a court, tribunal or forum should promote the values which underpin an open and democratic dispensation founded on human dignity, equality and freedom and in executing this function may consider foreign law.¹⁰ Devenish encapsulates the need for foreign perspectives by stating:¹¹

“It must be borne in mind that the scarcity of local precedents securing fundamental rights makes it necessary that the international and foreign case law be used to resolve jurisprudential issues precipitated by the justifiability of the provisions of the Bill of Rights.”

Even though foreign law will not be decisive when interpreting the Bill of Rights, it will play an important role within our constitutional dispensation in attempting to promote the values of human dignity, equality and freedom.¹²

Reference to foreign law, in this chapter the United States of America, could add value in respect of the interpretation of the Bill of Rights in order to promote the values of human dignity, freedom and equality.¹³ Foreign law could also play a vital role in the process of developing the common law in order to provide

¹⁰ Currie, I and De Waal, J “The Bill of Rights Handbook” (2005) at 159; Devenish, GE “The South African Constitution” (2005) at 199. See also *Shabalala v The Attorney-General of Tvl* (1994) (6) BCLR 85 (T).

¹¹ Devenish (2005) *supra* note 10 at 200. See also Currie and De Waal (2005) *supra* note 10 at 160-161. *S v Makwanyane* (1995) (3) SA 391 (CC) at paragraph 37.

¹² *Ibid.* See also *Fose v Minister of Safety and Security* (1977) (3) SA 786 (CC).

¹³ See Section 39(1) of the Constitution of the Republic of South Africa, 1996. See also Devenish (2005) *supra* note 10 at 205 where it is noted:
“... the Bill of Rights encapsulates universal moral and ethical values, and therefore in its application and its interpretation it has an important moral dimension to it. It is for this reason that a value-based theory of interpretation is the most satisfactory one.”

guidelines as to how such development could possibly be effected. Frase¹⁴ clearly states that a comparative study should always lead us to a closer analysis of our own system and more often than not when guided by the insights of comparative study and a systematic, empirical methodology such analysis often reveals that our own system is not as different in practice from foreign systems as we thought.

4 Setting the stage: From Frye to the Federal Rules of Evidence

For the greatest part of the twentieth century, the admissibility of expert scientific and technical evidence was governed by the so-called “general acceptance” test enunciated in *Frye v United States*¹⁵ by Van Orsdel J who noted:¹⁶

”Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle

¹⁴ Frase, RS “Comparative Criminal Justice as a guide to American Law Reform: How do the French Do It; How can we find out; and Why should We Care” (1990) *Cal. L. Rev* 539, 664 as quoted in Van Kampen (1998) *supra* note 5 at 237.

¹⁵ *Frye, United States*, 293 F. 1013 (D.C. Cir. 1923). The facts of this decision were the following: The defendant was convicted of murder in the second degree. Counsel for the defence sought to introduce expert evidence derived from a systolic blood pressure deception test. Counsel introduced an expert who would testify as to the results of a deception test performed on the defendant. It was contended that changes in blood pressure would be induced by changes in the emotions of the witness and accordingly that systolic blood pressure increases were caused as a result of nervous impulses sent to the autonomic nervous system. The defence contended that scientific experiments established that fear, rage and pain resulted in an elevation of systolic blood pressure and that conscious deception, concealment of facts or feelings of guilt as a result of the criminal activities in conjunction with fear of detection caused an increase in the systolic blood pressure in a curve corresponding with the conflict with the individual’s mental state between fear and control of such fear due to the fact that the examination addresses those issues in respect of which the individual was trying to deceive the examiner. The main premise upon which the defendant’s (in terms of South African law the “accused”) case was founded, related to the rule that the opinions of expert or skilled witnesses were frequently admissible in cases where the matter for inquiry is of such a nature as to be beyond the experience of the lay person due to the matter dealing with science or scientific issues. The court per Van Orsdel J held that the systolic blood pressure deception test had not gained general acceptance and scientific recognition among psychological and physiological authorities as to warrant the admission of expert evidence deduced from the discovery, developments and experiments (at 1014 of judgment). See also Kiely (2000) *supra* note 5 at 11; Blair (1998) *supra* note 5 at 56; Slovenko, R (2002) *supra* note 5 at 43; Sales and Shuman (2005) *supra* note 5 at 30-33; Van Kampen (1998) *supra* note 5 at 188-193; Sparks, J “Admissibility of Expert Psychological Evidence in Federal Courts” (1995) *Arizona State Law Review* at 1315-1333; Black, Ayala and Saffron-Brinks (1994) *Texas Law Review* *supra* note 5 at 15; Shapiro (1999) *supra* note 5 at 2-3.

¹⁶ At 1014. See also Graham, ES and Kabacy, RE “Expert testimony by Psychologists: Novel Scientific Evidence” (1990) *Law and Psychology Review* at 71-85.

must be recognized, and while the courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have general acceptance in the particular field in which it belongs.”

The general acceptance rule entailed that the expert’s opinion should be premised on information, data or deductions that were generally accepted by the majority of professionals within the specific area of specialisation.¹⁷ In applying the *Frye* test to the reliability of expert evidence pertaining to an individual’s mental state, a three-dimensional test has to be applied.¹⁸

- The individual must establish that the alleged disorder is recognised by the relevant community of experts;
- The experts then has to establish a casual *nexus* between the illness caused by the disorder and the offence committed;
- The facts must be such to create a question to the jury that the specific individual indeed suffers from such disorder.

The infusion of the “general acceptance” test in *Frye* resulted in this test prevailing for several decades thereafter.¹⁹ The “general acceptance” test, however, illuminated numerous criticisms:

- The acceptance by the scientific community as the threshold test for admissibility did not keep out “junk science”;²⁰

¹⁷ Blau (1998) *supra* note 5 at 56; Sales and Shuman (2005) *supra* note 5 at 30-31; Slovenko (2002) *supra* note 5 at 44-46. See also Freckelton and Selby (2005) *supra* note 5 at 77 where it is noted that the support of the *Frye* test averred that it promoted consistency; eliminated time consuming trials of the degree of reliability; it protected juries from having to decide complex and conflicting expert evidence; it excluded unsubstantiated scientific methods from misleading the court.

¹⁸ McKay, IM “Scientific reliability of Psychiatric Expert Witness Testimony Involving the use of classifications from the diagnostic and statistical manual at Mental Disorders” (1992) *Criminal Justice Journal* 345-384 at 358.

¹⁹ Kiely (2000) *supra* note 5 at 12; Slovenko (2002) *supra* note 5 at 44-45; Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 722.

²⁰ Slovenko (2002) *supra* note 5 at 45.

- The rule in *Frye* obscured issues and was difficult to apply;²¹
- In terms of the *Frye* test, a court is required to define the scientific entity, device, method, theory or technique before it can embark upon applying the general acceptance test. The issue in this regard pertains to the fact that a court has to consider the entire pattern of reasoning by which experts arrive at their conclusions.²²
- Due to the fact that *Frye* requires that a scientific principle should be generally accepted in the specific field it belongs, a court applying this test is burdened with the task of both having to define and determine the boundaries of what must be accepted.²³
- As a result of the difficulties in defining what precisely should be accepted, courts end up using surrogate tests instead of assessing the scientific merits of scientific expert evidence.²⁴
- Concerns were raised as to the soundness of the “general acceptance” theory or test in *Frye* as an analytical tool for assessing the admissibility of (novel) scientific evidence.²⁵
- There existed the danger that the test could result in the admission of invalid theories and techniques merely as a result of the fact that they have obtained widespread acceptance,²⁶

²¹ Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 726-728.

²² *Ibid.*

²³ Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 729-731; Freckelton and Selby (2005) *supra* note 5 at 78.

²⁴ *Ibid.* See also *Reed v State* 391 A.2d 364 (Md 1978), *United States v Addison* 498 F.2d 741 (D.C. Cir. 1974).

²⁵ Van Kampen (1998) *supra* note 5 at 193. See also Kreiling, KR “Scientific Evidence: Toward Providing the Lay Trier with the Comprehensible and Reliable Evidence Necessary to meet the Goals of the Rules of Evidence” (1990) *Arizona Law Review* at 929-935. See also Freckelton and Selby (2005) *supra* note 5 at 79. See also *United States v Williams* 583 F.2d 1194 (1978) where the court specifically departed from the *Frye*-test at 1198 and also *United States v Jacobetz* 747 F.supp 250 (1990) where Billings, CJ listed nine factors to be taken into consideration of the admissibility which were the following (at 255):

- The expert’s qualifications and standing;
- The existence of specialised literature;
- The novelty of the technique and its connection to more established fields of scientific analysis;
- The nature and extent of the inference adduced;
- The clarity with which the technique is offered;
- The extent to which basic data may be investigated into by the court;
- The availability of other experts to assess the technique;
- The probative value of the evidence.

²⁶ Freckelton and Selby (2005) *supra* note 5 at 78-79; Van Kampen (1998) *supra* note 5 at 193.

- The test is prone to selective application;²⁷
- The test is predicated upon the possibly erroneous belief that jurors are unable to deal effectively with complex scientific evidence;²⁸
- It is unclear how one is to ascertain the “scienticity” of a specific theory or technique and also whether such test applies to mental health and other sciences;²⁹
- The test only applies to theory and not the application which is controversial to most theories or techniques;³⁰
- Criticism was also raised that the “general acceptance” test often excludes otherwise relevant and reliable evidence.³¹

In response to the debate as to the *Frye* test, the Federal Rules of Evidence were adopted in 1975.³² Sales and Shuman note that the Federal Rules of Evidence were promulgated in 1974 with the specific aim of making the rules of evidence more accessible by codifying the vast amount of common law case law pertaining to the various rules of evidence.³³ In addition the Federal Rules of Evidence were aimed at modernising the law of evidence by conscious preference for the admission of relevant evidence without seeking justification for its exclusion.³⁴ The Federal Rules of Evidence advocated a more liberal approach to the admission of expert evidence.³⁵ The modernisation approach propounded in the Federal Rules of Evidence was endorsed by the majority of state courts that elected to codify

²⁷ *Ibid.*

²⁸ *Ibid.*

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 740. See also *United States v Downing*, 753 F.2d 1224, 1236-1237 (3d Cir.1985). See also Freckelton and Selby (2005) *supra* note 5 at 78.

³² Van Kampen (1998) *supra* note 5 at 193; Blau (1998) *supra* note 5 at 56.

³³ Sales and Shuman (2005) *supra* note 5 at 31. Sales and Shuman indicate that although the Federal Rules of Evidence are not binding on the states, the majority of the states have adapted those rules. See also Slobogin (1998) *William and Mary Law Review, supra* note 5 at 17; Murphy (2000) *Georgetown Journal of Ethics, supra* note 5 at 219.

³⁴ *Ibid.*

³⁵ Van Kampen (1998) *supra* note 5 at 194; Pipkin (1989) *Law and Psychology Review supra* note 5 at 110; Sales and Shuman (2005) *supra* note 5 at 29. See also Sales, BD and Shuman, DW “Science, Expert, and the Law: Reflections on the Past and the Future” in Costanzo, M; Krauss, D and Pezdek (eds), K “Expert Psychological Testimony for the Courts” (2007) at 9-30 at 11 where it is stated:
“In both the state and federal courts, the rules that governed the admissibility of evidence at trial developed through a patchwork of judge-made, common law decision-making.”

their rules.³⁶

The Federal Rules of Evidence constitute a set of codified rules relating to the admissibility of evidence in the federal courts. The goals of these rules are encapsulated in Rule 102 which states:³⁷

”These rules shall be construed to secure fairness in the administration, elimination of unjustifiable expense and delay, and the promotion of growth and development of the law of evidence to the end that the truth may be ascertained and proceedings justify determined.”

The Federal Rules of Evidence encompass the principles of fairness, efficiency, growth and development of the law, truth and justice.³⁸ Murphy submits that the Federal Rules of Evidence permeates the framework according to which every expert appears at trial before a trier of fact.³⁹

It remains trite that regardless of the specific test applied in respect of the defence of criminal incapacity, the testimony provided by the mental health professional must describe the accused’s state of mind at the time of the offence. The relevance, admissibility, reliability and validity of such testimony will be determined by the specific rules of expert evidence. The search for a more appropriate application of the role of expert evidence in support of the defence of criminal incapacity should thus be embarked upon on the backdrop of the law of evidence. The latter forms the cornerstone for comparative reflections from the United States of America. The Federal Rules of Evidence of relevance for this study will be addressed below within the framework of the rules of expert evidence.⁴⁰

4.1 Relevance

³⁶ Sales and Shuman (2005) *supra* note 5 at 31.

³⁷ Sales and Shuman (2005) *supra* note 5 at 14; Graham (1981) *supra* note 5 at 2-3; Graham (1991) *supra* note 5 at 2-3; Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 218.

³⁸ Sales and Shuman (2005) *supra* note 5 at 14.

³⁹ Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 219; Van Kampen (1998) *supra* note 5 at 194.

⁴⁰ See Chapter 4 above.

In terms of Federal Rule 401, “Relevant evidence” is defined as:⁴¹

“.....evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.”

The basic tenet of the law of evidence – relevance – is thus recognised and firmly established in terms of Federal Rule 401. The question as to whether evidence is relevant will be dependent upon whether it possesses a tendency to render a fact or consequence more or less probable than it would be without such evidence.⁴² Blau notes that this rule acknowledges that probability is an essential component of evidentiary issues.⁴³ In addition to Federal Rule 401, Federal Rule 402 provides that all relevant evidence shall be admissible unless it is specifically otherwise provided for in terms of the Constitution of the United States or other rules prescribed by the Supreme Court pursuant to statutory authority.⁴⁴ The Federal Rules of Evidence thus confirm the basic principle that evidence should be relevant in order to be admitted. Federal Rule 402 to some extent corresponds with the South African equivalent in terms of Section 211 of the Criminal Procedure Act as Federal Rule 402 in addition states that evidence which is not relevant is not admissible.⁴⁵ The latter *proviso* empowers the judicial officer to impose basic restrictions to the admissibility of evidence in the sense of excluding irrelevant or immaterial evidence. Smith correctly notes that relevant evidence is both material as well as probative.⁴⁶ Smith⁴⁷ explains that a fact in consequence comprises of facts which include direct evidence of an element of a claim or defense, facts from whose establishment may be inferred facts amounting to elements of claims or defenses, and facts relating circumstantially to the assessment of the probative value attributed to other evidence in the case and

⁴¹ Federal Rule, 401. See also Graham (1991) *supra* note 5 at 139; Graham (1981) *supra* note 5 at 63-66; Blau (1998) *supra* note 5 at 56-57.

⁴² *Ibid.*

⁴³ Blau (1998) *supra* note 5 at 56.

⁴⁴ Federal Rule 402. See also Blau (1998) *supra* note 5 at 57; Graham (1991) *supra* note 5 at 171; Graham (1991) *supra* note 5 at 77.

⁴⁵ *Ibid.*

⁴⁶ Smith (1987) *Marquette Law Review supra* note 5 at 505.

⁴⁷ Smith (1987) *Marquette Law Review supra* note 5 at 505-506. See also Slobogin (1998) *William and Mary Law Review supra* note 5 at 30-42.

consequently when the mental state of an accused is an element of the crime charged, it can be assumed that psychiatric testimony would have a tendency to establish that element.

4.2 The Expertise Rule

Federal Rule 702 encapsulates the expertise rule as follows:⁴⁸

”If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise if (a) the testimony is based upon sufficient facts or data; (b) the testimony is the product of reliable principles and methods, and (c) the witness has applied the principles and methods reliably to the facts of the case”.

Federal Rule 702 addresses in direct terminology the importance of expert evidence as an informal assessment of the facts is often problematic and impossible in the absence of the application of some scientific, technical or other specialised knowledge.⁴⁹

Federal Rule 702 furthermore addresses three important principles:

- The expert evidence must assist the trier of fact;
- The expert witness must be qualified;
- The expert evidence should be reliable.

⁴⁸ Federal Rule 702. It is notable that Federal Rule 702 as quoted above is the product of an amendment effected in 2000. The previous Federal Rule 702 did not include the second part after the words “... or otherwise”. The amendment was implemented to reequip that expert testimony should be the product of reliable principles which are reliably applied to the facts of a case. See Sales and Shuman (2005) *supra* note 5 at 40; Melton *et al* (2007) *supra* note 5 at 16; Van Kampen (1998) *supra* note 5 at 201; Slovenko (1995) *supra* note 5 at 136-137; Graham (1991) *supra* note 5 at 612; Graham (1981) *supra* note 5 at 198; Blau (1998) *supra* note 5 at 57; Wallace (1985) *University of Florida Law Review supra* note 5 at 1038; Gold (2004) *supra* note 5 at 498; Sales and Shuman in Costanzo, M; Krauss, D and Pezdek (eds), (2007) *supra* note 35 at 11.

⁴⁹ Gold (2004) *supra* note 5 at 498.

The first two principles will be discussed below and the third aspect, the reliability of the expert opinion, will be addressed later in this chapter.

- **The expert evidence must assist the trier of fact**

The following factors are important in respect of this portion of Federal Rule 702:⁵⁰

- The expert evidence should firstly be relevant and will not “assist” if it is not connected to the facts at issue;
- Expert testimony will in addition be irrelevant if the reasoning behind it is so illogical that it cannot support the probabilities of the presence of facts in issue;
- The opinion of an expert should be supported by a sufficient foundation of relevant facts, data or opinions.

- **The expert witness must be qualified**

The following aspects are important pertaining to this section of Federal Rule 702:⁵¹

- The five bases for qualifying as an expert are “knowledge, skill, experience, training or education”.
- The level of “knowledge, skill, experience, training or education” required to qualify as an expert witness is only that which is necessary to guarantee that the testimony will “assist” the Court.
- “Gaps” in an expert witness’ qualification or training generally affect the weight rather than the admissibility of the expert evidence.
- The level and manner of knowledge and experience required of the expert is dependent on the complexity of the matter.

Federal Rule 702 thus provides a framework for both ascertaining expertise and also determining the helpfulness of expert evidence to the court. Melton *et al* note that even in cases where the research premise of opinions is weak, the underlying

⁵⁰ Gold (2004) *supra* note 5 at 499-500. See also Graham (1991) *supra* note 5 at 613-619. Graham (1981) *supra* note 5 at 201-202.

⁵¹ *Ibid.* See also Carson and Bull (2003) *supra* note 5 at 372 where it is noted: “Hence, experts on medical matters are expected to have medical degrees appropriate certifications and experience.”

knowledge may very well be sufficient in order to permit the admission of the opinion.⁵²

Melton *et al*⁵³ state that mental health professionals are trained and experienced in generating explanations of abnormal behaviour and even if these formulations are at times mere “stories” their narration may provide valuable explanations of an accused’s behaviour that would otherwise be unavailable to the trier. If these explanations are presented with the necessary caution, they may assist the fact-finder in reaching a judgment despite the fact that they have not or cannot be verified.

Federal Rule 702 provides a useful balance between on the one hand, following a relatively liberal approach towards the admission of expert evidence by a trained and specialised expert whilst, on the other hand, including the *proviso* that the opinion should be based upon sufficient facts which is the product of reliable principles applied to the facts in a reliable fashion.

4.3 The Basis Rule

Federal Rule 703 provides the following in respect of the basis of opinion testimony by experts:⁵⁴

”The facts or data in the particular case upon which an expert bases an opinion or inference, may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the

⁵² Melton *et al* (2007) *supra* note 5 at 19. See also Morse, SJ “Failed Explanations and Criminal Responsibility: Experts and the Unconscious” (1982) *VA L.Rev* at 1016-1018

⁵³ Melton *et al* (2007) *supra* note 5 at 19.

⁵⁴ Federal Rule 703. See also Gold (2004) *supra* note 5 at 522; Melton *et al* (2007) *supra* note 5 at 16; Blau (1998) *supra* note 5 at 57; Graham (1991) *supra* note 5 at 633; Graham (1981) *supra* note 5 at 205; Van Kampen (1989) *supra* note 5 at 201-203. See also Sales, MJ and Wissler, RL “Legal and Psychological Bases of Expert Testimony: Surveys of the Law and the Jurors (1984) *Behavioural Sciences and the Law* at 435-449.

opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the experts' opinion substantially outweighs their prejudicial effect.”

Federal Rule 703 provides that the expert opinion can be based on three possible sources: first-hand knowledge; evidence already admitted; and facts or data not admitted that is of a type which is reasonably relied upon by experts within a specific field in arriving at opinions or inferences upon the specific subject.⁵⁵ Van Kampen notes that reliance upon data not itself admissible needs to be custom in the expert's field and also needs to be reasonable.⁵⁶

Graham explains that the requirement that the facts, data or opinions should constitute those reasonably relied upon by experts within the specific field ensures reliability of both the opinion and its basis.⁵⁷ The fact that Federal Rule 703 permits that the underlying facts or data underlying the opinion need not be admissible in order for the opinion to be admitted, could in particular cases result in a relaxation of the traditional hearsay rule.

Van Kampen submits that some courts have held that the data should be admissible as substantive proof whenever an expert places reliance upon it, whilst other courts have held that such data or facts can only be used in assisting the trier of fact to evaluate the expert's opinion and cannot be received unless it conforms to one of the traditional exceptions to the hearsay rule.⁵⁸ The latter construction seems to be more in line with the purport and objectives of Federal Rule 703. The underlying data or facts are used to make the opinion more probable and increase its probative value. The underlying data and facts or opinions are also utilised to assist the trier of fact to assess the opinion. It is,

⁵⁵ Gold (2004) *supra* note 5 at 522; Van Kampen (1998) *supra* note 5 at 203; Blau (1998) *supra* note 5 at 57; Graham (1991) *supra* note 5 at 634.

⁵⁶ Van Kampen (1998) *supra* note 5 at 203.

⁵⁷ Graham (1991) *supra* note 5 at 637. See also *United States v Williams* 431 F.2d 1168, 1172 (5th Cir. 1970).

⁵⁸ Van Kampen (1998) *supra* note 5 at 204. See also Graham (1981) *supra* note 5 at 207 where it is noted that Federal Rule 703 operates as an exception to the rule against hearsay evidence. See also Graham (1991) *supra* note 5 at 643 where it is noted that the effect of Rule 703 in most cases operates in a similar fashion as a hearsay exception to such extent that courts often fail to adequately note the distinction.

however, important to adequately weigh the probative value of such information against its prejudicial effect.⁵⁹ Within the ambit of the defence of criminal incapacity, a rule similar to Federal Rule 703 could assist mental health professionals when testifying as to the mental state of an accused person specifically when the expert relies on data or information which substantiates his or her opinion, but which is generally inadmissible. The facts or data relied on, should be of a type reasonably relied upon by experts within the particular field of mental health. Gold submits that Federal Rule 703 affords a trial judge more authority as a “gatekeeper” as the admissibility of an expert opinion will depend on two factors.⁶⁰

- The party presenting the expert evidence should indicate that the expert relied on facts or data of a type relied on by experts in the field; and
- The party must in addition indicate that such reliance is reasonable.

One of the main considerations in applying Federal Rule 703 denotes an assessment of the probative value of the evidence as opposed to its possible prejudicial effect. The Advisory Committee to Federal Rule 703 noted the following:⁶¹

”When information is reasonably relied upon by an expert and yet is admissible only for the purpose of assisting the jury in evaluating an expert’s opinion, a trial court applying this Rule must consider the information’s probative value in assisting the jury to weigh the expert’s opinion on the one hand, and the risk of prejudice resulting from the jury’s potential misuse of the information for substantive purposes on the other.”

Slovenko is of the opinion that in terms of Federal Rule 703, the expert’s basis

⁵⁹ See also Van Kampen (1998) *supra* note 5 at 211 where it is noted that even if the data upon which the expert relied on in arriving at his opinion, is deemed reliable enough for the court to rely upon it in determining a case, to admit such data could nevertheless in some instances violate an individual’s right to confront the witnesses against him or her. See also Slovenko (2002) *supra* note 5 at 56; *United States v Lawson* 653 F.2d 299 (7th Cir. 1981).

⁶⁰ Gold (2004) *supra* note 5 at 523. See also Federal Rule 104(9).

⁶¹ Gold (2004) *supra* note 5 at 524.

need not be admissible in evidence provided that experts routinely place reliance on such data.⁶² In terms of Federal Rule 703, the emphasis is not on the admissibility of the underlying data of the expert's opinion, but rather falls on the reliability and validity of the opinion to ensure a reliable basis for the expert's testimony.⁶³

The specific data relied upon can vary and a psychiatrist conducting an evaluation will typically consider for example, the criminal record of an accused and may include such record in support of his or her opinion.⁶⁴ A rule similar to Federal Rule 703 could be usefully applied in the assessment of the defence of criminal incapacity, specifically if the mental health expert's basis of opinion rests on facts or data reasonably relied upon by other experts in the particular field. It could be argued that a similar rule could result in a more informative opinion more capable of assisting the trier of fact in the determination of the issue of criminal capacity.

4.4 The Ultimate Issue Rule

It was during summer in 1976 when a young John Hinckley, Jr, watched Travis Bickle plot to assassinate a presidential candidate in the film 'Taxi Driver'. Hinckley instantaneously fell in love with actress Jodie Foster who played the role of a 12-year old prostitute in the film. Hinckley developed an obsession with Jodie Foster and the President. This obsession culminated in Hinckley shooting and wounding President Ronald Reagan on 30 March 1981 in an attempt to impress Jodie Foster.⁶⁵

⁶² Slovenko (2002) *supra* note 5 at 53.

⁶³ *Ibid.*

⁶⁴ *Ibid* at 56.

⁶⁵ Cohen (1988) *University of Florida Law Review supra* note 5 at 541-542; Rogers, R and Ewing, CD "Ultimate Opinion Proscriptions: A Cosmetic Fix and a Plea for Empiricism" (1980) *Law and Human Behavior* at 357-374 at 357-358; Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law*. See also *United States v Hinkley* United States District Court for the District of Columbia, Criminal Case Number 81-306 (1982). See also "The Hinkckley Trial: Hinckley's Communications with Jodie Foster" at <http://www.law.umke.edu/faculty/projects/ftrials/hinckley/jfostercommun.HTM> [accessed on 2010/03/09] where a letter from Hinckley to Jodie Foster is quoted, written shortly before the attempted assassination of President Ronald Regan which read as follows:
"3/31/81
12:45 PM
Dear Jodie,

Various psychiatrists testified for the defence and due to the fact that Hinckley suffered from “process Schizophrenia” they unanimously concluded by stating that he was insane when he shot the president. Despite contradictory expert evidence by prosecution psychiatrists, the jury nevertheless found Hinckley not guilty by

There is a definite possibility that I will be killed in my attempt to get Reagan. It is for this very reason that I am writing this letter to you.

As you well know by now I love you very much. Over the past seven months I've left you dozens of poems, letters and love messages in the faint hope that you could develop an interest in me. Although we talked on the phone a couple of times I never had the nerve to simply approach you and introduce myself. Besides my shyness, I honestly did not wish to bother you with my constant presence. I know the many messages left at your door and in your mailbox were a nuisance, but I felt that it was the most painless way for me to express my love for you.

I feel very good about the fact that you at least know my name and know how I feel about you. And by hanging around your dormitory, I've come to realize that I'm the topic of more than a little conversation, however full of ridicule it may be. At least you know that I'll always love you.

Jodie, I would abandon this idea of getting Reagan in a second if I could only win your heart and live out the rest of my life with you, whether it be in total obscurity or whatever. I will admit to you that the reason I'm going ahead with this attempt now is because I just cannot wait any longer to impress you. I've got to do something now to make you understand, in no uncertain terms, that I am doing all of this for your sake! By sacrificing my freedom and possibly my life, I hope to change your mind about me. This letter is being written only an hour before I leave for the Hilton Hotel. Jodie, I'm asking you to please look into your heart and at least give me the chance, with this historical deed, to gain your respect and love.

love you forever,
John Hinckley.”

See also <http://www.law.umko.edu/faculty/projects/trials/hinckley/hinckleymono.HTM> [accessed on 2010/03/09] where selected poems are quoted written by Hinckley. The one poem is entitled “Guns are fun!” and reads as follows:

“Guns are fun!
See that living legend over there?
With one little squeeze of this trigger
I can put that person at my feet
Moaning and groaning and pleading with God.
This gun gives me pornographic power.
If I wish, the president will fall
And the world will look at me in disbelief
All because I own an inexpensive gun
Guns are lovable, Guns are fun
Are you lucky enough to own one?”

In another poem entitled “The Painful Evolution”, the last phrase reads as follows:

“.....
In the end,
I cursed myself and suffered
I have become what I wanted
To be all along, a psychotic poet”

These poems inadvertently denotes an abnormal mind and accordingly it could be argued, despite various criticisms against the eventual finding of the court, that Hinckley was after all suffering from severe mental illness, rendering him insane at the time of the offence.

reason of insanity.⁶⁶ These facts are used to set the stage for the proper comprehension as to how it came about that Federal Rule 704 was eventually amended to make provision for Federal Rule 704(a) and (b) of the Federal Rules of Evidence which deals with opinion evidence pertaining to ultimate issues.

The semantics and characteristics of the ultimate issue rule have already extensively been assessed in Chapter 4. It was indicated that the author supports the abdication of the ultimate issue rule in support of a more liberal approach towards the admission of expert evidence. It was in addition noted that relevance should be the determining factor in respect of the admissibility of expert evidence and not necessarily whether the expert opinion embraces an ultimate issue.

In this section it is necessary to reflect on the ultimate issue doctrine as espoused in the Federal Rules of Evidence.

Federal Rule 704 states the following pertaining to opinion evidence on ultimate issues:⁶⁷

”(a) Except as provided in subdivision (b), testimony in the forum

⁶⁶ *Ibid.* See also Linder, D “The Trial of John Hinckley” in “Famous American Trials – The John Hinckley Trial 1982” at <http://www.law.umke.edu/faculty/projects/Ftrials/hinckleytrial.html> [accessed on 2010/03/09] where it is stated that the verdict of “not guilty” by reason of insanity in the trial of John Hinckley, Jr in 1982 for the attempted assassination of President Reagan caused intense outrage amongst many Americans. An ABC News poll conducted the day after the verdict was rendered, indicated 83% of those who polled, took the view that “justice was done”. Many other citizens, however, blamed the legal system in that they averred that it was too easy for juries to render “not guilty” verdicts in insanity trials despite the reality that these pleas were made in only 2% of felony cases and failed almost 75% of the time. The Hinckley verdict pressurised the Congress to enact new laws pertaining to the use of the insanity defence. Linder *supra* further encapsulates the dilemma in respect of trials where the defence of criminal incapacity is at issue, by stating: “The Hinckley trial highlights the difficulty of a system that forces jurors to label a defendant either ‘sane’ or ‘insane’ when the defendant may in fact be close to the middle on a spectrum ranging from Star Trek’s Mr Spock to the person who strangles his wife thinking that he’s squeezing a grapefruit”.

⁶⁷ Federal Rule 704. See also Melton *et al* (2007) *supra* note 5 at 16; Sales and Shuman (2005) *supra* note 5 at 32. Gold (2004) *supra* note 5 at 522; Slovenko (1995) *supra* note 5 at 138-140; Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law* *supra* note 5 at 22; Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law* *supra* note 5 at 14; Cohen (1988) *University of Florida Law Review* *supra* note 5 at 541-562; Murphy (2000) *supra* note 5 at 221-223; Smith (1987) *Marquette Law Review* *supra* note 5 at 493-533; Graham (1991) *supra* note 5 at 660-675; Freckelton and Selby (2005) *supra* note 5 at 293-294.

of an opinion or inference otherwise admissible is not objectionable, because it embraces an ultimate issue to be decided by the trier of fact.

- (b) No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defence thereto. Such ultimate issues are matters for the trier of fact alone.”

When the Federal Rules of Evidence were introduced in 1975, it originally only more or less provided for part (a) as quoted above and accordingly expressly permitted expert opinions to embrace an ultimate issue provided it was helpful in assisting the trier of fact.⁶⁸ The common law ultimate issue rule was thus abolished as a result of Federal Rule 704.⁶⁹ In 1985, in the aftermath of the Hinckley verdict, Federal Rule 704 was amended and the ultimate issue rule was reinstated in cases where the mental state of a person had to be determined.⁷⁰

⁶⁸ Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law* supra note 5 at 22; Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law* supra note 5 at 14; Cohen (1988) *University of Florida Law Review* supra note 5 at 542-544; Slovenko (1995) supra note 5 at 138-139.

⁶⁹ *Ibid.*

⁷⁰ This amendment was enacted by means of the Insanity Defence Reform Act of 1984, Title IV, Pub.L. No. 98-473, 98 Stat. 2067 (1984) as discussed in Cohen (1988) *University of Florida Law Review* supra note 5 at 545. Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law*, supra note 5 at 14; Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law*, supra note 5 at 22; Slovenko (1995) supra note 5 at 138. See also Smith (1987) *Marquette Law Review* supra note 5 at 511 where it is noted that the American Psychiatric Association’s statement as to why the Ultimate Issue rule should have been re-enacted was the following:

“It is clear that psychiatrists are experts in medicine, not the law. As such, it is clear that the psychiatrist’s first obligation and expertise in the courtroom is to ‘do psychiatry’, i.e. to present medical fact and opinion about the defendant’s mental state and motivation and to explain in detail the reason for his medical-psychiatric conclusions. When, however, ‘ultimate issue’ questions are formulated by the law and put to the expert witness who must then say ‘yea’ or ‘nay’, then the expert witness is required to make a leap in logic. He no longer addresses himself to medical concepts but instead must infer or intuit what is in fact unspeakable, namely, the probable relationship between medical concepts and legal or moral constructs such as free will. These impermissible leaps in logic made by expert witnesses confuse the jury. Juries thus find themselves listening to conclusory and seemingly contradictory psychiatric testimony that defendants are either ‘sane’ or ‘insane’ or that they do or do not meet the relevant legal test for insanity. This state of affairs does considerable injustice to psychiatry and, we believe, possibly to criminal defendants. In fact, in many criminal insanity trials both prosecution and defense psychiatrists do agree about the nature and even the extent of mental disorder exhibited by the defendant at the

The former Federal Rule 704 merely provided that:

”Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.”⁷¹

The amendment of Federal Rule 704 was specifically aimed at curbing expert testimony in cases of insanity.⁷² Rogers and Ewing explain that the amended rule does not completely prohibit expert evidence in insanity trials, but that such opinions may not include statements of opinion concerning so-called ultimate issue opinions.⁷³

The *Hinckley* trial took place before the enactment of Federal Rule 704(b). It is interesting to note that the experts called by the defence unanimously held that Hinckley was psychotic when he shot the president, whilst all of the experts called for the prosecution tendered evidence that Hinckley was not psychotic at the time of the act.⁷⁴ Defence experts contended that the shooting was the sole consequence of Hinckley’s delusional thoughts that shooting the president would win him the love of much-adored film star Jodie Foster. Prosecution experts, on the other hand, argued that Hinckley shot the president as a result of a narcissistic

time of the act.” (American Psychiatric Association Statement on the Insanity Defense, December 1982, p.14).

⁷¹ Rogers, R and Ewing, CP “Ultimate Opinion Proscriptions: A cosmetic Fix and a Plea for Empiricism” (1989) *Law and Human Behavior* at 357-359; Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law*, *supra* note 5 at 22-23.

⁷² *Ibid.*

⁷³ Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 360. See also Greenberg, JS “Criminal Law and Evidence Using Psychiatric Testimony to Negate *Mens Rea* Under the Insanity Defense Reform Act – *United States v Pohl*, 827 F.2d 8989 (3d Cir. 1987) cert. denied, 108 5, 710 (1988)” (1988) *Temple Law Review* 953-989 at 974 where the following is stated in respect of the Insanity Defense Reform Act of 1984 and opinion evidence pertaining to ultimate issues: “The Insanity Defense Reform Act of 1984 brought changes to the federal courts by providing the first statutory formulation of insanity ... the Act amended Rule 706(b) of the Federal Rules of Evidence by excluding expert testimony on the ultimate issue of a defendant’s mental state. ... Congress did not intend, however, to bar all evidence of mental disease where it was not offered for the affirmative defense of insanity. Instead, the Senate Judiciary Committee intended to prevent non-psychiatric disorders, such as immature personality or neuroses, from being considered legal insanity.” See also Bloom, JD and Rogers, JL “The Legal Basis of Forensic Psychiatry: Statutory Mandated Psychiatric Diagnoses” (1987) *American Journal of Psychiatry* at 847.

⁷⁴ Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 360.

desire to become famous.⁷⁵ Rogers and Ewing interestingly note that in the event of Hinckley having been tried after Rule 704 was amended the experts would not have been permitted to express a direct conclusion as to whether Hinckley had the capacity to appreciate the wrongfulness of his conduct or the ability to conform his conduct with the requirements of the law. However, the bulk of the remaining part of their testimony which typically falls within the zone of the “battle of the experts” would still have been admissible.⁷⁶

In order to assess the viability of the ultimate issue doctrine, now within the American context, it is necessary to reflect on both sides of the coin to this rule and thus the reasons in support of the reinstatement of the rule as opposed to the arguments against the rule.

Rogers and Ewing state that the submissions in favour of the proscription on ultimate opinions pertaining to the mental status of individuals are the following:⁷⁷

- **Professional taint**

This argument seeks to curb the role of mental health professionals in insanity trials in an attempt to avoid public and collegial disapproval as well as the so-called “appalling circus atmosphere” which follows when mental health professionals present conflicting opinions pertaining to ultimate issues.

- **Insufficient clinical data**

This argument is premised upon the untested assumption that mental health professionals render such opinions in the absence of adequate clinical observations, test results or explicit data-based opinions and decision-making.

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

⁷⁷ Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 361-364. See also Cohen (1988) *University of Florida Law Review supra* note 5 at 552; Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law supra* note 5 at 16-17; Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law supra* note 5 at 23-25; Smith (1987) *Marquette Law Review supra* note 5 at 510; Slovenko (2002) *supra* note 5 at 138-140.

- **Undue influence**

This argument is founded on the assumption that ultimate issue testimony will unduly influence the trier of fact or usurp the function of the jury.

- **Lack of legal and moral expertise**

This argument is also often referred to as definitional exclusion. Legal professionals as well as some mental health professionals often contend that ultimate opinions are moral and not psychological in origin. The latter comment was espoused by the House Committee Report in 1984, which supported the 1984 Amendment, where it was stated:⁷⁸

”While medical and psychological knowledge of expert witnesses may well provide data that will assist the jury in determining the existence of the (insanity) defense, no person can be said to have expertise regarding the legal and moral decision involved. Thus with regard to the ultimate issue, the psychiatrist, psychologist or other similar expert is no more qualified than a lay person.”

Cohen in addition notes that the rationale behind the enactment of Federal Rule 704(b) was further that mental health experts often express impermissible legal conclusions despite their lack of legal expertise.⁷⁹ The latter occurs when an expert incorrectly testifies that an individual was sane or insane as a result of the reliance placed on an incorrect standard when rendering an opinion.⁸⁰ The objection most frequently raised in support of the proscription on ultimate issue testimony relates to the fact that expert testimony pertaining to the issue of an individual’s mental condition invades the province of the trier of fact or, within the

⁷⁸ Reform of the Federal Insanity Defence Hearings Before the Subcommittee on Criminal Justice of the House Committee on the Judiciary”, 98th Congress, 1st Session, 16 (1983) as discussed in Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 30. See also Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law supra* note 5 at 16; Cohen (1988) *University of Florida Law Review supra* note 5 at 559; Gold (2004) *supra* note 5 at 525-528.

⁷⁹ Cohen (1988) *University of Florida Law Review supra* note 5 at 553-554.

⁸⁰ *Ibid.*

American context, the jury.⁸¹

Despite the statutory basis of the ultimate issue proscription and accordingly the prohibition on ultimate opinions in respect of the mental state or condition of an individual in a criminal case, it becomes clear that there is strong opposition to this rule as will be addressed below.

The ultimate issue rule contained in Federal Rule 704(b) may on face value seem quite attractive especially to those sceptical of the abilities of mental health experts. Research, however, indicates that this rule is unsatisfactory in practice. The various arguments against this rule will be summarised below.

- Clinical judgments and clinical observations are inseparable – forensic assessments and insanity evaluations are both structured and determined to a large extent by the examiner’s initial judgements pertaining to the individual’s history and presentation.⁸² Such judgment not only sets the parameters of the evaluation, but also dictates the expert’s interpretation of the clinical observations. These observations⁸³ are also structured in accordance with the expert’s evolving clinical assessments. Denying the expert the opportunity to present these judgments does not alter but conceals their value and impact.⁸⁴

Accordingly, triers of fact will have no way of evaluating the assumptions that eventually resulted in the interpretation of the expert’s assessments and there will be no way by which to assess the weight and probative value to be accorded to the expert’s observations.⁸⁵

⁸¹ *Ibid.* See also Slovenko (1995) *supra* note 5 at 138.

⁸² Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 364-365.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.* See also Note: “Resurrection of the Ultimate Issue Rule: Federal Rule of Evidence 704(b) and the Insanity Defence” (1987) *Cornell Law Review* 620 at 635 where it is stated: “Ironically, an evidentiary rule intended to make mental health testimony less confusing to fact finders may actually deprive jurors of if necessary to make that testimony helpful ... Expansive application of (the ultimate opinion rule) could lead to jury members leaving the courtroom impressed by tales of the defendant’s bizarre behavior, but with no sense of whether the defendant’s disease or defect had legal significance to the crime charged.” (As discussed in Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 365).

- Even in the event of fact finders or juries being inclined to blindly adopt and accept psychiatric testimony, Rule 704(b) would not remedy the problem.⁸⁶ The mental health expert would generally be permitted to state a diagnosis and explain the phenomena of the disease even though the presence of the disease is also an ultimate issue for the trier of fact or jury.⁸⁷ Cohen⁸⁸ explains that, if courts allow opinion testimony that logically requires the jury to reach a certain conclusion and then refuse to allow the expert to state the conclusion, the jury might erroneously assume that it arrived at the conclusion itself and as such jurors are likely to be more overawed by their own conclusions of even the most impressive witness.
- Federal Rule 704(b) negatively impacts on an accused's (defendant's) right to introduce expert testimony.⁸⁹
- Ultimate opinions are an inevitable and inescapable result of the forensic assessment process.⁹⁰ The main goal of any insanity assessment is to reach an informed conclusion as to a defendant's criminal responsibility. The ultimate opinion rule poses an impossible situation in terms of which the mental health expert is expected to strive toward a highly specific goal, but also to abandon that goal in the final stage.⁹¹ The evidence of such a mental health expert will inadvertently appear contrived and leave the trier of fact with the prospect to "read between the lines" and to assess precisely what the expert knew but failed to disclose.⁹²

⁸⁶ Cohen (1988) *University of Florida Law Review supra* note 5 at 577.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ Smith (1987) *Marquette Law Review supra* note 5 at 513. See also *United States v Alexander* 805 F.2d 1485 (11th Cir. 1986) at 1464 where the following was held:

"Defendants should be free, as Alexander was in this case, to question expert witnesses extensively concerning their diagnosis of the defendant's mental condition, its symptoms and treatment, and the effect such condition or illness may have on a defendant's mental state. In addition, any relevant medical records or reports should be admitted into evidence and the defendant should be allowed to question an expert witness about them so they may be explained or interpreted for the jury. The operation of Rule 704(b) makes it essential that juries be completely informed. A liberal approach towards the admissibility of evidence relating to the issue of insanity ensures this."

⁹⁰ Rogers and Ewing (1989) *Law and Human Behavior supra* note 71 at 365.

⁹¹ *Ibid.*

⁹² *Ibid.*

- It is impossible to meaningfully distinguish between ultimate opinions and ordinary expert opinions.⁹³ During the course of insanity assessments, mental health experts often render scores of judgments pertaining to a defendant's condition and the relevance of that particular condition to the alleged criminal conduct.⁹⁴ The ultimate opinion rule strives to single out particular judgments and to restrain experts from making or at the very least, reporting them to the triers of fact.⁹⁵
- Prohibitions on ultimate opinions may paradoxically expand the scope of expert testimony by mental health professionals within the insanity context.⁹⁶
- Prohibitions on ultimate opinions may result in mental health experts exercising less care in their assessments of criminal responsibility.⁹⁷
- Federal Rule 704(b) admits the most confusing expert testimony, the mental health expert's diagnosis, whilst excluding the least confusing testimony, the expert's opinion as to the mental state or sanity of the defendant.⁹⁸

It is clear that there is much controversy surrounding Federal Rule 704(b). Although penultimately framed in statutory form, this rule is unworkable and problematic as it leads to unnecessary complications in the application of the insanity defence. In order to adequately adduce and challenge evidence, it is pivotal that such evidence be tendered as comprehensively and informatively as possible. Federal Rule 704(b) unnecessarily restricts the presentation of expert evidence in insanity trials. It is clear that the addition to Federal Rule 704 has not produced success. Cohen correctly asserts that Rule 704(b) mandates the exclusion of relevant and probative evidence in the fear that it may be too persuasive and exclusion as such is prejudicial to the criminal justice system.⁹⁹

⁹³ Rogers and Ewing (1989) *Law and Human Behavior* *supra* note 71 at 365-366.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ Rogers and Ewing (1989) *Law and Human Behavior* *supra* note 71 at 367.

⁹⁷ *Ibid.*

⁹⁸ Cohen (1988) *University of Florida Law Review* *supra* note 5 at 559. See also Buchanan (2006) *Journal of the American Academy of Psychiatry and the Law* *supra* note 5 at 17.

⁹⁹ Cohen (1988) *University of Florida Law Review* *supra* note 5 at 561.

Federal Rule 704(a) can be welcomed also in comparison with South Africa where no such rule is codified. Federal Rule 704(b) is, however, an unnecessary amendment to the rules of evidence and as such superfluous. Slovenko submits that Federal Rule 704(b) renders expert witnesses less useful to triers of fact as it enhances indirect and incomplete testimony.¹⁰⁰ Rogers and Ewing correctly propose the elimination of the terminology “ultimate opinion” due to the fact that when opinions are at issue, the “ultimate is, by definition, unattainable”.¹⁰¹ Rogers and Ewing encapsulate the latter by stating:¹⁰²

”The expert’s opinion is not even penultimate, for it is the judge who instructs the jury as to how to weigh the evidence and reach its “ultimate” judgment. At best, the mental health expert renders what might be called an antepenultimate opinion.”

It is submitted that a rule similar to Federal Rule 704(a) is a welcoming response to the traditional ultimate issue rule and a similar rule could be usefully applied within the South African context. Federal Rule 704(b) unnecessarily restricts the presentation of expert evidence in insanity trials. As Smith correctly indicates, expert witnesses in a criminal trial should be afforded the opportunity to adequately and fully express their findings as well as their opinions pertaining to their findings.¹⁰³

5 SCIENTIFIC RELIABILITY AND VALIDITY OF EXPERT EVIDENCE BY MENTAL HEALTH EXPERTS – APPLYING THE *DAUBERT* RESOLUTIONS

”Soon there will be no jury. No hordes of detectives and witnesses, no charges and counter charges, and no attorney for the defense. These impedimenta of our courts will be unnecessary. The state will

¹⁰⁰ Slovenko (1995) *supra* note 5 at 144; Slovenko (2006) *Journal of the American Academy of Psychiatry and the Law* *supra* note 5 at 25.

¹⁰¹ Rogers and Ewing (1989) *Law and Human Behavior* *supra* note 71 at 373.

¹⁰² *Ibid.*

¹⁰³ Smith (1987) *Marquette Law Review* *supra* note 5 at 533. See also Conley, WM “Restricting the Admission of Psychiatric Testimony on a Defendant’s mental State: Wisconsin’s Steel Curtain” (1981) *Wisconsin’s Law Review* 733-789 at 764-765

merely submit all suspects in a case to the test of scientific instruments, and as these instruments cannot be made to make mistakes nor tell lies, their evidence would be conclusive of guilt or innocence.”

(“*Electrical Machines to Tell Guilt of Criminals*“ *The New York Times* (1911) at 2)

One of the most frequently raised criticisms levelled against the scientific discourses of psychiatry and psychology and probably more in respect of forensic psychiatry and psychology, relates to the scientific reliability and validity of the testimony proffered by the respective mental health professionals.¹⁰⁴

From the outset it should be noted that the terms “reliability” and “validity” are not synonyms but refer to two distinctly different concepts.

According to Ennis and Litwack, “reliability” refers to:¹⁰⁵

”...the probability of frequency of agreement when two or more independent observers answer the same question.”

“Validity” refers:¹⁰⁶

¹⁰⁴ Ennis, BJ and Litwack, TR “Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom” (1974) *California Law Review* at 693-745, 694-699; 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 345-386; Rogers, T “Diagnostic Validity and Psychiatry Expert Testimony” (2004) *International Journal of Law and Psychiatry* at 281-290; Faust, D and Ziskin, J “The Expert Witness in Psychology and Psychiatry” (1988) *Science* at 31-35. See also Freckelton, I and Selby, H (1999) *supra* note 5 at 580-581.

¹⁰⁵ Ennis and Litwack (1974) *California Law Review supra* note 104 at 697.

¹⁰⁶ *Ibid.* See also Meintjes-Van der Walt, L “Expert Evidence in the Criminal Justice Process – A Comparative Perspective” (2001) at 206-207 where it is noted that the Oxford English Dictionary defines “reliability” as “the quality of being reliable” which is defined as “that may be relied upon, in which reliance or confidence may be put; trustworthy, safe, sure”. “Validity” on the other hand is defined as “the quality of being well-founded on fact, of established on sound principles, and thoroughly applicable to the case or circumstances; soundness and strength (of argument, proof, authority, etc.)”. See also Rogers (2004) *International Journal of Law and Psychiatry supra* at 285-286, where “reliability” is defined as: “... an expression of the probability with which two independent clinicians will reach the same diagnosis.” “Validity” refers: “... to the extent to which a particular diagnosis maps on to what is known about the underlying reality”.

“not to how likely psychiatrists are to agree about a particular judgment but to how accurate their judgments are”.

Another method of assessing the essential difference between reliability and validity is by defining reliability as denoting the degree of correlation or correspondence amongst professionals employing the same method, whereas validity denotes the degree of correlation or correspondence between the judgment derived at by professionals and some fact in the external world.¹⁰⁷

Within the ambit of the defence of criminal incapacity, the mental health expert's opinion will be founded on psychiatric classifications enunciated in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*.¹⁰⁸

The question which falls to be assessed is how the reliability and validity of psychiatric testimony premised upon the DSM-IV should be determined. McKay notes that some of the earliest concerns raised towards the scientific reliability and validity of expert psychiatric opinions related to the inconsistency of diagnoses amongst psychiatrists.¹⁰⁹ The fear exists that individual psychiatrists in the process of diagnosing the same condition, would arrive at different results depending on the particular methodology employed by the particular psychiatrists.¹¹⁰ McKay further asserts that the majority of American jurisdictions, including the federal courts, have expressly acknowledged the DSM as scientifically reliable when applied in support of forensic expert evidence.¹¹¹ Such scientific reliability is restricted to a forensic expert's use of the DSM as a basis for the expert testimony.¹¹² Rogers in addition attests to the scientific reliability and validity of expert testimony founded on the diagnostic

¹⁰⁷ Ennis and Litwack (1974) *supra* note 104 at 697-698.

¹⁰⁸ American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (2000). The diagnostic framework was extensively discussed in Chapter 3 *supra* (hereafter DSM-IV.).

¹⁰⁹ McKay (1992) *Criminal Justice Journal supra* note 104 at 353. See also Kenny, A “The psychiatric expert in court” (1984) *Psychological Medicine* at 291-302.

¹¹⁰ *Ibid.*

¹¹¹ McKay (1992) *Criminal Justice Journal supra* note 104 at 356.

¹¹² *Ibid.* See also *Kramer v United States* 579 F. supp.314 (D.Md.1984).

classification in the DSM and states as follows:¹¹³

“In fact, psychiatric classification systems are few in number (only two are widely used, ICD and DSM), show a remarkable degree of confluence, and can be shown to possess high degrees of internal consistency and integrates reliability. Psychiatrists from around the world can readily agree with one another about, for example, what is meant by the term ‘schizophrenia’ and whether a given individual satisfies the criteria. For most of the major psychiatric disorders, the agreement reached by psychiatrists is as high or higher than for many general medical conditions.”

The anomaly which arises is how to assess the scientific reliability and validity of opinions by mental health experts. Which criteria should be employed to assist the trier of fact in determining reliability and validity? The fact that the diagnostic framework from which a diagnosis is made is reliable and valid, does not necessarily render the opinion based upon it, scientifically reliable and valid. Ennis and Litwack indicate that psychiatric diagnoses often have very low scientific reliability and validity.¹¹⁴ Rogers also indicates that even though psychiatrists might agree that a specific individual has a particular disorder, it is still not indicative whether such disorder exists or whether it is merely “a taxonomic fiction”.¹¹⁵ Freckelton and Selby, however, correctly note that “scientific in exactitude” is not a phenomenon exclusive to the fields of psychiatry and psychology and in addition does not detract from their usefulness within the judicial process and criticisms motivate these two professions to constantly assess its performance in accordance with scientific standards.¹¹⁶

¹¹³ Rogers (2004) *International Journal of Law and Psychiatry supra* note 104 at 285.

¹¹⁴ Ennis and Litwack (1974) *California Law Review supra* note 104 at 708-709. See also Ziskin, J “Coping with Psychiatric and psychological Testimony” (1988) at 1, where it is critically stated: “... despite the ever increasing utilization of psychiatric and psychological evidence in the legal process, such evidence frequently does not meet reasonable criteria for admissibility and should not be admitted in a court of law and, if admitted, should be given little or no weight”. These words, it is submitted, is over-critical in respect of psychiatry and psychology as advances in these sciences, enhances the reliability and validity of each respectively. See also Faust and Ziskin (1988) *Science supra* note 104 at 32.

¹¹⁵ Rogers (2004) *International Journal of Law and Psychiatry supra* note 104 at 287.

¹¹⁶ Feckelton and Selby (1999) *supra* note 104 at 580.

The question which still needs to be addressed is whether set criteria should not be established in terms of which scientific reliability and validity can be assessed.

It is trite that even where criteria is formulated in terms of which reliability and validity can be measured, the application thereof will fluctuate as each case will present its own distinct characteristics. It is further important to bear in mind the divergent opinions which can ensue in respect of the mental state of an individual. Relative criteria will, however, assist the trier of fact in making a determination in respect of validity and reliability.

Davoli notes that despite media and court opinions constantly depicting psychiatry as an inexact “pseudo science”, there exists great integrity in the diagnoses of mental illness.¹¹⁷ The validity of a diagnosis that a specific person is suffering from a mental illness such as schizophrenia is to a large extent subject to the thoroughness of the assessment similar to the validity of any other diagnosis. As easy as it is to misdiagnose a mental illness as a result of poor medical practice, just as easy is it to misdiagnose a physical illness and thus both types of assessments must adhere to accepted medical practice to ensure validity.¹¹⁸ Davoli also notes that those scholars classifying psychiatry as an inexact science, often rely on data which is dated and such dated material fails

¹¹⁷ Davoli, JI “Psychiatric Evidence on Trial” (2003) *SMU Law Review* at 2191-22234 at 2217. One area where the field of Psychiatry is often the subject of much criticism and debate is in respect of the prediction of future dangerousness. For purposes of this study, future dangerousness will not be addressed. For further reading on the prediction of dangerousness see Monahan, J “Violence Risk Assessment: Scientific Validity and Evidentiary Admissibility” (2000) *Wash & Lee L.Rev.* 901; Bonta, J; Hanson, RK and Law, J “The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meter Analysis” (1998) *Psychological Bulletin* at 125-142; Rogers, R and Lynett, E “The Role of Canadian Psychiatry in Dangerous Offender Testimony” (1991) *Canadian Journal of Psychiatry* at 79-84; Lafond, M “Disorder in the Court: The Use of Psychiatric Testimony in the Prediction of Dangerousness” (2005) *Dalhousie Journal of Legal Studies* at 1-34; Junginger, J “Command Hallucinations and the Prediction of Dangerousness” (1995) *Psychiatry Serv.* 911-915; Levinson, RM and York, MZ “The Attribution of ‘Dangerousness’ in Mental Health Evaluations” at <http://www.jstor.org/view/00221465/di976050/97po938d./0> [accessed on 2007/08/15]; Cocozzo, JJ and Steadman, HJ “Prediction in Psychiatry: An Example of Misplaced Confidence in Experts” at <http://www.jster.org/view/00377791/apo30107/05a00040/0> [accessed on 2007/08/15]; Diamond, BL “The Psychiatric Prediction of Dangerousness” (1974) *University of Pennsylvania Law Review* at 439.

¹¹⁸ Davoli (2003) *SMU Law Review supra* note 117 at 2217-2218.

to give recognition to the great advances made in the study of mental illness and the fact that psychiatry has refined its diagnosis methods and methods of assessment over the past fifty years.¹¹⁹

Davoli notes the following important aspects in respect of the reliability of psychiatric diagnosis:¹²⁰

- An accurate psychiatric diagnosis should be preceded by a complete assessment and examination also referred to as a diagnostic workup;
- The “diagnostic workup” should provide for the history and mental status examination; a review of the individual’s prior medical history as well as an adequate physical and neurological examination;
- Psychological tests could also assist the professional in arriving at an accurate diagnosis;
- The thoroughness of the “diagnostic workup” ensures a diagnosis with a high level of accuracy;
- The reliability of a diagnosis of mental illness is supported by scientific research;
- Psychiatric diagnosis share similar levels of reliability with other medical fields;
- The DSM-IV provides clarity and coherent standards for the diagnosis of mental illness;
- In respect of the DSM-IV numerous studies were performed to assess psychiatric diagnosis;
- Structured interviews give rise to more accurate diagnosis;
- An individual does not suffer from a mental illness merely as a result of the fact that he or she meets the criteria for a diagnosis in the DSM-IV and in addition, some mental illnesses are completely irrelevant for forensic legal purposes;
- Courts need to critically assess the relevance of a person’s diagnosis when assessing whether to admit testimony.

¹¹⁹ Davoli (2003) *SMU Law Review supra* note 117 at 2218.

¹²⁰ Davoli (2003) *SMU Law Review supra* note 117 at 2218-2221.

Probably one of the most influential American decisions relating specifically to scientific reliability and validity of expert evidence, is the case of *Daubert v Merrell Dow Pharmaceuticals*.¹²¹ The facts of this decision were briefly as follows:

The plaintiffs instituted a tort claim seeking redress for injuries to children born with limb reduction birth defects. It was alleged that the birth defects were caused by the mother's use of *Bendectin*, a prescription anti-nausea drug, during the first trimester of pregnancy. The defendant then sought summary judgment on the basis of the affidavits of a physician and epidemiologist who reviewed the published studies on *Bendectin* and reported that none found it to be capable of causing malformations in human fetuses. In response, the plaintiffs presented the opinion of eight well-qualified experts who concluded that the drug caused the defects. The federal district court granted the defendant's motion for summary judgment and dismissed the lawsuit. It was concluded that the plaintiff's experts were unable to demonstrate that the defendant's drug caused the plaintiff's injury because epidemiological studies were the only generally accepted method of proving this link, and the epidemiological studies failed to prove such casual *nexus*. The United States Court of Appeals confirmed this decision and the Supreme Court granted review.¹²² In delivering judgment per Blackmun J, the Supreme Court stated:¹²³

“In the 70 years since its formulation in the *Frye* case, the ‘general acceptance’ test has been the dominant standard for determining the admissibility of novel scientific evidence at trial.”

It was contended on behalf of the plaintiffs that the *Frye* standard applied by the

¹²¹ *Daubert v Merrell Dow Pharmaceuticals* 509, U.S. 579 (1993). See also Sales and Shuman (2005) *supra* note 5 at 33-45; Carson and Bull (2003) *supra* note 5 at 373-385; Slovenko (2002) *supra* note 5 at 43-59; Blau (1998) *supra* note 5 at 58-59; Shapiro (1999) *supra* note 5 at 4-8; Kiely (2001) *supra* note 5 at 12-14; Brodsky (1999) *supra* note 5 at 31-34; Kastenbergl (2003) *Seattle University Law Review supra* note 5 at 816-820; Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 223-224; Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 750-752.

¹²² See Sales and Shuman (2005) *supra* note 5 at 33.

¹²³ At 585.

district court had been overridden by the Federal Rules of Evidence. It was further held that the Federal Rules of Evidence were aimed at relaxing the traditional barriers to opinion evidence by experts and that the continued reliance on the *Frye* standard would obfuscate this goal.¹²⁴ It was in addition held that the Federal Rules of Evidence had replaced the *Frye* test.¹²⁵ The court also considered that the Federal Rules of Evidence required trial judges to admit only relevant and reliable expert evidence. The court¹²⁶ noted that the adjective ‘scientific’ implies a foundation in the methods and procedures of science. Similarly, the word ‘knowledge’ denotes more than subjective belief or unsupported speculation but ‘applies to any body of known facts or to any body of ideas inferred from such facts or accepted as truths on good grounds’ and consequently it would be unreasonable to conclude that the subject of scientific testimony must be ‘known’ to a certainty as there are no certainties in science. In order to qualify as ‘scientific knowledge’, an inference or assertion must be derived by the scientific method.

It was also held that the requirement that an expert’s evidence should relate to “scientific knowledge” establishes a standard of evidentiary reliability.¹²⁷ The Court distinguished scientific validity (“proof of what something is intended to prove”) from scientific reliability (“consistency in application of science”) and held that in matters pertaining to scientific evidence, *evidentiary reliability* will be premised on *scientific validity*.¹²⁸

Federal Rule 702 was also addressed with specific reference to the meaning to be accorded to the terminology “assist the trier of fact to understand the evidence or to determine a fact in issue” contained in Rule 702. The Supreme Court concluded that the terminology refers to the concept of relevance and

¹²⁴ At 585. See also Sales and Shuman (2005) *supra* note 5 at 34.

¹²⁵ See also Gutheil and Simon (2002) *supra* note 5 at 115.

¹²⁶ At 590. See also Sales and Shuman (2005) *supra* note 5 at 35.

¹²⁷ At 590. See also Sales and Shuman (2005) *supra* note 5 at 35; Redmayne, M “Expert Evidence and Criminal Justice” (2001) at 101-106. See also Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 223-224 where it is noted: “Scientific” requires a basis in the methods and procedures of science, and “knowledge connotes more than subjective belief or unsupported speculation. According to the Court, these two concepts would ensure a standard of evidentiary reliability.”

¹²⁸ At 593. Sales and Shuman (2005) *supra* note 5 at 35. See also Kiely (2001) *supra* note 5 at 13.

stated the following:¹²⁹

“Expert testimony which does not relate to any issue in the case is not relevant and, ergo, non-helpful. ... (“An additional consideration under Rule 702 – and another aspect of relevancy – is whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving the factual dispute.”) The consideration has been aptly described ... as one of ‘fit’. ‘Fit’ is not always obvious and scientific validity for one purpose is not necessarily scientific validity for other, unrelated purposes ... Rule 702’s ‘helpfulness’ standard requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility.”

Regarding the question of admissibility of expert scientific testimony, a three-staged approach was suggested providing for the following:¹³⁰

- A trier of fact should first assess whether an expert is presenting scientific evidence;
- A trier of fact then has to assess whether such evidence will be likely to assist the court to comprehend or ascertain a fact which is in issue in the trial;
- To ensure the abovementioned two criteria, the trier of fact has to

¹²⁹ At 591-592. See also Sales and Shuman (2005) *supra* note 5 at 35. Carson and Bull (2003) *supra* note 5 at 371 where it is stated: “Focussing on the language ‘assist the trier of fact’ in Rule 702. Many courts and commentators characterised this rule as a “relevancy test”. In the area of scientific evidence, the Daubert court explained, relevance foremost is a question of fit. Specifically whatever the validity of the science, it must pertain to some disputed issue in the case. As the Daubert Court stated succinctly, Rule 702 ‘requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility. Only when the science pertains to a factual question in the case can expert testimony be helpful to the trier of fact. This helpfulness component is at core of Rule 702’. The latter principle is especially of importance where expert evidence of mental health professionals is presented in support of the defence of criminal incapacity. Federal Rule 702 which provides for the helpfulness of expert testimony and inadvertently requires a rational connection between the science and the factual issue, provides a useful framework for also establishing the causal *nexus* between the expert testimony presented and the issue of for example criminal capacity. See also Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 224; Carson and Bull (2003) *supra* note 5 at 380.

¹³⁰ At 592-593. Sales and Shuman (2005) *supra* note 5 at 36; Carson and Bull (2003) *supra* note 5 at 371-372.

assess:¹³¹

“whether the reasoning or methodology underlining the testimony is scientifically valid and whether that reasoning or methodology can properly be applied to the facts in issue.”

As a result of Federal Rule 702, the trier of fact now becomes a “gatekeeper” who assesses whether the theory or application can provide assistance in the deliberation of issues.¹³² Regarding the assessment of scientific reliability and validity the Supreme Court outlined four factors to be considered as a contextual framework in terms of which reliability and validity can be evaluated. These criteria constitute the following:¹³³

- In the first instance, for a theory or technique to constitute scientific knowledge, it should be established whether the theory or technique can be tested or ideally has been tested;
- Secondly, a court should ascertain as to whether the theory or technique has been subjected to peer review and publication. Although publication does not ensure evidentiary reliability, it becomes relevant as it indicates

¹³¹ *Ibid.* See also Gutheil and Simon (2002) *supra* note 5 at 115. See also Brodsky (1999) *supra* note 5 at 31-32 where it is noted: “When the U.S. Supreme Court issued its ruling in *Daubert v Merrell Dow* in 1993, an observer from Mars or Paris might have thought a revolution had taken place in admissibility of expert evidence into federal courts. No revolution occurred, but rather an existing path became more clearly marked.” Brodsky in addition submits that the essential elements necessary to ensure admissibility in terms of *Daubert*, are the following: Reliability of the Methodology; Relevance; Reasonable reliance; and probative value outweighing the prejudicial value of the evidence. See also Sparks, J “Admissibility of Expert Psychological Evidence in the Federal Courts” (1995) *Arizona State Law Journal* at 1315-1333 at 1327 where it is noted that even if a theory meets the *Daubert* requirement of “scientific knowledge” it should also be relevant and even if it is found to be relevant, it should not interfere with judicial discretion in terms of Federal Rule 405 to exclude evidence “if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury.”

¹³² See Kastenberg (2003) *Seattle University Law Review supra* note 5 at 816-818.

¹³³ At 594. See also Sales and Shuman (2005) *supra* note 5 at 36-37; Kiely (2001) *supra* note 5 at 14; Carson and Bull (2003) *supra* note 5 at 373; Kastenberg (2003) *Seattle University Law Review supra* note 5 at 504, 818; Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 224; Blau (1998) *supra* note 5 at 58; Shapiro (1999) *supra* note 5 at 5; Black, Ayala and Saffron-Brinks (1994) *Texas Law Review supra* note 5 at 750-751. See also Allan, A “The Psychologist as Expert Witness” in Tredoux, C; Foster, D; Allan, A; Cohen, A and Wassenaar, D (“Tredoux *et al*”) “Psychology and Law at 292; Allan, A and Meintjes-Van der Walt, L “Expert Evidence in Kaliski (ed)(2006) *supra* note 5 at 344 where the *Daubert*-decision is specifically discussed. See also Slovenko (2002) *supra* note 5 at 44.

that the knowledge has been subjected to the scrutiny of other experts in the field which inadvertently increases the likelihood that problems in the knowledge would have been detected.¹³⁴

- It was recommended that trial courts have due regard to the known or potential error rate for the knowledge and standards prescribing the manner in which the technique is to be applied;
- It should also be determined whether the methodology is generally accepted in the relevant scientific community where similar concepts are applied. General acceptance could thus still have an influence in respect of the inquiry into the validity of scientific evidence.

It was noted that these factors should be considered pertaining to the question scientific validity with reference to the specific context of the issues raised in a specific case. Factors such as vigorous cross-examination opposing evidence and due consideration of the burden of proof, were held to be adequate to deal with insufficient scientific evidence presented at a trial.¹³⁵ Carson and Bull note that no single list of factors can ever encapsulate the various considerations taken into account in assessing validity as a result of the following:¹³⁶

“Scientists tend to speak of validity in terms of the strength of the evidence and reasoning supporting a conclusion, not in terms of its ‘truth’. Similarly, although judges must assess validity in order to make a categorical decision – admitting or excluding the testimony – judges need not have a categorical view of science. Judges are expected to use the *Daubert* factors (and others) to determine if its more likely than not that the methods and reasoning validity support the proffered expert

¹³⁴ Black, Ayala and Saffron-Brinks (1994) *Texas Law Review* *supra* note 5 at 757.

¹³⁵ See Shapiro (1999) *supra* note 5 at 5. See also *United States v Downing* 753 F.2d 224, 1238 (3d Cir.1985) where additional factors were stated which a court could consider when assessing the admissibility of expert evidence such as the novelty of a new technique; the existence of specialised literature pertaining to the technique and its exposure to scientific scrutiny. In addition independent research emanating from established procedures which generates specialised literature would also ensure reliability. A court should also evaluate the qualifications and expertise of the expert witness. See also Murphy (2000) *Georgetown Journal of Ethics* *supra* note 5 at 225. See also “Challenging Expert Witness Testimony” (2000) by the International Association of Defense Counsel (New York) at 72.

¹³⁶ Carson and Bull (2003) *supra* note 5 at 374.

testimony.”

Carson and Bull elaborate on an important aspect enunciated in *Daubert* – the principle of causation which could also be useful pertaining to expert testimony in cases of criminal incapacity.¹³⁷ Carson and Bull distinguish “general causation” from “specific causation” present in expert testimony. General causation refers to the assertion that one factor can produce particular results. Specific causation refers to those factors having had those results pertaining to the specific case before the court.¹³⁸ Within the context of criminal incapacity and more specifically, pathological criminal incapacity, the general causation will denote whether schizophrenia can induce a particular result; whereas specific causation will entail whether schizophrenia had or produced those results in the specific case at hand. The dichotomy of general and specific causation is prevalent in almost all forms of scientific evidence.¹³⁹

With reference to *Daubert’s* application to the field of forensic mental health assessments, Shapiro notes that the criteria in *Daubert* could prove to be very useful to forensic assessments within the paradigm of criminal responsibility.¹⁴⁰ Shapiro in addition asserts the general model adhered to by most serious forensic practitioners when conducting criminal responsibility assessments would meet the criteria enunciated in *Daubert*.¹⁴¹

Another important principle of *Daubert* relates to the fact that the Supreme Court entrusted the trier of fact with a prominent role as “gatekeeper” in assessing expert evidence. As such the court has to assess whether the science advanced in support of the evidence is sufficiently reliable to be deemed valid.¹⁴² It is submitted that the criteria established in *Daubert* could provide a valuable benchmark in terms of assessing the scientific reliability and validity of expert evidence. Within the defence of criminal incapacity these criteria could be most

¹³⁷ Carson and Bull (2003) *supra* note 5 at 376.

¹³⁸ *Ibid.*

¹³⁹ *Ibid.*

¹⁴⁰ Shapiro (1999) *supra* note 5 at 5-6.

¹⁴¹ *Ibid.*

¹⁴² At 592-593. See also Murphy (2000) *Georgetown Journal of Ethics supra* note 5 at 224; Kastenber (2003) *supra* note 5 at 818.

usefully applied whenever the scientific reliability and validity of psychiatric and psychological evidence has to be assessed.

In the subsequent decision of *Kumho Tire Co. v Carmichael*,¹⁴³ a court's "gatekeeping" obligation was extended to apply not only to "scientific" knowledge, but also to testimony premised on "technical" and other specialised knowledge.¹⁴⁴ The salient facts of this decision were briefly the following:¹⁴⁵

The plaintiff instituted a product liability claim against the manufacturer and retailer of a tire ["tyre" in South Africa] which allegedly failed and resulted in an accident in which one person was killed and several other persons were severely injured. Their claim was premised on the evidence of their expert witness who testified that the failure of the tire was caused by a defect in the manufacture or design of the tire. The expert, however, conducted no tests on the specific tire or on similar tires and did not provide any statistical information in relation thereto, linking the factors indicative of tire failure to a manufacturing defect. The defendant applied for the exclusion of the expert's testimony on the basis that the expert testimony failed to meet the *Daubert* yardstick as it was not based on tested research; no known error rate was proved; it had not been published in peer-reviewed journals and was not generally accepted within the specific field.

The trial court held that the expert evidence did not satisfy the criteria for reliability as set forth in *Daubert* and refused to admit it.¹⁴⁶ The plaintiffs then applied for a reconsideration of the case based on the argument that the court

¹⁴³ *Kumho Tire Co. v Carmichael* 526 U.S. 137 (1999), 119 S.Ct 1167 (1999). The facts of this decision is discussed in this section for purposes of illustration within the context of expert evidence. See also *General Electric Co. v Joiner* 522 U.S. 136 (1997) where the court of appeals held in respect of the admissibility of expert testimony: "(b)ecause the Federal Rules of Evidence governing expert testimony display a preference for admissibility, we apply a particularly stringent standard of review to the trial judge's exclusion of expert testimony." See also Sales and Shuman (2005) *supra* note 5 at 41.

¹⁴⁴ At 141 (of 526 U.S. (1999)). See also Bursztajn, HJ, Pulde, MF, Dirakitikulr, D and Perlin, M "Kumho for clinicians in the courtroom" at <http://www.forensicpsych.com/articles/antkunhoClinicians.php> [accessed on 2007/05/03].

¹⁴⁵ See Carson and Bull (2003) *supra* note 5 at 385-385; Sales and Shuman (2005) *supra* note 5 at 38-40; Slovenko (2002) *supra* note 5 at 44-48; Kiely (2000) *supra* note 5 at 16-17.

¹⁴⁶ 145-146 (of 526 U.S. (1999)). See Sales and Shuman (2005) *supra* note 5 at 38-39; Carson and Bull (2003) *supra* note 5 at 385.

had applied the *Daubert* factors too inflexibly.¹⁴⁷ It was consequently held that no matter how flexibly it applied the *Daubert* test, the plaintiffs' expert testimony was not sufficiently reliable to allow. The Court of Appeals reversed the trial court's decision and held that *Daubert* only applied to scientific evidence. The United States Supreme Court reviewed the Court of Appeals' decision and noted per Breyer J that in terms of Federal Rule 702 trial judges had an obligation to assess whether expert evidence is both irrelevant and reliable regardless whether it is scientific, technical or other specialised knowledge. The general meaning of Federal Rule 702 extends the "gatekeeping" responsibility to all experts, as experts, are granted latitude in testifying and it would be extremely difficult for courts to enforce evidentiary rules in terms of which reliance is placed on a distinction between "scientific" knowledge and "technical" or "other specialised" knowledge as there is no clear dividing line distinguishing the one from the other.¹⁴⁸ In respect of evidentiary reliability the court¹⁴⁹ noted that a trial court may consider one or more of the specific factors stated in *Daubert* if it will aid in assessing the reliability of the testimony. The list of factors do not apply to all experts or to every case as the test for reliability is flexible.

It was further stressed that some of the *Daubert* questions could aid in assessing the reliability of experience-based testimony and in selected instances it will be appropriate for the trial judge to ascertain whether a specific method is generally accepted within the relevant community.¹⁵⁰ Similarly, it will be useful in some cases where an expert's expertise is founded on experience to ascertain whether his or her preparation is of such a nature that others in the field would deem it as acceptable.¹⁵¹ It was further held per Beyer J that the legal standard for allowing expert evidence to be heard by the jury was the same standard employed by the relevant professional community:¹⁵²

"The objective of ... (the *Daubert*) requirement is to ensure the

¹⁴⁷ *Ibid.*

¹⁴⁸ At 149 (of 526 U.S. (1999)); Carson and Bull (2003) *supra* note 5 at 386.

¹⁴⁹ At 151 (of 526 U.S. (1999)); Sales and Shuman (2005) *supra* note 5 at 39; Carson and Bull (2003) *supra* note 5 at 386.

¹⁵⁰ Gutheil and Simon (2002) *supra* note 5 at 120.

¹⁵¹ *Ibid.*

¹⁵² At 1176 (of 119 S.Ct (1999)). See Gutheil and Simon (2002) *supra* note 5 at 120.

reliability and relevancy of expert testimony. It is to make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.”

In summary, the following issues were decided in *Kumho*:¹⁵³

- The requirement of “reliability” in Federal Rule 702 is not limited to “scientific” opinions only, but extends all those opinions embraced within Federal Rule 702 which includes those that are “scientific, technical or other knowledge”;
- The gatekeeping function of the trier of fact is not limited to “scientific” knowledge;
- The gatekeeping requirement in *Daubert* applies to the entire process in terms of which an expert selects “knowledge” in the term of basic principles to be applied, as well as the deductive application of such knowledge to the particular facts of a case in reaching an opinion;
- Any distinction which separates “scientific” knowledge from “technical or other specialised knowledge” is artificial as the overriding criteria for admissibility is knowledge, its selection and application.

Even though the *Daubert*- and *Kumho* decisions dealt effectively with delictual claims, the principles set forth in these two decisions pertaining to the admissibility of expert evidence provides an invaluable contribution in establishing guidelines for assessing the admissibility of expert evidence and concomitancy of determining scientific reliability and validity of expert opinions. These guidelines could inadvertently also be applied in assessing the admissibility of forensic psychiatric and psychological opinions advanced in support of a defence of criminal incapacity.

¹⁵³ See “Challenging Expert Witness Testimony” (2000) by the International Association of Defence counsel at 48-49. See also Kiely (2001) *supra* note 5 at 16; Kastenberg (2003) *supra* note 5 at 819.

Within the South African context, there are currently no similar guidelines to be followed when the reliability and validity of expert opinions in support of the defence of criminal incapacity falls to be assessed. As such, the American system in this regard provides a benchmark according to which the South African position could be improvised. Upon analysis of *Daubert* and also *Kumho*, two basic tenets are emphasised which play a vital role in respect of expert testimony – *relevance* and *reliability*. It is submitted that these two considerations should be the cornerstones in establishing admissibility of expert forensic psychiatric and psychological testimony in cases where criminal incapacity is advanced as a defence. Davoli in addition notes that when a court is confronted with psychiatric evidence, it should not only be determined whether psychiatry in general is reliable and relevant, but also whether psychiatry is reliable and relevant pertaining to the specific issue it is addressing in the particular case.¹⁵⁴ The latter would entail that, in addition to expert testimony pertaining to the diagnosis and assessment of an individual, the psychiatrist would also be required to explain the significance and relevance of psychological tests administered, the error rate of such tests, the current status of scientific research into the diagnosis as well as reliability of the diagnosis.¹⁵⁵

In the aftermath of *Daubert* and *Kumho*, Gutheil and Simon propose the following recommendations in respect of forensic psychiatric and psychological evidence:¹⁵⁶

- Expert opinions are strengthened by gleaning from established clinical entities as opposed to *ad hoc* novel entities which require departures

¹⁵⁴ Davoli (2003) *SMU Law Review supra* note 117 at 2232.

¹⁵⁵ *Ibid.* See also Slobogin (1998) *William and Mary Law Review supra* note 5 at 54 where it is suggested that all psychiatric evidence should be subject to admissibility thresholds which should be assessed using a four-step analysis provided by the Federal Rules of Evidence. Firstly, the evidence should be material; secondly, the evidence should be probative and as such its basis should be generally accepted by a significant number of professionals specifically if the evidence is advanced in respect of a past mental state; thirdly, it should be helpful; fourthly it must be fairly and understandably offered.

¹⁵⁶ Gutheil and Simon (2002) *supra* note 5 at 122. See also Bohan, TL and Heels, EJ “The case against Daubert: The new scientific evidence “standard” and the standards of the several states” (1995) *Journal of Forensic Science* at 1030-1044; Brodsky (1999) *supra* note 5 at 33.

from clinical traditions. Gutheil and Simon¹⁵⁷ assert that it does not mean that innovation is not possible, but only that it should be approached with great circumspection to avoid the promiscuous creation of diagnostic entities to meet the needs of a specific case.

- Literature review and the use of citations that are “on point” are extremely important techniques in order to comply with the requirements of both a general acceptance standard and a scientific reliability standard.¹⁵⁸
- The question relating to relevance does not flow from professional literature but requires expert “self-scrutiny” and as such assessing the question as to whether psychiatry can provide a contribution to the case.
- Peer consultation embarked on confidentially and anonymously, could be useful in complicated cases.

Bursztajn *et al* suggest that experts should have a credible experience in the practice of knowledge about the legal process and standards as well as the ability to provide an adequate translation of “clinical decision-making fundamentals into a meaningful forensic opinion”.¹⁵⁹ Bursztajn *et al* further assert that the practice of evidence-based medicine and the core characteristics of *Daubert* are essentially similar - the methods employed to arrive at a conclusion should be scientifically accurate, valid and applicable to the specific case at hand.¹⁶⁰ Bursztajn *et al*¹⁶¹ conclude by stating that in the new

¹⁵⁷ Gutheil and Simon (2002) *supra* note 5 at 122.

¹⁵⁸ See also Brodsky (1999) *supra* note 5 at 34 where it is noted:

“For all such expert proclaiming no research evidence, I suggest looking harder. It may be that there is a related or extrapolated field of knowledge to explore. No better way exists to prepare oneself for judicial scrutiny than delving into and maturing directly related scientific research.” See also Blau (1998) *supra* note 5 at 60.

¹⁵⁹ Bursztajn, HJ, Pulde, MF; Pirakitikulr, D and Perlin, M “Kumho for Clinicians in the Courtroom – Inconsistency in the Trail Courts” at <http://www.forensicpsych.com/articles/artKumhoClinicians.php> [accessed on 2007/05/03]. Bursztajn *et al* in addition notes:

“In the post-*Daubert/Kumho* world, there are more incentives to identify and use qualified clinical expert and to collaborate with them; *Daubert/Kumho* challenges to exclude or limit expert testimony, the increased complexity of clinical decision-making and if and the growing sophistication of judges and jurors secondary to the dissemination of knowledge by the media and internet, all contribute to the need for guideline distinguishing between acceptable and unacceptable expert evidence.”

¹⁶⁰ *Ibid.* See also Gutheil, TG and Bursztajn, HJ “Avoiding *Ipse Dixit* Mislabelling: Post-*Daubert* Approaches to Expert Clinical Opinions” (2003) *American Academy of Psychiatry and the Law* at <http://www.forensic-psych.com/articles/artAvoidIpsedixit.php> [accessed on 2007/03/28], “Expertise in Law, Medicine and Health Care – Much Ado about Little: The

post–*Daubert/Kumho* environment attorneys and judges will find most helpful those experts who are able to present not merely their opinion but also the process by which they employed their expertise in data review and analysis, and the methods of inference employed to formulate their opinion to the requisite degree of professional certainty required by the trier of fact.

Psychiatry and psychology are essentially science-based professions. As such opinions advanced by forensic psychiatrists and psychologists need to comply with the threshold standards of being scientifically reliable and valid in order to contribute to the assessment of the defence of criminal incapacity. Expert opinions by forensic mental health professionals will be meaningless if the facts upon which it is based lack scientifically reliable and valid premises. The formula enunciated in *Daubert* and consequently extended in application in *Kumho* could usefully assist the trier of fact in determining the reliability and validity of expert forensic opinion evidence in order to ensure that the most relevant and reliable expert testimony is provided for where the assessment of criminal capacity is at hand.

6 Ethical considerations pertaining to forensic psychiatry and psychology

6.1 Forensic psychiatry and the ethical guidelines for the practice of forensic psychiatry

The American Academy of Psychiatry and the Law has adopted specific ethical guidelines for the practice of forensic psychiatry.¹⁶² These guidelines provide a useful framework which could also be applied to the practice of forensic psychiatry in South Africa.

Effect of *Daubert, Joiner* and *Kumho Tire* on Claims of Medical Expertise at <http://www.ahrq.gov/clinic/jhppl/shuman2.htm> [accessed on 2007/05/03].

¹⁶¹ *Ibid.*

¹⁶² American Academy of Psychiatry and the Law – Ethics Guidelines for the Practice of Forensic Psychiatry” adopted in May (2005) (hereafter “AAPL ethical Guidelines”) as obtained at www.mentalhelp-net/poc/view-doc.php?type=cloc&id [accessed on 2010/03/09] at 1. See also Gutheil and Simon (2002) *supra* note 5 at 135; Melton *et al* (2007) *supra* note 5 at 87.

An aspect which is crucial to the practice of forensic psychiatry is the fact that these guidelines were specifically designed for the practice of forensic psychiatry. Such a step would be welcomed in South Africa as a codification of this nature could aid in “streamlining” the practice of forensic psychiatry in circumscribing the responsibilities of the forensic psychiatrist within an ethical context whilst at the same time defining the boundaries of the forensic assessment process. These guidelines will be summarised below.

6.1.1 Preamble to the ethical guidelines for the practice of forensic psychiatry

The preamble to the ethical guidelines reads as follows:¹⁶³

“The American Academy of Psychiatry and the Law (AAPL) is dedicated to the highest standards practice in forensic psychiatry. Recognizing the unique aspects of this practice, which is at the interface of the professions of psychiatry and the law, the Academy presents these guidelines for the ethical practice of forensic psychiatry.”

In terms of the ethical guidelines forensic psychiatry is defined as a sub-speciality of psychiatry in terms of which scientific and clinical expertise is applied in legal matters pertaining to, amongst other practices, criminal matters and it is further noted that the guidelines apply to psychiatrists performing a forensic role.¹⁶⁴ The ethical guidelines further acknowledge that forensic psychiatrists practice at the interface of law and psychiatry and as a result of forensic psychiatry carries the potential for various conflicts, misunderstandings and abuses.¹⁶⁵

¹⁶³ *Ibid.*

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

6.1.2 Confidentiality

The ethical guidelines acknowledge that within the paradigm of a forensic assessment, the forensic evaluation requires due notice to the evaluatee and also collateral sources of possible restrictions on confidentiality.¹⁶⁶ The evaluatee should in addition be informed that the psychiatrist conducting the assessment is not the evaluatee's "doctor"¹⁶⁷ and as such the necessary care should be exercised in ensuring that the evaluatee does not develop the belief that there is a treating relationship.¹⁶⁸

6.1.3 Consent

The ethical guidelines provide the following principles pertaining to consent:¹⁶⁹

- The evaluatee should be informed of the nature and purpose of the assessment and the constraints and limitations relating to confidentiality.
- The informed consent of the individual undergoing the forensic assessment (the evaluatee) should be obtained and in the event that the evaluatee is incompetent to provide consent, the evaluator should seek the proper legal recourse and adhere to the appropriate laws at the jurisdiction.
- In particular situations such as court ordered assessments for competency to stand trial, informed consent is not a prerequisite. In such cases the evaluatee should be informed that a refusal on his/her part to participate may be mentioned in any report or testimony.
- Psychiatrists should preferably not conduct forensic assessments on individuals who have not consulted with legal counsel when such individuals are charged with criminal acts; under investigation for criminal or quasi-criminal acts; held in custody or detention; or being interrogated for criminal or quasi-criminal conduct.

¹⁶⁶ AAPL Ethical Guidelines *supra* note 162 at 2.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ AAPL Ethical Guidelines *supra* note 162 at 2. See also Gutheil and Simon (2002) *supra* note 5 at 137-138.

These guidelines reaffirm the importance of informed consent within the framework of forensic assessments. It is further pivotal that the evaluatee be informed of the limitations pertaining to confidentiality. The guidelines provide a useful framework in codifying these important aspects.

6.1.4 Honesty and striving for objectivity

The ethical guidelines provide the following principles:¹⁷⁰

- Psychiatrists functioning as experts within the legal process, should adhere to the principles of honesty and objectivity.
- Psychiatrists should strive at arriving at objective opinions.
- Psychiatrists performing a forensic role should base their forensic opinions, forensic reports and testimony on all available data. The latter is effected by distinguishing between verified and unverified information as well as clinical “facts”, “inferences” and “impressions”.
- Psychiatrists should preferably perform a personal examination but in certain instances a personal examination is not required. When, within the forensic context, it is not feasible to perform a personal examination or assessment, an opinion may be granted based on other information.
- It is further noted that psychiatrists assuming a forensic role for patients they are treating, may adversely affect the therapeutic relationship with them.
- The forensic assessment as well as the credibility of the practitioner may be undermined by conflicts inherent in the differing clinical and forensic roles and as such treating psychiatrists should refrain from acting as an expert witness for their patients or performing assessments of their patients for legal purposes.
- In scenarios where the dual role is required or unavoidable regard should be taken of the inherent differences inherent between clinical and legal obligations.

¹⁷⁰ AAPL Ethical Guidelines *supra* note 162 at 3. See also Gutheil and Simon (2002) *supra* note 5 at 138-139.

The most important aspect addressed in this ethical guideline relates to the problematic aspect of the assumption of dual relationships in terms of which a treating clinician in addition assumes the role of forensic evaluator. The prohibition on psychiatrists acting as expert witnesses for their patients or performing assessments on their patients is a welcoming aspect contained in the ethical guidelines.

6.1.5 Qualifications

The ethical guidelines provide that expertise within the profession of forensic psychiatry will only relate to areas of actual knowledge, skills, training or experience.¹⁷¹ It is further noted that psychiatrists should present their qualifications accurately and precisely when providing an expert opinion.¹⁷²

6.2 Forensic psychology and the ethical guidelines for the practice of forensic psychology

The Speciality Guidelines for Forensic Psychologists were adopted by the majority of the members of the American Psychology Law Society.¹⁷³ These guidelines were specifically designed to provide more specific guidance to forensic psychologists in order to control their professional conduct when providing assistance to courts, parties to legal matters, correctional and forensic mental health institutions and legislative agencies.¹⁷⁴ The main objection of these guidelines is “to improve the quality of forensic psychological services offered to individual clients and the legal system and thereby to enhance forensic psychology as a discipline and profession”.¹⁷⁵ In addition, the guidelines provide the following statement pertaining to its objective:¹⁷⁶

¹⁷¹ AAPL Ethical Guidelines *supra* note 162 at 4. See also Gutheil and Simon (2002) *supra* note 5 at 139-140.

¹⁷² *Ibid.*

¹⁷³ “Specialty Guidelines for Forensic Psychologists” (1991) (hereafter “Guidelines”) *Law and Human Behavior* at 655-685. See also Melton *et al* (2007) *supra* note 5 at 87-99.

¹⁷⁴ Guidelines (1991) *Law and Human Behavior supra* note 173 at 655.

¹⁷⁵ *Ibid.*

¹⁷⁶ Speciality Guidelines (1991) *Law and Human Behavior supra* note 173 at 656.

“The Guidelines provide an aspirational model of desirable professional practice by psychologists, within any sub-discipline of psychology, ... when they are engaged regularly as experts and represent themselves as such, in an activity primarily intended to provide professional psychological expertise to the judicial system.”

The most important aspects of these guidelines will be addressed below:

6.2.1 Purpose and scope of the ethical guidelines for forensic psychologists

The guidelines provide that the professional standards pertaining to the ethical practice of psychology in general, are addressed in the American Psychological Association’s *Ethical Principles of Psychologists*, but that these principles do not relate to the objectives of desirable professional conduct for forensic psychologists.¹⁷⁷ The guidelines do not contradict any provisions of the *Ethical Principles of Psychologists*, but rather amplify them within the context of the practice of forensic psychologists.¹⁷⁸ The guidelines provide the following definitions of a “psychologist”, “forensic psychology” and a “forensic psychologist”, and these terms are distinctively defined as follows:¹⁷⁹

- “Psychologist”
“... any individual whose professional activities are defined by the American Psychological Association or by regulation of title by state registration or licensure, as the practice of psychology.
- “Forensic psychology”
“... all forms of professional psychological conduct when acting, with definable foreknowledge, as a psychological expert on explicitly psychological issues, in direct assistance to courts, parties to legal proceedings, correctional and forensic mental health facilities, and

¹⁷⁷ Guidelines (1991) *Law and Human Behavior supra* note 173 at 656. For purposes of this study, only the Specialty Guidelines for Forensic Psychologists will be discussed.

¹⁷⁸ Guidelines (1991) *Law and Human Behavior supra* note 173 at 657.

¹⁷⁹ *Ibid.*

administrative, judicial, and legislative agencies acting in an adjudicative capacity.”

- “Forensic psychologist”
“... means psychologists who regularly engage in the practice of forensic psychology.”

An important aspect of the guidelines is the accordance of adequate definitions to the concepts of psychology, forensic psychology and a forensic psychologist and as such a clear demarcation between the professions of psychology and forensic psychology is established. The guidelines do not apply to psychologists requested to provide services when such psychologists were not informed at the time of providing such services that they were intended for use as forensic psychological services.¹⁸⁰

6.2.2 Responsibility

The guidelines provide that forensic psychologists are obliged to conduct their services consistent with the highest standards of their profession and in addition forensic psychologists should take the necessary steps to ensure that their services are used in a responsible manner.¹⁸¹

6.2.3 Competence

The guidelines provide the following in respect of competence:¹⁸²

¹⁸⁰ *Ibid.*

¹⁸¹ Guidelines (1991) *Law and Human Behavior supra* note 173 at 657-658.

¹⁸² Guidelines (1991) *Law and Human Behavior supra* note 173 at 658. See also Melton *et al* (2007) *supra* note 5 at 87-88 where it is noted in respect of competence and qualifications of forensic mental health professionals that mental health professionals conducting assessments for the courts need more than basic clinical training. In addition it is noted that forensic work requires familiarity with the legal system; forensic assessment instruments, the legal doctrines which provide relevance to mental health evaluation; research pertaining to syndromes and similar phenomena; and the demands at being an expert witness. Melton *et al* notes the following: “The need for speciality training for forensic mental health practice has been noted in the professional literatures and it is reflected in the growth in recent years of interdisciplinary programs in forensic psychiatry and psychology and law. But it remains the case that most mental health professionals will

- Forensic psychologists should only render services in specific fields of psychology in which they have acquired specialised knowledge, skill, experience and education;
- Forensic psychologists are obliged to provide the court with the factual bases of their qualification as an expert and also indicating the way in which those bases to their qualifications are relevant to the specific issues in a case;
- Forensic psychologists should possess a fundamental and reasonable level of comprehension of legal and professional standards pertaining to their participation as experts in legal matters.
- Forensic psychologists should be aware of the fact that their own personal values, moral convictions, or personal and professional relationships with parties to a legal matter may interfere with their ability to practice efficiency and in such circumstances, forensic psychologists should refrain from participating or curb their assistance in a manner consistent with professional obligations.

6.2.4 Relationships

The guidelines provide the following important aspects in respect of relationships:¹⁸³

- The forensic psychologist has an obligation during initial consultations with the legal representative of a particular party seeking services, to inform such party of factors which may impact on a decision to contract

obtain the significant part of their forensic training through self study, on-the-job opportunities with experienced colleagues and continuing education programs.”

Melton *et al* further notes that regard should also be taken of the fact that competence in one area of forensic assessment practice does not ensure one’s competence in another area. Appreciation should also be taken of the limits of what behavioural medical sciences have to offer the legal system. Qualifications are also no guarantee against error in practice. Mental health professionals should also be mindful of legal constraints on the practice of forensic mental health assessments.

¹⁸³ Guidelines (1991) *Law and Human Behavior supra* note 173 at 658-659. See also Melton *et al* (2007) *supra* note 5 at 90-91 where it is stated: “Also implicating the ethical requirement that relationships be clarified are current or prior activities, obligations, or relationships at the clinician that might produce a conflict of interest in the case.”

with the forensic psychologist. Such factors include prior and current personal or professional relationships which might result in a conflict of interests; limitations in areas of competence as well as limitations in procedures employed.

- Forensic psychologists are aware of potential conflicts of interests in dual relationships and as such they refrain from providing professional services to individuals in legal proceedings with whom they are engaged in a personal or professional relationship which conflicts with the anticipated relationship.
- In the event that it is necessary to provide both evaluation and treatment to a party in a legal proceeding, the forensic psychologist shall take reasonable measures to reduce the negative impact on rights to the party, confidentiality as well as the process of treatment and assessment.
- Forensic psychologists should inform prospective clients of their respective rights in respect of an anticipated forensic assessment, the purpose of the assessment as well as the nature of the procedures to be employed. In addition, the informed consent of the party or the particular legal representative should be obtained. If a party is unwilling to proceed after having been informed of the purposes, methods and uses of the forensic assessment, such assessment should be postponed and the forensic psychologist should seek legal advice. Where an individual lacks the capacity to provide informed consent to the assessment, the forensic psychologist should provide reasonable notice to the individual's legal representative before proceeding with the assessment.
- Whenever there is a conflict between the forensic psychologist's professional standards and the requirements of legal standards, the forensic psychologist is obliged to divulge and disclose the source of conflict and to take reasonable steps to resolve it.

The guidelines pertaining to relationships once again contain a prohibition on dual relationships. The latter is of utmost importance within a forensic context. This provision is similar to the one discussed in the preceding discussion pertaining to forensic psychiatry. Another important aspect emphasised in this section of the guidelines, is the principle of informed consent which is

reaffirmed.

6.2.5 Confidentiality and privilege

The guidelines state the following pertaining to confidentiality and privilege:¹⁸⁴

- Forensic psychologists should have regard to their legal standards which may affect or limit the confidentiality or privilege that may be relevant to their services and they should further perform their professional activities in a manner which respects those rights and privileges.
- Forensic psychologists should inform their clients of the limitations to confidentiality of their services provided and in the event where a party's right to confidentiality is restricted, the forensic psychologist should take reasonable steps to maintain confidentiality in respect of any information not directly related to the purpose and scope of the assessment.

6.2.6 Methods and procedures

The most important aspects of the guidelines relating to specifically the methods and procedures of forensic psychologists are the following:¹⁸⁵

- Forensic psychologists are obliged to document and be prepared to provide subject to court order or the rules of evidence, all data and information constituting the basis of their evidence.
- Forensic psychologists should be aware that hearsay evidence as well as other rules relating to expert testimony places a unique ethical burden upon them and in addition, when hearsay or other inadmissible evidence forms the basis of their opinion, they should attempt to minimise sole reliance upon such evidence.
- Forensic psychologists should refrain from providing information from their assessments which do not bear directly upon the legal purpose of

¹⁸⁴ Guidelines (1991) *Law and Human Behavior supra* note 173 at 660. See also Melton *et al* (2007) *supra* note 5 at 93-94.

¹⁸⁵ Guidelines (1991) *Law and Human Behavior supra* note 173 at 661-663.

their professional activities and is not essential as support for their evidence or testimony except where such disclosure is required by law.

- Whenever a forensic psychologist relies upon data or information gathered by others, the origins of such information should be clarified.
- Forensic psychologists should be aware that no statement made by a defendant during the course of any forensic assessment, no testimony by the expert promised upon such statements, may be admitted into evidence against the defendant in any criminal proceeding except on an issue respecting mental condition on which the defendant has introduced testimony.¹⁸⁶
- Forensic psychologists will avoid providing written or oral evidence pertaining to the psychological characteristics of a specific individual in the absence of having had the opportunity to conduct an examination of the individual adequate to the scope of the statements or conclusions to be issued.

6.2.7 Public and professional communications

The most relevant aspects pertaining to public and professional communications set forth in the guidelines are the following:¹⁸⁷

- Forensic psychologists should have regard that their role as “expert to the court” or as “expert representing the profession” accords them a particular responsibility for fairness and accuracy in their public statements.
- Generally, forensic psychologists should refrain from rendering detailed public statements pertaining to particular legal proceedings in which they have been involved.
- Forensic psychologists should address specific legal proceedings in publications or communications only to the extent that the information relied upon forms part of the public record or the necessary consent for

¹⁸⁶ This provision in the Guidelines is similar to Section 78(7) of the Criminal Procedure Act 51 of 1977 discussed in Chapters 2 and 3 *supra* pertaining to admissibility of statements by an accused during the course of a forensic assessment.

¹⁸⁷ Guidelines (1991) *Law and Human Behavior supra* note 173 at 663-665.

such use has been adequately obtained.

- When testifying, forensic psychologists have an overriding duty to all parties involved in the legal process to provide their findings or evidence in a fair manner and as such forensic psychologists shall not, either by commission or omission, participate in a misrepresentation of their evidence nor will they participate in partisan attempts to avoid or deny the presentation of evidence contrary to their own standing.

The guidelines conclude with the following most important statement:¹⁸⁸

“Forensic psychologists are aware that their essential role as expert to the court is to assist the trier of fact to understand the evidence or to determine a fact in issue. In offering expert evidence, they are aware that their own professional observations, inferences, and conclusions must be distinguished from legal facts, opinions, and conclusions. Forensic psychologists are prepared to explain the relationship between their expert testimony and the legal issues and facts of an instant case.”

The motivation for a discussion of the relevant and specific aspects of the ethical guidelines on both forensic psychiatry and forensic psychology is multifarious. In the first instance specific guidelines are enunciated specifically for each distinctive profession. It has already been indicated during the course of this study that these two professions differ markedly and as such even though certain guidelines will overlap, these two professions each have certain guidelines specifically applicable to the particular profession.

Secondly, within the profession of psychology, a clear demarcation is established between the professions of psychology, on the one end, and forensic psychology on the other. The latter is especially important as an ordinary psychologist will not necessarily have qualifications and experience within the forensic field.

¹⁸⁸ Guidelines (1991) *Law and Human Behavior* supra note 173 at 665.

Thirdly, these guidelines establish a codified set of principles according to which forensic mental health professionals can adequately measure their activities as well as the ethical consideration connected thereto. Such codification inadvertently establishes certainty for both the legal as well as forensic professions. A codified set of guidelines could be usefully applied to the defence of criminal incapacity in order to canvass the various ethical duties and responsibilities of the forensic mental health expert in a proper and informed manner. The guidelines discussed above provide a template according to which the South African system could be developed and improved.

7 Conclusion

In this chapter the author focussed on specific aspects pertaining to the presentation of expert evidence which prevails in the United States of America. The background to the current Federal Rules of Evidence was illustrated in conjunction with a discussion of the most important rules contained in the Federal Rules of Evidence pertaining to expert evidence. The scientific reliability and validity of expert psychiatric and psychological evidence was disseminated against the backdrop of the influential decision of *Daubert* followed up by *Kumho*. The ethical guidelines applicable to the professions of forensic psychiatry and psychology were also assessed.

The following conclusions can be drawn from the research presented in this chapter:

- The Federal Rules of Evidence, and in particular, the rules pertaining to relevance and expert opinion evidence provide a template for a codified system of the rules of expert evidence. Such codification could provide invaluable assistance in the assessment of expert psychiatric and psychological evidence when a defence of criminal incapacity is raised. It will be naïve to suggest that a proposed framework will be applied in precisely the same manner in every case. Inexact sciences such as law and medicine negate such a proposition. A codified system, however,

provides clarity and certainty in respect of what precisely is expected of experts presenting expert opinions. As such, the Federal Rules of Evidence could be one avenue to follow.

- The Ultimate issue rule is redundant and superfluous. Despite the revival of this rule in terms of Federal Rule 704(b), authority strongly suggests that such rule presents numerous obstacles in practice and also unjustly limits the proper presentation and assessment of expert evidence. This rule, as was indicated from the American perspective, leads to unnecessary complications in the application of the insanity defence. Federal Rule 704(a) provides an example which can also be made applicable within the South African context.
- Assessing scientific reliability and validity of psychiatric and psychological expert opinions advanced in support of the defence of criminal incapacity, remains a highly specialised and complex task. The criteria set forth in *Daubert* could invariably assist the trier of fact in discharging this difficult task.
- The decision in *Daubert* further reaffirms the two most important and fundamental tenets also pivotal to the presentation of expert evidence, namely relevance and reliability. These two principles should be the cornerstones during the assessment of the probative value of expert evidence.
- The ethical guidelines applicable to the professions of forensic psychiatry and psychology respectively provide an invaluable framework for clarifying the various ethical responsibilities incumbent upon a mental health professional requested to perform a forensic assessment for purposes of the defence of criminal incapacity.

“The introduction of the scientist alters the narrative dynamic of the trial. A category of evidence and a language is introduced which requires the insertion of the expert as interpreter.”¹⁸⁹

¹⁸⁹ Alldridge, P “Scientific Expertise and Comparative Criminal Procedure” (1999) 141 E&P as quoted in Meintjes-Van der Walt, L “Expert Evidence in the Criminal Justice Process” (2001) at 121.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

1 Introduction

Proposing reform where inexact sciences such as law and medicine intersect is no easy task. Where the two oceans of law and medicine meet the defence of criminal incapacity falls to be assessed. Harmonising the “stormy waters” between these two professions in order to promote a more coherent application of the defence of criminal incapacity will inadvertently call for a reassessment of aspects pertaining to the formulation of the defence of criminal incapacity with specific reference to the necessity for expert evidence; the foundational principles of the rules relating to expert evidence; and the conduct of mental health professionals acting as expert witnesses in support of the defence of criminal incapacity.

The motivation for the current study is premised on the various obstacles facing the proper application of the presentation and assessment of expert forensic psychiatric and psychological evidence advanced in support of the defence of criminal incapacity. One of the cornerstones to a fair and just trial pertains to the right to adduce and challenge evidence. The latter further extends to the right to present and challenge expert evidence. Law and medicine are both sciences constantly evolving with due regard to changing values and needs of our modern society.

It was not too long ago that mental health professionals played a somewhat peripheral role in the criminal justice system. Today, mental health professionals play a vital and essential role in our criminal justice system with specific reference to the assessment of the defence of criminal incapacity. Mental health professionals do not only play a pivotal role in evaluating the intrinsic inner being and human mind or psyche of an accused, but in addition thereto fulfil an indispensable function in portraying the inner being to the ultimate trier of fact as credibly and comprehensibly as possible. The striking reality is, however, that the latter

goals are frequently not achieved.

The defence of criminal incapacity constitutes the centre stage where law and medicine meet and also where these two professions ultimately clash. In the ultimate search for truth and justice when the defence of criminal incapacity is raised as a defence, it is pivotal to enumerate some form of consensus between these two professions. The defence of criminal incapacity is probably one of the most underscored defences in our current criminal justice system and is often underestimated and misunderstood.

Research clearly indicates that despite scepticism, criticism and caution levelled towards the presentation of expert evidence in support of the defence of non-pathological criminal incapacity, it can severely prejudice an accused if adequate expert testimony is not advanced on behalf of the accused in order to canvass the mental state of an accused at the time of the offence.

A phenomenon often encountered within the realm of the defence of non-pathological criminal incapacity is the “battered woman syndrome”. Battered woman syndrome evidence advanced in support of a defence of non-pathological criminal incapacity is often underscored due to the overarching negativity towards expert evidence advanced in support of the defence of non-pathological criminal incapacity. Abuse against partners within intimate relationships is a common phenomenon of our society in modern times. Research indicates that abuse nowadays encompasses far more than merely physical abuse. In addition psychiatric and psychological advances within the context of abuse within intimate relationships have developed enormously, encompassing a vast amount of theories and explanations for abuse falling beyond the knowledge of the trier of fact.

The latter exacerbates the fundamental need for effective expert testimony albeit that the state of criminal incapacity falls within the “non-pathological” category. One of the most prevalent anomalies associated with the role of expert evidence in support of the defence of criminal incapacity relates to

the constant categorisation of a mental state either in the “non-pathological” or “pathological” boxes. Research indicates that this distinction creates confusion and places distrust in the medical testimony advanced in support of criminal incapacity. The fact remains that in the absence of a body of expert evidence in support of a defence of criminal incapacity, a court is left with merely the *ipse dixit* of an accused. The latter could be prejudicial for both the prosecution as well as the defence as without well advanced expert testimony, the prosecution will face a struggle in rebutting a malingered claim of criminal incapacity by an accused, whilst on the other hand an accused could be severely prejudiced if his or her true mental state at the time of the offence is not portrayed to the trier of fact from an expert’s point of view after a proper assessment.

The Diagnostic and Statistical Manual of Mental Disorders¹ forms the cornerstone of the diagnostic framework from which mental health professionals deduct their diagnoses of mental disorders in cases where criminal incapacity and specifically pathological criminal incapacity is raised as a defence. However, despite the essential importance of the DSM-IV for defining “mental illness” and/or “mental defect” as threshold requirements for the defence of pathological criminal incapacity, law and medicine most frequently diverge as to whether a diagnosis in terms of the manual meets the legal test for criminal incapacity. The puzzle of criminal incapacity can, however, not be completed without the correct piece from the manual, yet more often than not this piece cannot be found. The fundamental conflict between the professions of law and medicine in respect of the concept of mental illness could be traced to a lack of understanding on both sides of the respective goals, aspirations and limitations of each profession respectively. Law and medicine are both inexact sciences in a constant state of flux. As such proper recognition should be afforded to advancements made within the fields of forensic psychiatry and psychology with a concomitant appreciation of its

¹ American Psychiatric Association “Diagnostic and Statistical Manual of Mental Disorders” (DSM-IV-TR) (2000) as discussed in Chapter 3 paragraph 7 *supra* (“DSM-IV”).

contribution to the defence of criminal incapacity. Simultaneously the medical profession should also adhere to the boundaries of its profession and the knowledge associated therewith.

The assessment of the probative value, reliability and validity of expert evidence is yet another obstacle in achieving a more coherent and systematic approach to the assessment of the defence of criminal incapacity. Research indicated that a lack of systemised criteria to be utilised as a benchmark in the assessment of the reliability and validity of expert opinion renders the value attached to such opinion problematic, inadvertently resulting in the well-known dilemma of the “battle of the experts”.

A proper distinction is often not affected between the professions of psychiatry and psychology on the one hand, and forensic psychiatry and forensic psychology as specialist fields, on the other hand. The Criminal Procedure Act² in its current form does not make mention of the specific specialist fields of forensic psychiatry and forensic psychology. Without proper recognition of the specific areas of expertise required in support of the defence of criminal incapacity such evidence will inextricably lose probative value. The essential need for expert evidence in support of the defence of criminal incapacity is thus inextricably linked with the need to obtain the correct and most appropriate expert evidence. The latter is further prevalent in the light of the multifarious ethical dilemmas mental health professionals entering the forensic arena are confronted with. Forensic psychiatry and psychology are two of the least understood sub-specialties within the medical profession. The latter inadvertently exacerbates the conflict between law and medicine in the assessment of the defence of criminal incapacity. As a result of the continuous development of the scientific discourses of law and medicine, the languages spoken by the two professions respectively, differ increasingly. The translation of these languages is complicated by the lack of comprehension on both

² The Criminal Procedure Act 51 of 1977.

sides pertaining to what precisely is expected of each profession in the ultimate analysis and assessment of the defences of criminal incapacity. Triers of fact are often confused in respect of the opinions proffered by mental health professionals and in addition thereto, the exact meaning to be ascribed to a specific opinion. Specific terminology and explanations contained in an expert opinion is often not conveyed to the court in a clear and understandable manner, thus decreasing the probative value of the opinion. Mental health professionals on the other hand are often confused as to what the legal profession expects of them and where the boundaries of their expert opinions lie. The latter is further exacerbated by the “ultimate issue” doctrine barring ultimate conclusions pertaining to the mental state of accused persons at the time of the offence.

With the backdrop of the aforementioned as a starting point, the time has arrived for a reassessment of the role of expert evidence in support of the defence of criminal incapacity in order to promote a more consistent dialogue between the professions of law and medicine, thereby ensuring a more just and equitable application of the defence of criminal incapacity.

2 Synopsis

2.1 Chapter 1

In order to eliminate confusion in respect of specific terminology used during the course of this study and to provide an exposition of the author’s objectives and aim with the current research, Chapter 1 contained a clarification of key concepts of the theme of study. The title of this thesis, namely “the role of expert evidence in support of the defence of criminal incapacity” was nationally and thematically elucidated. As a result of the introduction and orientation a problem statement and hypothesis were presented in order to indicate the precise boundaries of the current study. In addition the central theoretical statement was formulated as follows:

“Mental health experts, and more specifically, forensic mental

health experts, play a pivotal and essentially crucial role in the assessment and proof of the merits and validity of the defence of criminal incapacity. There is a fundamental need for carefully trained specialists with a proper understanding of the mechanics of law, the sciences of psychology and psychiatry respectively and the complexities of human behaviour to assist the court in cases where the defence of criminal incapacity is raised. The role of the mental health expert in support of the defence of criminal incapacity is dual functional in the sense that it is in the first place pivotal to have the assistance of such an expert; and in the second place it is important that the expert be adequately trained and experienced in the particular field of mental health concerned.”

In the aftermath of the current study, the author can verify the abovementioned central theoretical statement. The current study further entails a theoretical descriptive and explorative research methodology aimed at assessing the fundamental role of expert evidence in support of the defence of criminal incapacity. In conclusion Chapter 1 provided an overview of the contextual framework enunciated in the consecutive chapters.

2.2 Chapter 2

The defence of non-pathological criminal incapacity is extensively assessed in Chapter 2 with specific reference to the role of expert evidence in support thereof. It is illustrated that the defence of non-pathological criminal incapacity is in need of reform. Possible developments of this defence against the backdrop of Section 39(2) of the Constitution by means of an indirect application of the Bill of Rights are suggested. It is indicated that legislative reform is essential to establish the defence of non-pathological criminal incapacity and to create legal certainty.

In addition it is illustrated that the probative value attached to and the application of expert evidence in respect of the defence of non-pathological criminal incapacity, has not been consistent. It is noted that the reason for such inconsistency lies in the fact that expert evidence is not a prerequisite in order to rely on the defence of non-pathological criminal incapacity as well as the common law rule entailing that expert evidence in cases of non-pathological criminal incapacity does not fulfil an indispensable function.

The author also illustrates the essential distinction between non-pathological criminal incapacity and sane automatism. The *onus* of proof is assessed with reference to the defence of non-pathological criminal incapacity and it is suggested that the *onus* of proof should fall on the accused. The role of the battered woman syndrome evidence advanced in support of the defence of non-pathological criminal incapacity is extensively assessed and disseminated against the backdrop of the psychosocial dynamics of abuse within intimate relationships and its impact with reference to the defence of non-pathological criminal incapacity. It is suggested that diminished non-pathological criminal incapacity should be provided for within the statutory framework of Section 78(7) of the Criminal Procedure Act.

2.3 Chapter 3

In Chapter 3 the fundamental and essential role of expert psychiatric and psychological evidence in support of an assessment of pathological criminal incapacity as a defence in criminal incapacity law is evaluated. The viability of the establishment of a fitness assessment unit is assessed and it is indicated that such unit could provide an alternative to referrals for observation as a more cost-effective and time-effective option as opposed to referrals for observation.

The conceptual analysis of the concepts of “mental illness” and/or “mental defect” as threshold requirements for the establishment of the defence of

pathological criminal incapacity is extensively assessed and it is indicated that the concepts of “mental illness” and/or “mental defect” represent one of the core areas where law and medicine do not see eye to eye. It is indicated that the DSM-IV plays a pivotal role in the definition and assessment of mental disorders as one of the main diagnostic references utilised by mental health professionals in order 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. Emphasis is placed on the fact that recognition of specific diagnostic categories of mental disorders within the contextual framework of the defence of pathological criminal incapacity is controversial and poses a challenge to the efficient application of the defence of pathological criminal incapacity. It is furthermore stressed that the reconciliation of diagnostic criteria with legal requirements for the defence of pathological criminal incapacity is problematic which concomitantly exacerbates the need for proper and efficient expert evidence to be advanced in such cases.

A thorough analysis of the role psychopathy plays in respect of the defence of pathological criminal incapacity is provided and it is noted that the diagnosis of psychopathy in conjunction with antisocial personality disorder remains controversial. The importance of expert psychiatric evidence in establishing extenuating circumstances in support of diminished criminal incapacity is illustrated.

The incorporation of two distinct pleas of incompetence to stand trial as well as criminal incapacity is addressed and it is indicated that such pleas could provide an alternative to the current position pertaining to competency to stand trial and criminal incapacity. The conclusion derived at is that mental health professionals fulfil an indispensable function in the assessment of competency to stand trial as well as the defence of pathological criminal incapacity. Proper judicial recognition of this fact remains crucial in the ultimate assessment of the defence of pathological criminal incapacity.

2.4 Chapter 4

In Chapter 4 the nature and scope of the basic rules of expert evidence as they would apply to mental health professionals acting as expert witnesses and accordingly testifying in support of the defence of criminal incapacity are addressed. Selected practical as well as ethical considerations relevant within the forensic context are also addressed. It is indicated that the rules of expert evidence play an essential role in respect of the role and probative value of expert evidence. It is suggested that these rules should be codified in a proper way so as to create legal certainty. The ultimate issue doctrine is extensively disseminated and it is concluded that such rule or doctrine is redundant and should be abolished. It is noted that expert evidence should be evaluated according to its relevance and not the alleged conclusory status of the opinion presented.

The assessment of the probative value of expert evidence is addressed and it is illustrated that such assessment remains a complex and intrinsic function of a court bearing upon various aspects, the most important of which are the expert's qualifications, credibility as a witness, the basis for the expert opinion and the probabilities of the case. The value of pre-trial consultations and disclosure is assessed and it is indicated that these procedures play a vital role in the assessment of expert evidence. It is emphasised that the cross-examination of expert witnesses within the adversarial climate constitutes a vital tool in order to challenge the veracity, credibility, reliability and probative value of expert evidence.

The following ethical conclusions are derived at in Chapter 4:

- Mental health professionals acting as expert witnesses should strive towards providing their opinions as impartial and unbiased as possible.
- Mental health experts should at all costs refrain from assuming dual relationships as treater and evaluator and as such treating clinicians

should not act as forensic expert witnesses and *vice versa* in cases where an assessment is requested for purposes of the defence of criminal incapacity.

- Mental health experts have an incumbent ethical duty of informing accused persons of the limitations pertaining to confidentiality within the context of the forensic assessment process.

It is indicated that the forensic report drafted and completed by the mental health professional also fulfils an integral part of the role of the mental health expert within the forensic context.

In conclusion a draft ethical code for mental health professionals acting as expert witnesses is provided.

2.5 Chapter 5

In Chapter 5 a comparative perspective is provided with reference to selected principles of expert evidence in the United States of America. An overview of the Federal Rules of Evidence is provided, with specific reference to the most important rules bearing upon opinion evidence and thus expert evidence. The scientific reliability and validity of expert psychiatric and psychological evidence are assessed against the backdrop of the influential decisions of *Daubert* and *Kumho*. It is illustrated that the Federal Rules of Evidence, and in particular the rules pertaining to relevance and expert opinion evidence, provide a template towards achieving a codified system in terms of the rules of expert evidence which could be a welcoming development in South Africa.

The ultimate issue rule as it stands in America is once again revisited and it is illustrated that despite the revival of the rule in the *Hinckley* aftermath³, research strongly indicates that the ultimate issue rule presents numerous obstacles in practice with a concomitant limitation of

³ See Chapter 5 *supra* paragraph 4.4.

the proper presentation and assessment of expert evidence.

It is illustrated that the assessment of scientific reliability and validity of expert medical evidence in support of the defence of criminal incapacity remains a complex and highly specialised task and as such the criteria enunciated in *Daubert* could provide assistance to the trier of fact during the course of assessing scientific reliability and validity.

In conclusion the ethical guidelines applicable to the professions of forensic psychiatry and psychology respectively are discussed in order to indicate the value of such guidelines for purposes of circumscribing the duties and responsibilities of these mental health professionals acting as expert witnesses.

3 Conclusions

Upon analysis of the research undertaken during the course of the current study, the following conclusions have been reached:

- In the light of the preceding literature study, the central theoretical statement is verified, namely that:
“Mental health experts, and more specifically, forensic mental health experts, play a pivotal and essentially crucial role in the assessment and proof of the merits and validity of the defence of criminal incapacity. There is a fundamental need for carefully trained specialists with a proper understanding of the mechanics of law, the sciences of psychology and psychiatry respectively, and the complexities of human behaviour to assist the court in cases where the defence of criminal incapacity is raised. The role of the mental health expert in support of the defence of criminal incapacity is dual functional in the sense that, firstly it is pivotal to have the assistance of such an expert and secondly it is important that the expert be

adequately trained and experienced in the particular field of mental health concerned.”

- Expert evidence forms an integral part of the fundamental right of an accused person to a fair and just trial encompassing the right to adduce and challenge evidence.
- Expert evidence plays an essential role in the assessment of the defence of criminal incapacity, albeit non-pathological criminal incapacity or pathological criminal incapacity.
- Negativity levelled at, as well as lack of adequate statutory recognition of, the defence of non-pathological criminal incapacity are considerations fundamentally linked to the inconsistent approach toward expert evidence in support of the defence of non-pathological criminal incapacity. The latter is exacerbated by the fact that expert evidence is not a prerequisite in order to rely on the defence of non-pathological criminal incapacity.
- The defence of non-pathological criminal incapacity constitutes one of the cornerstones of conflict between the medical and legal professions. The latter could be traced essentially to the inconsistent application of this defence and scepticism levelled at expert evidence advanced in support thereof.
- The fundamental misapprehension of the defence of non-pathological criminal incapacity and the concomitant inconsistent application of this defence, have given rise to controversial approaches in respect of battered woman syndrome evidence advanced in support of the defence of non-pathological criminal incapacity. The latter inadvertently results in the abused spouse or partner being left without a proper defence within the ambit of the criminal law due to falling in the middle of the dividing line between non-pathological and pathological criminal incapacity. The accused in such an instance will often be too “non-pathological” to rely on the defence of pathological criminal incapacity, yet at the same time not be able to satisfy the yardstick of the defence of non-pathological criminal incapacity as a result of scepticism,

controversy and ambiguity clouding such defence.

- Despite the statutory recognition of the defence of pathological criminal incapacity in conjunction with the statutory framework acknowledging expert evidence, the defence of pathological criminal incapacity more often than not represents a source of conflict between law and medicine. The latter could be traced to a lack of adequate training of mental health professionals testifying as expert witnesses in forensic psychiatry and psychology pivotal to the application and assessment of the defence of pathological criminal incapacity.
- The essential distinction between sane automatism and the defence of non-pathological criminal incapacity is often clouded and misunderstood, representing one of the main sources of conflict between mental health professionals and the law. The latter inadvertently affects the expert testimony advanced, as without a proper understanding of the specific defence raised, such expert testimony will lack probative value which in turn lessens the scientific reliability and validity of the expert opinion.
- The value of the expert opinion is founded on the knowledge, experience and training of the mental health expert. The latter factors will inherently influence the probative value, scientific reliability and validity of the expert opinion advanced in support of the defence of criminal incapacity.
- The sub-specialities of forensic psychiatry and forensic psychology are underscored in South Africa and in need of proper recognition as this will enhance the proper application of the defence of criminal incapacity.
- Expert evidence is essential not only in support of the defence of criminal incapacity, but also to aid in assessing the merits and validation of the defence with specific reference to the rebuttal of false claims of criminal incapacity.
- It is essential that both the prosecution and the defence retain their own expert witnesses as this provides a balanced view pertaining to

the defence of criminal incapacity.

- It is crucial that expert evidence advanced in support of the defence of criminal incapacity be causally connected to the facts of the case. In the absence of such causal *nexus*, the expert opinion will amount to nothing more than abstract theory.
- Mental health experts fulfil an essential role not only in support of the defence of criminal incapacity, but also in respect of the assessment of the competency to stand trial.
- The assessment of the scientific reliability and validity of expert psychiatric and psychological diagnoses and consequently expert opinions remain complex.
- The scientific reliability and validity of expert opinions inadvertently impact on the probative value of expert opinions.
- Mental health experts are faced with various ethical constraints and dilemmas when acting as forensic expert witnesses when the defence of criminal incapacity is raised.
- The approach to the role of expert evidence in support of the defence of criminal incapacity is in need of reform with the primary aim being to aid in a more coherent consistent application of the defence of criminal incapacity, in conjunction with the proper recognition of the essential role that expert evidence fulfils in support thereof.

4 Recommendations

- **Recommendation 1**

Expert evidence should be a prerequisite in support of the defence of criminal incapacity regardless of the alleged cause of incapacity.

- **Motivation and Elucidation**

Research indicates the severely prejudicial effect resulting from the absence of expert evidence in support of the defence of criminal

incapacity.⁴ Assessing the mental state of an accused person retrospectively at the time of the commission of the offence, remains a complex and intrinsic function, which will inevitably fall beyond the knowledge and experience of the trier of fact. Research indicates that even within the medical profession itself, one accused will not necessarily be diagnosed in similar terms by two different mental health professionals. Accordingly, if there are divergent opinions within the specialist fields of the medical profession, it is doubtful whether from a legal point of view, a trier of fact will, in the absence of expert evidence, be able to assess the mental state of an accused at the time of the commission of the offence. The latter exacerbates the need for expert evidence. Labelling an accused in terms of the category of incapacity he or she belongs to, is severely prejudicial to an accused's right to a fair trial and also constitutes an unnecessarily conservative approach in respect of expert evidence. In addition an accused might, on face value, fall within the "non-pathological" category, whilst after a proper assessment it might come to light that he or she suffered from a mental illness or mental defect at the time of the commission of the offence.

- **Recommendation 2**

Reform should be effected legislatively to make provision for a general defence of criminal incapacity.

- **Motivation and Elucidation**

Research indicates that the classical distinction between the defences of non-pathological and pathological criminal incapacity creates confusion from a medical as well as a legal perspective. Mental health professionals are generally not familiar with the terminology of non-pathological and pathological criminal incapacity. At the end of the day it is the mental state of the accused at the time of the offence which has to be assessed and not the

⁴ See chapter 3 *supra* at paragraph 9.

label best suited for the particular accused.

In terms of the current position, the defence of criminal incapacity is divided into the categories of pathological and non-pathological criminal incapacity. A court will first and foremost attempt to ascertain whether the defence is one of pathological criminal incapacity and thus whether the accused at the time of the commission of the crime was suffering from a mental illness or not. The latter will determine whether the court is statutorily obliged to refer an accused for observation in terms of Section 79 of the Criminal Procedure Act. If according to the court an accused was not suffering from a mental illness or mental defect, and the defence is not one of pathological criminal incapacity, a court merely retains a discretion whether to refer an accused for observation or not.

The essential need for expert evidence is accordingly not determined by the criminal incapacity itself, but rather by the cause of the incapacity. Research indicates that other causes, save for mental illness or mental defect, can also lead to a lack of criminal capacity. A general defence of criminal incapacity will not only create legal certainty, but will provide a more judicially sound approach to the application of the defence of criminal incapacity. In terms of a general defence of criminal incapacity, emphasis will not fall on the alleged cause of the incapacity but rather on the lack of criminal capacity itself. Accordingly, any factor which causes a person to lack the ability to appreciate the wrongfulness of his or her actions or to act in accordance with an appreciation of wrongfulness will be relevant in assessing the existence or lack of criminal capacity.

- **Recommendation 3**

An accused person relying on the defence of criminal incapacity should be required to lay a factual foundation for such defence, supported by expert psychiatric and/or psychological evidence.

- **Motivation and Elucidation**

Establishing a factual foundation for the defence of criminal incapacity represents one of the primary means by which to assess the validity and merits of the defence. The need for a factual foundation will in addition be necessitated if a general defence of criminal incapacity is established. The factual foundation required to establish the defence of criminal incapacity will inadvertently be structured and premised on expert psychiatric and psychological evidence in order to lay a *prima facie* basis for the alleged lack of criminal capacity.

Again the need for effective expert testimony is proclaimed. This requirement will also be implemented to curb the defence of criminal incapacity thereby excluding unwarranted claims of criminal incapacity by the mere reliance on the *ipse dixit* of an accused. Due to the biological–psychological essence of the test for criminal incapacity and the intrinsic nature of this defence, the *ipse dixit* of an accused that he or she lacked criminal capacity, should never be sufficient. Expert evidence should thus be a prerequisite in order to establish the factual foundation in support of the defence of criminal incapacity. In order to ensure a more balanced view, it is submitted that both defence and the state or prosecution retain their own experts.

- **Recommendation 4**

Due consideration should be afforded to the possibility of the establishment of a mental assessment unit during the pre-trial phase to assist in the assessment of accused persons allegedly having lacked criminal capacity at the time of the commission of the offence.

- **Motivation and Elucidation**

It is crucial that accused persons who allegedly lacked criminal

capacity at the time of the commission of the offence, be assessed as soon as possible in order to get a clear and coherent picture of the accused's mental state at the time of the commission of the offence. The fact of the matter remains that as time passes, it becomes more difficult for psychiatric experts to assess what the accused's precise mental state was during the commission of the crime. A further reality is that as time passes, the scientific reliability of the retrospective judgment will decrease which could inadvertently prejudice the accused who, as a result of a slow system, is prejudiced in presenting his or her defence of criminal incapacity as effectively as possible. Due to the fact that an accused's mental state can improve or degenerate with the passage of time, prompt psychiatric or psychological assessment is pivotal. The need exists for assessments to be conducted as soon as possible following the commission of the crime. The greater the gap between the crime and the eventual assessment, the greater the risk that the assessment will lack accuracy and, concomitantly, reliability and validity.⁵

The establishment of a mental assessment unit for purposes of determining competency to stand trial as well as criminal incapacity inquiries could assist in combating the danger of lapse of time and also in assessing the validity of claims of criminal incapacity. The unit could also assist an accused in establishing the required factual foundation for the defence of criminal incapacity. The mental assessment unit will comprise of a forensic psychologist and additional mental health professionals if the need exists. The mental assessment unit should ideally be convened during the pre-trial stage before the accused pleads or, alternatively, at any stage

⁵ It is interesting to refer to Dwares, RE "Due Process Concerns with Delayed Psychiatry Evaluations and the Insanity Defense: Time is of the Essence" (1984) *Boston University Law Review* at 861—893 at 871 where it is noted: "Delayed evaluations can be less reliable because some mental illnesses – for example alcohol psychoses, acute psychoses due to substance abuse, organic and metabolic disorders and infectious diseases, reactive conditions, and demented – develop quickly, last a short time, and terminate with total recovery."

before the accused is referred for observation.

The functions of the mental assessment unit will be similar to the responsibilities of the forensic mental health professionals during the assessment for purposes of referral for observation in terms of Section 77, 78 and 79 of the Criminal Procedure Act. The major difference would relate to the fact that the purpose of the mental assessment unit would be to effect a speedy procedure to assess the validity of an accused's claim of criminal incapacity together with a preliminary forensic report. If it is found by the mental assessment unit that there is a strong possibility that the accused is incompetent to stand trial or that he or she lacked criminal capacity at the time of the commission of the offence, or that his or her abilities to appreciate the wrongfulness of his or her conduct, or to act in accordance with such appreciation, were diminished, such fact or facts will be noted in the report compiled by the mental assessment unit. Such report could then be used in support of an application to be referred for observation in terms of either Section 77, 78 or both. Conversely, if it is found by the unit that the accused's claim of alleged lack of capacity or competency to stand trial is false, such fact will be noted in the report compiled by the mental assessment unit.

The benefits of such a unit will be that it is cost-effective as it will be of a much shorter duration than the thirty days for purposes of a referral, consisting mainly of consultations on an hourly basis. In addition time is saved by the fact that the *prima facie* merits of the accused's defence are assessed at a relatively early stage. A further benefit would also be that the accused is assessed as soon as possible after the offence was committed. The forensic report compiled by the mental assessment unit will be preliminary and it will be within the trial court's discretion to accept or reject it. If the findings in the report are accepted, the accused will be referred for observation in the ordinary manner. If the report is rejected, the

accused will still have to establish a foundation for the defence of criminal incapacity, failure of which will result in the defence also failing.

The members of the mental assessment unit should ideally be qualified forensic mental health professionals selected from a specific list compiled for the said purposes of the mental assessment unit.

- **Recommendation 5**

There should be two distinct pleas of incompetence to stand trial and criminal incapacity incorporated within the framework of Section 106 of the Criminal Procedure Act, 51 of 1977.

- **Motivation and Elucidation**

Research indicates the benefits of incorporating two novel pleas of incompetence to stand trial, or put differently, non-triability and criminal incapacity within the contextual framework of Section 106 of the Criminal Procedure Act.⁶ By developing these two pleas, each plea could provide for its own distinct set of rules and these rules could provide evidence being advanced in support of each plea. The legislative incorporation of these two pleas would be fairly simple and it could aid in addressing fundamental problems associated with incompetence to stand trial as well as the defence of criminal incapacity, with specific reference to the role of expert evidence as the presentation of expert evidence could be incorporated as an essential requirement for reliance on such plea of either non-triability or criminal incapacity.

- **Recommendation 6**

The burden of proof should in all instances of criminal incapacity be placed on an accused where the accused pertinently relies on the

⁶ See chapter 3 *supra* at paragraph 9.

defence of criminal incapacity.

- **Motivation and Elucidation**

Research indicates the current anomalies surrounding the burden of proof pertaining to the defence of criminal incapacity. It is indicated that the current distinction relating to the burden of proof pertaining to the defences of non-pathological criminal incapacity and pathological criminal incapacity entailing that the burden of proof in the case former, falls on the State, whereas in the latter it falls on the accused, is constitutionally unviable and discriminatory. It is submitted that the burden of proof should in all cases where the criminal capacity or responsibility of an accused is in issue, be placed on the accused if the accused pertinently relies on the defence or, alternatively, the party raising the issue as specifically stated in Section 78(1B) of the Criminal Procedure Act. It is submitted that the proper interpretation of Section 78(1B) without a doubt places the burden of proof in cases where the criminal responsibility of an accused is in issue, on the party raising the issue. It is only fair that he or she bears the burden of proving it regardless of the cause of the alleged incapacity.

- **Recommendation 7**

Diminished criminal capacity should statutorily pertain to all forms of criminal incapacity regardless of the alleged cause of incapacity.

- **Motivation and Elucidation**

Research indicates that in many cases where reliance was placed on the defence of criminal incapacity, even though the defence did not succeed, the courts nevertheless took into account the accused's diminished criminal capacity as an extenuating factor during the imposition of an appropriate sentence. Section 78(7) of the Criminal Procedure Act however, only mentions diminished criminal capacity by reason of mental illness or mental defect. It is submitted that diminished criminal capacity should statutorily be

provided for in respect of all forms of criminal incapacity, irrespective of whether it is non-pathological or pathological in nature.

Making provision for diminished criminal capacity within a statutory framework creates legal certainty as it inevitably ensures that even if a defence of criminal incapacity does not succeed, such diminished capacity could be taken into account during sentencing. As criminal incapacity is often difficult to prove, reliance on diminished capacity in the alternative is accordingly advisable where the evidence in support of the defence of criminal incapacity is not strong enough for the defence to succeed but nevertheless weighs strongly in favour of mitigation of sentence.

- **Recommendation 8**

The Criminal Procedure Act should specifically provide for the introduction of the professions of forensic psychiatry and forensic psychology in cases of criminal incapacity.

- **Motivation and Elucidation**

Section 79 of the Criminal Procedure Act currently only mentions the professions of psychiatry and clinical psychology. Research with specific reference to the United States of America indicates that there are fundamental differences between the functions of psychiatrists as opposed to forensic psychiatrists as well as clinical psychologists as opposed to forensic psychologists. It is submitted that the Criminal Procedure Act should specifically require the assistance of forensic mental health professionals as the training and expertise of the mental health professional inadvertently affects the scientific reliability and validity of the expert opinion which in turn impacts on the probative value of the expert opinion. Obtaining expert evidence in support of the defence of criminal incapacity represents the first crucial step in the assessment of the defence of criminal incapacity. The second step involves obtaining the most appropriate and well credentialed forensic mental health professionals to assess an accused relying on the

defence of criminal incapacity.

- **Recommendation 9**

There should be specific training courses and/or postgraduate diploma courses pertaining to the interface between forensic psychiatry and forensic psychology and the law with specific reference to mental health professionals wishing to serve as expert witnesses in respect of the defence of criminal incapacity.

- **Motivation and Elucidation**

One of the fundamental ways of bridging the “gap” between law and medicine relates to training and education. In the first instance psychiatrists and psychologists wishing to enter the forensic practice, should obtain the appropriate postgraduate diploma and/or degree or certification to practice as forensic mental health professionals. Training courses in forensic psychiatry and forensic psychology should in addition include appropriate modules addressing fundamental legal concepts and principles relevant to forensic practice, with specific reference to the interface between law and medicine where the defence of criminal incapacity is raised. With a proper understanding of the mechanics of the law and legal terminology frequently encountered in respect of the defence of criminal incapacity, the forensic mental health professional will inevitably be in a better position to understand precisely what the law expects of him or her when the defence of criminal incapacity is raised. Similarly, legal professionals with specific reference to criminal practitioners, should receive training in basic concepts of forensic mental health practice, with specific reference to aspects pertaining to the DSM-IV as well as the basic processes followed during the assessment of accused persons with reference to standard tests and techniques employed during the assessment process. Such training will assist the legal professional towards a more informed comprehension of the forensic assessment process as well as understanding diagnosis rendered in respect of an accused from a medical perspective.

- **Recommendation 10**

Mental health professionals need to adhere to a code of conduct when acting and serving as expert witnesses.

- **Motivations and Elucidation**

Research indicates the various ethical dilemmas facing forensic mental health professionals who have to testify in cases where the defence of criminal incapacity is raised as a defence. In order to create legal certainty as well as certainty amongst mental health professionals, the essential need exists for a formal codification of the various duties and ethical responsibilities incumbent upon forensic mental health professionals when assessing and ultimately testifying in support of the defence of criminal incapacity. Such codification will circumscribe the duties and responsibilities of mental health professionals acting as expert witnesses. Legal professionals could also benefit in such codification by being sufficiently informed as to precisely what to expect from the forensic mental health professional.

- **Recommendation 11**

The rules for expert evidence should be codified.

- **Motivation and Elucidation**

Research indicates the need for a codification of the current common law rules pertaining to expert evidence. A comparative perspective of the Federal Rules of Evidence illustrates the value of a codified system of the rules relating to expert evidence. A codified system pertaining to the rules of expert evidence will assist in providing legal certainty insofar as expert evidence is concerned and also in respect of what precisely is expected of expert witnesses. Codification of the rules of expert evidence will inadvertently apply to mental health professionals serving as expert witnesses. A codification of the rules of expert evidence will also provide certainty and clarification as to precisely what is expected of mental health professionals when acting as expert

witnesses in support of the defence of criminal incapacity.

5 Proposals

- **Proposal 1**

A proposed code of professional conduct for forensic mental health professionals serving as expert witnesses in matters relating to the criminal responsibility of accused persons and related matters.

- **Draft code**

Code of Professional and Ethical Conduct for Forensic Mental Health Professionals Serving as Expert Witnesses in Matters Relating to the Criminal Responsibility Of Accused Persons and Related Matters

1. Preamble

To relate the various professional and ethical duties and responsibilities conferred upon mental health professionals performing assessments for purposes of enquiries into the capacity of accused persons to understand proceedings and the criminal responsibility of accused persons, and to clarify the subsequent role of forensic mental health professionals presenting expert opinions in respect of the aforesaid assessments for legal purposes.

2. Definitions

In this Code, unless the context otherwise indicates, the following definitions are ascribed to the following terms:

<i>“Act”</i>	The Criminal Procedure Act, No 51 of 1977.
<i>“criminal responsibility”</i>	As defined in terms of Section 78(1) of the Act.
<i>“expert witness”</i>	A witness, who by virtue of his or her specialised training, skill or experience is deemed to have acquired specialised knowledge in a specific field of expertise to a sufficient degree enabling such witness by virtue of such specialised knowledge, training and experience to render an opinion as to

a particular fact or facts in issue and if required, to present expert testimony in support of such opinion in a court of law with the inherent aim of assisting the trier of fact in the determination of such fact or facts in issue;

“forensic psychiatry”

A sub-speciality of psychiatry encompassing the interaction between law and psychiatry applying scientific and clinical entities within the legal context with specific reference to criminal proceedings and matters relating to the criminal responsibility of accused persons and acting as a psychiatric expert on explicitly psycho-legal issues in direct assistance to courts, correctional and forensic mental health facilities.

“forensic psychiatrist”

A psychiatrist sufficiently trained in and who regularly engages in the practice of forensic psychiatry.

“forensic psychology”

A sub-speciality of psychology concerned with the collection, assessment and presentation of psychological evidence for judicial and legal purposes with reference to the application of psychological theory and skills to the understanding and functioning of the legal and criminal justice system, pertaining specifically to matters of a psycho-legal nature in direct assistance to courts, correctional and forensic mental health facilities.

“forensic psychologist”

A psychologist sufficiently trained in and who regularly engages in the practice of forensic psychology.

“forensic mental health professional”

A forensic psychiatrist and forensic psycho-psychologist, unless expressly otherwise indicated.

3. Scope

- 3.1 The Code of Professional and Ethical Conduct is specifically designed as a model of desirable professional and ethical conduct by forensic mental health professionals when they are regularly engaged as expert witnesses and accordingly represent themselves as such in activities directed primarily at providing professional forensic mental health expertise to the judicial system in matters relating to the capacity of accused persons to understand legal proceedings or matters relating to the criminal responsibility of accused persons.
- 3.2 These guidelines by no means deny its applicability to other related criminal matters such as its use within correctional and other related forensic mental health settings.
- 3.3 These guidelines should be adhered to in accordance with the *Ethical and Professional Rules of the Health Professions Council of South Africa as promulgated in Government Gazette R717/2006*.
- 3.4 These guidelines by no means purport to be all encompassing and as such address essential duties and responsibilities of forensic mental health professionals serving as expert witnesses in matters relating to the capacity of accused persons to understand proceedings as well as the criminal responsibility of accused persons.
- 3.5 These guidelines were drafted in consultation with the *Ethics Guidelines for the Practice of Forensic Psychiatry* by the American Academy of Psychiatry and the Law as well as the *Specialty Guidelines for Forensic Psychologists* by the American Psychology – Law Society.
- 3.6 These guidelines should be construed and interpreted in conjunction with Sections 77, 78 and 79 of the Act.

4. Duties and Responsibilities

- 4.1 Forensic mental health professionals have an obligation to execute their services in accordance with the highest standards of their profession.
- 4.2 Forensic mental health professionals should take reasonable steps to ensure that their services are used in a responsible fashion especially when serving as expert witnesses.
- 4.3 Forensic mental health professionals shall take reasonable steps to

ensure that evidence relating to assessments conducted or procedures applied will be of such quality as to assist the trier of fact in the determination of the issues, whether it be the capacity of the accused to understand the proceedings or the criminal responsibility of an accused person.

- 4.4 Forensic mental health professionals shall ensure that evidence or opinions advanced are directly related or substantially related to the specific issues before the court and as such establish a causal relation between the opinion advanced and the specific issues, whether it be the capacity to understand proceedings or the criminal responsibility of an accused person.
- 4.5 Forensic mental health professionals accept that when acting as expert witnesses, their overriding obligation and duty is to the court which duty overrides any obligation to the person or authority, whether the instructing person or authority or any other party in whatever capacity.
- 4.6 Forensic mental health professionals serving as expert witnesses and in addition providing an opinion in matters relating to the capacity of accused persons to understand proceedings or the criminal responsibility of accused persons, or both, shall as far as possible ensure that such testimony is premised upon sufficient facts or data; the testimony is the result of reliable procedures and methods; and consequently that the forensic mental health professional has applied the procedures and methods reliably to the facts of the specific case.
- 4.7 Forensic mental health professionals shall during the assessment of the reliability of procedures and methods applied, have due regard of the following criteria:
 - 4.7.1 Whether such procedures, methods or techniques have been tested;
 - 4.7.2 Whether such procedures, methods or techniques have been subjected to stringent peer review and publications;
 - 4.7.3 The extent of or known potential error rate associated with such procedures, methods or techniques;
 - 4.7.4 Whether such methods or procedures enjoy general acceptance within the scientific discourse where similar methods and

procedures are employed.

- 4.8 Forensic mental health professionals shall clearly disclose the facts or data upon which their opinion is based when serving as expert witnesses.
- 4.9 Testimony by forensic mental health professionals contextualised in the form of an opinion or inference which would otherwise be admissible, shall not be objectionable merely as a result of the fact that such opinion embraces the issue relating to the mental state or condition of an accused person, and as such embraces an ultimate issue to be decided by the trier of fact, provided that such forensic mental health professional has due regard to the professional boundaries of his or her profession, competence and experience.
- 4.10 Expert evidence presented by forensic mental health professionals shall constitute the independent product of the forensic mental health professional, uninfluenced by whichever means as to form or content.
- 4.11 Forensic mental health professionals shall provide independent assistance to the judicial authority and thus to the court by means of an objective, unbiased and impartial expert opinion.
- 4.12 A forensic mental health professional shall clearly indicate when a particular question or issue falls beyond his or her field of expertise.
- 4.13 In the event of a forensic mental health professional's opinion not being adequately researched due to insufficient data being available, such fact shall be clearly expressed and such opinion advanced shall be deemed a provisional opinion.

5. Competence and Qualifications

- 5.1 Forensic mental health professionals shall claim expertise only in relation to areas of actual specialised knowledge, skills, training, and experience.
- 5.2 Forensic mental health professionals shall, when presenting expert opinions, forensic reports or testimony, disclose their qualifications correctly, truthfully and precisely.
- 5.3 Forensic mental health professionals have an obligation to disclose to the court the boundaries of their competence and/or qualifications and

the relation of such boundaries to the specific matters in issue.

- 5.4 Forensic mental health professionals are responsible for an essential and reasonable degree of knowledge and comprehension of the various legal and professional standards regulating their participation and engagement as expert witnesses in legal proceedings.

6. Confidentiality and Privilege

- 6.1 Forensic mental health professionals have an obligation to be alert to the legal standards which may impact on or limit the confidentiality or privilege that may be associated with or connected to their services as forensic mental health professionals.
- 6.2 Forensic mental health professionals shall timeously inform an evaluatee as to an assessment as well as all other collateral sources of the anticipated limitations pertaining to confidentiality and privilege prevalent within a forensic relationship.
- 6.3 Forensic mental health professionals, to the extent applicable, shall inform an evaluatee to an assessment that such forensic mental health professional is not the evaluatee's "doctor" or "therapist" or "treating clinician".
- 6.4 Forensic mental health professionals shall to the extent possible, maintain confidentiality and only disclose information bearing upon the legal purpose of the assessment or evaluation.

7. Informed Consent

- 7.1 Forensic mental health professionals shall at the outset of an assessment, inform the evaluatee of the nature and scope of the assessment and limits of its confidentiality. The informed consent of an evaluatee to the forensic assessment shall be obtained as soon as possible.
- 7.2 Forensic mental health professionals shall inform an evaluatee that refusal to cooperate to an assessment will be duly noted in a forensic report and/or conveyed in a subsequent testimony.
- 7.3 In the event of an evaluatee not comprehending the information provided pertaining to the assessment, the forensic mental health professional

shall note such fact in any forensic report and/or convey such fact in subsequent testimony.

8. Honesty and Objectivity

- 8.1 When functioning as expert witnesses within the legal process, forensic mental health professionals shall adhere to the principle of honesty and should strive towards objectivity.
- 8.2 Forensic mental health professionals shall enhance the honesty and objectivity of their opinions by basing their opinions, forensic reports and subsequent forensic testimony on all available data and information.
- 8.3 Forensic mental health professionals shall take cognisance of the fact that their essential role as expert witnesses is to assist the trier of fact to understand the evidence or to assess a fact in issue and as such their own professional observations, deductions, inferences and conclusions should be distinguished from legal facts, opinions, inferences and conclusions.

9. Relationships

- 9.1 Forensic mental health professionals shall inform legal representatives seeking their services in respect of a potential evaluatee of any fact or facts which might impact on the proposed forensic relationship with due regard to prior and/or current personal or professional relationships that might result in a conflict of interests.
- 9.2 Forensic mental health professionals shall to the extent possible, refrain from acting as expert witnesses for patients with whom they are engaged in a treatment relationship or with whom they have any other personal or professional relationship.
- 9.3 In circumstances where the assumption of a dual relationship becomes unavoidable, regard shall be had by the forensic mental health professional to the essential differences between clinical and legal obligations and the negative impact of such dual relationships on confidentiality and the process of treatment and evaluations.

- **Proposal 2**

Selected amendments should be effected in respect of Sections 78 and 79 of the Criminal Procedure Act.

- **Draft Amendment Bill**

CRIMINAL MATTERS AMENDMENT ACT No. 1 of 2011

(ASSENTED TO) (DATE OF COMMENCEMENT:)

(English text signed by the President)

To amend the Criminal Procedure Act, 1977, so as to further regulate the referral of an accused for enquiry regarding the criminal responsibility of that accused concerning the offence with which he or she is charged, and to provide for matters connected therewith.

1. *Section 78(1) of the Criminal Procedure Act 51 of 1977 is amended as follows:*

"(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 or any other cause 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."

2. *Section 78(1C) is inserted after Section 78(1B) of the Criminal Procedure Act 51 of 1977 providing as follows:*

"Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the party who raises such issue shall establish a sufficient foundation in support of such contention which foundation shall be supported by efficient and adequate evidence, including forensic medical evidence."

3. *Section 78(2) of the Criminal Procedure Act is amended as follows:*
“If it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other cause not criminally responsible for the offence charged, or it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79.”

4. *Section 78(7) of the Criminal Procedure Act is amended as follows:*
“If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act, but that his or her capacity to appreciate the wrongfulness of the act was diminished by reason of mental illness or mental defect or for any other cause, the court may take the fact of such diminished responsibility into account when sentencing the accused.”

5. *Section 79(1)(b) is amended as follows:*
“79(1) Where a court issues a direction under Section 77(1) or 78(2), the relevant enquiry shall be conducted and
 - (a) be reported on –
 - (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 forensic psychiatrist appointed by such medical superintendent at the request of the court;
 - (ii) by a forensic psychiatrist appointed by the court and who is not in the full-time service of the State;

- (iii) by a forensic psychiatrist appointed for the accused by the court; and
- (iv) by a forensic psychologist where the court so directs.”

6. *Short title and commencement*

“This Act shall be called “Criminal Matters Amendment Act, 2011”, and shall come into operation on a date fixed by the President by proclamation in the Gazette.”

6 Possible criticisms and *lacunae* in respect of research

The theme of the current study represents an area where consensus has not been achieved and in terms of the recommendations enunciated in this study, the researcher acknowledges the possibility of criticisms being raised from various sources. Not all criminal practitioners acknowledge the pivotal role of expert evidence in support of the defence of criminal incapacity. More often than not mental health professionals not adequately trained or with a lack of experience testify in cases where the defence of criminal incapacity is raised as a defence, ultimately resulting in negativity, scepticism and criticisms levelled against the ability of mental health professionals to testify in support of the defence of criminal incapacity.

Each and every case where the defence of criminal incapacity is raised as a defence will differ from the previous case in the sense that no two accused persons even in the event of both having suffered from the same mental disorder at the time of the commission of the offence, will ever react precisely similar during a forensic assessment. Due to the latter dissimilarities in the outcome of assessments, trust is often lost in the reliability of the validity of assessments as no precise hard and fast rule can be applied in each and every case. The outcomes and results of assessments will differ with due regard to malingering, the specific tests and procedure employed by the specific mental health professionals as well as the possibility of “human error”. Scepticism levelled against the defence of criminal incapacity *per se* leads to

the concomitant distrust and negativity levelled towards expert evidence advanced in support thereof.

In particular, the following selected aspects could lead to criticism and *lacunae* in respect of the research undertaken in this study:

- Limited literature pertaining to cost implications of referrals for observations in the different mental health institutions;
- Limited research pertaining to the effectiveness of assessment procedures within mental health institutions;
- Supporters of the traditional approach in respect of expert evidence may still adhere to the argument that expert evidence does not fulfil an indispensable function;
- Lack of an in-depth analysis of the criticisms levelled towards the scientific reliability and validity of psychiatric diagnoses;
- Limited research pertaining to judicial perceptions of the role of expert evidence in support of the defence of criminal incapacity;
- Limited literature pertaining to the assessment of scientific reliability and validity of expert opinion within the South African context;
- Limited information pertaining to the effectiveness of tests and procedures employed by forensic mental health professionals during the forensic assessment.
- Limited reflections on the role of expert evidence in cases where criminal incapacity is raised as a defence, from the prosecution's perspective.

The purpose of this study was fundamentally to illustrate the essential and pivotal role of expert evidence in support of the defence of criminal incapacity. The realisation that expert evidence by forensic mental health professionals can play a significant role in support of the defence of criminal incapacity is proclaimed in the research enunciated in this study, in spite of the probable factors mentioned in the paragraph above.

7 Implications and possibilities for further research

The current study should by no means be construed as an all-encompassing exposition of the complete spectrum of the role of expert evidence within our current criminal justice system. The author proposes the following additional aspects relevant for purposes of further research:

- The role of expert evidence by forensic mental health professionals during sentencing;
- The role of forensic psychiatry in the prediction of future dangerousness in dangerous criminals;
- The admissibility of expert evidence concerning psychological syndromes;
- The protection and recognition of fundamental constitutional rights of accused persons whilst detained in mental institutions;
- The role of expert evidence in support of the defence of criminal incapacity raised by youthful offenders and accordingly the impact of youthfulness on criminal capacity;
- The role of expert evidence in respect of battered spouse or partner syndrome evidence advanced in support of the defence of criminal incapacity also from the male perspective;
- The impact of therapeutic jurisprudence on the defence of criminal incapacity and the concomitant role of expert evidence;
- The role of neuropsychiatry and the neurosciences in explaining criminal incapacity and criminal behaviour;
- The role of mental illness in children and youthful offenders;
- Research pertaining to the specific circumstances within mental hospitals designated for purposes of assessment and whether such circumstances constitute human rights infringements;
- The effectiveness of specific tests and procedures utilised for purposes of the forensic assessment and its impact on the defence of criminal incapacity.

8 Synthesis

The current study of the role of expert evidence in support of the defence of criminal incapacity was embarked upon in order to expose the intrinsic anomalies associated with the application of the defence of criminal incapacity. It sought to indicate that the approach followed in respect of the role and essential need for expert evidence has been inconsistent and clouded with controversy.

A further aim was to indicate that the role of the forensic mental health professional in the ultimate analysis and assessment of this defence has been largely neglected.

The fundamental cornerstone to the defence of criminal incapacity – the forensic mental health professional – has been overlooked and underestimated partially as a result of the semantic distinction drawn between non-pathological and pathological criminal incapacity rendering the proof of the defence of criminal incapacity problematic, controversial and inconsistent. The time has arrived for a proactive approach in respect of the defence of criminal incapacity. The current study proposed possible recommendations and proposals aimed at enhancing the application of the defence of criminal incapacity.

Proposing reform which is limited to legislative reform would perhaps be an overly conservative approach as improving the role of expert evidence in support of the defence of criminal incapacity extends far beyond legislation alone. It essentially encompasses a process by which two oceans are brought together in an attempt to harmonise the interaction between law and medicine by improving the dialogue between these two professions in order to enhance the application of the defence of criminal incapacity.

Only by means of proper recognition of the fundamental and essential role of expert evidence in support of the defence of criminal incapacity in conjunction with appropriate rules of ethical and professional conduct for mental health

professionals serving as expert witnesses in support of the defence of criminal incapacity, can the hope be expressed of the ultimate harmonisation of the conceptual interface between law and medicine when the defence of criminal incapacity falls to be assessed:

“Perhaps many of the lovers’ quarrels or power struggles are more semantic than anything else. However, whatever the case might be, for the sake of fairness and justice it is of utmost importance that the two lovers should sit down on a regular basis, discussing the weak and strong points of each other. This will not only lead to solutions but to a better general understanding of the other, but also to the long awaited embrace – and especially healthy offspring”.⁷

⁷ Gillmer, BT, Louw, DA and Verschoor, T “Law and Psychology: An exploration of the conceptual interface” (1997) SACJ 19-32 at 32.

BIBLIOGRAPHY

BOOKS

Africa, A (2005) "Psychological evaluations of mental state in criminal cases" *in* Tredoux, C *et al* (2005) "Psychology and Law"

Allan, A (2005) "The psychologist as expert witness" *in* Tredoux, C *et al* (2005) "Psychology and Law"

Allan, A and Meintjes-Van der Walt, L (2006) "Expert evidence" *in* Kaliski, S (ed.) (2006) "Psycho-legal assessment in South Africa"

Alsdurf, J and Alsdurf, P (1989) "Battered into submission – the tragedy of wife abuse in the Christian home"

American Psychiatric Association (1994) "Diagnostic and statistical manual of mental disorders – DSM-IV"

American Psychiatric Association (2000) "Diagnostic and statistical manual of mental disorders – DSM-IV-TR" (text revision)

Arrigo, BA and Shipley, SL (2005) "Introduction to Forensic Psychology: issues and controversies in law, law enforcement and corrections" 2nd ed.

Arrigo, CEA (2002) "Punishing the mentally ill: a critical analysis of law and psychiatry"

Barlow, DH and Durand, VM (1995) "Abnormal psychology: an integrative approach"

Barnett, OW and LaViolette, AD (1993) "It could happen to anyone – why battered women stay"

Bartol, CR (1991) "Criminal behavior – a psychosocial approach" 3rd ed.

Bartol, CR and Bartol, AM (2005) "Criminal behavior: a psychosocial approach" 7th ed.

Bean, P (2008) "Madness and crime"

Bekker, PM *et al* (2007) "Criminal procedure handbook" 8th ed.

Bentham, A (1925) "Treatise on judicial evidence" *in* Freckelton, I and Selby, H (2005) "Expert evidence"

Bergenthuin, JG (1985) "Provokasie as verweer in die Suid-Afrikaanse strafreg" (Unpublished LLD thesis University of Pretoria)

Berlin, FS *et al* (2009) "Mental illness and sex offending" *in* Saleh, FM *et al* (eds.) (2009) "Sex offenders"

Black, HC (1990) "Black's Law Dictionary" 6th ed.

Blau, T (1998) "The psychologist as expert witness"

Bleiberg, KL and Markowitz, JC (2008) "Interpersonal psychotherapy for depression" *in* Barlow, DH (2008) "Clinical handbook of psychological disorders"

Bluglas, R and Bowden, P (1990) "Principles and practice of forensic psychiatry"

Bond, C *et al* (2007) "The expert witness: a practical guide"

Bond, C *et al* (1999) "The expert witness in court – a practical guide"

Bondi, MW *et al* (1996) "The neuropsychology of dementia" *in* Grant, I and Adams, KM (1996) "Neuropsychological assessment of neuropsychiatric disorders"

Booyesen, WH (chair)(1994) “Commission of Enquiry into the Continued Inclusion of Psychopathy and Other Violent Offenders – interim report”

Bradsky, SL *et al* (2002) “The mental health professional in court” *in* Van Dorsten, B (ed.)(2002) “Forensic psychology”

Brakel, SJ and Brooks, AD (2001) “Law and psychiatry in the criminal justice system”

Brodsky, SL (1999) “The expert expert witness – more maxims and guidelines for testifying in court”

Brodsky, SL and Poythress, NG (1985) “Expertise on the witness stand” *in* Ewing, CP (ed.)(1985) “Psychology, psychiatry and the law”

Brody, BA and Engelhardt, HT (1980) “Mental illness: law and public policy”

Bromberg, W (1969) “Psychiatrists in court – the psychiatrists’ view”

Bronstein, DA (1999) “Law for the expert witness”

Brown, A (1987) “When battered women kill”

Bruyn, GW *et al* (1979) “Huntington’s chorea: current neuropathological status” *in*

Chase, T *et al* (1979) “Advances in neurology: Huntington’s disease”

Burchell, EM and Hunt, PMA (1983) “South African criminal law and procedure – general principles of criminal law”

Burchell, EM and Hunt, PMA (1997) “South African criminal law and procedure – general principles of criminal law” vol 1, 3rd ed.

Burchell, J and Milton, J (2005) “Principles of criminal law” 3rd ed.

Burchell, J and Milton, J (2007) "Cases and materials on criminal law" 3rd ed.

Caine, ED and King, DA (1996) "Cognitive impairment and major depression" *in* Grant, I and Adams, KM (eds.)(1996) "Neuropsychological assessment of neuropsychiatric disorders"

Card, R (2004) "Criminal law" 3rd ed.

Carson, D *et al* (ed.)(2007) "Applying psychology to criminal justice"

Carstens, PA (1996) "Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid" (Unpublished LLD thesis University of Pretoria)

Carstens, PA and Pearmain, D (2007) "Foundational principles of South African Medical Law"

Cavenar, JO and Brodie, HKH (1983) "Signs and symptoms in psychiatry"

Cheadle, MH *et al* (2002) "South African constitutional law: the bill of rights"

Chiswick, D (2001) "Forensic psychiatry" *in* Mason, JK (2001) "Forensic medicine for lawyers" 4th ed.

Cleckley, HM (1982) "The mask of sanity" 6th ed.

Comer, RJ (2008) "Fundamentals of abnormal psychology" 5th ed.

Committee on Psychiatry and Law (1991) "The mental health professional and the legal system"

Constantino, MJ *et al* (2006) "Adult depression" *in* Plante, TG (ed.)(2006) "Mental disorders of the new millennium: vol. 1: behavioral issues"

Cordozo, BN (1928) *in* Allen, RC *et al* (1968) “Readings in law and psychiatry”

Cox, M and Theilgaard, A (1994) “Shakespeare as prompter – the amending imagination and the therapeutic process”

Curran, WJ (1980) “Courtroom presentation of forensic scientific evidence” *in* Curran, WJ *et al* (eds.)(1980) “Modern legal medicine, psychiatry and forensic science”

Currie, I and De Waal, J (2005) “The Bill of Rights handbook” 5th ed.

Dahl, PR (1985) “Legal and psychiatric concepts and the use of psychiatric evidence in criminal trials”

Davies, G *et al* (2008) “Forensic Psychology”

Davis, D *et al* (1997) “Fundamental rights in the Constitution – commentary and cases”

De Villiers, DS (2007) “Evidence through the cases” 3rd ed.

De Waal, J *et al* (2001) “The Bill of Rights handbook” 4th ed.

De Waal, J *et al* (2005) “The Bill of Rights handbook” 5th ed.

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

De Wet, JC and Swanepoel, HL (1960) “Die Suid-Afrikaanse Strafreg” 2nd ed.

Delisle, R and Stuart, D (2001) “Evidence: principles and problems”

Dennis, I (2007) “The law of evidence” 3rd ed.

Dennison, S (2007) "Criminal responsibility" *in* Carson, D (ed.) *et al* (2007) "Applying psychology to criminal law"

Dershowitz, AM (1994) "The abuse excuse – and other cop-outs, sob stories and evasions of responsibility"

Devenish, GE (1998) "A commentary on the South African Constitution"

Devenish, GE (2005) "The South African Constitution"

"Diagnostic and Statistical Manual of Mental Disorders" DSM-IV 4th ed.

Diamond, BL (1990) "The psychiatric expert witness" *in* Rosner, R and Weinstock, R (1990) "Ethical practice in psychiatry and the law"

Dobash, RE and Dobash, RP (1979) "Violence against wives"

Dobash, RE and Dobash, RP (1992) "Women, violence and social change"

Dressler, J (2001) "Understanding Criminal Law"

Du Toit, E *et al* (2007) "Commentary on the Criminal Procedure Act"

Dughard, CJR (1967) "Whither insane automatism?"

Dutton, DG (1998) "The abusive personality – violence and control in intimate relationships"

Dutton, DG (2007) "The abusive personality – violence and control in intimate relationships" 2nd ed.

Dziegielewski, SF (2002) "DSM-IV-RR in action"

Ewing, CP (1987) “Battered women who kill – psychological self-defence as legal justification”

Eysenok, HJ (1989) “Personality and criminality” in Laufer, WS and Adler, F (1989) “Advances in criminology theory”

Faigman, D (2003) “Expert evidence” in Carson, D and Bull, R (2003) “Handbook of psychology in legal contexts”

Faulk, M (1994) “Basic forensic psychiatry” 2nd ed.

Faurie, A (2000) “The admissibility and evaluation of scientific evidence in court” (Unpublished LLM thesis University of South Africa)

Fesch, EA (1980) “Psychology and psychiatry in courts and corrections: controversy and change”

Finkel, NJ (1988) “Insanity on trial”

First, MB *et al* (2002) “DSM-IV-TR: handbook of differential diagnosis”

Flemming, J (1979) “Stopping wife abuse”

Forward, S (2002) “Men who hate women and the women who love them”

Fradella, HF (2007) “From insanity to diminished capacity”

Freckelton, I and Selby, H (1999) “Expert evidence in criminal law”

Freckelton, I and Selby, H (2005) “Expert evidence – law, practice, procedure and advocacy”

Gelles, RJ and Strauss, MA (1988) “Intimate violence: the definitive study of causes and consequences of abuse in the American family”

Glueck, S (1962) “Law and Psychiatry – cold war or *entente cordiale*”

Gold, L (2004) “Evidence: a structural approach”

Golding, SL *et al* (1999) “The assessment of criminal responsibility” *in* Hess, K and Weiner, IB (eds.)(1999) “The handbook of forensic psychology”

Goodwin, DW and Guze, SB (1989) “Psychiatric diagnosis”

Gorman, WF (1983) “Are there impartial expert psychiatric witnesses?”

Graham, DLR *et al* (1994) “Loving to survive: sexual terror – men’s violence and women’s lives”

Graham, MH (1981) “Federal rules of evidence”

Graham, MH (1991) “Handbook of federal evidence”

Graycar, R and Morgan, J (1996) “Including gender issues in the Core Law Curriculum Project” *in* Stubbs, J (1996) “Self-defence and defence of others”

Greig, DN (2002) “Neither bad nor mad: the competing discourses of psychiatry, law and politics”

Group for the Advancement of Psychiatry (1991) “The mental health professional and the legal system”

Gudjonsson, GH and Howard, LRC (1998) “Forensic Psychology: a guide to practice”

Gunn, J and Taylor, PJ (1993) “Forensic Psychiatry – clinical, legal and ethical issues”

Gutheil, TG (2002) “Assessment of mental state at the time of the criminal offense”
in Simon, RI and Shuman, DW (eds.)(2002) “Retrospective assessment of mental
states in litigation”

Gutheil, TG (2006) “Psychiatric expert witnesses in the new millennium”

Gutheil, TG and Simon, RI (2002) “Mastering forensic psychiatric practice –
advanced strategies for the expert witness”

Gutheil, TG and Appelbaum, PS (2000) “Clinical handbook of psychiatry and the
law”

Gutheil, TG and Simon, RI (2002) “Mastering forensic psychiatric practice –
advanced strategies for the expert witness”

Gutheil, TG *et al* (1991) “Decision making in psychiatry and law”

Guttmacher, MS (1968) “The role of psychiatry in law”

Guze, S (1976) “Criminality and psychiatric disorders”

Halleck, SL (1980) “Law in the practice of psychiatry – a handbook for clinicians”

Hammen, C and Watkins, E (2008) “Depression”

Harris, T (1989) “The silence of the lambs”

Hazelwood, R and Michaud, SG (2001) “Dark dreams”

Health Professions Council of South Africa (2006) “Ethical Rules of Conduct for
Practitioners registered under the Health Professions Act, 1974 chapter 7” *in*
Government Gazette no 29079, GNR 717, 4 August 2006, p. 24.

Health Professions Council of South Africa (2007) “Confidentiality, protecting and providing information – ethical guidelines”

Herman, JL (1992) “Trauma and recovery”

Hess, AK and Weiner, IB (1999) “The handbook of forensic psychology” 2nd ed.

Hiemstra, VG (1986) “Suid-Afrikaanse Strafproses” 4th ed.

Hoffmann, LH (1963) “South African law of evidence”

Hoffmann, LH and Zeffertt, DT (1988) “The South African law of evidence”

Hogget, B (1976) “Mental health”

Horder, J (1992) “Provocation and responsibility”

Howitt, D (2005) “Introduction to forensic and criminal psychology” 2nd ed.

Hughes, MJ and Jones, L (2000) “Women, domestic violence, and posttraumatic stress disorder”

Imwinkelried, EJ (1983) “The standard for admitting scientific evidence”

International Association of Defence Counsel (2000) “Challenging expert witness testimony”

Johann, SL and Osanka, F (1989) “Representing...battered women who kill”

Jones, DW(2008) “Understanding criminal behaviour – psychosocial approaches to criminality”

Jorg, N *et al* (1995) “Criminal justice in Europe: a comparative study”

- Joubert, WA and Faris, JA (2004) "The Law of South Africa" vol 6 2nd ed.
- Kaliski, SZ (2006) "Psycholegal assessment in South Africa"
- Kantor, M (1992) "Diagnosis and treatment of the personality disorders"
- Karsten, C (2007) "Dodelike vroue: wanneer passie in bloed eindig"
- Keane, A (2006) "The modern law of evidence"
- Kelly, L and Radford, J (1998) "Sexual violence against women and girls" *in*
Dobash, RE and Dobash, RP (1998) "Rethinking violence against women"
- Kendall, PC and Hammen, C (1995) "Abnormal psychology"
- Kermani, E (1989) "Handbook of psychiatry and the law"
- Kisker, SW (1964) "The disorganised personality"
- Kiely, T (2001) "Forensic evidence: science and the criminal law"
- Kriegler, J and Kruger, A (2009) "Hiemstra's criminal procedure"
- Kriegler, J and Kruger, A (2007) "Hiemstra – Suid-Afrikaanse strafprosesreg 6th
ed.
- Kruger, A (1980) "Mental health law in South Africa"
- Kruger, A (2008) "Hiemstra's criminal procedure"
- LaBruzza, AL and Mendez-Villarubia, JM (1994) "Using DSM-IV: a clinician's
guide to psychiatric diagnosis"

Lambrechts, H (2005) “n Ondersoek na nie-patologiese ontoerekeningsvatbaarheid en die regverdiging vir die voortbestaan van gesonde outomatisme en aanverwante verwerre in die Suid-Afrikaanse strafreg” (Unpublished LLD thesis University of the Free State)

Lansdown, AV and Campbell, J (1982) “South African criminal law and procedure”

Lay, S (2006) *in* Kaliski, SZ “Psycholegal assessment in South Africa”

Le Roux, J (1994) “Geweldsmisdade binne huweliksverband” (Unpublished LLD thesis University of Pretoria)

Lerner, PM (2004) “Dissociative identity disorder” *in* Weiner, IB (ed.) (2004) “Adult psychopathology – case studies”

Louw, R (2006) “Principles of Criminal Law: pathological and non-pathological criminal incapacity” *in* Kaliski, SZ (2006) “Psycholegal assessments in South Africa”

Ludsin, H (2003) “Legal defences for battered women who kill their abusers: discussion document I [Research report written for the Centre for the Study of Violence and Reconciliation]

Ludsin, H (2003) “South African Criminal Law and battered women who kill: discussion document II” [Research report written for the Centre for the Study of Violence and Reconciliation]

Ludsin, H and Vetten, L (2005) “Spiral of entrapment”

MacDonald, JM (1976) “Psychiatry and the criminal” 3rd ed.

MacFarlane, JD (2003) “Criminal defence in cases of infanticide and neonaticide” *in* Spinelli, MG (ed.) (2003) “Infanticide – psychosocial and legal perspectives on mothers who kill”

Madalo, MJ (2000) “Towards a standard for the admissibility and evaluation of psychiatric evidence in war crimes prosecutions” (Unpublished LLM dissertation Georgetown University Law Centre)

Madikizela, PG and Foster, D (2005) “Psychology and human rights” *in* Tredoux, C *et al* (2005) “Psychology and Law”

Martin, D (1976) “Battered wives”

Marvasti, J (2004) “Psychiatric treatment of sexual offenders”

Mason, JK (2001) “Forensic medicine for lawyers” 4th ed.

McAuley, F (1993) “Insanity, psychiatry and criminal responsibility”

McHugh, PR and Folstein, MF (1975) “Psychiatric syndromes of Huntington’s chorea” *in* Benson, DF and Blumer, D (1975) “Psychiatric aspects of neurologic disease”

Meerloo, JAM (1956) “The rape of the mind: the psychology of thought control, menticide, and brainwashing”

Meintjes-Van der Walt, L (2001) “Expert evidence in the criminal justice process”

Melton, GB *et al* (2007) “Psychological evaluations for the courts – a handbook for mental health professionals and lawyers” 3rd ed.

Memon, A *et al* (2003) “Psychology and law – truthfulness, accuracy and credibility”

Meyer, CL and Spinelli, MG (2003) “Medical and legal dilemmas of postpartum psychiatric disorders” *in* Spinelli, MG (ed.) (2003) “Infanticide – psychosocial and legal perspectives on mothers who kill”

Meyer, RG *et al* (1988) “Law for the psychotherapist”

Miller, F *in* Horder, J (1992) “Provocation and responsibility”

Moenssens, AA *et al* (1973) “Scientific evidence in criminal cases”

Monahan, J and Steadman, HJ (1983) “Crime and mental disorder” *in* Tonry, M and Morris, N (eds.)(1983) “Crime and Justice”

Monahan, J and Steadman, HJ (1983) “Mentally disordered offenders”

Monahan, J and Walker, L (1990) “Social Science and Law: cases and materials” 2nd ed.

Monroe, RR (1966) “The psychiatric examination” *in* Slovenko, R (ed.)(1966) “Crime, law and corrections”

Moriarty, JC (ed.)(2001) “The rule of mental illness in criminal trials”

Moore, D (1979) “Battered women”

Morris, E (2003) “Technique in litigation”

Mueser, KT and Gingerich, S (1994) “Coping with schizophrenia”

Mullins, J and Da Silva, C (2010) “Morris technique in litigation” 6th ed.

Murphy, P (2008) “Murphy on evidence” 10th ed.

National Task Team on ICD-10 Implementation (2006) “ICD-10 implementation review: January 2004 – October 2006”

Nel, PW (2008) “Toerekeningsvatbaarheid in die Suid-Afrikaanse strafreg” (Unpublished LLM dissertation University of Pretoria)

O’Brien, K (1999) “Forensic psychiatry: criminal issues” *in* Freckelton, I and Selby, H (1999) “Expert evidence in criminal law”

O’Donohue, W *et al* (2007) “Personality disorders – toward the DSM-V”

Okun, L (1986) “Woman abuse: facts replacing myths”

Oosthuizen, H (1990) “’n Regsvergelykende ondersoek na verhoorbaarheid” (Unpublished LLD thesis University of the Free State)

Oxford Concise Medical Dictionary (1998) 5th ed.

Oxford Dictionary of Law (2006) 6th ed

Paciocco, DM (2005) “The law of evidence”

Patrick, CJ (2007) “Antisocial personality disorder and psychopathy” *in* O’Donohue, W *et al* (2007) “Personality disorders”

Patterson, D (2000) “Challenges to expert testimony pre- and post-Daubert” *in* Linder, RK *et al* (2000) “Challenging expert witness testimony”

Perlin, ML (1977) “The legal status of the psychologist in the courtroom”

Peskin, SG (ed.) (1978) “Macbeth – William Shakespeare”

Peter, LP (2006) “Domestic violence” *in* Kaliski, SZ (2006) “Psycholegal assessment in South Africa”

Pistorius, M (2004) “Fatal females – women who kill”

Power, DJ *et al* (1996) "Criminal law and forensic psychiatry"

Radford, L (1998) "Pleading for time: justice for battered women who kill" *in*

Bridgeman, J and Millns, S (1998) "Feminist perspectives on law: laws engagement with the female body"

Ray, I (1962) "A treatise on the medical jurisprudence of insanity"

Reddi, M (2007) "Violence against women" *in* Hooctor, SV and Schwikkard, PJ (eds.)(2007) "The exemplary scholar: essays in honour of John Milton"

Redmayne, M (2001) "Expert evidence and criminal justice"

Resick, PA *et al* (2008) "Posttraumatic stress disorder" *in* Barlow, DH (ed.)(2008) "Clinical handbook of psychological disorders"

Roche, P (1958) "The Criminal mind...a study of communication between the criminal law and psychiatry"

Rosenhan, DL and Seligman, MEP (1995) "Abnormal psychology"

Rothstein, PF *et al* (2006) "Evidence: cases, materials and problems"

Rubin, JG (1968) "The psychiatric report" *in* Allan, RC *et al* (1968) "Readings in law and psychiatry"

Rubin, S (1965) "Psychiatry and criminal law: illusions, fictions and myths"

"Rules of Conduct for Practitioners registered under the Health Professions Act, 1974" *in* GNR 717 of 4 August 2006

Rumpff Report (1967) "Report of the Commission of Inquiry into the responsibility of mentally deranged persons and related matters"

RP 69/1967

Ryan, C and Butters, N (1983) "Cognitive deficits in alcoholics" *in* Kissen, B and Begeiter, H (1983) "The pathogenesis of alcoholism" vol. 7

Sadock, BJ and Sadock, VA (2003) "Kaplan and Sadock's synopsis of psychiatry: behavioural sciences/clinical psychiatry" 9th ed.

Sales, BD and Elwork, A (1980) "Issues in training forensic psychologists" *in* Cooke, G (ed.)(1980) "The role of the forensic psychologist"

Sales, BD and Shuman, DW (2005) "Experts in court: reconciling law, science and professional knowledge"

Sales, BD and Shuman, DW (2007) "Science, experts, and law: reflections on the past and the future" *in* Costanzo, M *et al* (eds.) (2007) "Expert psychological testimony for the courts"

Schapp, RF (1991) "Automatism, insanity and the psychology of criminal responsibility: a philosophical enquiry"

Schechter, H (2003) "The serial killer files – the who, what, where, how and why of the world's most terrifying murders"

Schefflin, AW and Opton, EM (1978) "The mind manipulators: a non-fiction account"

Schiffer, ME (1978) "Mental disorder and the criminal trial process"

Schmallegger, F (1996) 'Criminology today'

Schmidt, CWH (1998) "Bewysreg"

Schmidt, CWH and Rademeyer, H (2000) "Bewysreg" 4th ed.

Schneider, EM (1986) "Describing and changing: women's self-defence and the problem of expert testimony on battering" *in* Weisberg, K (1996) "Applications of feminist legal theory to women's lives"

Schopenhauer, A (1955) "The world as will and idea" *in* Barlow, DH and Durand, VM (1995) "Abnormal psychology: an integrative approach"

Schopp, RF (1991) "Automatism, insanity, and the psychology of criminal responsibility"

Schulte-Markwort, M *et al* (2003) "Cross-walks ICD-10-DSM-IV-TR – a synopsis of classifications of mental disorders"

Schwikkard, PJ "Insanity: the tenacious reverse onus, *in* Hoctor, S and Schwikkard, PJ (eds.)(2007) "The exemplary scholar: essays in honour of John Milton" 80

Schwikkard, PJ and Van der Merwe, SE (2002) "Principles of evidence"

Schwikkard, PJ and Van der Merwe, SE (2006) "Beginsels van die Bewysreg"

Schwikkard, PJ and Van der Merwe, SE (2009) "Principles of evidence" 3rd ed.

Shapiro, DL (1999) "Criminal responsibility evaluations"

Shapiro, DL (1991) "Forensic psychological assessment – an integrative approach"

Shorter Oxford English Dictionary (1992)

Simon, RI (1987) "Clinical psychiatry and the law"

Slovenko, R (1966) "Crime, law and corrections"

Slovenko, R (1995) "Psychiatry and criminal culpability"

Slovenko, R (2005) "Psychiatry and criminal culpability"

Slovenko, R (1973) "Psychiatry and law"

Slovenko, R (2002) "Psychiatry in law – law in psychiatry"

Slovenko, R (1998) "Psychotherapy and confidentiality"

Slovenko, R (1966) "Psychotherapy, confidentiality and privileged communication"

Slovenko, R (1990) "The role of the (psychiatric) expert in the judicial process" *in*

Rosner, R and Weinstock, R (1990) "Ethical practice in psychiatry and the law"

Smith, JC (2002) "Smith and Hogan Criminal Law" 10th ed.

Smith, JC (2005) "Smith and Hogan Criminal Law" 11th ed.

Snyman, CR (1995) "Criminal Law" 3rd ed.

Snyman, CR (2002) "Criminal Law" 4th ed.

Snyman, CR (2008) "Criminal Law" 5th ed.

Snyman, CR (2003) "Criminal Law casebook" 3rd ed.

Snyman, CR (2006) "Strafreg" 5th ed.

Snyman, JL (1981) "Die siviele opneming van geestesongesteldes: regte en regsbeskerming van die betrokke" (Unpublished LLD thesis University of South Africa)

South African Law Commission (1995) “The declaration and detention of persons as state patients under the Criminal Procedure Act 51 of 1977, and the discharge of such persons under the Mental Health Act 18 of 1973, including the burden of proof with regard to the mental state of an accused or convicted person” Project 89.

Sperry, L (2006) “Cognitive behavior therapy at DSM-IV-TR personality disorders”

Spitzer, RL *et al* (2002) “DSM-IV-TR; case book” (text revision) 4th ed.

Stark, E (2007) “Coercive control – how men entrap women in personal life”

Steyl, GC (1971) “Regters aan die woord”

Steytler, N (1998) “Constitutional criminal procedure – a commentary on the Constitution of the Republic of South Africa, 1996”

Stone, A (1976) “Mental health law: a system in transition”

Stone, MH (1998) “Healing the mind”

Strauss, A (1977) “A sociological perspective on the prevention and treatment of wifebeating” *in* Roy, M (1977) “Battered women: a psychological study of domestic violence”

Strauss, M *et al* (1980) “Behind closed doors: violence in the American family”

Strauss, SA (1991) “Doctor, patient and the law” 3rd ed.

Strauss, SA (1971) “Regsaspekte van geestesversteurdheid – legal aspect of mental disorder”

Strentz, T (1979) “The Stockholm syndrome: law, enforcement policy and ego defences of the hostage”

Styron, W (1990) “Darkness visible” in Hammen, C and Watkins, E (2008) “Depression”

Tapper, C (2007) “Cross and Tapper on evidence”

Tarrier, N (2008) “Schizophrenia and other psychotic disorders” in Barlow, DH (ed) (2008) “Clinical handbook of psychological disorders” 4th ed.

Taska, RJ and Sullivan, JL (1983) “Depression” in Cavenar, JO and Brodie, HKH (1983) “Signs and symptoms in psychiatry”

Taylor, K (2004) “Brainwashing: the science of thought control”

Taylor, PJ (1982) “Schizophrenia and violence” in Gunn, J and Farrington, DP (eds.) (1982) “Abnormal offenders, delinquency and the criminal justice system”

Tredoux, C *et al* (2005) “Psychology and law”

Van der Merwe, FW (1996) “Nie-patologiese ontoerekeningsvatbaarheid as verweer in die Suid-Afrikaanse strafreg” (Unpublished LLM dissertation University of South Africa)

Van der Schyff, G (2005) “Limitation of rights – a study of the European Convention and the South African Bill of Rights”

Van Kampen, PTC (1998) “Expert evidence compared”

Van Kraft-Ebing, R (1933) “Psychopathia sexualis: with especial reference to the antipathic sexual instinct: a medico-forensic study”

Visser, PJ and Mare, MC (1990) “Visser & Vorster’s general principles of criminal law through the cases” 3rd ed.

Volow, MR (1983) "Delirium, dementia and other organic mental disorders" *in* Cavenar, JO and Brodie, HKH (1983) "Signs and symptoms in psychiatry"

Vorster, M (2002) "An analysis of the amnesias with specific reference to 'non-pathological sane automatism'" (Unpublished PhD thesis University of Witwatersrand)

Walker, LE (1994) "Abused women and survivor therapy: a practical guide for the psychotherapist"

Walker, LE (1979) "The battered woman"

Walker, LE (1984) "The battered woman syndrome"

Walker, LE (1989) "Terrifying love – why battered women kill and how society responds"

Walker, LE (1984) "Women and mental health policy"

Wallace, D (1985) "The syndrome syndrome: problems concerning the admissibility of expert testimony on psychological profiles"

Weiner, IB (2004) "Adult psychopathology – case studies"

Weinstein, HC (1990) "The impartial expert" *in* Rosner, R and Weinstock, R (1990) "Ethical practice in psychiatry and the law"

Weisstub, DN (1980) "Law and psychiatry in the Canadian context"

Whitlock, FA (1963) "Criminal responsibility and mental illness"

Whitty, CWM and Zongwill, OL (1977) "Amnesia – clinical, psychological and medicolegal aspects" 2nd ed.

Widiger, TA *et al* (2006) “Dimensional models of personality disorders – refining research agenda for DSM-IV”

Wigmore, JH (1978) “Evidence in trials at common law”

Winstone, J and Pakes, F (2007) “The mentally disordered offender: disenablers for the delivery of justice” *in* Carson, D *et al* (ed.)(2007) “Applying psychology to criminal justice”

Wisner, KC *et al* (2003) “Postpartum disorders” *in* Spinelli, MG (ed.)(2003) “Infanticide – psychosocial and legal perspectives and mothers who kill”

Wolmarans, A (1986) “Die sielkundige as deskundige getuie in strafsake” (Unpublished masters dissertation in Clinical Psychology, University of Johannesburg)

Woo, SM and Keatinge, C (2008) “Diagnosis and treatment of mental disorders across the lifespan”

“World Book Medical Encyclopedia (1997) 7th ed.

Wright, F *et al* (1980) “Forensic psychology and psychiatry”

Zabow, T (2001) “Forensic psychiatry” *in* Dada, M and McQuoid-Mason, DJ (2001) “Introduction to medico-legal practice”

Zabow, T and Kaliski, SZ (2006) “Ethical considerations” *in* Kaliski, SZ “Psycholegal assessment in South Africa”

Zeffert, DT *et al* (2003) “The South African law of evidence”

Zeffert, DT and Paizes, AP (2009) “The South African law of evidence” 2nd ed.

Ziskin, J (1988) “Coping with psychiatric and psychological testimony”

Zuckerman, M (1999) "Vulnerability to psychopathology: a biosocial model"

JOURNALS

American Psychology Law Society "Specialty Guidelines for Forensic Psychologists" 1991 *Law and Human Behavior* 655

Appelbaum, PS "The parable of the forensic psychiatrist: ethics and the problem of doing harm" 1990 *International Journal of Law and Psychiatry* 249

Astin, MC *et al* "Post-traumatic stress disorder among battered women: risk and resiliency factors" 1993 *Violence and Victims* 17

Baker, BM "Provocation as a defence for abused women who kill" 1998 *Canadian Journal of Law and Jurisprudence* 193

Banks, NK "Trials and tribulations: social science evidence, expert witnesses, the voice of authority and the discourse of ideology in the courts" 1999 *Murdoch University Electronic Journal of Law* 1

Bargai, N *et al* "Posttraumatic stress disorder and depression in battered women: the mediating role of learned helplessness" 2007 *Journal of Family Violence* 267

Barlow, TB "Medical negligence resulting in death" 1948 *Journal for Contemporary Roman Dutch Law* 173

Bennett, G "A guided tour through selected ABA standards relating to incompetency to stand trial" 1985 *George Washington Law Review* 375

Bergenthuin, JG "Die algemene toerekeningsvatbaarheidsmaatstaf" 1985 *De Jure* 273

Bergenthuin, JG "Provokasie in die Suid-Afrikaanse strafreg" 1986 *De Jure* 98

Black, B *et al* "Science and the law in the wake of Daubert" 1994 *Texas Law Review* 715

Blackman, J "Potential uses for expert testimony: ideas toward the representation of battered women who kill" 1986 *Women's Rights Law Reporter* 227

Bloom, JD and Rogers, JL "The legal basis of forensic psychiatry" 1987 *American Journal of Psychiatry* 847

Bloom, JD *et al* "The forensic psychiatric system in the United States" 2000 *International Journal of Law and Psychiatry* 605

Bohan, TL and Heels, EJ "The case against Daubert" 1995 *Journal of Forensic Science* 1030

Boister, N "General principles of liability" 1995 *South African Journal of Criminal Justice* 367

Boister, N "General principles of liability" 1996 *South African Journal of Criminal Justice* 371

Boister, N "General principles of liability" 1997 *South African Journal of Criminal Justice* 315

Bonnie, R "The competence of criminal defendants: a theoretical reformulation" 1992 *Behavioral Sciences and the Law* 291

Bonta, J *et al* "The prediction of criminal and violent recidivism among mentally disordered offenders" 1998 *Psychological Bulletin* 125

Bromberg, W "Psychiatrists in court: the psychiatrist's view" 1969 *American Journal of Psychiatry* 1343

Buchanan, A “Psychiatric evidence on the ultimate issue” 2006 *The Journal of the American Academy of Psychiatry and the Law* 14

Burchell, J “Criminal justice at the crossroads” 2002 *South African Law Journal* 579

Burchell, J “Non-pathological incapacity: evaluation of psychiatric testimony” 1995 *South African Journal of Criminal Justice* 837

Burchell, J “A provocative response to subjectivity in the criminal law” 2003 *Acta Juridica* 23

Burchell, JM “Intoxication and the criminal law” 1981 *South African Journal of Criminal Justice* 177

Burke, AS “Rational actors, self-defence, and duress: making sense, not syndromes, out of battered woman” 2002 *North Carolina Law Review* 211

Calitz, FJW *et al* “Die ontwikkeling en problematiek van die verhoorbaarheidsbegrip” 1992 *Tydskrif vir Regswetenskap* 29

Campbell, TW “Psychotherapy with children of divorce” 1992 *Psychotherapy* 646

Camper, PM and Lottis, EF “The role of psychologists as expert witnesses in the courtroom” 1985 *Law and Psychology Review* 1

Carmen, EH *et al* “Victims of violence and psychiatric illness” 1984 *American Journal of Psychiatry* 378

Carstens, PA “Nalatigheid en verskillende gedagte rigtings (“schools of opinion”) binne die mediese praktyk” 1991 *Journal for Contemporary Roman Dutch Law* 673

Carstens, PA “Paraphilia in South African criminal case law” 2002 *South African Law Journal* 603

Carstens, PA “Setting the boundaries for expert evidence in support or defence of medical negligence” 2002 *Journal for Contemporary Roman Dutch Law* 430

Carstens, PA & Le Roux, J “The defence of non-pathological incapacity with reference to the battered wife who kills her abusive husband” 2000 *South African Journal of Criminal Justice* 180

Carstens, PA “Criminal liability and sentencing for murder committed with diminished criminal capacity due to provocation-*S v Mnisi* 2009 (2) SACR 227 (SCA)” (2010) *De Jure* 388

Casey, P “Expert testimony in court” 2003 *Advances in Psychiatric Treatment* 177

Chaplow, DG *et al* “The expert witness in forensic psychiatry” 1992 *Australia/New Zealand Journal of Psychiatry* 624

Cochrane, G “Psychology, expert testimony and the law” 2001 *Washington State Bar Review* 24

Coetzee, LC “Criminal capacity – sane automatism – evidence of prolonged sexual abuse of accused by his mother” 1996 *Codicillus* 96

Cohen, D “Punishing the insane” 1988 *University of Florida Law Review* 541

Conley, WM “Restricting the admission of psychiatric testimony on a defendant’s mental state” 1981 *Wisconsin’s Law Review* 733

Cook, CM and Missouri, C “The role and rights of the expert witness” 1964 *Journal of Forensic Sciences* 456

Crocker, PL “The meaning of equality for battered women who kill men in self-defence” 1985 *Harvard Women’s Law Journal* 121

Crous, AJ “Die beslegtingsproblematiek in gevalle van mediese wanpraktykgeskille” 1996 *Journal for Contemporary Roman Dutch Law* 22

Dahl, P “Legal and psychiatric concepts and the use of psychiatric evidence in criminal trials” 1985 *California Law Review* 411

Davies, W and Feldman, P “The diagnosis of psychopathy by forensic specialists” 1981 *British Journal of Psychiatry* 329

Davis, DM “Are psychopaths for real – or just another ideological obfuscation” 1982 *South African Journal of Criminal Law and Criminology* 143

Davis, DM “The psychopath and criminal justice – a critical review” 1983 *South African Journal of Criminal Law and Criminology* 259

Davoli, JI “Psychiatric evidence on trial” 2003 *Southern Methodist University Law Review* 2191

De Vos, P “S v Moses 1996 (1) SACR 701 (C) – criminal capacity, provocation and HIV” 1996 *South African Journal of Criminal Justice* 354

Derschowitz, A “Abolishing the insanity defence” 1975 *Criminal Law Bulletin* 434

Diamond, B “Reasonable medical certainty, diagnostic thresholds, and definitions of mental illness in the legal context” 1985 *Bulletin of the American Academy for Psychiatry and the Law* 121

Diamond, BL “The psychiatric prediction of dangerousness” 1974 *University of Pennsylvania Law Review* 439

Diamond, BL “The psychiatrist as advocate” 1973 *The Journal of Psychiatry and Law* 5

Dietz, PA and Evans, B “Pornographic imagery and prevalence of paraphilia” (1982) *The American Journal of Psychiatry* 1493

Dix, GE “Criminal law: psychological abnormality as a factor in grading criminal liability” 1971 *The Journal of Criminal Law, Criminology and Police Science* 313

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

Du Plessis, JR “The extension of the ambit of ontoerekeningsvatbaarheid to the defence of provocation – a strafregwetenskaplike development of doubtful practical value” 1987 *South African Law Journal* 539

Dutton, D and Painter, S “Emotional attachments in abusive relationships: a test of traumatic bonding theory” 1993 *Violence and Victims* 105

Dutton, MA “Pathways linking intimate partner violence and post-traumatic stress disorder” 2009 *Trauma, Violence and Abuse* 211

Dutton, MA “Understanding women’s responses to domestic violence: a redefinition of battered women’s syndrome” 1993 *Hofstra Law Review* 1191

Dwares, RE “Due process concerns with delayed psychiatry evaluations and the insanity defence” 1984 *Boston University Law Review* 861

Ellis, J “Emotional Stress” – ‘n nuwe handelingsuitsluitingsgrond?’ 1986 *De Jure* 340

Engelbrecht, J “The art of cross-examination” 1975 *The Magistrate* 54

Engelbrecht, J “Cross-examining expert witnesses” 1982 *De Rebus* 556

Ennis, B and Litwack, T “Psychiatry and the presumption of expertise: flipping coins in the courtroom” 1974 *California Law Review* 693

Faust, D and Ziskin, J “The expert witness in psychology and psychiatry” 1988 *Science* 31

Fenwick, P “Brain, mind and behaviour” 1993 *British Journal of Psychiatry* 163

Fingarette, H “The concept of mental illness in criminal law insanity tests” 1965-1966 *University of Chicago Law Review* 229

First, MB and Halon, RL “Use of DSM paraphilia diagnoses in sexually violent predator commitment cases” 2008 *The Journal of the American Academy of Psychiatry and the Law* 443

First, MB and Pincus, HA “Classification in psychiatry” 1999 *British Journal of Psychiatry* 175

First, MB and Pincus, HA “The DSM-I text revision” 2002 *Psychiatric Services* 288

Foa, E and Meadows, E “Psychosocial treatment for post-traumatic stress disorder” 1997 *Annual Review of Psychology: a critical review* 449

Frase, RS “Comparative criminal justice as a guide to American law reform: how do the French do it; how can we find out; and why should we care” 1990 *California Law Review* 539

Fraser, IS “Psychiatry and law” 1992 *SALUS* 18

Gelles, RJ and Harrop, JW “Violence, battering and psychological distress among women” 1989 *Journal of Interpersonal Violence* 400

Gerard, JB “The medical model of mental illness” 1999 *International Journal of Law and Psychiatry* 65

Gerard, JB “The usefulness of the medical model to the legal system” 1987 *Rutgers Law Review* 377

Gilmer, BT *et al* “Forensic expertise” 1995 *South African Journal of Criminal Justice* 259

Gilmer, BT *et al* “Law and psychology: an exploration of the conceptual interface” 1997 *South African Journal of Criminal Justice* 19

Goldstein, RL and Stone, M “When doctors disagree: differing views on competency” 1977 *Bulletin of the American Academy for Psychiatry* 90

Graham, ES and Kabacy, RE “Expert testimony by psychologists” 1990 *Law and Psychology Review* 71

Greenberg, JS “Criminal law and evidence using psychiatric testimony to negate mens rea under the Insanity Defense Reform Act” 1988 *Template Law Review* 953

Greenfield, DP “Organic approaches to the treatment of paraphilics and sex offenders” 2006 *Journal of Psychiatry and Law* 437

Greenspan, EL “The role of the psychiatrist in the criminal justice system” 1978 *American Psychiatric Association Journal* 137

Grisso, T “The differences between forensic psychiatry and forensic psychology” 1993 *Bulletin of the American Academy of Psychiatry and Law* 133

Gutheil, TG “Psychiatric expert witnesses in the new millennium” 2006 *Psychiatric Clinic North America* 829

Gutheil, TG “Psychiatrists as expert witnesses” 2004 *American Journal of Psychiatry* 2141

Haque, Q and Cumming, I “Intoxication and legal defences” 2003 *The Royal College of Psychiatrists – Advances in Psychiatric Treatment* 144

Harris, DA “Ake revisited: expert psychiatric witnesses remain beyond reach for the indigent” 1990 *North Carolina Law Review* 763

Haysom, N *et al* “The mad Mrs Rochester revisited” 1990 *South African Journal of Human Rights* 341

Hazelwood, R *et al* “Compliant victims of the sexual sadist” 1993 *Australian Family Physician* 474

Henderson, A “An independent product: the role of expert evidence in the preparation and presentation of High Court cases involving allegations of (professional) negligence” 1997 *De Rebus* 63

Henning, PH “Beleid ten opsigte van die ontslag van Presidents-pasiënte” 1983 *Tydskrif vir Regswetenskap* 132

Hector, S “Amnesia and criminal responsibility” 2000 *South African Journal of Criminal Justice* 273

Hector, S “Road rage and reasoning about responsibility” 2001 *South African Journal of Criminal Justice* 195

Hudsmith, R “The admissibility of expert testimony on battered woman syndrome in battered women’s self-defence cases in Louisiana” 1987 *Louisiana Law Review* 979

Humphreys, J *et al* “Psychological and physical distress of sheltered battered women” 2001 *Health Care for Women International* 401

Jackson, JD “The ultimate issue rule: one rule too many” 1984 *Criminal Law Review* 75

James, FE “Psyche” 1991 *Psychiatric Bulletin* 429

Jeffries, JC and Stephan, PB “Defences, presumptions, and burden of proof in criminal law” 1979 *Yale Law Review* 1325

Jonck, JW and Verschoor, T “Noodsaaklikheid van toestemming deur ‘n beskuldigde by ‘n ondersoek kragtens artikel 79 van die Strafproseswet” 1997 *Tydskrif vir Regswetenskap* 196

Jones, L *et al* “Post-traumatic stress disorder (PTSD) in victims of domestic violence” 2001 *Trauma, Violence and Abuse* 99

Jones, TH “Insanity, automatism, and the burden of proof on the accused” 1995 *Law Quarterly Review* 475

Jonker, GJ “A treatment programme for certified psychopathic offenders” 1983 *South African Journal of Criminal Law and Criminology* 271

Junginger, J “Command hallucinations and the prediction of dangerousness” *Psychiatric Service* 911

Kaliski, SZ “My brain made me do it” 2009 *South African Journal of Psychiatry* 4

Kastenbergh, MJE “A three-dimensional model for the use of expert psychiatric and psychological evidence in the false confession defences before the trier of fact” 2003 *Seattle University Law Review* 785

Kemp, A *et al* “Post-traumatic stress disorder in battered women: a shelter sample” 1991 *Journal of Traumatic Stress* 137

Kendall, RE “The distinction between personality disorder and mental illness” 2002 *British Journal of Psychiatry* 110

Kenny, A “The psychiatric expert in court” 1984 *Psychological Medicine* 291

Kleinplatz, PJ and Moser. C “Politics versus science: an addendum and response to Drs Spitzer and Fink” 2005 *Journal of Psychology and Human Sexuality* 135

Kreiling, KR “Scientific evidence” 1990 *Arizona Law Review* 929

Kruger, A “Tekortkominge in wetgewing oor geestesongesteldheid” 1983 *Tydskrif vir Regswetenskap* 182

Kruger, HB “Addressing domestic violence: to what extent does the law provide effective measures” 2004 *Tydskrif vir Regswetenskap* 152

Kutchins, H and Kirk, SA “The business of diagnosis” 1988 *Social Work* 215

Labuschagne, JMT “Die mishandelde vrou sindroom, die redelike persoonstandaard en die grense van noodweer – R v Malott (1998) 121 CCC (3d) 456 (SCC)” 1998 *Journal for Contemporary Roman Dutch Law* of 538

Lacoursiere, RB “Forensic psychiatry” 1990 *Washburn Law Journal* 29

Lafond, M “Disorder in the court” 2005 *Dalhousie Journal of Legal Studies* 1

Lawton, LJ “The limitations of expert scientific evidence” 1980 *Journal of Forensic Science* 237

Le Roux, J “Strafregtelike aanspreeklikheid en die verweer van tydelike nie-patologiese ontoerekeningsvatbaarheid – verlies van konatiewe geestesfunksie onderskei van blote verlies van humeur” 2002 *Journal for Contemporary Roman Dutch Law* 478

Le Roux, J “Strafregtelike aanspreeklikheid en die verweer van nie-patologiese oftewel gesonde outomatisme – ware amnesie onderskei van psigogene amnesie – blote verlies van humeur onderskei van nie-patologiese verlies van kognitiewe bewussyn” 2000 *De Jure* 190

Lenkevich, MH “Admitting expert testimony on battered woman syndrome in Virginia courts: how Peoples changed Virginia self-defence law” 1998 *William and Mary Journal of Women and the Law* 297

Lipkin, RJ “Free will, responsibility and the promise of forensic psychiatry” 1990 *International Journal of Law and Psychiatry* 331

Louw, PF “Die algemene toerekeningsvatbaarheidsmaatstaf” 1987 *South African Journal of Criminal Justice* 368

Louw, R “Recent cases – Criminal Law Amendment Act 1 of 1988” 1997 *South African Journal of Criminal Justice* 104

Louw, R “S v Eadie: road rage, incapacity and legal confusion” 2001 *South African Journal of Criminal Justice* 206

Louw, R “S v Eadie: the end of the road for the defence of provocation?” 2003 *South African Journal of Criminal Justice* 200

Ludsin, H “Ferreira v The State: a victory for women who kill their abusers in non-confrontational situations” 2004 *South African Journal of Human Rights* 642

Lunde, DT and Wilson, TE “Brainwashing as a defense to criminal liability: Patty Hearst revisited” 1977 *Criminal Law Bulletin* 314

Mackay, RD “Fact and fiction about the insanity defence” 1990 *The Criminal Law Review* 247

Maguire, JB *et al* "Battered women who kill: variables affecting simulated jurors' verdicts" 2005 *Journal of Family Violence* 403

Maroney, T "Law and emotion: a proposed taxonomy of an emerging field" 2006 *Law and Human Behavior* 119

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

Marwick, C "What constitutes an expert witness?" 1995 *Journal of the American Medical Association* 2057

Mather, VM "The skeleton in the closet: the battered woman syndrome, self-defence, and expert testimony" 1988 *Mercer Law Review* 545

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* 345

McSherry, B "Criminal responsibility, fleeting states of mental impairment, and the power of self-control" 2004 *International Journal of Law and Psychiatry* 449

Mega, LT *et al* "Brainwashing and battering fatigue: psychological abuse in domestic violence" 2000 *North Carolina Medical Journal* 260

Meintjes-Van der Walt, L "A few plain rules? A comparative perspective on exclusionary rules of expert evidence in South Africa" 2001 *Journal for Contemporary Roman Dutch Law* 236

Meintjes-Van der Walt, L "Cross-examination of expert witnesses" 2001 *De Rebus* 22

Meintjes-Van der Walt, L “Decision-makers dilemma: evaluating expert evidence”
2000 *South African Journal of Criminal Justice* 319

Meintjes-Van der Walt, L “Expert odyssey: thoughts on the presentation and
evaluation of scientific evidence” 2003 *South African Law Journal* 352

Meintjes-Van der Walt, L “Eyewitness evidence and eyewitness science” 2009
South African Journal of Criminal Justice 305

Meintjes-Van der Walt, L “Making a muddle into a mess?: The amendment of s78
of the Criminal Procedure Act” 2002 *South African Journal of Criminal Justice* 242

Meintjes-Van der Walt, L “Many a slip...The need for strengthening the chain of
expert evidence” 2000 *Comparative and International Law Journal of South Africa*
348

Meintjes-Van der Walt, L “The presentation of expert evidence at trials in South
Africa, the Netherlands and England and Wales” 2001 *Stellenbosch Law Review*
283

Meintjes-Van der Walt, L “The proof of the pudding: the presentation and proof of
expert evidence in South Africa” 2003 *Journal of African Law* 88

Meintjes-Van der Walt, L “S v Huma (1) 1995 (2) SACR 407 (W) – shooting at
science: expert evidence and equality of arms” 1996 *South African Journal of
Criminal Justice* 361

Meintjes-Van der Walt, L “Science friction: the nature of expert evidence in general
and scientific evidence in particular” 2000 *South African Law Journal* 771

Menzies, RJ *et al* “Legal and medical issues in forensic psychiatric assessments”
1981 *Queens Law Journal* 3

Mezzich, JE “International surveys on the use of ICD-10 and related diagnostic systems” 2002 *Psychopathology* 72

Mihalik, J “Legal aspects of forensic psychiatry in South Africa” 1992 *Medicine and Law* 239

Mills, LG “Killing her softly: intimate abuse and the violence of state intervention” 1999 *Harvard Law Review* 550

Milton, J “Law reform: the Criminal Matters Amendment Act 1998 brings some sanity (but only some) to the defence of sanity” 1999 *South African Journal of Criminal Justice* 46

Moas, EB “Domestic violence: competing conceptions of equality in the law of evidence” 2001 *Loyola Law Review* 81

Monahan, J “Violence risk assessment” 2000 *Washington and Lee Law Review* 901

Monohan, J and Loftus, EF “The psychology of law” 1982 *Annual Review of Psychology* 441

Morse, S “Speciality guidelines for forensic psychologists” 1991 *Law and Human Behavior* 655

Morse, S “Why amnesia and the law is not a useful topic” 1986 *Behavioral Science and the Law* 99

Mose, SJ “Failed explanations and criminal responsibility” 1982 *Virginia Law Review* 1016

Mueser, KJ *et al* “Trauma and posttraumatic stress disorder in severe mental illness” 1998 *Journal of Consulting and Clinical Psychology* 493

Murphy, JP “Expert witnesses at trial” 2000 *Georgetown Journal of Ethics* 217

Norrie, A “Crime, reason and history” (1993) in Tadros, V “Insanity and the capacity for criminal responsibility” 2001 *Edinburgh Law Review* 325

O’Donovan, K “Defences for battered women who kill” 1991 *Journal of Law and Society* 219

Oosthuizen, H and Verschoor, T “Faktore wat ‘n invloed op die verhoorbaarheid van ‘n beskuldigde kan hê” 1991 *Tydskrif vir Regswetenskap* 138

Oosthuizen, H and Verschoor, T “Herstel van verhoorbaarheid deur psigotropiese middels” 1990 *Tydskrif vir Regswetenskap* 74

Oosthuizen, H and Verschoor, T “Verlof en ontslag van staatspasiënte” 1994 *South African Journal of Criminal Justice* 358

Oosthuizen, H and Verschoor, T “Verwysing van onverhoorbare beskuldigdes en die daarstelling van ‘n verhoorbaarheid-vasstellingseenheid” 1993 *South African Journal of Criminal Justice* 155

Paizes, A “Intoxication through the looking glass” 1988 *South African Journal of Criminal Justice* 776

Pattenden, R “Expert opinion evidence based on hearsay” 1982 *The Criminal Law Review* 85

Perlin, M “The legal status of the psychologist in the courtroom” 1977 *Journal of Psychiatry* 41

Perlin, ML “Unpacking the myths: the symbolism mythology of insanity defence jurisprudence” 1989/1990 *Western Reserve Law Review* 599

Pipkin, W “Expert opinion testimony” 1989 *Law and Psychology Review* 105

Platt, A and Diamond, BL “The origins of the ‘Right and Wrong’ test of criminal responsibility” 1966 *California Law Review* 1227

Plomp, J “Die psigiater en die vasstelling van toerekeningsvatbaarheid” 1983 *Tydskrif vir Regswetenskap* 154

Pope, KS and Garcia-Peltoniemi, RE “Responding to victims of torture: clinical issues, professional responsibilities, and useful resources” 1991 *Professional Psychology: research and practice* 221

Rappeport, JR “Differences between forensic and general psychiatrists” 1982 *American Journal of Psychiatry* 331

Reddi, M “Battered woman syndrome: some reflections on the utility of this ‘syndrome’ to South African women who kill their abusers” 2005 *South African Journal of Criminal Justice* 259

Reddi, M “General principles – non-pathological incapacity” 2001 *South African Journal of Criminal Justice* 241

Reddi, M “General principles – non-pathological incapacity” 2002 *South African Journal of Criminal Justice* 250

Reddi, M “General principles of liability” 1999 *South African Journal of Criminal Justice* 87

Reddi, M “General principles – private defence” 2005 *South African Journal of Criminal Justice* 335

Redding, R “Psychology and the law: how common-sense Psychology can inform Law and psycholegal research” 1998 *University of Chicago Law School Roundtable* 107

Redmayne, M “Expert evidence and scientific disagreement” 1997 *University College of Davis Law Review* 1027

Reid, J “Criminal insanity and psychiatric evidence” 1962 *Howard Law Journal* 1

Reid, W “Law and psychiatry – the insanity defence” 2000 *Journal of Psychiatric Practice* 169

Reid, WH “The insanity defence: bad or mad or both” 2000 *Journal of Psychiatric Practice* 169

Reily, A “The heart of the matter: emotion in criminal defences” 1997 *Ottawa Law Review* 117

Rix, KJ “Psychiatry and the Law: uneasy bedfellows” 2006 *Medico-legal Journal* 148

Roberts, JW “Between the heat of passion and cold blood: battered woman’s syndrome as an excuse for self-defence in non-confrontational homicides” 2003 *Law and Psychology Review* 135

Roberts, P “Science in the criminal process” 1994 *Oxford Journal of Legal Studies* 469

Robinson, PH “Criminal law defences: a systematic analysis” 1982 *Columbia Law Review* 199

Rogers, A “Prosecutorial use of expert testimony in domestic violence cases: from recantation to refusal to testify” 1998 *Columbia Journal of Gender and Law* 67

Rogers, R and Cavanaugh, J “Amnesia” 1986 *Behavioral Science and the Law* *Introductory note*

Rogers, R and Ewing, CP “Ultimate opinion proscriptions” 1989 *Law and Human Behavior* 357

Rogers, R and Lynett, E “The role of Canadian psychiatry in dangerous offender testimony” 1991 *Canadian Journal of psychiatry* 79

Rogers, R *et al* “The clinical presentation of command hallucinations in a forensic population” 1990 *American Journal of Psychiatry* 1304

Rogers, R *et al* “Psychiatrists and the parameters of expert testimony” 1992 *International Journal of Law and Psychiatry* 387

Rogers, T “Diagnostic validity and psychiatry expert testimony” 2004 *International Journal of Law and Psychiatry* 281

Rubinsky, EW and Brandt, J “Amnesia and criminal law: a clinical overview” 1986 *Behavioral Science and the Law* 27

Rumpff, F “Feite of woorde” 1990 *Consultus* 19

Ryan, C and Smith, ME “When insanity is convenient” 2005 *Without Prejudice* 7

Sales, MJ and Wissler, RL “Legal and psychological bases of expert testimony” *Behavioral Sciences and the Law* 435

Samuels, A “Mental condition as a defence in criminal law: a lawyer addresses medical men” 1988 *Medicine, Science and the Law* 21

Saunders, DG “Posttraumatic stress symptom profiles of battered women” 1994 *Violence and Victims* 31

Schacter, DL “On the relation between genuine and simulated amnesia” 1986 *Behavioral Science and the Law* 47

Schmidt, CWH “Laying the foundation for a defence of sane automatism” 1973 *South African Law Journal* 329

Schneider, E and Jordan, S “Representation of women who defend themselves in response to physical or sexual assault” 1978 *Women’s Rights Law Reporter* 148

Schneider, EM “Describing and changing women’s self-defense work and the problem of expert testimony on battering” 1986 *Women’s Rights Law Reporter* 195

Schuller, RA and Cripps, A “Expert evidence pertaining to battered women: the impact of gender of expert and timing of testimony” 1998 *Law and Human Behavior* 17

Schuller, RA and Rzepa, S “Expert testimony pertaining to battered woman syndrome: its impact on juror’s decisions” 2002 *Law and Human Behavior* 655

Schuller, R and Vidmar, N “Battered woman syndrome evidence in the courtroom – a review at the literature” 1992 *Law and Human Behavior* 273

Schulze, H “Criminal law – S v Eadie 2002 (3) SA 719 (SCA)” 2002 *De Rebus* 38

Scott, CL “Commentary: a road map for research in restoration of competency to stand trial” 2003 *Journal of the American Academy of Psychiatry and Law* 36

Seymour, ML “Isn’t it a crime: feminist perspectives on spousal immunity and spousal violence” 1996 *Northwestern University Law Review* 1032

Shaffer, M “The battered woman syndrome revisited: some complicating thoughts five years after R v Lavalley” 1997 *University of Toronto Law Journal* 1

Sheehy, E *et al* “Defending battered women on trial, the battered women’s syndrome and its limitations” 1992 *Criminal Law Journal* 369

Sheldon, DH “From normative to positive data” 1991 *Criminal Law Review* 811

Shieber, A *et al* "The psychiatric diagnosis: is it an instrument of help or one of doom" 1987 *Medicine and Law* 165

Shuman, DW "Expertise in law, medicine, and health care" 2001 *Journal of Health Politics, Policy and Law* 267

Slobogin, C "Psychiatric evidence in criminal trials: to Junk or not to Junk?" 1998 *William and Mary Law Review* 1

Slovenko, R "A history of the intermix of psychiatry and law" 2004 *The Journal of Psychiatry and Law* 561

Slovenko, R "Commentary: deceptions to the rule on ultimate issue testimony" 2006 *Journal of American Academy of Psychiatry and the Law* 22

Slovenko, R "The developing law on competency to stand trial" 1977 *Journal of Psychiatry and Law* 165

Slovenko, R "Expert testimony: use and abuse" 1993 *Medicine and Law* 627

Slovenko, R "The lawyer and the forensic expert" 1987 *Behavioral Science and Law* 119

Slovenko, R "The meaning of mental illness in criminal responsibility" 1984 *The Journal of Legal Medicine* 1

Slovenko, R "The mental disability requirement in the insanity defense" 1999 *Behavioral Science and the Law* 165

Slovenko, R "The multiple personality and the criminal law" 1993 *Medicine and Law* 329

Slovenko, R “Multiple personality: perplexities about the law” 1995 *Medicine and Law* 623

Slovenko, R “On a therapist serving as expert witness” 2002 *Journal of American Academy Psychiatry* 10

Slovenko, R “Psychiatric expert testimony: are the criticisms justified? (Part 1) 1991 *Medicine and Law* 1

Slovenko, R “Psychiatric expert testimony: are the criticisms justified? (Part 2) 1991 *Medicine and Law* 107

Slovenko, R “Responsibility of the psychopath” 1999 *Philosophy, Psychiatry and Psychology* 53

Smith, KT “The psychiatry expert in the criminal trial” 1987 *Marquette Law Review* 493

Snyman, CR “Is there such a defence in our Criminal Law as ‘emotional stress’? 1985 *South African Law Journal* 240

Snyman, CR “’n Koel ontvangs vir ‘Statutere Dronkenskap’” 1990 *Tydskrif vir die Suid-Afrikaanse Reg* 504

Snyman, CR “The tension between legal theory and policy considerations in the general principles of Criminal Law” 2003 *Acta Juridica* 1

Snyman, CR “Die verweer van nie-patologiese ontoerekeningsvatbaarheid in die strafreg” 1989 *Tydskrif vir Regswetenskap* 1

Snyman, J “The declaration of a person as a President’s patient” 1988 *Acta Juridica* 128

Sparks, J “Admissibility of expert psychological evidence in the Federal Courts”
1995 *Arizona State Law Journal* 1315

Spitzer, RL and Wakefield, JC “DSM-IV diagnostic criterion for clinical
significance” 1999 *American Journal of Psychiatry* 1856

Stark, E “Re-presenting woman battering: from battered woman syndrome to
coercive control” 1995 *Albany Law Review* 973

Steinmetz, SK “Wife-beating: a critique and reformulation of existing theory” 1978
Bulletin of the American Academy of Psychiatry and the Law 322

Stone, A “The insanity defence on trial” 1982 *Hospital and Community Psychiatry*
636

Stone, AA “Revisiting the parable: truth without consequences” 1994 *International
Journal of Law and Psychiatry* 79

Strassburger, LH *et al* “On wearing two hats: role conflict in serving as both
psychotherapist and expert witness” 1997 *American Journal of Psychiatry* 448

Strauss, SA “Geestesongesteldheid en die strafreg: die voorgestelde nuwe reeling
in die strafproseswetsontwerp” 1974 *Journal for Contemporary Roman Dutch Law*
219

Strauss, SA “Nie-patologiese ontoerekeningsvatbaarheid as verweer in die
Strafreg: ‘n nuwe uitdaging vir deskundige, mediese getuienis” 1995 *South African
Practice Management* 14

Strauss, SA “Opmerkings oor toorn as faktor by die vasstelling van strafregtelike
aanspreeklikheid” 1959 *Journal for Contemporary Roman Dutch Law* 14

Strauss, SA “Regsaspekte van geestesversteurdheid – legal aspects of mental
disorder” 1971 *Journal for Contemporary Roman Dutch Law* 1

Strauss, SA “The person with schizophrenia and criminal justice” 1996 *Comparative and International Law Journal of South Africa* 282

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* 65

Tadros, V “Insanity and the capacity for criminal responsibility” 2001 *The Edinburgh Law Review* 325

Taylor, PJ and Kopelman, MD “Amnesia for criminal offences” 1984 *Psychological Medicine* 581

Trowbridge, BC “The admissibility of expert testimony in Washington on post traumatic stress disorder and related trauma syndromes” 2003 *Seattle University Law Review* 453

Van der Merwe, DP “Die begrip verminderde toerekeningsvatbaarheid en die implementering daarvan” 1983 *Tydskrif vir Regswetenskap* 172

Van der Merwe, DP “Toerekeningsvatbaarheid v ‘Specific Intent’ – die Chretien-beslissing” 1981 *Obiter* 142

Van der Merwe, RP “Sielkundige perspektiewe op tydelike nie-patologiese ontoerekeningsvatbaarheid” 1997 *Obiter* 138

Van Niekerk, B “A witch’s brew from Natal – some thoughts on provocation” 1972 *South African Law Journal* 169

Van Oosten, FFW “The insanity defence: its place and role in the criminal law” 1990 *South African Journal of Criminal Justice* 1

Van Oosten, FFW “Non-pathological criminal incapacity versus pathological criminal incapacity” 1993 *South African Journal of Criminal Justice* 127

Van Oosten, FFW “Psychopathic violent and sex offenders: a legal appraisal” 1992 *De Jure* 1

Van Rensburg, PHJ *et al* “Psigiatiese en juridiese aspekte van die begrip geestesongesteldheid” 1983 *Tydskrif vir Regswetenskap* 162

Van Rensburg, PHJ and Verschoor, T “Medies-geregtelike aspekte van amnesia” 1989 *Tydskrif vir Regswetenskap* 40

Veinsrerderis, ME “The prospective effects of modifying existing laws to accommodate preemptive self-defence by battered women” 2000 *University of Pennsylvania Law Review* 613

Verschoor, T *et al* “Deskundige getuienis” 1994 *Geneeskunde* 5

Vetten, L “Addressing gender bias in the sentencing of men and women convicted of killing their intimate partners” Oct 2002 *Gender Bulletin* 4

Viljoen, G “Toerekeningsvatbaarheid: wrywingspunte en raakvlakke tussen reg en psigiatrie” 1983 *Tydskrif vir Regswetenskap* 121

Warburton, IG “The commandeering of free will: brainwashing as a legitimate defense” 2003 *Capital Defense Journal* 73

Warren, JI and Hazelwood, RR “Relational patterns associated with sexual sadism: a study of 20 wives and girlfriends” 2002 *Journal of Family Violence* 75

Weihofen, H “The definition of mental illness” 1960 *Ohio State Law Journal* 1

Wells, G “Expert psychological testimony” 1986 *Law and Human Behavior* 83

Wolhuter, L “Excuse them though they know what they do – the distinction between justification and excuse in the context of battered women who kill” 1996 *South African Journal of Criminal Justice* 151

Yeo, S “The insanity defence in the criminal laws of the Commonwealth of Nations” 2008 *Singapore Journal of Legal Studies* 241

Zabow, T “Psychiatric evidence in extenuation: assessment and testimony in homicide defendants” 1989 *Medicine and Law* 631

CONFERENCE PAPER

Chapman, FE (2008) “The compliant victim of the sexual sadist and the proposed Canadian defence of coercive persuasion”. Paper submitted at the International Society for the Reform of Criminal Law – 22nd International Conference Dublin, Ireland.

DAILY NEWSPAPERS

Beeld 27 February 2009

Beeld 11 March 2009

Pretoria News 27 February 2009

Pretoria News 10 March 2009

Pretoria News 11 March 2009

Pretoria News 14 March 2009

Rapport 5 April 2009

LEGAL OPINION

Pillay, K “Battered women who kill: avenues for legal/political recourse (2005)
Legal opinion commissioned by the Centre for the Study of Violence and Reconciliation

ELECTRONIC RESOURCES

AAPL Ethics Guidelines:

<http://www.mentalhelp-net/poc/view-doc.php?type=cloc8id> [accessed on 2010/03/09]

Abusive brainwashing techniques: (anonymous)

<http://www.heart-2-heart.ca/men/page3.html> [accessed on 2009/04/07]

Britannica Concise Encyclopedia (2007): http://www.encyclopedia.com/doc/1_B1-35_6756.html [accessed on 2008/07/16]

Bursztajn, HJ *et al* “Kumbo for clinicians”:

<http://www.forensic-psych.com/articles/artKumboClinicians.php> [accessed on 2007/05/03]

Cocozzo, JJ and Steadman, HJ:

<http://www.jstor.org/view/00377791/apo30107/05a00040/0> [accessed on 2007/08/15]

Dental Dictionary:

<http://www.answers.com/topic/mental-illness> [accessed on 2009/06/11]

Diagnostic classification:

<http://www.icd10.ch/ebook/FRetENetGe-Omset> DMDI-FR/vzpzzi [accessed on 2009/07/07]

<http://en.wikipedia.org/wiki/ICD> [accessed on 2009/07/07]

DSM-V future publication:

<http://en.wikipedia.org/wiki/Diagnostic-and-Statistical-Manual-of-Mental-Disorders>

[accessed on 2009/07/27]

“Expertise in Law”:

<http://www.ahrq.gov/clinic/jhppl/shuman2.htm> [accessed on 2007/05/03]

Forensic psychologist definition:

<http://www.geocities.com/Athens/7429/forensicpsychprep.html> [accessed on 2008/07/15]

Gutheil, TG and Bursztajn, H “Avoiding Ipse Dixit mislabelling”:

<http://www.forensic-psych.com/articles/artAvoidIpsedixit.hph> [accessed on 2007/03/28]

Hinckley Trial:

<http://www.law.umke.edu/faculty/projects/ftrials/hinckley/jfostercommun.htm>

[accessed on 2010/03/09]

<http://www.law.umko.edu/faculty/projects/ftrials/hinckley.mono.htm> [2010/03/09]

International statistical classification:

<http://en.wikipedia.org/wiki/ICD> [accessed on 2009/06/11]

Levinson, RM and York, MZ:

<http://www.jstor.org/view/00221465/di976050/97po938./o> [accessed on 2007/08/15]

Levy, M “Shrink in the courtroom: forensic psychiatry and law”

http://www.fpamed.com/forensic_psychiatry/2008/05/shrink-in-the-c.html

[accessed 2009/02/23]

Linder, D “The trial of John Hinckley”:

<http://www.law.umke.edu/faculty/projects/Ftrials/hinckleytrial.html> [accessed on 2010/03/09]

Love and Stockholm syndrome:

<http://counsellingresource.com/quizzes/stockholm/index.html> [accessed on 2009/02/23]

Malin, HM and Saleh, FM (2007) "Paraphilias" at:

<http://www.psychiatryonline.com/display/article/10168/55266> [accessed on 2009/08/04]

Medical dictionary: <http://www.answers.com/topic/battered-womansyndrome?cat=health> [accessed on 2008/07/16]

Merriam-Webster Online Dictionary:
<http://www.merriam-webster.com/dictionary/provocation> [accessed on 2008/07/21]

"Mouthful of glass" in

<http://findarticles.com/p/articles/mimOJOP/is-330/ai-30443224> [accessed on 2009/05/09]

National Alliance definition for mental illness:

<http://karisable.com/crmh.htm> [accessed on 2009/04/01]

Paraphilias:

<http://en.wikipedia.org/wiki/list-of-paraphilias> [accessed on 2009/08/04]

Prevent and remedy coercive persuasion, brainwashing and mind control:

<http://www.systemiccoaching.com/coercion.html> [accessed on 2009/04/07]

Ramsland, K "Andrea Yates: ill or evil" at

http://www.trutr.com/library/crime/notorious_murders/women/andrea_yates/index.html [accessed on 2009/09/23]

Reid psychiatry:

<http://www.reidpsychiatry.com/reidfaq.html> [accessed on 2008/07/15]

Schuller, RA “Expert evidence and its impact on juror’s decisions in homicide trials involving battered women” *in* <http://www.duke.edu/journals/diglp.articles/gen10p225.htm> [accessed on 2006/05/19]

Statistics:

<http://www.powa.co/za/Display.asp>.ID-12> [accessed on 2009/03/16]

<http://www.settlement.org/downloads/woman-Abuse-factsheet.pdf> [accessed on 2009/03/16]

Stark, E “Coercive control” *at*

<http://www.justiceformothers.com/Documents/coercivecontrol.pdf> [accessed on 2009/03/23]

Stress definition:

<http://en.wikipedia.org/wiki/stress-medicine> [accessed on 2009/03/23]

Tsafendas: the tapeworm assassin:

<http://diatribe-column.blogspot.com/2009/02/tsafendas-tapeworm-assasin.html>
[accessed on 2009/05/09]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/Amnesia> [accessed on 2009/02/04]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/Clinical-psychology> [accessed on 2008/09/05]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/provocation> [accessed on 2008/07/21]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/Forensic-psychiatry> [accessed on 2008/07/15]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/Forensic/psychology> [accessed on 2008/07/15]

Wikipedia encyclopedia:

http://en.wikipedia.org/wiki/Mental_illness [accessed on 2009/06/11]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/psychiatry> [accessed on 2008/08/26]

Wikipedia encyclopedia:

<http://en.wikipedia.org/wiki/stockholm-syndrome> [accessed on 2009/02/23]

Wolff, N “Interactions between mental health and law enforcement systems: problems and prospects for cooperation” *Journal of Health Politics, Policy and Law* (1998) 133: <http://jhpl.dukejournals.org/cgi/content/abstract/23/1/133> [accessed on 2008/07/03]

Woman Abuse Fact Sheet:

<http://www.settlement.org/downloads/woman-abuse-factsheet.pdf> [accessed on 2009/03/16]

Women’s Rural Advocacy Programs:

<http://www.letswrap.com/dvinfo/myths.htm> [accessed on 2006/03/27]

<http://www.letswrap.com/dvinfo/whystay.htm> [accessed on 2006/03/27]

STATUTES

Arms and Ammunition Act 75 of 1969

Canadian Charter of Rights and Freedoms

Civil Proceedings Evidence Act 25 of 1965

Constitution of the Republic of South Africa, 1996

Constitution of the Republic of South Africa Act 200 of 1993

Criminal Code of Canada

Criminal Law (Sentencing and Related Matters) Amendment Act 32 of 2007

Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

Criminal Law Amendment Act 1 of 1988

Criminal Law Amendment Act 105 of 1997

Criminal Matters Amendment Act 68 of 1998

Criminal Procedure Act 51 of 1977

Domestic Violence Act 116 of 1998

Health Professions Act 56 of 1974

Immorality Act 23 of 1957

Insanity Defence Reform Act of 1984 (USA)

Law of Evidence Amendment Act 85 of 1988

Legal Aid Amendment Act 20 of 1996

Mental Disorders Act 38 of 1916

Mental Health Act 18 of 1973

Mental Health Care Act 17 of 2002

Promotion of Access to Information Act 2 of 2000

Rents Amendment Act 51 of 1972

Trial of Lunatics Act 1883

Transkei Penal Code

Wet op Geestesgebrekken 38 of 1916

LAW REPORTS

Afrox Healthcare v Strydom 2002 (6) SA 21 (SCA)

Amod v Multilateral Motor Vehicle Accidents Fund 1998 (4) SA 753 (CC)

Attorney-General v Dow 1994 (6) BCLR 1 (Bot)

Bernstein v Bester 1996 (2) SA 751 (CC)

Bernstein v Bester 1996 (4) BCLR 449 (CC)

Bolitho v City and Hackney Health Authority 1998 AC 232 (HL)

Botha v Minister of Transport 1956 (4) SA 375 (W)

Bratty v Attorney-General for Northern Ireland (1961) 3 All E.R. 523 (H.L.)

Carmichele v Minister of Safety and Security 2001 (10) BCLR 995 (CC), 2002 (1) SACR 79 (CC)

Carmichele v Minister of Safety and Security 2001 (4) SA 938 (CC), 2001 (1) SA 481 (SCA)

Carter v United States 252 F.2d 608 (1957)

Christian Education South Africa v Minister of Education 1999 (2) SA 83 (CC)

Coopers v Deutsche Gesellschaft fur Schadlingsbekampfung MBH 1976 (3) SA 352 (A)

Coppen v Impey 1916 CPD 309

Curtis v Minister of Safety and Security 1996 (5) BCLR (CC), 1996 (3) SA 617 (CC), 1996 (1) SACR 587 (CC)

Daubert v Merrell Dow Pharmaceuticals 509 US 579 (1993)

De Lange v Smuts 1998 (7) BCLR 658 (CC)

De Lille v Speaker of the National Assembly 1998 (3) SA 420 (C)

Dean v Commonwealth 777 S.W. 2d. (1989) 900

Deutchmann and Another; Shelton v Commissioner for the South African Revenue Service 2000 (6) BCLR 571 (E)

Dingley v The Chief Constable, Strathclyde Police 2000 SC 77 (HL)

Director of Public Prosecutions v Venter 2009 (1) SACR 165 (SCA)

DPP v A and BC Chewing Gum 1968 AC 159

DPP v Kilbourne 1973 AC 729

Du Plessis v De Klerk 1996 (3) SA 850 (CC)

Du Plessis v De Klerk 1996 (5) BCLR 658 (CC)

Durham v Unites States 214 F2d 862 (1954)

Dusky v United States 362 US 402 (1960)

Ex parte Haney 603 So.2d 412 (1992)

Ex parte Minister of Safety and Security: In re S v Walters 2002 (4) SA 613 (CC)

Ferreira v Levine and Vryenhoek v Powell 1996 (1) BCLR 1 (CC)

Frye v United States 293 F. 1013 (1923)

General Electric v Joiner 522 US 136 (1997)

Gentiruco AG v Firestone SA 1972 (1) SA 589 (A)

Govender v Minister of Safety and Security 2001 (4) SA 273 (SCA)

Holtzhauzen v Roodt 1997 (4) SA 766 (W)

Hudson v Commonwealth 979 S.W. 2d. (1998) 106

Kramer v United States 579 F.Supp. 314 (1984)

Kumho Tire v Carmichael 526 US 137 (1999), 119 S.Ct 1167 (1999)

Lavallee v The Queen (1990) SCR 85 (55 CCC)(3d) 97 (SCC)

Louwrens v Oldwage 2006 (2) SA 161 (SCA)

Mandela v Falati 1994 (4) BCLR 1 (W)

Master of the High Court v Deedat 1999 (1) BCLR 1285 (W)

McClellan v Commonwealth 715 S.W. 2d (1986) 464

McDonald v United States 312 F. 2d 847 (1962)

Menday v Protea Assurance 1976 (1) SA 565 (E)

Michael v Linksfield Park Clinic 2001 (3) SA 1188 (SCA)

National Coalition for Gay and Lesbian Equality v Minister of Home Affairs 2000
(2) SA 1 (CC)

National Coalition for Gay and Lesbian Equality v Minister of Justice 1998 (12)
BCLR 1517 (CC)

National Justice Compania Naviera SA v Prudential Assurance, (“The Ikarian
Reefer”) (1993) 2 Lloyd’s Rep 68 (QB)

Omar v Government of the Republic of South Africa 2006 (1) SACR 359 (CC)

Pennington v Minister of Justice 1995 (3) BCLR 270 (C)

Pharmaceutical Manufacturers Association of SA, In re Ex parte President of
Republic of South Africa 2000 (2) SA 674 (CC)

Pringle v Administrator, Transvaal 1990 (2) SA 379 (WLD)

R v Abadom (1983) 1 WLR 126

R v Anderson 1928 CPD 195

R v Arnold (1724) 16 Howell’s State Trials 695

R v Biyana 1938 (EDLD) 310

R v Bourke 1916 (TPD) 303

R v Burgess (1991) 2 All ER 769 (CA)

R v Byrne (1960) 3 AER 1

R v Chaulk 1991 CRR (2d) 1 (SCC)

R v Dhlamini 1955 (1) SA 120 (T)

R v H 1962 (1) SA 197 (A)

R v Harris 1965 (2) SA 340 (A)

R v Hay (1899) 16 SC 290

R v Holiday 1924 (AD) 250

R v Hughes 1987 (3) SA 97 (A)

R v Hugo 1940 (WLD) 285

R v Ivory 1916 WLD 17

R v Jacobs 1940 TPD 142

R v Johnson 1970 (2) SA 405 (R)

R v Katz 1946 AD 781

R v Kemp (1956) 3 All ER 249; 1957 (1) QB 339

R v Kruger 1958 (2) SA 320 (T)

R v Malott 1998 SCR 123

R v Matthews 1960 (1) SA 752 (A)

R v M'Naghten 1843 8 ER 718

R v Mofokeng 1928 (AD) 132

R v Morela 1947 (3) SA 147 (A)

R v Noll (1999) 3 VR 704

R v Orsmond 1936 EDL 142

R v Quick 1973 QB 910

R v Roberts 1957 (4) SA 265 (A)

R v Senekal 1969 (4) SA 478 (RA)

R v Smit 1906 TS 783

R v Steyn 1954 (1) SA 324 (AD)

R v Sullivan 1984 AC 156, (1983) 2 All ER 673

R v Taylor 1949 (4) SA 702 (A)

R v Theunissen 1946 (2) PH H 242 (N)

R v Thibani 1949 (4) SA 720 (A)

R v Trupedo 1920 AD 58

R v Turner (1975) 1 QB 834

R v Van der Veen 1909 TS 853

R v Vilbro 1957 (3) SA 223 (A)

R v Von Zell 1953 (3) SA 301 (A)

R v Westrich 1927 CPD 466

R v Zulch 1937 (TPD) 400

Reed v State 391 A.2d 364 (1978)

Ruto Flour Mills v Adelson (1) 1958 (4) SA 235 (T)

S v Adams 1986 (4) SA 882 (A)

S v April 1985 (1) SA 639 (NC)

S v Arnold 1985 (3) SA 256 (CPD)

S v Azov 1974 (1) SA 808 (T)

S v Bailey 1982 (3) SA 772 (A)

S v Baloyi 2000 (1) SACR 81 (CC), 2000 (2) SA 425 (CC), 2000 (1) BCLR 86 (CC)

S v Bezuidenhout 1964 (2) SA 651 (A)

S v Bhulwana; S v Gwadiso 1995 (12) BCLR 1579 (CC)

S v Blaauw 1980 (1) SA 536 (C)

S v Boyce 1990 (1) SACR 13 (T)

S v Calitz 1990 (1) SACR 119 (A)

S v Campher 1987 (1) SA 940 (A)

S v Chretien 1981 (1) SA 1097 (A)

S v Coetzee 1997 (4) BCLR 437 (CC)

S v Collop 1981 (1) SA 150 (A)

S v Cunningham 1996 (1) SACR 631 (A)

S v D 1995 (2) SACR 502 (C)

S v De Beer 1995 (1) SACR 128 (SE)

S v Di Blasi 1996 (1) SACR 1 (A)

S v Dobson 1993 (2) SACR 86 (E)

S v Dobson 1993 (4) SA 55 (E)

S v Dodo 2001 (3) SA 382 (CC)

S v Dyani 2004 (2) SACR 365 (E)

S v Eadie (1) 2001 (1) SACR 172 (CPD)

S v Eadie 2001 (2) (1) SACR 185 (CPD)

S v Eadie 2002 (1) SACR 663 (SCA)

S v Eadie 2002 (3) SA 719 (SCA)

S v Ebrahim 1973 (1) SA 868 (A)

S v Edley 1970 (2) SA 223 (NPD)

S v Edward 1992 (2) SACR 429 (ZH)

S v Els 1993 (1) SACR 723 (O)

S v Engelbrecht 2005 (2) SACR 41 (WLD)

S v Eyden 1982 (4) SA 141 (T)

S v Ferreira 2004 (2) SACR 454 (SCA)

S v Flanagan 2003 (2) SACR 98 (ECD)

S v Forbes 1970 (2) SA 594 (C)

S v Francis 1999 (1) SACR 650 (SCA)

S v Gakool 1965 (3) SA 461 (N)

S v Gesualdo 1997 (2) SACR 68 (W)

S v Gouws 1967 (4) SA 527 (E)

S v Griessel 1993 (1) SACR 178 (O)

S v Gxako 1965 (4) SA 12 (E)

S v Harman 1978 (3) SA 767 (A)

S v Harris 1965 (2) SA 340 (A)

S v Henry 1999 (1) SACR 13 (SCA)

S v Huma (1) 1995 (2) SACR 407 (W)

S v Ingram 1995 (1) SACR 1 (A)

S v Ingram 1999 (2) SACR 127 (WLD)

S v J 1975 (3) SA 146 (EPD)

S v Johnson 1969 (1) SA 201 (A)

S v Jones 2004 (1) SACR 420 (CPD)

S v Jordan 2002 (6) SA 642 (CC)

S v Kahita 1983 (4) SA 618 (C)

S v Kalogoropoulos 1993 (1) SACR 12 (A)

S v Kamimbi 1963 (3) SA 250 (CPD)

S v Kavin 1978 (2) SA 731 (W)

S v Kensley 1995 (1) SACR 646 (A)

S v Kleynhans 2005 (2) SACR 582 (WLD)

S v Kok 1998 (1) SACR 532 (NPD)

S v Kok 2001 (2) SACR 106 (SCA)

S v Kosztur 1988 (3) SA 926 (A)

S v Kruv 1959 (3) SA 392 (A)

S v Kubeka 1982 (1) SA 534 (W)

S v Lange 1989 (1) SACR 199 (W)

S v Larsen 1994 (2) SACR 149 (A)

S v Laubscher 1979 (3) SA 47 (A)

S v Laubscher 1988 (1) SA 163 (A)

S v Lawrence 1991 (2) PH (H) 74

S v Lawrence 1991 (2) SACR 57 (A)

S v Leaner 1996 (2) SACR 347 (C)

S v Leeuw 1980 (3) SA 815 (A)

S v Leeuw 1987 (3) SA 97 (A)

S v Lehnberg 1975 (4) SA 553 (A)

S v Lesch 1983 (1) SA 814 (EPD)

S v Loubscher 1979 (3) SA 47 (A)

S v M 1985 (1) SA 1 (A)

S v M 1989 (3) SA 887 (W)

S v Mabena 2007 (1) SACR 482 (SCA)

S v Mahlinza 1967 (1) SA 408 (A)

S v Majola 2001 (1) SACR 337 (NPD)

S v Makaula 1964 (2) SA 575 (E)

S v Maki 1994 (2) SACR 414 (E)

S v Makwanyane 1995 (3) SA 391 (CC); 1995 (6) BCLR 665 (CC)

S v Malgas 2001 (2) SA 1222 (SCA)

S v Malindi 1983 (4) SA 99 (TPD)

S v Marais 2010 (2) SACR 606 (CC)

S v Mashimbi 1958 (1) SA 390 (T)

S v Matlabane 1995 (8) BCLR 951 (B)

S v Mbatha 1996 (2) SA 464 (CC)

S v Mbele 1991 (1) SA 307 (WPD)

S v McBride 1979 (4) SA 313 (W)

S v McDonald 2000 (2) SACR 493 (N)

S v Meyer 1981 (3) SA 11 (A)

S v Mhetoa 1968 (2) SA 773 (O)

S v Mhlungu 1995 (3) SA 867 (CC)

S v Mkhize 1999 (1) SACR 256 (WLD)

S v Mkohle 1990 (1) SACR 95 (A)

S v Mngomezulu 1972 (1) SA 797 (A)

S v Mnisi 2009 (2) SACR 227 (SCA0)

S v Mnyanda 1976 (2) SA 751 (A)

S v Mogorosi 1979 (2) SA 938 (A)

S v Mokonto 1971 (2) SA 319 (A)

S v Morake 1979 (1) SA 121 (B)

S v Moses 1996 (1) SACR 701 (C)

S v Motshekga 1993 (2) SACR 247 (A)

S v Mphungatje 1989 (4) SA 139 (O)

S v Nangatuuala 1997 (4) SA 766 (SWA)

S v Nell 1968 (2) SA 577 (A)

S v Nursingh 1995 (2) SACR 331 (D)

S v Olivier 2007 (2) SACR 596 (CPD)

S v Olivier (2007) 4 All SA 1029 (T)

S v Oliphant 1989 (4) SA 169 (EPD)

S v Pederson 1998 (2) SACR 383 (NPD)

S v Phillips 1985 (2) SA 727 (NPD)

S v Piccione 1967 (2) SA 334 (N)

S v Pieterse 1982 (3) SA 678 (A)

S v Pietersen 1994 (2) SACR 434 (C)

S v Pineiro 1993 (2) SACR 412 (Nm)

S v Potgieter 1994 (1) SACR 61 (A)

S v Ramgobin 1986 (4) SA 117 (NPD)

S v Ramokoka 2006 (2) SACR57 (WLD)

S v Rittman 1992 (2) SACR 110 (Nm)

S v Scholtz 2006 (1) SACR 442 (EPD)

S v September 1996 (1) SACR 235 (A)

S v Shapiro 1994 (1) SACR 112 (A)

S v Shivute 1991 (1) SACR 656 (Nm)

S v Sibiyi 1984 (1) SA 73 (A)

S v Simxadi 1997 (1) SACR 169 (C)

S v Sindane 1992 (2) SACR 223 (A)

S v Sishi 2000 (2) All SA 56 (N)

S v Sithole 2005 (1) SACR 311 (W)

S v Smit 1906 TS 783

S v Smith 1990 (1) SACR 130 (A)

S v Stellmacher 1983 (2) SA 181 (SWA)

S v Steyn 1963 (1) SA 797 (W)

S v Swart 1978 (1) SA 503 (C)

S v T 1986 (2) SA 112 (O)

S v Thebus 2003 (6) SA 505 (CC); 2003 (2) SACR 319 (CC)

S v Tom 1991 (2) SACR 249 (B)

S v Trickett 1973 (3) SA 526 (TPD)

S v V 1984 (1) SA 33 (T)

S v V 1996 (2) SACR 290 (C)

S v Van As 1989 (3) SA 881 (W)

S v Van As 1991 (2) SACR 74 (W)

S v Van der Sandt 1998 (2) SACR 627 (W)

S v Van Lill 1969 (2) PH H 219 (T)

S v Van Niekerk 1992 (1) SACR 1 (A)

S v Van Vuuren 1983 (1) SA 12 (A)

S v Van Zyl 1964 (2) SA 113 (A)

S v Van Zyl 1996 (2) SACR 22 (A)

S v Veldthuisen 1982 (3) SA 413 (A)

S v Viljoen 1992 (1) SACR 601 (T)

S v Visser unreported case number CC 545/09

S v Volkman 2004 (4) All SA 697 (C)

S v Volkman 2005 (2) SACR 402 (C)

S v Walters 2002 (4) SA 613 (CC)

S v Webb (1) 1971 (2) SA 340 (T)

S v Wiid 1990 (1) SACR 561 (A)

S v Williams 1985 (1) SA 750 (C)

S v Williams 1995 (7) BCLR 861 (CC)

Sell v United States 539 US 166 (2003)

Shabalala v Attorney-General of Transvaal 1996 (1) SA 725 (CC), 1995 (2) SACR (CC), 1995 (12) BCLR 1593 (CC), 1994 (6) BCLR 85 (T)

Speaker of the National Assembly v De Lille 1999 (11) BCLR 1339 (SCA)

State v Kelly 478 A.2d 364 (1984)

State of Louisiana v Heads 370 So.2d 564 (1979)

Stock v Stock 1981 (3) SA 1280 (A)

Strydom v Minister of Correctional Services 1999 (3) BCLR 342 (W)

Swanepoel v Transnet 2000 (2) SA 191 (T)

United States v Addison 498 F.2d 741 (1974)

United States v Alexander 805 F.2d (1986)

United States v Downing 753 F.2d 1224 (1985)

United States v Jacobetz 747 F.Supp 250 (1990)

United States v Lawson 653 F.2d 299 (1981)

United States v Williams 431 F.2d 1168 (1970)

United States v Williams 583 F.2d 1194 (1978)

Van Wyk v Lewis 1924 AD 438

Watkins v People 158 Col. 485, 408 P.2d 425 (1965)

Webb v Isaacs 1915 EDL 273

Youtsey v United States 97 F 937 (1899)

Zantsi v Council of State, Ciskei 1995 (4) SA 615 (CC)