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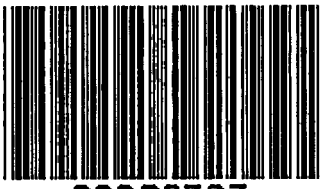

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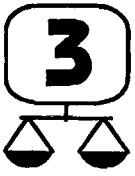
Juror Reciprocal Antagonism and Intermittent Explosive Disorder: A Plausible Clinical Diagnosis of the O.J. Simpson Case

Laurence Armand French



A Contextual Perspective

A PROBLEM in American jurisprudence is the often contravening mandate of the criminal justice system vis-a-vis that of the mental health professions. Wide differences exist between both systems despite the fact that each had developed elaborate criteria in an attempt to make their respective process objective. The criminal justice system's "ideals" are based on a number of presumptions which are designed to balance the power of the "state" (prosecution) versus that of the defense, with the understanding that the former usually has access to far greater resources than the latter. This is especially the case when "minorities," notably those from the lower socio-economic strata of society are concerned. Critical to this adversarial legal contest is the presumption of innocence until proven guilty — "beyond a reasonable doubt." Thus, the objectivity of the criminal justice system is designed to determine a discrete finding of either "innocence" or "guilt." Indecisiveness among those determining the outcome of this contest leads to a mistrial with the option for subsequent trials left up to the state (prosecution). Appeals are based on procedural matters concerning how the legal game was played.

Mental health professionals, while also striving for objectivity, play by a different set of rules. The mental health professions, notably psychiatry, psychology and social work, attempt to provide a broader profile of the client (defendant) providing a diagnosis that is more fluid than the dichotomous "innocence" or "guilty" verdict generated by the criminal justice system. Since 1980, the standard for mental health diagnoses has been the multiaxial assessment profile generated by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*

(DSM). While the intent of the DSM is for a universal diagnostic criteria, the complexities of psychiatry and psychology are often beyond the scope of the general knowledge base of the average juror. In fact, those potential jurors with training in either law, criminal justice or the mental health professions are usually dismissed by either the prosecution or the defense.

This matter is further complicated by sensational cases like those of John Wayne Gacy, Ted Bundy, Jeffrey Dahmer and O.J. Simpson. In these cases the complex nature of clinical issues are often skewed and distorted by "experts" and their appearances on the television "talk show" circuit, further compromising the objective criteria set forth by the DSM. In these cases, the talk show host, Oprah, Geraldo, Donahue, etc., take on clinical creditability with the viewing public far beyond that which their education, training and professional experiences warrant. Memories of child sexual abuse, spousal abuse, multiple personalities (now termed, Dissociative Identity Disorder), sexual dysfunctions and substance related disorders have been widely discussed, often with considerable distortion, on the talk shows. Unfortunately, it is within this context that a considerable portion of the general public develops its clinical knowledge base. The same process holds true for the criminal justice process, especially regarding issues relevant to alleged biases within the criminal justice system.

Hence, two factors tend to complicate the adjudication of potentially mentally ill defendants. First, there is the seemingly oversimplified legal definition of mental competence (e.g. the insanity plea). Second, there is the public's distorted image of clinical issues which tends to bias not only jury pools, both grand and petite, but prosecutors, defense attorneys and judges as well. These factors were paramount in a number of sensational cases which preceded the O.J. Simpson trial, most notably the Jeffrey Dahmer legal competency factors directed the jury to find Dahmer to be "not mentally ill," when, in fact, his clinical profile was clearly that of a serious and dangerous mental disorder — paraphilia. Here, a finding of "guilty but dangerously mentally ill" would have been more appropriate and perhaps would have spared his brutal murder within the general prison population. In Dahmer's case, the complex clinical picture presented by the defense was at a level beyond the jury's empathic reach and, secondly, his decorum during the trial did not seem to fit that of a "madman" as he sat in the court calm and well groomed.

These two features were replayed in the O.J. Simpson case except here it was the complexities of the prosecution's evidence coupled with O.J.'s court room deportment and the unintended third factor, the LAPD race issue, which most likely swayed the jury from its objective mandate. It appears in the O.J. case that a prolong overload of complex information, much of it beyond the academic and professional knowledge base of the jury, raised the collective stress level of the jury thereby obviating their objective mandate and subsequently allowing for a collective emotional decision based on pretrial racial biases. And since O.J.'s attorneys did not attempt to have his mental competency evaluated, the idea of a mental disorder was presented by neither the defense, the prosecution, or the judge.

Both the jury's verdict and the racially polarized post-verdict public reactions clearly illustrate what Simmell and Coser termed, "reciprocal antagonism," a social psychological phenomenon that applies to the relationship between hostile groups and

cohesive ingroups (Coser, 1956; 1965; 1967). In the O.J. Simpson case, the jury, long stressed over the length and content of the trial, came to identify with O.J. and his plights and to distance themselves from the prosecution and the LAPD. This combination served to reinforce the jury's "confirmation bias" regarding both Simpson's innocence and the ineptitude and corruptibility of the LAPD. The confirmation bias is the process of reinforcing our preconceptions — in this case, those about O.J. the superstar, on the one hand, and those of a corruptible, racist LAPD, on the other (Fishchhoff, Lichtenstein, and Slovic, 1977; Klayman and Ha, 1987; Watson, 1960).

In this classic case of reciprocal antagonism, the jury came to view the prosecution and its representation of the state of California, as the hostile outgroup while, at the same time, absorbing O.J. into their cohesive ingroup. The irony is that O.J.'s traditional psychological reference group is comprised more of affluent whites than it is of working class people of color. Herein lies O.J.'s unending quest to win back his white audience. Unfortunately, O.J.'s frustration appears to focus on his legal and not on his mental health status. While the black community is willing, for the most part, to accept his legal exoneration, whites basically still see O.J. as a dangerous, maladapted person who "beat the system."

The attribution bias comes into play in this process of the public's perception of O.J. In short, the attribution bias posits that within our ingroup we tend to over attribute individual (dispositional) cause to ourselves in situations with favorable outcomes and to over attribute external (situational) influences to situations with unfavorable outcomes. By the same token, we tend to over attribute situational cause in situations regarding favorable outcomes when members of outgroups are concerned and to over attribute dispositional cause to outgroup members regarding situations with unfavorable outcomes. Subsequently, blacks are more prone to over attribute external (situational) causes, like being framed by the LAPD in O.J.'s case, while whites tend to over attribute internal (dispositional) causes to his dilemma. Perhaps this common social psychological process best explains the wide gap between whites and blacks regarding O.J.'s post verdict acceptability (Heider, 1958; Jones and Davis, 1965; Jones and Harris, 1967; Jones and Nisbett, 1971; Kelley, 1973).

The O.J. Diagnosis

The *Diagnostic and Statistical Manual* incorporated the multiaxial format in 1980 with the DSM-III. With the latest edition, the DSM-IV, "Clinical Disorders" and "Other Conditions that may be a focus of clinical attention" appear on Axis I. "Personality Disorders" and "Mental Retardation" are on Axis II while Axis III is reserved for "General Medical Conditions" associated with Axis I or Axis II classifications (American Psychiatric Association, 1994). Major Clinical Disorders are those in which a person's behaviors, including homicide, are driven by the severity of the mental illness. Such a clinical condition does not, in itself, excuse the behavior. Often this factor depends on the state's insanity statute. Today, the trend is toward a more reasonable clinical/legal finding for these dangerous mental disorders, that of "guilty but mentally ill." In the O.J. Simpson case the plausible DSM-IV clinical profile is as follows:

Axis I: 312.34 Intermittent Explosive Disorder.

309.90 Adjustment Disorder with Mixed Disturbances of Emotions (Anxiety & Depression) and Conduct.
300.12 Dissociative Amnesia (rule-out).
V61.10 Partner Relational Problem (history of).
Axis II: 301.90 Personality Disorder NOS (with Paranoid, Borderline, Antisocial, Narcissistic & Dependent qualities).
Axis III: Rule-out prefrontal lobe insult secondary to violent sport activities.

The primary clinical item in this diagnosis is the Intermittent Explosive Disorder. The other diagnoses are associated, or supportive, elements of this plausible profile. In legal terms, they could have provided the mitigating circumstances leading to the impulsive double murder. To best understand the diagnostic profile, we first need to conceptualize what is meant by Intermittent Explosive Disorder and, secondly, ascertain how it fits the O.J. case. What follows is the DSM-IV definition of this disorder:

312.34 Intermittent Explosive Disorder

Diagnostic Features

The essential feature of Intermittent Explosive Disorder is the occurrence of discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property (Criterion A). The degree of aggressiveness expressed during an episode is grossly out of proportion to any provocation or precipitating psychosocial stressors (Criterion B). ...The individual may describe the aggressive episodes as "spells" or "attacks" in which the explosive behavior is preceded by a sense of relief. Later the individual may feel upset, remorseful, regretful, or embarrassed about the aggressive behavior.

Associated Features and Disorders

Signs of generalized impulsivity or aggressiveness may be present between explosive episodes. Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be especially prone to having explosive outbursts of anger when under stress. ...There may be nonspecific EEG findings (e.g., slowing) or evidence of abnormalities or neuropsychological testing (e.g., difficulty with letter reversal). ...There may be nonspecific or "soft" findings on neurological examinations. ...Developmental difficulties indicative of cerebral dysfunctioning may be present... A history of neurological conditions (e.g., head injury, episodes of unconsciousness, or febrile seizures in childhood) may be present (American Psychiatric Association, 1994: 609-612).

In many cases where the Intermittent Explosive Disorder is present poor subcortical filtration is often a factor which, combined with the distortion of cause and effect (paranoid ideation) leads to a peripheral nervous system (PNS) function as the "fight or flight" response. Here the sympathetic mode of the autonomic nervous component of the PNS provides us with exceptional strength necessary to address a perceived threat. The physiology of this process involves decreased pulmonary secretions along with bronchodialation there by increasing blood oxygenation; increased heart rate and contractility which increases cardiac output; arteriolar constriction shunting blood from the skin and digestive tract with dilation of arterioles in the heart and skeletal

muscles hence providing more blood to these organs; glycogen and lipid decomposition allowing glucose syntheses for energy; and a decrease in GI motility and secretion along with urine retention. Together this process provides what is commonly termed "an adrenaline (epinephrine) rush." The sympathetic mode process occurs without immediate cerebral cortex input and may even produce an overload to the cerebral filters causing amnesia. That is, we are not thinking about what we are doing at the time of these episodes even though our paranoid ideations, or some other cause of reality distortion, placed us in this situation. The thinking today is that disproportionate impulsivity is due to a combination of neuro factors. There appears to be subcortical dysfunctioning notably within the limbic system ("emotional brain") coupled with a faulty or damaged frontal lobe (the most dense neuro net which is responsible for subcortical filtration). The frontal lobe is that portion of the cerebral cortex responsible for our judgment and personality. Delayed gratification is a major frontal lobe function which, in turns, mediates the appetite and urges of the emotional subcortical region (Bear, et. al., 1996; Thomas, 1993). Moreover, this excited state obviates any otherwise handicapping conditions such as arthritis. In short, O.J. was quite capable of the acts for which he was tried.

The other associated classifications in this diagnosis are supportive of the Impulse Control Disorder manifested in the O.J. case. O.J.'s early socialization in a lower working class Bay Area neighborhood along with his subsequent rise to superstar status via an aggressive sport provides precipitating traits which became internalized thereby providing the paradoxical O.J. personality. His football activity probably also contributed to frontal lobe damage common to Impulsive Control Disorders. In mediated reality, the more negative attributes of his personality and behavior either lay latent or were discounted by the public due to his superstar status. Yet, when one looks carefully at his interpersonal relationships, especially those involving women, one sees a history of behaviors indicative of a Personality Disorder with Paranoia (compulsive ownership of women with jealousy and stalking), Borderline (instability in his relationships with women; promiscuous sexual behaviors), Antisocial (verbal and physical violence especially against women), Narcissistic (need for admiration coupled with a lack of empathy for his victims), and Dependent (an excessive need for white America to accept him at his pre-trial status) qualities. Related to his pervasive personality traits is his relational problems, notably his impaired interactions with women, including black women (first wife), and his children.

While these personality characteristics were somewhat controllable, the inevitable breakup with Nicole could have certainly served to exacerbate the personality features while at the same time causing increased anxiety and depression over the situation. This is where the Adjustment Disorder enters the picture: "The essential feature of an Adjustment Disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors" (American Psychiatric Association, 1994: 623-625). These clinical features are likely to have heightened the paranoid and antisocial personality features which lead to increased stalking activity and which probably culminated in the deadly encounter with his ex-wife and Ronald Goldman. In addition, the intensity of this autonomic impulsivity can be such that it defies cerebral interpretation, hence leading to Dissociative

Amnesia: "The essential feature of Dissociative Amnesia is an inability to recall important personal information usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness" (American Psychiatric Association, 1994: 478). In this case, it could very well be that O.J. is suffering from "selective amnesia" whereby he knows he committed these acts but can not recall all the vivid details of their occurrence. And his self-centered, self-serving personality has created a situation where his sorrow is not for his victims, but rather for himself.

Prognosis

A person with this type of diagnosis does not cure himself. The programs for these types of diagnosis, moreover, are generally poor to begin with, even for those who seek treatment. This is due mainly to the nature of the clinical situation which is not easily mediated by therapies (psychotherapies) reliant upon the cerebral cortex for resolution. Clinical psychopharmacologic interventions, at best, merely mask the subcortical urges. If in fact, Intermittent Explosive Disorder does apply to Orenthal James Simpson, then O.J.'s quest for approval from the dominant white public will most likely only aggravate his clinical condition. Finally, if the diagnoses fit O.J., then it seems that it is only a matter of time for a reoccurrence of impulsive aggression in some form or fashion (Cooper, et al, 1991; Gilman, et al, 1993).

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