Examining the Mr Tsafendas enquiry trial: Current insights on forensic psychiatric assessment and ethics

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On 6 September 1966, the prime minister of South Africa, Dr HF Verwoerd was killed by Mr Tsafendas, a Portuguese national of Greek descent, in parliament by stabbing him in the chest. Mr Tsafendas was a messenger in parliament. At the enquiry trial of Mr Tsafendas, he was found unfit to stand trial on the ground that he suffered from schizophrenia. The psychiatric evidence during the enquiry trial was reviewed and discussed under the following headings: Diagnosis of schizophrenia; Consideration of cultural factors in forensic psychiatric settings; Delusional infestation v. extreme overvalued beliefs; Simulation of psychosis; Ethical considerations in criminal capacity and trial competency assessments. Lessons from the Mr Tsafendas enquiry trial for forensic psychiatrists where a defendant previously diagnosed with schizophrenia commits a prominent political murder, are summarised. It is emphasised that the personhood of an accused referred for forensic observation should be respected and protected, instead of focusing exclusively on a specific diagnosis.

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Mr Demitri Tsafendas became a well-known figure after he stabbed and killed the prime minister of South Africa (SA), Dr HF Verwoerd, in September 1966. The subsequent trial was shrouded in controversy, and to this day many different opinions persist about conclusions that were reached during the trial, especially about the psychiatric expert testimony.

At the enquiry trial in the Cape Supreme Court, he was found unfit to stand trial on the grounds that he suffered from schizophrenia.[1] After the assassination of Dr Verwoerd the Rumpff Commission was appointed to investigate the efficacy and legal rules regarding criminal cases involving persons alleged to be suffering from some form of mental illness. The Rumpff Commission reviewed international and SA cases dealing with diminished criminal responsibility. Following the recommendations from the commission, the rules for determining criminal responsibility of individuals with mental illness were included in the Criminal Procedure Act, Sections 77, 78 and 79 as amended and are currently still in use.[2]

The conclusion that Mr Tsafendas was not fit to stand trial was confirmed by a subsequent commission of enquiry. Arising from this, Mr Tsafendas was declared a State President's patient and was detained in prison, and then in a psychiatric hospital until his death in 1999 at the age of 81 years. This article focuses on the psychiatric evidence during the summary trial enquiry into the mental status of Mr Tsafendas.

Methods

Despite the psychiatric evidence being provided 57 years ago, the authors reflect on lessons for forensic psychiatrists from this case that remain relevant today. This is done by analysing the psychiatric evidence presented during the court enquiry.[1] Additionally, the 2018 book, *The Man Who Killed Apartheid*, *The Life of Dimitri Tsafendas* by Harris Dousemetzis with Gerry Loughran[3] and a book by Henk van Woerden, *Domein van Glas*, translated by Antjie Krog were reviewed as background information.[4]

This case study aims to highlight some of the issues that psychiatrists have to take into consideration when they are doing similar forensic assessments with an emphasis on ethical, cultural and social meanings and a focus on generalisability considerations.

Results

The forensic psychiatric testimony provided during the trial will be discussed under the following headings:

1. Diagnosis of schizophrenia
2. Consideration of cultural factors in forensic psychiatric settings
3. Delusional infestation v. extreme overvalued beliefs
4. Simulation of psychosis
5. Ethical considerations in criminal capacity and trial competency assessments

1. Diagnosis of schizophrenia

Making a psychiatric diagnosis in a forensic setting has many challenges. One of these is an assessment of the mental state of the accused at the time of the offence, which is usually a retrospective assessment. This has a bearing on the criminal responsibility of the accused, including the retrospective nature of the mental state of the alleged offender at the time of the offence in question. Psychotic conditions are the mental disorders most often leading to a verdict of legal insanity.[5] To make a diagnosis of schizophrenia, the psychiatrist will use standardised diagnostic criteria, such as the criteria from the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

During the Mr Tsafendas enquiry trial, there was no mention of the diagnostic criteria used to make a diagnosis of schizophrenia. One

psychiatrist said he had to take shortcuts and another psychiatrist requested that the accused be admitted to a psychiatric hospital for further assessment.[1] This never happened, and Mr Tsafendas was consulted in a prison and police environment. During one interview, three psychiatrists and the police were present.[1] He was never observed by trained psychiatric staff in a hospital environment to ensure that due consideration was given to normative cultural variation. A diagnosis in the forensic psychiatric context should only be made after reflection on a global overall impression, including behavioural observation, historical information and collateral reports.[6]

In the Mr Tsafendas enquiry trial, the emphasis was on the positive symptoms (tapeworm delusional infestation) more than the general and negative symptoms. At the time of the trial, there was a history indicating that Mr Tsafendas had previously feigned psychiatric illness. In situations where there is a history of previous malingering, the psychiatrists should be very critical and less accepting of their impressions during the conduct and interpretation of the psychiatric examination.[7] Mr Tsafendas received previous psychiatric treatment in Germany, England and the USA. These treatment findings of overseas psychiatric units did not feature prominently in the trial. A request to evaluate a person without knowing what other professionals have found should be approached with great caution.[8]

How the diagnosis of schizophrenia is communicated in court and the way the court perceives the diagnosis is vital for the court to make the final findings. Description of symptoms and signs related to schizophrenia at the time of the crime is essential in forensic evaluations of criminal capacity. This aspect was not emphasised in the Mr Tsafendas enquiry trial.

When Mr Tsafendas was diagnosed with schizophrenia during the enquiry trial, the emphasis was on the delusional infestation surrounding the tapeworm as a positive sign of schizophrenia. It may be reasoned that the delusional infestation was an extreme overvalued belief, especially if his cultural background is taken into consideration.[9] The court accepted that Mr Tsafendas did not have a political motive for committing the crime, and this may have been influenced by the psychiatric evidence given in court. If an extreme overvalued belief is taken into account, we must distinguish political extremists' views from mental illness. Overvalued beliefs contain information that is useful for psychodynamic formulations and therapy, but it must not be confused with exculpatory mental illness. This permits defendants to exploit the untidy areas of the system of classification in psychiatry.[10] A clear description of the cultural factors relating to Mr Tsafendas' social interactions and functioning and the intercultural elements of the evaluating psychiatrists and how they may have affected the diagnosis of schizophrenia were not provided during the trial. This makes it unclear if due consideration was given to these important aspects.

2. Consideration of cultural factors in forensic settings

Mr Tsafendas was born in 1918 in Portuguese East Africa.[4] His father, Mr Michalis Tsafantakis was a Cretan marine engineer. His mother, Ms Amelia Williams, was the domestic worker of his father. She was of mixed race, her mother being an African of the Shangaan tribe, native to Mozambique, and her father a German.[3]

Genetic studies have called into question the validity of the concept of race. Ethnicity refers to cultural rather than genetic heritage. Forensic opinions are grounded on clinical assessment and forensic psychiatrists must be aware of the impact of ethnicity and culture on psychiatric diagnosis.[11] The forensic psychiatrist should monitor their own potential biases. The psychiatrist's neutrality may be affected in complicated ways such as the ethnicity of the psychiatrist v. the ethnicity of the accused and the interaction between dominant and non-dominant ethnic groups. All the psychiatrists who evaluated Mr Tsafendas during this trial were from dominant white ethnic groups in contrast to the accused. To complicate matters further, the psychiatrist's view of the prominent political figure at that time, who was murdered also comes into play.[11]

In forensic evaluations, the cultural formulation could serve to construct a fuller story of how the forensic event occurred.[12] The potential impact of culture on decision-making should be discussed openly, to increase awareness and reduce the capacity for bias.[13] A psychiatrist should remain culturally aware and sensitive to avoid diagnostic bias.[6] Forensic psychiatrists should recognise the different illness models related to ethnicity, and fears of stigma, psychiatric treatment and the medical establishment.[11]

A lack of insight regarding a psychiatric diagnosis should be studied in greater detail in different cultural groups. Members of cultural minority groups may be reluctant to accept diagnoses that they perceive as labels imposed on them by clinicians from a majority group, especially if they have had experiences with misdiagnosis or mistreatment. Cultural and historical perceptions may lead to behaviour that is interpreted as a lack of insight.[11] Together with cultural factors, communication difficulties in interpretation from both the client and the evaluator could also have played a role. This might have been the case in the Mr Tsafendas trial summary where he said 'They were trying to kill me with shock treatment'.[1] Language difficulties may also influence the making of a proper diagnosis. Mr Tsafendas could speak several languages. A neologism was diagnosed as part of schizophrenia symptomatology. The word was graphonola. There is such a word in Portuguese and English and the neologism was incorrectly diagnosed.[1]

The literature indicates that individuals may receive improper diagnoses and treatment if clinicians do not pay attention to ethnic/cultural background and context. One would ask the question, 'To what extent was the diagnosis of schizophrenia influenced by language and cultural factors?' when he was treated in Hamburg and the USA. African Americans are most often diagnosed with psychosis. Factors that contribute to the disparities include illness presentation, help-seeking patterns and clinical bias.[11]

Forensic experts are expected to review historical material in great detail, seek corroborating information, conduct lengthy examinations of the subject and consider multiple hypotheses. These measures are likely to improve the accuracy of an evaluation, determining whether additional testing is used. These aspects did not come to the fore when scrutinising the Mr Tsafendas trial summary.[1]

Psychological tests should be validated for different ethnic groups to ensure that they do not introduce systematic bias. Most tests are not adequately standardised for contemporary Hispanic subgroups or are not available in Spanish.[11] This standardisation and validity of the psychometric testing performed on Mr Tsafendas were not discussed during the trial summary.

Culture affects many aspects of mental illness and how a diagnosis is made. Cultural aspects should be documented and

taken into consideration when a differential diagnosis is made.[6] Cultural aspects came into play during the psychiatric evaluation of Mr Tsafendas where the experts had to distinguish between delusion and/or extreme overvalued belief and ultimately the diagnosis of schizophrenia. It is important to deliberate on these cultural aspects to avoid inaccurate forensic formulations and opinions that might have serious consequences.

3. Delusional infestation versus extreme overvalued belief

According to the psychiatric evidence, Mr Tsafendas had a fixed belief that he had a tapeworm inside him, despite all the negative medical investigations. This belief had an onset at the age of 18 years. He elaborated that the tapeworm had serrated edges, was larger than life and could smell food. He referred to it as a devil, dragon, snake and demon and it influenced his thoughts and behaviour. It was a human snake, but it did not tell him to kill Verwoerd.[1]

He said in his early life his mother influenced him against black people and the black people in revenge, by means of witchcraft, put the tapeworm in him. The tapeworm changed his whole character and physique and moved inside him. At times it caused severe pain and made him feel miserable and unwell. To another psychiatrist he said he was possessed by a tapeworm put there by African enemies; it was African witchcraft. He had to feed the tapeworm like he would a boa constrictor. The tapeworm purred like a cat. He struggled against the tapeworm and it turned him into a kind of a twisted saint.[1]

The tapeworm issue was referred to as a hypochondriacal delusion (delusion referring to bodily function). It was also mentioned that the tapeworm was a primary delusional imaginary issue. The tenacity and pervasiveness of his beliefs suggested delusional thinking, and this was accepted by the defence and state psychiatrist. This delusional belief featured prominently in the schizophrenia diagnosis that was made.[1] It will be prudent not to draw conclusions about a specific diagnosis or how it might have influenced criminal capacity without having personally evaluated an individual. However, from the available court documents, it would seem that the differential diagnoses that had to be considered in this case would have included delusional disorder, somatic type, an overvalued idea or malingering. Simulated psychosis or malingering will be further discussed in section 4.

In 1966, there were no real operational definitions to explain the difference between idiosyncratic psychotic thinking and shared subcultural beliefs. A basis for making such a distinction was reached when the concept of extreme overvalued belief was described. This concept can be applied in the criminal justice context.[10] The diagnostic and statistical manual of mental disorders (DSM-5) does not distinguish between idiosyncratic psychotic thinking and shared subcultural ideologies.[14] A definition exists of an extreme overvalued belief that is more operational in forensic psychiatry and does not refer to a classification system. The possessor of the belief often relishes, amplifies and defends the belief. This belief must be differentiated from a delusion and an obsession. Over time this belief becomes more dominant, refined and more resistant to challenge. There is an intense emotional commitment to the belief. The person may carry out violent behaviour to its service.[9]

Mr Tsafendas' description and belief of the tapeworm could fit in with this definition of a shared subcultural belief. The African witchcraft view of Mr Tsafendas, as a cultural phenomenon, was not discussed in much detail during the summary trial.[1] An overvalued idea is fundamentally different from a delusion. If an overvalued idea is seen as a delusion, any criminal act would wrongly be attributed to mental illness.[9] Individuals with extreme overvalued beliefs often carry out abhorrent and inexplicable acts of violence. They hold odd and bizarre beliefs that are shared by others in their culture or subculture. These beliefs do not comply with the definition of a delusion, and this becomes a dilemma for the forensic psychiatrist.[9]

The forensic psychiatrist must seek the psychological and sociocultural truth about the subject and his behaviour.[12] There must be an understanding of the subject's perspective on the incident under review. The impact of racism, violence and health inequities pertaining to the cultural identity of Mr Tsafendas were not discussed during the enquiry trial. He featured more as an illness (schizophrenia) than as a real person during the enquiry trial. It is important to respect and protect the personhood of an accused referred for forensic observation, instead of focusing exclusively on a specific diagnosis.

4. Simulation of psychosis

In the court enquiry, the simulation of mental illness featured in the evidence of the state and defence psychiatrists. The accused had a history of faking mental illness and a good knowledge of mental illness. Mr Tsafendas did not take the bait when leading questions were put to him, e.g., he denied experiencing auditory hallucinations. Emphasis was made on this fact, where simulation was excluded. The accused also experienced symptoms not so easily feigned, e.g., passivity phenomena and thought disorder. The consistent presentations of his symptoms were also mentioned. Taking into account collateral information is considered essential in contemporary forensic evaluations, but in Mr Tsafendas' trial, there were no reports of collateral information obtained to verify the accused's presentation, factual information provided or previous psychiatric treatment.[1]

Malingering is the intentional production of false or grossly exaggerated psychological or physical symptoms, motivated by external incentives.[7] People who feign psychiatric illness may use subjective or easily feigned symptoms to avoid imprisonment or the death penalty in countries where it is in place, as was the case in SA at the time of this trial. Instead of making a diagnosis the main focus, the accused's functioning and behaviour must also be taken into consideration.[8]

The unscientific basis of findings became clear as the different psychiatrists elaborated on their view of what they defined as schizophrenia. The basic psychiatric terminology definitions were not adhered to.[1] The expert must help the court recognise that psychiatric diagnosis is not an exact science, and even if it were, it is not an acceptable substitute for the accused's abilities and functioning. It should be made clear to the court that schizophrenia is not equivalent to 'psychotic'. Justice is served poorly by limiting discussions to diagnosis alone. A diagnosis of schizophrenia may be perceived differently in a variety of patients. It does not mean that the patient will always be psychotic. The clinical picture may vary, depending on the treatment, phase of illness as well as other variables.[8]

The judiciary should be made aware that psychiatric diagnosis is complex and that individual functioning differs from patient to patient. They must be made aware that there are limitations to psychiatric diagnostic classifications and the overlap between and variability

within diagnostic groups.[8] In the absence of diagnostic biological markers and the limitation of not having direct access to other people's thoughts make the possibility that an accused can withhold information, lie or malinger an ever-present concern. In addition, the presence of a specific symptom or diagnosis does not convey or describe the inner thoughts influencing a person's behaviour. To decrease the likelihood of being misled by the first-person account or feigned symptoms, continuous observation by trained personnel, correlation with observable symptoms and obtaining corroborating information from other sources are recommended.[15]

A psychiatrist should always consider the possibility that an accused can potentially malinger to avoid pain or punishment and should avoid leading questions and allow the person to report symptoms in their own words.[7] The psychiatrist with experience will have an advanced understanding of how genuine psychotic symptoms and behaviour manifest. This will enable the psychiatrist to develop the advanced psychiatric skills to detect malingered psychiatric illness.[7]

It is more difficult for a person to malinger thought process disturbance than thought content disturbance. Loose associations, neologisms, derailment and word salad are very rarely convincingly simulated. This would also include the negative symptoms of schizophrenia.[7] In Mr Tsafendas' case, it was reported by the psychiatrist that there was no formal syntactical schizophrenia disorder.[1]

In a 2015 study[16] examining the relationship between intelligence quotient (IQ) and schizophrenia within a Swedish National sample, the authors found that the risk for schizophrenia was the lowest in the group with the highest pre-morbid IQ. High intelligence substantially attenuates the impact of genetic liability for schizophrenia.[16] The Wechsler-Bellevue IQ Test on Mr Tsafendas was reported as: IQ=109, Verbal IQ =117, Practical=100. The findings of the IQ test, indicating a discrepancy between the verbal and non-verbal IQ, would put Mr Tsafendas at risk of a learning disorder, but at a lower risk group to develop schizophrenia.[1,16]

The revised Minnesota multiphase personality inventory (MMPI-2) has been validated for detecting malingered psychosis.[7] Mr Tsafendas's higher intelligence may have influenced his MMPI results, where it was reported that he was careless and inconsistent in his answers. The results were declared invalid. It has been reported that an individual with high intelligence and previous knowledge of the test could evade detection of malingering.[17] To conclude with confidence that an individual is malingering psychosis, the psychiatrist must understand genuine psychotic symptoms and consider beyond the individual's self-report. The psychiatrist should assemble clues from a thorough evaluation in the correct setting, clinical records, collateral information and psychological testing.[7]

Information about the criminal behaviour that should be taken into consideration during the assessment of the mental state of the accused includes planning (e.g., deliberation, obtaining a weapon, arranging escape routes and timing), avoidance of detection (e.g., forensic countermeasures and concealment of a weapon), disposing of evidence, escaping the crime scene, behaviour during the arrest and completion of complex tasks before, during and after the incident.[18] The fine planning of the murder of Verwoerd would fit in with a person of higher intelligence, but not with a person with schizophrenia in a psychotic state. In the Mr Tsafendas case, many inconsistencies were not addressed. The psychiatrist must focus on the inconsistencies in a case and try to make sense of all the information to provide the court with an honest and clear description of the case while also making the court aware of the limitations of psychiatric knowledge.[19]

5. Ethical considerations in criminal capacity and trial competency assessments

There is a complex relationship between criminal behaviour and mental illness. Schizophrenia is associated with cognitive and affective deficits that can be severe in certain individuals. This can influence judgment, empathy and behavioural control. The association that has been found between psychotic disorders and criminal incapacity is also influenced by sociodemographic, developmental and clinical factors. Psychiatrists should carefully examine the facts of a case to understand how a specific psychiatric diagnosis may or may not have been a factor in the commission of a crime. A nuanced approach to assessing the criminal capacity and legal responsibility of people with schizophrenia is essential to minimise stigmatisation. Even individuals who have been diagnosed with schizophrenia can have criminal capacity and be able to contribute to trial proceedings.[20]

Trial competency is best addressed from a functional rather than a diagnostic standpoint.[8] The form and content of beliefs are critical to understanding the *mens rea* in violent criminal acts.[9] The prosecution and the defence experts were in agreement that Mr Tsafendas was not competent to stand trial because of mental illness (schizophrenia) and the court decision was to stop the proceedings and commit Mr Tsafendas to a closed institution.[21]

This political assassination was highly publicised, and the psychiatric evaluation played a crucial role in the outcome of the trial. This criminal act as well as the trial and the verdict brought in its wake a huge emotional public response. In this case, the psychiatrists had to assist the court in deciding if Mr Tsafendas was a psychotic person who targeted the victim due to his intrapsychic delusional world or if he was not psychotic and chose to commit an extreme act of violence with a political motive.[21] When addressing these complex questions, it is essential to remain impartial and unbiased. Strong personal convictions and opinions, especially in such a high-profile case with political aspects can be very troublesome.[22] Addressing any potential biases or influences on one's objectivity should be an ongoing process in the pursuit of honesty and relating relevant knowledge to the court.[23]

By applying the facts gathered during the investigation and using the definitions of delusion and extreme overvalued belief, there could have been more calibrated views provided.[9] The final decisions regarding fitness to stand trial and criminal responsibility are made by the court based on the expert evidence presented, and after both sides and the court have examined the expert witnesses. The criminal act alone, extreme as it may be, cannot be the solitary manifestation of a mental disorder. The diagnosis should be independent of the commission of the crime.[20]

The diagnosis of schizophrenia was not refuted by the state attorneys. Evidence that Mr Tsafendas previously faked mental illness for his means was not presented by the state.[1] 'Unfit to plead' places an accused person in limbo concerning the potential non-resolution of their criminal culpability while exposing them to compulsory treatment for mental disorders.[24] A positive finding in this regard can be made which exposes an individual to the possibility of

compulsory detention and treatment, even though full criminal responsibility – establishing the person's *mens rea* for the offence – has not been made out. This was what happened in the Mr Tsafendas case. The lawyers for the accused may have reasoned that it protects a vulnerable person from the risk of unfair conviction due to the person's lack of ability to engage with various crucial aspects of the trial process. This provides a route out of the criminal justice system where the prosecution cannot establish that the individual committed the *actus reus* of the offence.[24]

Discussion

In the Supreme Court of SA (Cape of Good Hope, Provincial Division), in the case of the state v. Mr Demitrio Tsafendas on 20 October 1966, the court investigated questions regarding his mental condition.[1] He was deemed incompetent to stand trial owing to the schizophrenia he was suffering from and was subsequently committed to a closed institution. Once the judicial process started against Mr Tsafendas, it could be seen as the work of political machinery. Dominant v. nondominant issues were at play at every step of the judicial process, obviously controlled by the dominant group.[12] Forensic psychiatric intervention determined the outcome of Mr Tsafendas' life history after the crime in 1966.

Individuals subjected to forensic psychiatric intervention represent a particularly vulnerable subgroup, compared with the general population.[25] After 57 years, there has been progression in the field of forensic psychiatry and the ethical principles that should be taken into consideration during these assessments. The lessons that can be taken away from the examination of this case include the following important aspects: unpacking the cultural life experiences of the accused, distinguishing between delusions and extreme overvalued ideas, recognising that the complexity of malingered psychosis requires consideration of collateral information, acknowledging that individual behaviour and functioning are more important than a diagnostic label. It is important that the accused referred for forensic observation should not feature as an illness, but as a real person during the evaluation and court proceedings.

Recommendations for the ethical and responsible practice of forensic psychiatry in criminal cases include 'truth-telling' and 'respect for persons' as proposed by Applebaum in 1990.[26] Since then, there have been developments in this field, and the lessons drawn from the Mr Tsafendas trial highlight the importance of addressing potential bias that can influence one's objectivity, maintaining impartiality and emphasising the importance of training in forensic assessments. Additionally, familiarity with legal standards, scientific developments and professional ethical codes are essential considerations when psychiatrists perform forensic assessments.[22,23] The psychiatrist should always be conscious of the cultural aspects that might influence the clinical presentation, interpretation of tests and interpersonal interactions.[27] A focus on addressing the inconsistencies in a case to provide the court with an honest and clear description is essential. The psychiatrist should be familiar with personal and professional limitations and be aware of the irreversible impact that these opinions can have on people's lives.[19] The duty of the forensic expert is towards justice, but it remains extremely important not to cause any additional and avoidable harm.[25]

The complex nature of these assessments warrants a careful and rigorous approach to each case with an awareness of the potential moral pitfalls, biases and limitations related to these assessments. Navigating these moral issues requires careful deliberation and consideration of the values and principles of the psychiatrist, medical profession and legal system. It is important to maintain a balance between protecting individual rights, ensuring public safety, promoting justice and fairness and addressing the needs of individuals with mental illness.

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