STRICTLY CONFIDENTIAL

Forensic Psychological report

REPORT

1. Introduction

1.1 The writer

I am Jonathan Geoffrey Scholtz. My specialty is Clinical Psychology. My highest qualification is a Doctorate in Psychology with 23 years of experience. I have assessed approximately 90 forensic cases and provided testimony in 40. More details of my qualifications appear in annexure A.

1.2 Summary of the case

Mr Oscar Leonard Carl Pistorius stands accused of murder and various counts of contravention of the firearms control act. He was referred to Weskoppies psychiactric hospital in terms of section 78 and 79 of the Criminal Procedure Act, no. 51 of 1977. I was appointed to provide a report made in terms of section 78(2). In terms of the order I was instructed to:

"enquire into whether the accused by reason of mental illness or mental defect was at the time of the commission of the offence criminally responsible for the offences charged;

Whether he was capable of appreciating the wrongfulness of his act, or of acting in accordance with an appreciation of the wrongfulness of his act."

1.3 Identifying detail

Name	: Oscar Leonard Carl Pistorius
Age	: 27 years
Qualifications	: Grade 12.

Home : Waterkloof, Pretoria.

Marital Status : Single, never married.

Children : None

Occupation : Professional athlete.

1.4 Procedures

I had interviews with the following persons:

- Clinical interviews with Mr Pistorius for a total of 19 hours over the period 27 May 2014 to 20 June 2014;
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
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- [redacted]
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I perused the following documents:

- Affidavits by various witnesses;
- The official record of court proceedings;
- Report of Prof M Vorster, Psychiatrist;
- Report of Dr RG Holmes, Educational Psychologist;
- Electroencephalogram (EEG) report dated 11/06/14.

2. Issues addressed.

2.1 Clinical impressions of Mr Pistorius

On the 27th of May 2014 Mr Pistorius appeared neatly groomed. He was tense and seemed insecure and apprehensive. His mood was anxious and depressed with restricted affect. He spoke in a soft voice. His thought processes appeared normal. He seemed overwhelmed by his current circumstances. He became fatigued as the session wore on and with this his concentration waivered at times. He displayed and reported signs of posttraumatic stress disorder and depressive disorder. His memory was compromised at times. His manner was respectful and cooperative. He reported that he had been using anti-depressants, anxiolytics and sedatives since the events of 14 February, prescribed to him by a psychiatrist. He had also been consulting with a psychologist since that time.

At subsequent meetings with Mr Pistorius his clinical presentation was similar to that of the 27th May, although he seemed less tense and less insecure. His mood remained anxious and depressed. At times he became emotional and often cried. He became nauseous when discussing the events of 14 February 2013 and had to rush to the bathroom where he was seen to vomit. At times he displayed humor and could converse with confidence about subjects relating to athletics, business, cars, motorbikes and politics. He seemed to become more tired as the period of observation progressed. He remained cooperative and respectful of the process throughout.

2.2 History and development of Mr Pistorius

2.2.1 Family constellation and relationships.

Mr Pistorius is the middle child in a family of three children. He has an elder brother who is 18 months older than him and a sister who is 30 months his junior. Good relations exist between the siblings and they have had regular contact through the years. His siblings are both living decent productive lives. Over the years there were close ties both within the nuclear family and with the extended family and this seems to still be the case. His maternal aunt and paternal uncle and aunt specifically were heavily involved with Mr Pistorius especially after his mother passed away when he was 15 years old. Mr Pistorius' father however was away often and psychologically absent. He also struggled to achieve consistent success in his business ventures. There was never any violence or serious aggression between his mother and father that Mr Pistorius was exposed to. The couple divorced when Mr Pistorius was six years old.

2.2.2 Relationship with his mother.

Mr Pistorius speaks of his mother with respect and admiration. She had a strong bond with all her children and is described as loving, fun and spontaneous. She did her best after the divorce and remained positive and strong even though the family had to adapt to difficult circumstances, especially financially. She motivated Mr Pistorius to live his life as normal as possible in spite of the problems he experienced as a double amputee. She was however also an anxious person and got startled easily. She acquired a pistol when she met her husband and learned to shoot. After the divorce she would become scared and anxious at times when she felt they were under threat. Unfortunately there were a few

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times and was always respectful. No irregularities of mood were noted. He enrolled at Pretoria High School for Boys as a grade 8 day boy. At this point he lived with his father but owing to poor care and non-involvement from his dad he was admitted as a boarder halfway through that year. In February of his grade 9 year his mother passed away of a brain hemorrhage. This presented as a huge loss to him as she had been the most important consistent, loving and supportive figure in his life. With the help of his maternal aunt and paternal uncle and aunt he worked through this loss, his natural resilience also playing a role. He had to work hard at his studies but progressed without any incident. There were never any incidents of ill-discipline or behaviour problems. He was popular with fellow pupils and teachers and became a house prefect in grade 12, tasked with overseeing the grade 8 boys. There were never any problems with him in the hostel. He was known for his tremendous determination when engaged in a physically challenging task. Although he could misbehave at times he was always respectful and disciplined.

2.2.6 Post Grade 12.

After grade 12 Mr Pistorius enrolled at the University of Pretoria for a Bachelor of Commerce degree in Business Economics. However the demands of his athletics career were such that he had to opt out in order to focus on being a professional athlete. His life became very structured and pre-determined as he had a rigorous and fixed training program, which included a strict regimen regarding his dietary and sleeping habits. He also had numerous engagements with sponsors, the media and social events linked to his career. It is calculated that he flew up to 100 times per year, often across time zones. He was often under extreme time pressure and received extra-ordinary attention from the media and public. His press conferences attracted more journalists than those of the Olympic champion Usain Bolt. He would even be approached for an autograph whilst relieving himself in the men's room of a public place, or have a camera thrust in his face as he stepped of an airplane. Amongst others he received a Honourary doctorate from the University of Strathclyde for his work in developing prostheses'. He was voted one of the top 100 most influential people in the world three times by Time magazine. He also received keys to amongst others, the cities of Rome and Genoa. He counted amongst his acquaintances presidents of countries, royalty and elite sportsmen. More detail can be found in annexure F.

2.2.7 Relationships.

Mr Pistorius had various relationships since the time he was at school. Some were of short duration, based mainly on the need for companionship especially post-2011 when his career took off. One of the main reasons a relationship of almost five years ended was because of his hectic schedule and because he was away often. After that relationship ended he started living the lonely type of life often reported by elite athletes. It was also problematic that he would spend four months of the year in Italy, thereby losing contact with friends in South Africa. In these circumstances it was not only difficult to fit in with a group of friends when he returned but maintaining an intimate relationship was almost impossible. He was often approached by beautiful woman like models but never reacted to their offers. His experience was that many girls wanted to be with him because of his fame and the media attention he received. This made him suspicious of the motives of woman in general when they approached him. He even attempted to play down his status by dressing down and driving a cheaper car. His relationship with Ms Steenkamp at the end of this period (late 2012) was probably only the second one where he felt trust, sincerity and real companionship.

2.2.8 Religion.

It is clear from the history that Mr Pistorius was brought up with strong Christian values. He attended the Methodist church as a young boy and later moved to the Pentecostal Church. His mother was religious and attended various churches like the Assemblies of God or Rhema Church. After school Mr Pistorius joined the Centurion Christian Church in Irene, Pretoria. He struggled to attend services as he travelled a lot but would attend the Catholic Church in Italy whilst he was there. He prayed daily and still does. He held regular prayer and Bible discussion groups at his residence with fellow Christians. Although he would not force his views on others, he preferred that everybody hold hands while he prayed before a meal at his home. Ms Steenkamp shared his views on religion and would often listen to his "Hillsong" music whilst driving in her car.

2.2.9 Substances

Mr Pistorius experimented with Cannabis whilst being at high school but didn't enjoy the effect. After that he never ingested any substances other than those prescribed as medicine or as dietary supplements for his training program. He is a social drinker but always has to keep his training program in mind therefore he doesn't allow himself to become inebriated. At the odd special occasion he would have a bit more alcohol than usual but never to the extent that he was severely intoxicated.

2.2.10 Legal

Mr Pistorius has no previous convictions.

2.2.11 The incident on 14 February 2013

During my assessment Mr Pistorius indicated that he did not want to make any changes to his version of events as provided during his testimony. During this discussion he became visibly upset, cried and had to leave for the bathroom where he vomited.

3. Psychometric assessment.

3.1 The "Personality Assessment Inventory" (PAI)

The PAI is an objective personality test. It is used internationally and has appeared in research reports for more than ten years with established reliability coefficients – for internal consistency .83 and for test-retest reliability .75 (Morey, 2002). It consists of the following primary scales:

Inconsistency *(ICN)*

The *ICN* scale is an empirically derived scale that reflects the consistency with which the respondent completed items with similar content. *ICN* is more likely to reflect carelessness or confusion in responding. Generally low scores on *ICN* (i.e., < *64T*) suggest that the respondent answered consistently and probably attended appropriately to item content while responding to the PAI items. High scores on *ICN* (i.e., >*73T* suggest that the respondent did not attend consistently or appropriately to item content in responding to the PAI items.

Infrequency *(INF)*

The *INF* scale is useful in the identification of people who complete the PAI in an atypical way because of carelessness, confusion, reading difficulties, or other sources of random responding. Generally, low scores (i.e., <60*T*) suggest that the respondent attended appropriately to item content in responding to the PAI items. High scores on *INF* (i.e., >75*T* suggest that the respondent did not attend appropriately to item content in responding to the PAI items.

Negative Impression *(NIM)*

The Negative Impression (*NIM*) scale contains items that present an exaggerated unfavourable impression or represent extremely bizarre and unlikely symptoms. Generally, low scores (i.e., <*73T*) on NIM suggest that there is little distortion in a negative direction on the clinical scales and that the respondent likely did not attempt to present a more negative impression that the clinical picture would warrant. High scores on *NIM* (>92T) suggest that the respondent attempted to portray himself in an especially negative manner.

Positive Impression *(PIM)*

The content of *PIM* scale items involved the presentation of a very favourable impression or the denial of relatively minor faults. Low scores on *PIM* (i.e., < *44T*) are strongly indicative of candid responding. High scores on *PIM* (i.e., > *68T*) suggest that the respondent attempted to portray himself or herself as exceptionally free of the common shortcomings to which most individuals will admit.

SUPPLEMENTAL VALIDITY INDICATORS

Malingering Index *(MAL)*

Morey (1996) developed the Malingering Index (MAL) as a more specific indicator of malingering that would be relatively independent of psychopathology. A MAL raw score of 3 (i.e., *84T*) or greater, which is more than two standard deviations above the mean of the clinical standardization sample, should raise the question of malingering.

Defensiveness Index *(DEF)*

The Defensiveness Index (DEF: Morey, 1996) involves a set of indicators developed to further supplement the tools for identifying effortful defensive responding. Studies suggest that a person who obtains a raw score of 6 (i.e., *70T*) or greater on DEF is likely to be overtly defensive.

Cashel Discriminant Function *(CDF)*

The Cashel Discriminant Function (CDF) was derived in a detailed study of defensive responding on the PAI conducted by Cashel et al. (1995). These authors constructed a discriminant function that was designed to optimally distinguish between defensive and honest responding. Low scores on the Cashel function (i.e., raw score < 135 or < *48T*) indicate honest responding. High scores on CDF (i.e., > 168 or > *70T*) suggest that the respondent overtly attempted to portray himself or herself in a distorted way and that the profile likely reflects the way the respondent desired to appear, rather than reflecting the true experiences of the respondent.

Somatic Complaints *(SOM)*

The *SOM* scale includes items that reflect concerns about physical functioning and health matters. The *SOM* scale score reflects the degree of concern about physical functioning and health matters and the extent of perceived impairment arising from somatic symptoms.

Anxiety *(ANX)*

The *ANX* scale measures the degree of tension and negative affect experienced by the respondent as it is manifested across different diagnostic categories. The *ANX* scale score gives a broad indication of the involvement of anxiety in the overall clinical picture.

Anxiety- Related Disorders (ARD)

The *ARD* scale measures clinical and behavioural features of three areas of symptomatology related to specific anxiety disorders.

Depression (DEP)

The *DEP* scale measures clinical features common to the syndrome of depression. The *DEP* scale score indicates global severity of a broad spectrum of diagnostic depressive symptomatology.

Mania *(MAN)*

The *MAN* scale measures elements of the clinical presentation of mania and hypomania.

Paranoia *(PAR)*

The *PAR* scale focuses on symptoms and enduring characteristics of paranoia. The item content addresses vigilance in monitoring the environment for potential harm, a tendency to be resentful and to hold grudges, and a readiness to spot inequities in the way the respondent has been treated by others.

Schizophrenia *(SCZ)*

The *SCZ* scale was designed to measure a number of facets of schizophrenia. This multifaceted approach is necessary because schizophrenia is one of the most heterogeneous of all clinical groups. The item content includes unusual beliefs and perceptions, poor social competence and social anhedonia, as well as inefficiency and disturbances in attention, concentration, and associational processes.

Borderline Features *(BOR)*

The *BOR* scale assesses a number of elements related to severe personality disorder. Although all of these elements are a part of the

borderline syndrome, individually they also are common to numerous other disorders, particularly personality disorders. The item content includes indicators of:

(a) Poor control over emotions and anger,
(b) Confusion around issues of identity and self-worth,
(c) Intense and often combative interpersonal relationships,
(d) Impulsivity that often results in self-destructive behaviours.

Anti-social Features *(ANT)*

The *ANT* scale provides an assessment of personality and behavioural features relevant to the constructs of antisocial personality and psychopathy. The item content ranges from indicators of egocentricity, adventuresomeness, and poor empathy to items addressing antisocial attitudes and behaviours.

Alcohol Problems *(ALC)*

The ALC scale provides an assessment of behaviors and consequences related to alcohol use, abuse and dependence.

Drug Problems *(DRG)*

The DRG scale provides an assessment of behaviors and consequences related to drug use, abuse, and dependence.

Aggression *(AGG)*

The *AGG* scale provides an assessment of attitudinal and behavioural features relevant to aggression, anger, and hostility. The item content ranges from indicators of verbal assertiveness and poor anger control to violent and assaultive behaviors.

Suicidal Ideation *(SUI)*

The SUI scale provides an assessment of thoughts and ideas related to death and suicide. The item content ranges from hopelessness, although general and vague thoughts of dying and suicide, to thoughts representing distinct plans for the suicidal act.

Stress *(STR)*

The stress scale provides an assessment of life stressors that the client is currently experiencing or has recently experienced.

Nonsupport *(NON)*

The NON scale provides a measure of a perceived lack of social support, tapping both the availability and quality of the client's social relationships.

Treatment Rejection *(RXR)*

The RXR scale provides a measure of attributes and attitudes associated with an interest in personal changes of a psychological or emotional nature. Items reflect unwillingness to participate actively in treatment, a refusal to acknowledge problems, and a reluctance to accept responsibility for problems, and a reluctance to accept responsibility for problems in one's life.

INTERPERSONAL SCALES

Dominance *(DOM)*

The *DOM* scale provides a measure of the extent to which a person is controlling, submissive, or autonomous in interpersonal relationships. Item content involves being independent from others, outspoken and assertive, and directive and managerial in relationships.

Warmth *(WRM)*

The *WRM* scale provides a measure of the extent to which an individual is empathic and engaging versus withdrawing, rejecting, and mistrustful in interpersonal relationships. Item content involves being sociable, sympathetic, affectionate, and patient with others.

Suicide Potential Index *(SPI)*

Morey (1996) noted that the relationship between SPI and *SUI* appears to be moderated by the *NIM* score, suggesting that a SPI elevation obtained with a *NIM* score that falls within normal limits merits particular attention.

Violence Potential Index (VPI)

To supplement the use of individual scales in the difficult process of assessing dangerousness, Morey (1996) developed the Violence Potential Index (VPI). This index consists of 20 PAI features that represent a variety of risk factors for violence that have been found to be useful for the prediction of dangerousness. Examples of such risk factors include:

(a) Explosive expression of anger,

(b) Sensation seeking,

(c) Substance abuse,

(d) Impulsivity.

3.2 Results of the PAI.

Mr Pistorius' results are indicated below. Scores between 50 -70 are viewed as the normal expected response. All the significant scores are indicated in bold script:

ICN	31
INF	55
NIM	55
PIM	54

Somatic	(SOM)	54
Anxiety	(ANX)	61
Anxiety related disturbance	(ARD)	70
Depression	(DEP)	**78**
Mania	(MAN)	50
Paranoia	(PAR)	61
Schizophrenia	(SCZ)	49
Borderline personality	(BOR)	54
Anti-social	(ANT)	**45**
Alcohol	(ALC)	**49**
Drugs	(DRG)	**48**
Aggression	(AGG)	**42**
Suicide	(SUI)	54
Stress	(STR)	**73**
Non-support	(NON)	58
Rejection (treatment)	(RXR)	**46**
Dominance	(DOM)	56
Warmth	(WRM)	**35**

Supplemental indexes.

Malingering	(MAL)	**44**
Defensiveness	(DEF)	**51**
Cashel discriminant function	(CDF)	**46**
Suicide potential index	(SUI)	**65**
Violence potential index	(VPI)	**47**

The following scores could have relevance:

3.2.1 The scores on the first four scales (ICN, INF, NIM, and PIM) indicate that Mr Pistorius responded openly, that he did not attempt to manipulate and that he did not attempt to create an overly positive or negative impression.

3.2.2 The score of 61 on ANX indicates that Mr Pistorius does not suffer from clinically significant anxiety. This is consistent with clinical findings and collateral information.

3.2.3 The score of 70 on ARD indicates that although he measures high, Mr Pistorius does not suffer from a clinically diagnosable anxiety disorder. This is consistent with clinical findings and collateral information.

3.2.4 The score of 78 on DEP indicates that Mr Pistorius suffers from clinically significant depression. This is consistent with clinical findings and collateral information.

3.2.5 The score of 45 on ANT indicates that Mr Pistorius does not suffer from an anti-social personality disorder/psychopathy. This is consistent with clinical findings and collateral information.

3.2.6 The score of 42 on AGG indicates that Mr Pistorius does not suffer from clinically significant aggression, anger or hostility. This is consistent with clinical findings and collateral information.

3.2.7 The score of 73 on STR indicates that Mr Pistorius suffers from clinically significant stress. This is consistent with clinical findings and collateral information.

3.2.8 The score of 44 on MAL indicates that Mr Pistorius did not attempt to malinger.

3.2.9 The score of 51 on DEF indicates that Mr Pistorius was not overtly defensive in his responses.

3.2.10 The score of 46 on CDF indicates that Mr Pistorius responded honestly.

3.2.11 The score of 65 on SPI if taken with the NIM score indicates that Mr Pistorius has an elevated risk for suicide. Clinical findings support this however his religious beliefs and his strong family ties currently mediate against this possibility.

3.2.12 The score of 47 on VPI indicates that Mr Pistorius does not have

personality characteristics that would make him dangerous. Although he engaged in risky behavior at times this finding is consistent with clinical findings and collateral information in terms of a life-long pattern.

3.3 The "Psychiatric Diagnostic Screening Questionnaire (PDSQ)"

The PDSQ is an instrument that serves as a screening test for the presence of clinical conditions as defined by the Diagnostic and Statistical Manual-4. It has been administered more than 3000 times and has proven reliability coefficients: For internal consistency .86 and for test-retest reliability .89 (Zimmerman, 2002). It consists of the following subscales: (The scores achieved by Mr Pistorius and the cutoff score for significance is indicated.)

Subscale	Score	Cutoff
Major Depressive Disorder Suicidality	8	9
Posttraumatic Stress Disorder	12	5
Bulimia/Binge Eating Disorder	0	7
Obsessive-Compulsive Disorder	0	1
Panic Disorder	0	4
Psychosis	0	1
Agoraphobia	4	4
Social Phobia	5	4
Alcohol Abuse/Dependence	0	1
Drug Abuse/Dependence	1	1
Generalized Anxiety Disorder	5	7
Somatization Disorder	0	2
Hypochondriasis	0	1

3.3.1 Results of the PDSQ

Mr Pistorius had significant scores on the following:

- Posttraumatic Stress Disorder (PTSD). This was followed up clinically according to the follow-up interview guide of the PDSQ. He satisfies the criteria for a diagnosis to be made according to the Diagnostic Statistical Manual 5 (DSM-5);

- Agoraphobia. This was followed up clinically according to the follow-up interview guide of the PDSQ and with collateral. This fear seems to be indicative of Mr Pistorius' general feelings of vulnerability when he is out in the world and of specific situations where his prostheses might be a liability eg. On a bus or a plane, or standing in a long line, or in a crowded place;

- Social Phobia. This was followed up clinically according to the follow-up interview guide of the PDSQ and with collateral. This fear seems to point to an extreme self-consciousness and anxiety about being ridiculed or embarrassed. Although this has been a characteristic of Mr Pistorius for many years it did not make him dysfunctional. The incident he is being charged for and the resulting public and media attention has however exacerbated this underlying tendency;

- Alcohol Abuse/Dependence. This was followed up clinically according to the follow-up interview guide of the PDSQ and with collateral. Mr Pistorius feels he has been drinking more since the incident he is being charged for, mainly because he isn't in training. His use of alcohol is however not clinically significant.

3.4 Neuropsychological assessment.

Mr Pistorius underwent an extensive neuropsychological evaluation. This was done in order to establish the possible psychological and neuropsychological effects following a boating accident that he was involved in on the 21st February 2009. Mr Pistorius was subjected to a range of neuropsychological tests which cover a spectrum of cognitive functions including attention and concentration, memory and learning, visuo-construction ability, planning ability and verbal fluency. Information viewed as most salient of the neuropsychological assessment report have been included within this report. The complete neuropsychological assessment report can be found in annexure E.

The following subtests were in included in the neuropsychological assessment:

3.4.1 Certain subtests of The Wechsler Adult Intelligence Scale 3(WAIS-3):

-Digit Symbol Coding
-Symbol Copy
-Symbol Search
-Digit Span
-Letter-Number Sequencing
-Arithmetic
-Similarities
-Block Design

The Trail-Making Test (Trail A and B)

Tests of Mental Control
- Alphabet
- Serial 3 and 7
- Days of the Week/Months of the Year - forwards/backwards

The Rey Complex Figure Test (RCFT)
The Rey Auditory Verbal Learning Test (RAVLT)

The Controlled Oral Word Association Test (COWAT)

The Story Memory from the Senior South African Individual Scale-Revised

The Stroop Color and Word Test

The Ravens Progressive Matrices

The Continuous Visual Memory Test

The Test of Memory Malingering (TOMM)

The Tower of London

The Grooved Pegboard

The Behavioural Assessment of Dysexecutive Syndrome

The Beck Depression Inventory 2

3.4.2 History of the boating accident

According to Mr Pistorius the accident in question happened on the 21st February 2009. He stated that the boat accident happened on the Vaal River while he was steering the boat and struck a submerged pier in the river. He reported that he was not aware of the speed that he had been traveling at but did not believe that it had been fast. He reported striking his head face-first on the steering wheel and recalling a significant amount of blood on his hands and a strong smell of blood. He denied a loss of consciousness and stated that as the boat began to sink, he swam to the bank where family members travelling on another boat picked him up before taking him back to the residence that he had been staying at. He denied experiencing any pain at the time stating that he believes that he had been in a state of shock as the accident happened so quickly. He reports that he was then airlifted to the Milpark Hospital for further treatment. He reported having re-constructive surgery to his face and that he remained in the Intensive Care Unit for 4-5 days prior to being moved to High Care for a day. Thereafter he reported being discharged into the care of his family and returning to his training approximately 1 month post-accident.

3.4.3 Injuries sustained

Possible head injury;
Facial injuries/facial fractures.

According to medical records from the Milpark Hospital, Mr Pistorius underwent a Computerised Tomography (CT) scan of his brain on the 22nd February 2009. The report was signed by Dr van Bisbergen with the following comment: "**There is no evidence of acute intra cranial trauma. Multiple facial fractures are demonstrated and described**. These show features of a Le Forte fracture type II."

3.4.4 Current complaints

Mr Pistorius reported that post-accident he had no complaints – stating that he had made a full recovery from his injuries.

3.4.5 Neuropsychological symptoms

Irritability: He reports that his level of irritability did change post-accident and attributed this to the pain and discomfort he experienced when training shortly after the accident in question. However, he reported that once he was pain-free he was no longer irritable;

Memory: He denied experiencing any difficulties in this regard;

Concentration: He reported initially experiencing some difficulty in this regard and attributed this to the pain and discomfort that he experienced at the time of the accident in question. He stated no difficult post-recovery in this regard;
Planning abilities: He reports that his ability to plan has been intact;

Initiative: He reported no difficulty in making decisions post-accident;

Impulsivity: He denies experiencing any difficulties;

Visiting novel places and meeting unfamiliar people: He reports no interest in visiting novel places or meeting new, unfamiliar people;

Work performance: Mr Pistorius is currently a professional athlete. He has not trained or competed competitively since the incident on the 14th February 2013. He reported that although he enjoys training, he is unable to do so because of his trial and that the media scrutiny surrounding him that makes training difficult.

Ictal Symptoms

Olfactory sensation: None reported.
Gustatory sensation: None reported.
Tactile sensation: None reported.
Epileptic seizures: None reported.
Black outs: None reported.
Dizziness: None reported.
Visual disturbances: None reported
Déjà vu: None reported.
Jamais vu: None reported.
Premonitions: None reported.

3.4.6. Psychometric assessment

Mr Pistorius appeared interested and motivated to complete the assessment and little encouragement was offered by the examiner during the testing. He appeared to be concerned with failures. It is therefore the writer's opinion that this assessment may be a true reflection of Mr Pistorius's abilities. The following information necessitated that a neuropsychological assessment be performed:

- History of a head injury;
- Loss of awareness following the accident under discussion – duration uncertain, disorientation and confusion following the incident;
-Account of post-traumatic amnesia of less than 30 minutes – duration uncertain;
- Glasgow Coma Scale (GCS) – on scene – 3/15 – report of being intubated and ventilated, sedated with Morphine and Dormicum. Follow up recordings of GCS on admission – 14/15, 10/10 and 15/15.

Traumatic Brain Injuries (TBI) occur on a broad continuum of severity, from very mild transient injuries to catastrophic injuries resulting in death or severe disability. The severity of TBI typically is classified using the Glasgow Coma Scale, duration of unconsciousness, and duration of post-traumatic amnesia. Moderate and severe traumatic brain injuries can result in temporary, prolonged, or permanent neurological or neuropsychiatric problems such as:

- motor impairments and movement disorders;
- balance and dizziness;
- visual impairments;
- cranial nerve impairments;
- headaches;
- sexual dysfunction;
- fatigue and sleep problems;
- depression and anxiety disorders;
- psychotic disorders;
- personality changes and apathy;
- lack of awareness.

Moderate or severe TBIs frequently result in permanent neurocognitive and neurobehavioral impairments. As a general rule, as injury severity increases, the magnitude of impairment increases. Therefore a mild head injury is not expected to bring about permanent neuro-cognitive changes and any found cognitive difficulties would then mostly have to be ascribed to premorbid cognitive functioning. According to the World Health Organization (WHO)

Collaborating Center Task Force on Mild Traumatic Brain Injury (MTBI) a MTBI is an acute brain injury resulting from mechanical energy to the head from external physical forces. Operational criteria for clinical identification include:

- One (1) or more of the following: confusion or disorientation, loss of consciousness for 30 minutes or less, post-traumatic amnesia for less than 24 hours, and/or other transient neurological abnormalities such as focal signs, seizure, and intracranial lesion not requiring surgery and;
- Glasgow Coma Scale (GCS) score of 13–15 after 30 minutes post-injury or later upon presentation for healthcare. These manifestations of MTBI must not be due to drugs, alcohol, medications, caused by other injuries or treatment for other injuries (e.g. systemic injuries, facial injuries or 25 intubation), caused by other problems (e.g. psychological trauma, language barrier or coexisting medical conditions) or caused by penetrating craniocerebral injury.

Information obtained from Mr Pistorius indicates some confusion and a loss of consciousness for less than 30 minutes as well as post-traumatic amnesia of a couple of minutes indicative of a mild head injury. The initial GCS recording of 3/15 if taken at face value is indicative of a more severe injury. He was however intubated and ventilated at the scene and provided medication – Morphine and Dormicum making this an inaccurate account of his functioning at the time of injury.

3.4.7 Findings.

Mr Pistorius grasped the test instructions with ease and maintained a rapid work tempo. In addition to this, he was able to focus his attention on the tasks at hand and also demonstrated adequate levels of motivation and energy. He cooperated well and behaved appropriately throughout the assessment. With regard to Mr Pistorius's functioning – no evidence of neuropsychological impairment was identified during the assessment. Specifically, no evidence of impairment in the following domains was identified:

- his cognitive functioning;
- his executive functioning: the ability to achieve insight and self-awareness, initiate, evaluate, and regulate thinking and behaviour whilst also referring to a variety of higher order cognitive processes necessary for effective functioning, including planning, cognitive flexibility, concept formation and self-monitoring.
- his planning ability;

- his attention abilities and memory;
- his mental response speed, his mental flexibility and speed of information processing abilities;
- his psychomotor speed abilities;
- his verbal learning as well as his verbal memory abilities;
- his visual memory abilities;
- his construction, forward planning and problem solving abilities;
- his motor regulation abilities;
- his verbal fluency and concept generation abilities.

4. Integration and formulation.

Being born with a congenital abnormality (fibular haemimelia), Mr Pistorius faced strong challenges from the time he was born. He was also of low birth weight (below 3kg). The abnormality came as a big shock to his parents. His mother's reaction was one of sadness and loss, whilst his father was angry especially at the doctors who hadn't picked up the problem during pregnancy. This might have made his attachment with his mother an anxious one, leaving him to try and self-sooth (Goldberg, Benoit, Blokland & Madigan, 2003). Fortunately it seems he was born with a strong (fighting) temperament. He was a happy, contented baby instead of whining and crying and he reached all his milestones normally. A further positive factor was that his mother was able to overcome her initial reaction and that he then had a good bonding with her. She was able to externalize her emotions in a normal manner, passing on to Mr Pistorius the rudimentary "blueprint" of affect regulation. Good attachment and secure bonding has been shown to mediate against psychological adversity, build resilience factors into a personality and to reduce the chances of mental problems in individuals later in life (Cassidy and Shaver, 2008).

In spite of this the bilateral amputation he underwent at 11 months would have been traumatic. In that phase of development (approximately 0 to 2 Years) a child is supposed to gain trust in his world, to feel safe and secure (Upton, 2011). It is possible that a "blueprint" of mistrust, insecurity and being unsafe was already laid down at that stage of his personality development because of a traumatic experience his pre-verbal brain could not process and make sense of. Apart from the psychological impact the amputations represented a severe physical assault on his body, giving him a different experience of "bodyliness" ("me as a body vs me as a broken body"). Such "blueprints" are carried into following phases of development and are either exacerbated or moderated, depending on the situation and the context. It is also a crucial period for a child to start processing his object relations, at that time through his relationship with his mother (Gomez, 1996). He would have experienced fear and anger and felt

abandoned by her. This would have challenged his ability to view her as an integrated whole person, both good and bad. His attachment and bonding with his father was poor, owing to his father being psychologically absent and somewhat uninvolved. It is also possible that his mother "usurped" him out of guilt, pulling him further away from his father.

When viewing his later intimate relationships all these aspects come to the fore. He was confronted again with what he needed from a woman (at that stage an intimate partner), if he could trust her to supply that, what he needed to give her and how to regulate his affect in the process. The context he was in at that stage unfortunately played into these early "blueprints" and object difficulties. It needs to be remembered that Mr Pistorius had an abnormal adolescence, first losing his primary attachment figure (mother) at 15 then becoming instantly famous at 17. All of this happened against the background of an absent father that he couldn't rely on. Adolescence is the phase of "reworking" earlier "blueprints" and conflicts. In this period of a boy's development a strong father figure is crucial. Considering that adolescence presents most boys with difficult psychological challenges relating to identity, attitude towards authority, orientation towards leadership, adaptation to bodily changes, peer group pressures and the start of romantic and/or intimate relationships the presence and involvement of a father is of great importance (Flouri & Buchanan, 2003). His religiosity also functioned as a stabilizing factor in this time as his mother was a devout Christian and had instilled these values in him.

Concerning the opposite sex, Mr Pretorius realized that many women wanted to be with him because of his fame. Although he got a lot of attention from glamorous and beautiful women he never engaged with them on any meaningful level, being distrustful of their motives and not convinced that they could fulfill his emotional needs. In Grade 12 he was already being pursued by "girlie magazines", and "victoria's secret" publications, his headmaster having to act as the strict father to protect him and keep him grounded. In his mind he became desirable only for his status and fame but needed something more real and genuine. To add to this it was his body once again that he relied on to achieve a feeling of self-worth and meaning. It is interesting that his biggest dream was to race against able bodied athletes, perhaps in an attempt to give psychological credence to his mother's position that he was not disabled.

The approach of his mother to his disability probably enabled him to complete his next phase of development (approximately age 2-6 years) successfully, perhaps too much so. She had an attitude of "go out and play, do normal things". She would tell him and his brother to "put on your shoes and put on your legs and go and play outside". She also did not make a distinction between them because of Mr Pistorius' disability. The word disabled was never

mentioned. This allowed him the freedom to explore his environment and gain autonomy. It suited him because he was intelligent and inquisitive. He was described as "a little tear-away, always on the go". Using his body in space to run and jump and climb gave him a sense of confidence in his physical abilities and probably partially rehabilitated his view of "me as a broken body".

He adapted well to primary school (7-13 years) where the attitude of "you are like any other boy" was continued. He once more used his physicality to feel worthwhile, this time making friends because of it and gaining respect and admiration from authority figures. Competition with peers is an important aspect of middle-childhood life and Mr Pistorius reveled in it, participating in various sports. The initial "blueprint" of "physicality equals self-worth" and the competitive temperament he was born with coming to the fore strongly. It was probably at this point that he started realizing the value of using the psychological defense mechanism of compensation. This mechanism is seen in many areas of psychological life when an individual tries to "make up" for perceived shortcomings by striving for and often achieving major success in life, often "over-achieving" (Lemma, 2003). It was probably also the consolidation of a split in his personality, what I will refer to as "the two Oscar's". The one a vulnerable, scared disabled person, the other a strong physical person achieving beyond expectation and finding rewarded for it both intra-psychically and interpersonally.

Unfortunately it was at age7/8 that he had a traumatic experience where he felt a direct physical threat and became very fearful. He was in a street in Johannesburg central as his father had a business called "Cashwise" in the Carlton Center. There was a commotion of some sort with people throwing bricks and the police shooting. Mr Pistorius was caught up in this and ran back to the Carlton Center as fast as he could, but he was terrified. There were also numerous incidents of burglary/attempted burglary that Mr Pistorius was exposed to directly or indirectly (when it happened to family members) in his primary school years.

Being exposed to the formal systems of society (in this case school) for the first time is a normal challenge, for Mr Pistorius it was made more difficult because apart from his disability he had just "lost" his father. The psychological effects of such a loss to a boy could be far reaching (Erickson, 1998). Fortunately his brother Carl stepped into the breach, taking on a father role. This role included handling difficult situations with their mother, like when she had been anxious and drank a few glasses of wine too many or not waking up at night when the younger children cried out. Carl handled these situations often without the younger children knowing about it. In this sense Mr Pistorius was fortunate as he had an older male he could rely on and use to model his behaviour

accordingly. This aspect of reliance and modeling is the basis upon which the "big brother" concept was initially built in the USA, meeting with great success in the rehabilitation of problematic boys (Rohner and Veneziano, 2001). It is clear that Carl continued to fulfill that role and still does. It became important to Mr Pistorius later to help his siblings when he was financially able, being in the position for the first time to give and not only take, both psychologically and financially. This was part of the reason for the strong motivation he displayed as an athlete.

As he entered the next phase (14-17 years) he faced challenges anew. In spite of exposure to crime and the fear it brought, a certain amount of homeostasis had been reached in the previous phase, with consolidation and a sense of psychological settled-ness. However the untimely death of his mother when he was 15 came approximately 8 months after he became a boarder at High School. This necessitated quick and effective adaptation from him. This experience probably left him with the need to seek out similar qualities in a woman to those his mother had. He needed to feel honesty, caring, support, belief in him and good moral values in a woman. At this time he was already displaying an attitude of caring and respect towards his sister, other girls of his age and his female teachers.

It was also the period where he could experience the absence of his dad as a real "lived experience" as his brain achieved the ability of abstract thought and his emotions developed. In fact, he suffered a "double-loss" as he also lost the man who had been in his mother's life at that point. After courting for a year they were married in December and she passed away three months later, Mr Pistorius being in grade 9. As a male figure his mother's husband was a positive influence and they have maintained contact over the years. The impact of losing these male figures in his life at the beginning of adolescence was strong. Feelings of insecurity and the sense of a foreshortened future are some of the aspects often described for a boy in that situation (Osherson, 2002).

Unfortunately once again there were incidents of crime that he was exposed to or experienced directly in this phase of his life. One example is seeing a dead girl on an embankment across from his high school after she had been thrown from the train. Another was when he was caught up in the well documented robbery of the Spar in Lynwood road. His cousin Graham was with him during the ordeal.

The final phase (17- 27) was influenced mainly by his instant fame and the rigors of being an elite athlete and an international icon. He had adapted well to high school, made good friends and once again relied on his "never give up" attitude when it came to physical activity. It is recalled that he refused to get

into a truck carrying boys who couldn't complete the school march in grade 8, even though his legs were bleeding. He participated in various sports, including rugby. He was fortunate to have strong positive males like the headmaster, his housemaster, coach and manager to guide and structure him, thereby rehabilitating a lot of the pain and longing he felt for his father. Importantly it also provided him with a strict structure, predictability and fare punishment when he transgressed. These aspects are crucial for identity formation and resilience during adolescence. Research shows that adolescent boys with conduct disorder most often lack these aspects in their lives (Wasserman, Miller, Pinner & Taramillo, 1996).

After an injury in rugby he was spotted by his coach while receiving treatment at the University of Pretoria. Although he didn't know athletics his rise was meteoric. He is viewed by his coach as the type of athlete you find once in a generation. Coping with the normal expectations of school and the unknown, novel pressures of being an elite athlete would have tested his resilience to the utmost. Although he had faced tough challenges in his life the early "blueprints" and the influence of caring involved adults like his grandparents, aunts, uncles and teachers now presented as positive features of his personality. His search for a positive intimate relationship continued as would be expected with a young adult, this being one of the major and crucial psychological needs of this phase of life (St Claire, 1996).

He had relationships of both long (up to 4years) and short duration (a few months) but his hectic schedule and travelling made it very difficult to maintain a relationship. He had a lot of pressure and anxiety related to his career. One example of this was a condition whereby blood clots were forming in the veins of his stumps. This presented as a serious stressor to him and made him extremely anxious as it could potentially end his career. It is known that the stumps of amputees deteriorate over time (Derman, 2014). It was in this time when he became very lonely. The loneliness of elite athletes has been described comprehensively, especially individual sportsmen like swimmers and athletes (Hemeri, 1996). Being in Italy for 4 months of the year he struggled to find his place in a circle of friends on his return. His strict training, dietary restrictions and sleep hygiene did not advance his chances of getting settled into a group of friends. It was also difficult to share his amazing and extraordinary experiences with peers that were leading quite ordinary lives compared to him.

Unsurprisingly he lost his way somewhat. He admits that he went through a period where he made the wrong choice of friends and often acted in a way that he wasn't proud of. This phenomenon is well documented amongst young "superstars" in the entertainment and sports arena often leading to drug abuse, clashes with the law, and in severe cases a disintegration of the personality. The

main underlying mechanism here is the fact that they are ordinary people who have to handle extra-ordinary pressures whilst they don't have the necessary skills to do so. They also have to handle the anxieties and disappointments that come with failure (Human, 2014). As with these superstars Mr Pistorius never had the opportunity to make the shift from adolescent to young adult in a normal way as he was leading a highly abnormal life.

In spite of the challenges Mr Pistorius got involved in various projects to help other people in this time, especially those less fortunate than him. He would always make time for his fans and handled himself with aplomb in most stressful situations. As with the previous phases of his life he was unfortunate to experience various incidents where he was exposed to crime, directly and indirectly. These include burglary (at his house while he was overseas) an attempted burglary while he was home, the high-jacking of a family member in 2011 and an attempted murder he became part of when he wanted to help in 2013. These last two incidents were very traumatic for him. He became increasingly safety conscious and fearful. He became known for his nervousness and anxiety about safety measures, especially where he lived and when he was in South Africa. Whilst in Italy he would be less so, walking home alone after training till 10pm at night.

I believe the construction of "the two Oscar's" I referred to earlier finally gelled into a final split. The one Oscar being an international superstar, more confident and feeling more in control at 1.84 m tall. That part of him falling back on his physicality and "never say die" attitude that had served him so well. Although not completely at ease he felt less vulnerable in that state. The other Oscar being a vulnerable and fearful disabled person, at less than 1.5 m once his prostheses were removed and he was alone at night. That part of him falling back onto his anxiety and fear, not feeling in control. With his prostheses on many people can damage him but without them he feels defenseless. "I am stuffed without my legs on". For this reason he acquired a weapon and even searched for one that was lighter and smaller so that he could always keep it with him.

It was into this scenario that Ms Steenkamp entered his life. He was instantly taken with her and the relationship developed well. Differences occurred but were dealt with by talking them through. To everybody's surprise he took her to his grandfather's funeral. This was seen as a sign that she was very important as his family ties were extremely dear to him. She was also the first girl he ever introduced to his uncle Arnold. In the beginning of 2013 he instructed his manager and coach to make arrangements for her to travel with him that year, something he had never done before. The day before the incident he was discussing safety and other issues with an estate agent regarding a house he was

buying for him and Ms Steenkamp. Arrangements were being made for them to attend a special concert abroad later that year by the tenor Andrea Bocelli. They were described as "good together" and "a loving couple". Their relationship shows none of the characteristics associated with an abusive relationship (Ludsin & Vetten, 2005).

In terms of his personality and demeanor Mr Pistorius was described as argumentative, at times moody, anxious, fearful, controlling and suspicious. His positive characteristics were described as gentle, respectful, loving, caring, private, motivated, hardworking and religious.

5. Evaluation.

From my assessment of Mr Pistorius and with the information currently at my disposal I come to the following conclusions:

5.1 Mr Pistorius has been severely traumatized by the events that took place on the 14th of February 2014. He currently suffers from a Posttraumatic Stress Disorder and a Major Depressive Disorder as defined by the Diagnostic and Statistical manual-5 (DSM-5) (See annexure C). The degree of anxiety and depression that is present is significant. He is also mourning the loss of Ms Steenkamp.

5.2 Mr Pistorius is being treated and should continue to receive clinical care by a Psychiatrist and a Clinical Psychologist for his current condition. Should he not receive proper clinical care his condition is likely to worsen and increase the risk for suicide (Gelder, Andreansen, Lopez-Ibor & Geddes, 2012).

5.3 No evidence could be found to indicate that Mr Pistorius has a history of abnormal aggression or explosive violence. Abnormal aggression and violence was never incorporated into his personality, as borne out by both psychometric testing and collateral information. He does not display the personality characteristics of Narcissism and/or Psycopathy that are mostly associated with men in abusive relationships and have been linked to rage-type murders in intimate relationships. Those who know him describe him as gentle, respectful and conflict avoidant. The times when he did become angry were found to be suitable for the situation and context. His style of conflict resolution is to talk through the situation or remove himself from the situation. He also has the ability to self-reflect afterwards, mostly leading to feelings of guilt

and an apology from him. His ability to regulate his affect is well developed.

5.4 There is evidence to indicate that Mr Pistorius does have a history of feeling insecure and vulnerable, especially when he is without his prostheses. He has also been exposed to crime directly or indirectly throughout his life. A reaction to a threatening situation comprises more than "flight or fight", an appraisal takes place instantly whereby the individual assesses firstly the intensity of the threat and then his position to cope with the threat. These appraisals are influenced by amongst other things previous experience. When Mr Pistorius' appraisal of a situation is that he might be physically threatened a fear response follows which might seem extraordinary when viewed from the perspective of an able-bodied person, but normal in the context of a disabled person with his history.

5.5 No evidence could be found to indicate that Mr Pretorius suffered from anxiety to the extent that it impaired his functioning prior to the incident in February 2014. **He specifically does not meet criteria "D" of the DSM-5 for Generalised Anxiety Disorder – "The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."** (See annexure C). If his context is taken into account his functioning was superior prior to the incident in February 2014. For somebody of his age his achievements in both his occupation and the social sphere were enormous. The successful intimate relationship he craved and his inability to rehabilitate his relationship with his father being the only areas where he achieved less success.

5.6 There is evidence to indicate that Mr Pistorius was genuine with his feelings towards Ms Steenkamp and that they had a normal, loving relationship. He did become insecure and jealous at times but this was normal for the specific situation. He would express his displeasure and irritation but would try and sort it out later by talking with Ms Steenkamp. Although their relationship was still young there were no signs of abuse or coercion like those often found in these kinds of relationships (Ludson & Vetten, 2005; Mauricio & Gormley, 2009). In his previous long-term relationship of 4 years these aspects were also absent.

6. Findings.

6.1 Mr Pretorius did not suffer from a mental defect or a mental illness at the time of the commission of the offence that would have rendered him criminally not responsible for the offences charged.

6.2 Mr Pretorius was capable of appreciating the wrongfulness of his act and of acting in accordance with an appreciation of the wrongfulness of his act.

Prof J.G. Scholtz
27/06/14
072 449 7330