

Excited Delirium: Fallacy or Reality?

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Although not a medical or psychological diagnosis, excited delirium is real and is recognized by the National Association of Medical Examiners (NAME), the American College of Emergency Physicians (ACEP), and other medical and law enforcement professionals. According to the ACEP Excited Delirium Task Force, “[t]he term ‘excited delirium’ has been used to refer to a subcategory of delirium that has primarily been described retrospectively in the medical examiner literature” (ACEP, 2009, p. 4). Di Maio and Di Maio (2006) defined excited delirium as a person who is experiencing a delirium that involves combative and/or violent behavior. The acute onset of this condition is what helps to distinguish it from other types of delirium.

Law enforcement officers often confront individuals who are in a state of excited delirium, and being able to recognize the behavioral signs is a key variable in identifying the event as a medical emergency. Officers need to capture, control, and restrain the individual quickly and safely before medical intervention can occur. While not every person who is experiencing excited delirium dies, unfortunately, the outcome is sometimes fatal (ACEP, 2009). Hall, Kader, McHale, Stewart, and Vilke (2012) identified the frequency with which police officers come into contact with individuals who are exhibiting signs of excited delirium. Their retrospective study spanned 3 years: August 2006 – August 2009. Of the 1.56 million police-public interactions they reviewed, 1,269 (0.08%) of the incidents involved a use of force, 66% (n = 837) of these individuals were identified as having effects of emotional disturbances, drugs, alcohol, or a combination and 31.9% of individuals (n = 405) exhibited 1 or 2 signs of excited delirium behaviors, while 16.5% (n = 209) showed 3 or more behavioral signs.

Excited delirium behavioral cues can be grouped into 3 categories: psychological; communication; and physical (IPICD, 2010). Psychological behavioral cues include, but are not limited to: intense paranoia; extreme agitation; rapid emotional changes; disoriented about place, time, purpose; disoriented about self; hallucinations; delusional; easily distracted; psychotic in appearance; and, being described by others as having “just snapped” or “flipped out.”

Communication behavioral cues include, but are not limited to: screaming for no apparent reason; pressured speech; grunting; growling; talking to imaginary people; and, having irrational speech (IPICD, 2010).

Physical behavioral cues include, but are not limited to: violent behavior toward objects, particularly glass; bizarre behavior; running into traffic; running for no apparent reason; naked; stripping off clothing; apparent superhuman strength; seemingly unlimited endurance; resisting officers before, during, and after being restrained; and, diminished sense of pain (IPICD, 2010).

The ACEP panel noted there were several well-documented incidents involving people who were in an excited delirium state and then died, even though they were minimally restrained (e.g., handcuffed). Hall,

Kader, McHale, Stewart, and Vilke (2012) reported 1 death during the range of their study, which indicated fatal outcomes are rare. However, regardless of a low probability of a fatal outcome, such outcomes are costly to municipalities, involved officers, their agencies, etc., because of likely litigation, not to mention the emotional and public relations costs.

What often adds to the complexity of these deaths is a negative autopsy (Di Maio & Di Maio, 2006). “Excited delirium syndrome involves the sudden death of an individual, during or following an episode of excited delirium, in which an autopsy fails to reveal evidence of sufficient trauma or natural disease to explain the death” (p. 1). Often times when there is a negative autopsy the general public, news organizations, and anti-law enforcement groups are quick to claim the officer(s) killed the person. They claim that handcuffing the person face-down was the last thing that happened and therefore that caused the person’s death. In short, they are confusing temporality (focusing on time) with causation (Peters, 2009). Temporality is not an absolute basis for causation, but may be an important clue to causation. However, temporality does not eliminate the need to show causation (Dey v. Colt Construction & Development Co., 1994).

Training officers in excited delirium behavioral cues is important not only for their safety and the safety of the individual, but also to reduce time in the medical treatment of the person and to also minimize governmental entity and officer liability. When one or more excited delirium behavioral cues are identified by responding officers it immediately become a medical emergency with ambulance personnel sent to a staging area until the person is captured, controlled, and restrained. Then appropriate medical intervention can take place, prior to transporting the restrained individual to a hospital in an ambulance. Medical professionals and law enforcement officers know that excited delirium is real, even though it may not have its own medical or psychological diagnosis.

References

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