

Pathological criminal incapacity and the conceptual interface between law and medicine

J LE ROUX* AND GP STEVENS**

ABSTRACT

This article addresses the problematic conceptual interface between law and the fields of psychiatry and psychology when the defence of pathological criminal incapacity is raised in a criminal court. The definition and assessment of 'mental illness' or 'mental defect' as threshold requirements for the defence are analyzed according to the medical model, legal model and cross-dimensional model of mental illness.

1. Introduction

'So fearfully and wonderfully are we made, so infinitely subtle is the spiritual part of our being, so difficult is it to trace with accuracy the effect to all who hear me, whether there are any causes more difficult, or which, indeed, so often confound the learning of judges themselves, as when insanity, or the effects and consequences of insanity, become the subjects of legal consideration and judgment.'¹

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 South African Criminal Procedure Act 51 of 1977 (CPA) provides for a panel of three psychiatrists and a clinical psychologist to evaluate, observe and report on the mental status of the accused. At 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.

* BJuris, LLB (NMMU), LLD (UP); former Professor at the University of Pretoria.

** LLB (UP), LLM (UP), LLD (UP); Senior lecturer, University of Pretoria, Advocate of the High Court of South Africa, associate member of the Pretoria Bar.

¹ T Erskine as quoted in DN Robinson *Wild Beasts and Idle Humours – The Insanity Defence from Antiquity to – The Present* (1996) 20.

Hiemstra describes the interface between law and psychiatry by stating that psychiatry views a human being as a dynamic entirety;² psychiatry wants to treat, not condemn. The criminal law wants to know whether it is justifiable to hold an individual punishable for his or her conduct. It was also stated in the Rumpff Report that psychiatry is essentially therapeutic and is not orientated towards morality of the law.³ It is precisely this difference between the essential purpose of the law and that of psychiatry which is responsible for the lack of mutual appreciation between these fields. The Appeal Court of South Africa has demonstrated a fair degree of scepticism towards the psychiatric profession through the words of Van den Heever JA in *R v Von Zell*⁴ where expert psychiatric evidence was rejected as 'deductions [from a] speculative science with rather elastic notation and terminology, which is usually wise after the event'. Innes CJ in *R v Smit*⁵ similarly summarised the problematic fundamental differences in outlook between law and mental health experts by stating that the two classes approach the matter from different standpoints, and are perhaps unwittingly influenced by different predilections and by varying importance of different considerations. 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 responsibility. Individual responsibility presupposes freedom of will as advocated by

² A Kruger *Hiemstra's Criminal Procedure* (May 2011, Service Issue 4) 13-3. See also BA Arrigo *Punishing the Mentally Ill – A Critical Analysis of Law and Psychiatry* (2002) 128 who highlights the importance of the interface between law and psychiatry by stating that '[t]he intersecting categories of crime and behaviour provide many relevant examples that demonstrate just how important law and psychiatry are for setting social policy or for shaping forensic practice.' See further A Stone *The Insanity Defense on Trial* (1982) 636.

³ Rumpff Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters R.P. 69/1967 at para [9.39]. See also FA Whitlock *Criminal Responsibility and Mental Illness* (1963) 1-93; DN Greig *Neither Bad Nor Mad – The Competing Discourses of Psychiatry, Law and Politics* (2002) 107-122; DW Jones *Understanding Criminal Behaviour – Psychosocial approaches to criminality* (2008) 37-71; P Bean *Madness and Crime* (2008) 1-60; CR Bartol and A Bartol *Criminal Behavior – A Psychosocial Approach* (2005) 187-235; SZ Kaliski 'The criminal defendant' in *Psychological Assessment in South Africa* SZ Kaliski (ed) (2006) 93-112; HF Fradella *From Insanity to Diminished Capacity – Mental Illness and Criminal Excuse in Contemporary American Law* (2007) 15-58; R Slovenko *Psychiatry in Law – Law in Psychiatry* Volume 1 (2002) 187-290.

⁴ *R v Von Zell* 1953 (3) SA 303 (AD) at 311A-B.

⁵ *R v Smit* 1906 TS 783 at 784-785.

the deterministic school of thought. Conversely, psychiatrists follow a more deterministic school of thought.⁶

Whenever the criminal 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 clear. One of the primary sources of conflict between criminal law and psychiatry 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 wrongfulness of his or her act or omission and/or acting in accordance with such appreciation of wrongfulness. Accordingly, the threshold requirement for pathological criminal incapacity is 'mental illness or defect'.

The problem with South Africa's 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 as a consequence of a particular 'mental illness' or 'mental defect'. This problem is exacerbated by the fact that the term 'criminal capacity' is a legal term and not a medical one.⁷ The question which falls to be considered is whether harmonious co-operation between the law and psychiatry has not perhaps become indispensable for a proper understanding of the concept of 'mental illness' and the defence of pathological criminal incapacity?

2. Defining and assessing 'mental illness' or 'mental defect' as threshold requirements for 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.'⁸ 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

⁶ SA Strauss 'Legal aspects of mental disorder' (1971) *Journal of Juridical Science* 3. See also BT Gilmer, DA Louw and T Verschoor 'Law and psychology: An exploration of the conceptual interface' (1997) *SACJ* 19; J Monohan and EF Loftus 'The psychology of law' (1982) *Annual Review of Psychology* 441-475.

⁷ SA Strauss *Doctor, Patient and the Law – A Selection of Practical Issues* (1991) 121-135.

⁸ DH Barlow and VM Durand *Abnormal Psychology* (1995) 14.

mind' or as defined in section 78(1) of the CPA, a 'mental illness' or a 'mental defect'.⁹ 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 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.¹⁰

The concept of mental illness is not a static one but an evolving and changing concept amenable to the changing conditions of life.¹¹ 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.¹² Historically various tests for insanity were applied including the 'wild

⁹ Section 78(1) of the Criminal Procedure Act 51 of 1977 reads 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 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.' The assessment of mental illness or mental defect denotes the pathological leg of the test for criminal incapacity.

¹⁰ CR Snyman *Criminal Law* 5ed (2008) 171; J Burchell *Principles of Criminal Law* 3ed (2005) 370; R Slovenko 'The meaning of mental illness in criminal responsibility' (1984) *The Journal of Legal Medicine* 1; JB Gerard 'The medical model of mental illness – its application to the insanity defence' (1999) *International Journal of Law and Psychiatry* 65-78; SJ Brakel and AD Brooks *Law and Psychiatry in the Criminal Justice System* (2001) 61; H Fingarette 'The concept of mental disease in criminal law insanity tests' (1965-1966) *University of Chicago Law Review* 229; R Slovenko 'The mental disability requirement in the insanity defense' (1999) *Behavioral Sciences and the Law* 165.

¹¹ R Slovenko *Psychiatry and Criminal Culpability* (1995) 1-66 explains that notions expand, or contract, with increased knowledge of mental disorders (or what are accepted as mental disorders) and of different conditions causing different disorders.

¹² Burchell op cit (n10) 374.

beast' test, the 'right or wrong' test and the M'Naghten test.¹³ These tests focused strongly on mental illnesses leading to an impairment of the cognitive capacity ('insight') to the exclusion of illnesses impairing the conative capacity ('self control').¹⁴

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.¹⁵

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 as a consequence of 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 describes this dilemma by stating the following:¹⁶

'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 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.'

¹³ A Platt and BL Diamond 'The origins of the "right and wrong test" of criminal responsibility and its subsequent development in the United States: A historical survey' (1966) 54 *California Law Review* 1227. See also Slovenko op cit (n11) where it is stated that, in Biblical times, mental disease was strongly 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.

¹⁴ It was argued in the Rumpff Report op cit (n3) para [9.84] that the test should be broadened to also accommodate impairment of the conative capacity and in terms of the law in force in South Africa, insight and self-control should be regarded as criteria of responsibility.

¹⁵ Snyman op cit (n10) 172; Burchell op cit (n10) 374.

¹⁶ Slovenko (1984) op cit (n10) 4.

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 thus becomes necessary to disseminate the issues related 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.

3. A conceptual analysis of mental illness and mental defect

In terms of section 78(1) of the CPA the two terms are used interchangeably, namely ‘mental illness’ and ‘mental defect’. These two terms are not defined within the legislative framework of the CPA and it is accordingly often unclear what the precise distinction between these two concepts actually entails.¹⁷

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 associated with 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 any criminal justice system is currently faced with is how to better or 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.¹⁸

¹⁷ SA Strauss ‘Geestesontsteldheid en die stafreg: Die voorgestelde nuwe reeling in die strafproseswetsontwerp’ (1974) *THRHR* 229 notes that it is unclear where the borderline between these two concepts can be found. In the Rumpff Report op cit (n3) para [9:97] no clear demarcation of these terms is provided and the Mental Health Care Act 17 of 2002 also does not resolve the issue.

¹⁸ B Hoggett *Mental Health Law* (1990) 89-91 opines that 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. See also A Kruger *Mental Health Law* (1980) 49 and N Haysom, M Strous and L Vogelman ‘The mad Mrs Rochester revisited: The involuntary confinement of the mentally ill in South Africa’ (1990) *SAJHR* 341.

The South African Mental Health Care Act currently defines mental illness as follows:¹⁹ ‘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 is not a determinant of criminal capacity.²⁰ 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 person also being mentally ill in terms of section 78(1) of the CPA.²¹ 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.²² 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.²³ Burchell and Milton state the following:²⁴

‘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

¹⁹ Section 1 of the Mental Health Care Act 17 of 2002.

²⁰ See *R v Kruger* 1958 (2) SA 320 (T) at 320; *S v Harman* 1978 (3) SA 767 (A) at 770; *S v Mnyanda* 1976 (2) SA 751 (A) at 764; *S v Mablinza* 1967 (1) SA 408 (A) at 416. See also *R v Von Zell* supra (n4) 309 where Van den Heever JA clearly states that the fact that a person charged with a crime of violence is or is not certifiable under the Mental Disorders Act is relevant, as it narrows the issue. 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.

²¹ Act 51 of 1977.

²² J Burchell *South African Criminal Law and Procedure – General Principles of Criminal Law* 3ed (1997) 164, based on the work of EM Burchell and PMA Hunt.

²³ Burchell op cit (n10) 377; Kruger op cit (n18) 184.

²⁴ Burchell op cit (n10) 377. See also C Tredoux *Psychology and the Law* (2005) 420-421 where the term ‘mental retardation’ is provided as a synonym for the terms ‘mental defect’, ‘mental handicap’ or ‘intellectual disability’. A person with an intellectual disability is described here as one whose cognitive or intellectual ability is markedly below the average level and whose ability to adapt to his or her environment is decreased. In *Durham v United States* 214 F.2d 862 (DC Cir 1954) at 875 the court distinguishes between ‘disease’ and ‘defect’ in that the former phrase is used in the sense of a condition which is considered capable of either improving or deteriorating, whilst the latter condition denotes a non-changing state which may be either congenital, or the result of injury or the residual effect of a physical or mental disease. See also Fingarette op cit (n10) 239.

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 Mablinza*.²⁵ 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 while the other children escaped. The accused pleaded not guilty to the charges. The trial court found her not guilty. On appeal the following question of law was, amongst others, reserved for consideration:²⁶ 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 the Mental Disorders Act 38 of 1916 (a predecessor of the Mental Health Care Act).

The district medical practitioner, Dr Fismer, stated the following in respect of the accused’s mental state:²⁷

‘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 Fismer] – Yes, yes she was.’

A psychiatrist, Dr Boyd, testified that the accused was mentally disordered at the time of the crime.²⁸ 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

²⁵ *S v Mablinza* supra (n20). See also J Burchell *Cases and Materials on Criminal Law* 3ed (2007) 349.

²⁶ *S v Mablinza* supra (n20) at 411D-E.

²⁷ *Ibid* at 412B-C.

²⁸ *Ibid* at 412E-F.

temporary mental disorder but not a permanent mental illness which would render her certifiable.²⁹

Rumpff JA in *Mablinza* referred to the conceptual interface between law and medicine by emphasizing that the concepts ‘criminal liability’ and ‘elements of a crime’ are purely legal concepts. When an investigation is conducted into the mental capacities of an accused in order to evaluate his or her criminal capacity, the evidence of medical experts is obviously in many instances of great importance, but not conclusive. The concepts ‘mental illness’ and ‘mental defect’ are, however, psychiatric concepts and not legal concepts. When considering those concepts the evidence of medical experts is, in all instances, of utmost importance.³⁰ 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.³¹
- A court will have to determine on the facts deposed before it whether a mental disorder is of a temporary or permanent nature.³²
- Due to a lack of definition of the concept of mental illness, medical psychiatric evidence becomes indispensable.³³
- 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

²⁹ Ibid at 414A. See also 413D-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.’

³⁰ *S v Mablinza* supra (n20) at 416B-C.

³¹ Ibid at 417D-E. See also *R v Senekal* 1969 (4) SA 478 (RA) at 487 and *S v Edward* 1992 (2) SACR 429 (ZH).

³² *S v Mablinza* supra (n20) at 417E-F.

³³ Ibid at 417F-G.

disorder as this could amount to speculation by the courts in a field which they do not have expertise in. Such an approach could be medically and scientifically unjust.³⁴

- When assessing the issue whether mental illness was present, the cause of the mental illness is not important provided that the disorder is pathological.³⁵

Rumpff JA held that there was no evidence of a mental state of unconsciousness without mental illness and, 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 question of law had to be answered in the affirmative.³⁶

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

In *S v Mabena* Nugent JA emphasized the importance of expert evidence in the following way:³⁷

“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* Mouton J conceptualized the term ‘mental illness’ as referring to a pathological disturbance of the accused’s mental abilities and not merely a temporary mental confusion due to external triggers such as alcohol or provocation.³⁸ The fact that the accused’s mental condition could have deviated from what is considered ‘normal’ is not proof of a mental illness.³⁹

Smith and Hogan define mental illness in broader terms by stating 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

³⁴ Ibid at 417F-H.

³⁵ Ibid at 418D-E.

³⁶ Ibid at 419D-F.

³⁷ *S v Mabena* 2007 (1) SACR 482 (SCA) at para [16]. See also E du Toit, FJ de Jager, A Paizes, A Skeen and S van der Merwe *Commentary on the Criminal Procedure Act* (2008) (Service Issue 41) 13-11.

³⁸ *S v Stellmacher* 1983 (2) SA 181 (SWA).

³⁹ *S v Stellmacher* supra (n38) at 187. See also Strauss op cit (n6) 127 and JW Jonck and T Verschoor ‘Noodsaaklikheid van toestemming deur ‘n beskuldigde by ‘n ondersoek kragtens artikel 79 van die Strafproseswet’ (1997) 2 *Journal for Juridical Science* 198.

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.⁴⁰

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 the person him/herself or to other persons.⁴¹ In *R v Byrne*⁴² Lord Parker defined 'abnormality of the mind' as follows:⁴³

'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 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 South African 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.⁴⁴ The question which arises is whether the circumstances of

⁴⁰ JC Smith *Smith and Hogan – Criminal Law* (2008) 12ed 258-259.

⁴¹ Tredoux *et al* op cit (n24) 420.

⁴² *R v Byrne* 1960 (3) All ER 1.

⁴³ *R v Byrne* supra (n42) 4. This aspect is also discussed by PHJ van Rensburg, T Verschoor, and JL Snyman 'Psychiatric and legal aspects of the concept of mental illness' (1983) *Journal for Juridical Science* 168.

⁴⁴ The National Alliance for the Mentally Ill defines mental illness, available at <http://karisable.com/crmb.htm>, accessed on 17 April 2009, as 'disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. Mental illnesses are brain disorders resulting in a diminished capacity for coping with the demands of life'. The Wikipedia encyclopedia defines mental illness, available at http://en.Wikipedia.org/wiki/Mental_illness, accessed on 11 June 2006, as 'a psychological or behavioural 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.'

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 *Mablinza*-decision should also apply to the current application of the insanity defence. The law should not lay down general 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.⁴⁵
- There exists an implicit analogy between physical disease and mental disease. Fingarette encapsulates this analogy as follows:⁴⁶

“Disease” offers a serviceable analogy for use in the context of criminal responsibility because it is possible to view some criminal-like conduct as morally similar to the symptom of a disease. The ordinary physical disease symptom is an abnormality which is produced from within the person himself; it is the result of something in the person, or of something about the person’s makeup which is at least for the time a part of him. 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.⁴⁷

In *R v Harris*⁴⁸ 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 in South Africa 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, Professor Hurst, stated that the accused suffered from manic ecstasy which precluded criminal

⁴⁵ R Louw ‘Principles of criminal law: Pathological and non-pathological criminal incapacity’ in SZ Kaliski *Psychological Assessment in South Africa* (ed) (2006) 47.

⁴⁶ Fingarette op cit (n10) 245.

⁴⁷ Strauss op cit (n17) 230; PJ Visser and MC Maré *Visser and Vorster’s General Principles of Criminal Law through the Cases* 3ed (1990) 326.

⁴⁸ *R v Harris* 1965 (2) SA 340 (A).

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 Professor 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 Professor 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. Professor Hurst stated the following in respect to the definitions of manic ecstasy:⁴⁹

'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 Professor Hurst with reference to the characteristics of manic ecstasy, Steyn CJ dismissed the appeal and held:⁵⁰

'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 arteriosclerosis⁵¹ and either permanent or temporary in nature. In *R v Kemp*⁵² an elderly man who suffered from arteriosclerosis, struck his wife with a hammer and inflicted a grievous wound on her. He was charged with causing grievous bodily harm to her. At the subsequent trial medical evidence was

⁴⁹ *R v Harris* supra (n48) at 351F-H.

⁵⁰ *Ibid* at 360D-E.

⁵¹ See *S v Campher* 1987 (1) SA 940 (A).

⁵² *R v Kemp* 1957 (1) QB 339; 1956 All ER 249.

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 thus 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 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*. It was further held 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. It was accordingly immaterial whether the disease had a mental or physical origin or whether it was permanent or temporary.

In delivering judgment, Lord Devlin stated the following:⁵³

'I should think that it would probably be recognised by medical men that there are mental diseases which have an organic cause; that there are disturbances of the brain which can be traced to some hardening of the arteries, to some degeneration of the brain cells or to some physical condition which account for mental derangement. It would probably be recognised that there are diseases functional in origin about which it is not possible to point to any physical cause but simply to say that there has been a mental derangement of the functioning of the mind, such as melancholia, schizophrenia and many other of those diseases which are primarily handled by psychiatrists, but that distinction is rightly not pressed as part of the argument for the defence in the present case. 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 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

⁵³ *R v Kemp* supra (n52) at 253B-I.

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.⁵⁴ The illness must be endogenous and not exogenous.⁵⁵ 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.⁵⁶

According to Fingarette the question whether a disease has its source in mental disease or defect, can be resolved by asking three questions:⁵⁷

- (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.
- (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

⁵⁴ R Card *Card, Cross and Jones – Criminal Law* 17ed (2004) 727-728. See also *R v Quick; R v Paddison* 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.'

⁵⁵ See *S v Swart* 1978 (1) SA 503 (C).

⁵⁶ Visser and Maré op cit (n47) 326.

⁵⁷ Fingarette op cit (n10) 246.

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.⁵⁸

- 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*.⁵⁹
- The mere tendency to violent behaviour is not *per se* indicative of mental illness.⁶⁰
- 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.⁶¹

In *R v Harris* Williamson JA held the following in respect of expert psychiatric evidence:⁶²

‘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 thus far focused on the fundamental guidelines that have 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 then 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? A discussion of the various arguments in support of a medical *versus* a legal model of mental illness would accordingly be of value.

⁵⁸ *S v Steyn* 1963 (1) SA 797 (W); Strauss op cit (n7) 128; Van Rensburg *et al* op cit (n43) 163.

⁵⁹ See *R v Bourke* 1916 TPD 303; *R v Holiday* 1924 AD 250.

⁶⁰ CJR Dugard ‘Whither insane automatism’ (1967) 84 *SALJ* 134.

⁶¹ FFW van Oosten ‘The insanity defence: Its place and role in the criminal law’ (1990) 3 *SACJ* 6.

⁶² *R v Harris* supra (n48) at 365B-C.

4. The medical model of mental illness

It has been held that whilst the term ‘insanity’ is a legal concept, the concept of mental disease remains essentially a medical concept.⁶³ Weihofen argues in favour of the medical model of mental illness by stating that the existence of mental illness, like physical illness, is a medical question.⁶⁴ 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.⁶⁵ According to Diamond, the diagnosis and assessment of mental illness should be governed by clinical criteria and definitions.⁶⁶ Diamond notes that it is not up to the law to establish the threshold for the existence of mental illness in a criminal defendant.⁶⁷ 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 diagnosis, mental state and motivation at the time of the alleged offence in order to assist the judge in reaching the ultimate conclusion.⁶⁸

Gerard submits that the question, whether a specific disorder classified in terms of the DSM-IV⁶⁹ qualifies as a disorder for purposes

⁶³ NJ Finkel *Insanity on Trial – Perspectives in Law and Psychology* (1988) 73; RJ Menzies, CD Webster and MA Jackson ‘Legal and medical issues in forensic psychiatric assessments’ (1981-1982) *Queens Law Journal* 14; ME Schiffer *Mental Disorder and Criminal Trial Process* (1978) 127; Gerard op cit (n10) 67; Slovenko (1999) op cit (n10) above 167.

⁶⁴ H Weihofen ‘The definition of mental illness’ (1960) 21(1) *Ohio State Law Journal* 4; R Slovenko ‘The meaning of mental illness in criminal responsibility’ (1984) *The Journal of Legal Medicine* 1-12.

⁶⁵ B Diamond ‘Reasonable medical certainty, diagnostic thresholds, and definitions of mental illness in the legal context’ (1985) *Bulletin American of the Academy of Psychiatry and the Law* 121.

⁶⁶ Slovenko (1999) op cit (n10) 168; Slovenko op cit (n3) 249.

⁶⁷ Diamond op cit (n65) 121.

⁶⁸ The American Psychiatric Association’s ‘Statement on the Insanity Defence’ as quoted in Finkel op cit (n63) 79.

⁶⁹ See Gerard op cit (n10) 67.

of the insanity defence, remains a legal and not a medical question.⁷⁰ 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.⁷¹ Gerard confirms the medical prerogative of the term 'mental disease or defect' but notes the following:⁷²

'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 remarks that supporters of the medical model demand that the study and assessment of psychiatric disorders is a medical problem and that mental illnesses are thus the consequence of physical malfunctions.⁷³ The hypothesis of physical 'malfunction' correlates with the concept of 'disease' as understood in medicine.⁷⁴ Gerard further states that the natural history of a disease consists of five elements, namely:⁷⁵

- clinical description
- etiology
- epidemiology
- physiology
- pathology

The most important element is a valid clinical description.⁷⁶ According to the medical model, a clinical description must consist of three requirements in order for a particular phenomenon to constitute a disease, namely:⁷⁷

- A comprehensive description of the disease's signs and symptoms, its origin and progression;

⁷⁰ JB Gerard 'The usefulness of the medical model to the legal system' (1987) *Rutgers Law Review* 391-394.

⁷¹ *Ibid* at 391.

⁷² *Ibid*.

⁷³ Gerard *op cit* (n10) 70.

⁷⁴ *Ibid*.

⁷⁵ *Ibid*.

⁷⁶ Gerard *op cit* (n10) 71. See also S Guze *Criminality and Psychiatric Disorders* (1976) 30-56.

⁷⁷ Gerard *op cit* (n10) 73.

- The description must distinguish the particular disease from other diseases and accordingly constitute a 'differential diagnosis';
- The description must elaborate on the consequences if the particular disease is left untreated.

If the abovementioned criteria are 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. The medical model therefore establishes a scientific foundation for distinguishing disorders that are legally significant from those that are not.⁷⁸ 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.⁷⁹ Gerard 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.⁸⁰ According to Gerard there are two major obstacles to reliable diagnoses:⁸¹

- (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.⁸²
- (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 does, however, contain extensive diagnostic criteria of the particular clinical descriptions and expert witnesses should

⁷⁸ Ibid. Gerard notes that these disorders are: (1 and 2) affective disorders (mania and depression); (3) schizophrenia; (4) panic disorder (anxiety neurosis); (5) obsessive 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.

⁷⁹ Gerard op cit (n10) 77. See also BJ Ennis and TR Litwack 'Psychiatry and the presumption of expertise: Flipping coins in the courtroom' (1974) 62 *California Law Review* 693.

⁸⁰ Gerard op cit (n10) 77.

⁸¹ Ibid.

⁸² Ibid.

accordingly not be allowed to present diagnoses that fall short of the DSM criteria for that illness.⁸³

The medical model proposes that the insanity defence should only succeed if the following questions are answered positively:⁸⁴

- 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?

The description of the medical model of mental illness to some extent resembles the definition of mental illness as contained in Mental Health Care Act of South Africa as quoted above. The dictums in *Mablinza* and *Mabena* stated above could also be construed as supporting the medical model of mental illness.⁸⁵

The medical model accordingly asserts that the definition, diagnosis and assessment of mental illness should remain within the realm of the medical profession. A mental health professional which in almost all cases where the defence of insanity is raised will be the psychiatrist who 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. 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 for providing answers to the insanity defence will therefore be problematic.

In the decision of *Carter v United States* the dichotomy of the medical model was personified as follows:⁸⁶

'Mental "disease" means mental illness. Mental illnesses are of many sorts and have many characteristics. They, like physical illnesses, are the subject

⁸³ Ibid. See also Slovenko op cit (n64) 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.'

⁸⁴ Gerard op cit (n10) 78.

⁸⁵ *S v Mablinza* supra (n20) at 416B-C; *S v Mabena* supra (n37) at para [16].

⁸⁶ *Carter v United States* 252 F.2d 608 (DC Cir 1957) at paras [52] & [53].

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.

5. The legal model of mental illness

Proponents of the legal model of mental illness assert that the meaning of this concept is a legal rather than a psychiatric question.⁸⁷ 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 provided by the decision of *McDonald v United States*⁸⁸ where the court stated:⁸⁹

‘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 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 insanity would result in the disregard for modern psychiatric science, which is essential for determining criminal capacity. Melton *et al*⁹⁰ 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.

6. 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 arises is whether mental illness should not be construed as a cross-dimensional

⁸⁷ F McAuley *Insanity, Psychiatry and Criminal Responsibility* (1993) 63.

⁸⁸ *McDonald v United States* 312 F.2d 847 (DC Cir 1962).

⁸⁹ *McDonald v United States* supra (n88) at para [12].

⁹⁰ GB Melton, J Petrila, NG Poythress and C Slobogin *Psychological Evaluations for the Courts* (2007) 212.

concept providing for legal and medical principles? Within the paradigm of criminal incapacity, law requires that 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:⁹¹

‘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.’

Fingarette correctly asserts that as a result of the fact that 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.⁹² Fingarette acknowledges the cross-dimensional nature of the concept of mental illness by stating that 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 non-medical.⁹³

According to this model, 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 agrees 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.⁹⁴

7. Conclusion

Strauss refers to the interface between law and psychiatry by acknowledging the truth that the law is a normative science and, being ‘sovereign’, might theoretically set up its own norms for defining any

⁹¹ Finkel op cit (n63) 78.

⁹² Fingarette op cit (n10) 238.

⁹³ Ibid.

⁹⁴ Strauss op cit (n6) 10-11; Visser and Maré op cit (n47) 323.

legally relevant fact.⁹⁵ But to disregard modern scientific knowledge would be totally unjustifiable. Full recognition should be accorded to modern sciences in all spheres of law. If this is not done, the law would run the risk of degenerating into some kind of intellectual game unrelated to the realities of life. On the other hand the psychiatrist is not entitled to demand that the definition and assessment of criminal responsibility should be an exclusively psychiatric prerogative. Criminal responsibility and mental disease are not identical concepts. Psychiatry is in essence a therapeutic science, whereas the law defines minimum standards for human social conduct. Obviously not any degree of mental abnormality can lead to complete exoneration from criminal liability. The minimum standards of conduct set by society in the form of legal rules should, however, 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.⁹⁶

It is pivotal that scientific psychiatric knowledge is provided when the defence of criminal incapacity is raised. Courts should 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 conclusory opinions on criminal responsibility. This remains essentially a legal phenomenon.

⁹⁵ Ibid.

⁹⁶ Ibid.