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COMMENTARY - UNSOLICITED

"Excited delirium," erroneous concepts, dehumanizing language, false narratives, and threat to Black lives

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Addressing health equity starts at home. This entails adopting transparent actions to improve health equity within one's discipline including reexamining the validity of data upon which prior decisions rest. A 2009 task force of the American College of Emergency Physicians (ACEP) issued a "white paper" on excited delirium. Today, there is a dispute between medical specialties regarding "excited delirium." This dispute is not arcane. Diagnostic terms and associated words have potential unintended consequences of harming people and contributing to social injustice. Thus, we write in the spirit of seeking a reconsideration of the findings in that white paper.

ISSUE #1: LACK OF SCIENTIFIC VALIDITY FOR "EXCITED DELIRIUM"

The diagnosis of delirium, with/without hyperactivity, is recognized in psychiatry and medicine through the Diagnostic and Statistical Manual (DSM-5) criteria. "Excited delirium" is neither recognized within the DSM-5 nor recognized by the International Classification of Diseases (ICD-10). To earn a spot in those diagnostic manuals, there must be rigorous science. The DSM-5 requires rigorous validity field testing, in addition to numerous scientific evidence reviews and widespread feedback. In contrast, the formal term and conceptualization of "excited delirium" lacks this scientific validity.

The ACEP acknowledged, "… there is no current standardized case definition by which to identify "Excited Delirium [Syndrome]."[1] The task force report suggested that "excited delirium" is characterized by multiple "syndromic" features (Table 1). These features are largely based on police reports filed following use of force and have not been independently corroborated by neutral observers nor have these features been tested for reliability or validity.

The American Psychiatric Association (APA) approved a position statement in 2020: "The term 'excited delirium' is too non-specific to meaningfully describe and convey information about a person. 'Excited delirium' should not be used until a clear set of diagnostic criteria are validated."[2] The American Medical Association (AMA) stated that current evidence does not support "excited delirium" as an official diagnosis stating that it "opposes its use until a clear set of diagnostic criteria has been established."[3]

Evidence supports the APA and AMA positions statements. A systematic review showed "low to very low levels of evidence for excited delirium."[4] A synthesis of research on "excited delirium" concluded that it is typically used when deaths occur following aggressive restraint methods.[5] The authors found no valid evidence that "excited delirium," absent aggressive restraint, is inherently lethal and recommended that "agitated delirium" replace "excited delirium," modified by a description of the degree of restraint used by law enforcement.

ISSUE #2: THE TERMINOLOGY'S EVOLUTION AND ITS POTENTIAL HARMS TO INDIVIDUALS

One could argue, what's in a name? A likely unintended consequence of the original white paper is that "excited delirium" signals extreme and unmanageable violence, "priming" responses involving force. The construct has evolved to justify use of force among law enforcement through poorly validated claims of science. It poses a potential threat to Black lives and persons with behavioral health disorders who often face violent interactions with law enforcement. Delirium is a medical emergency, and the term within medicine calls for an assessment and treatment of underlying medical causes, yet the threat evoked by its purported features, i.e., superhuman strength

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TABLE 1 DSM-5 versus excited delirium

DSM-5 criteria for delirium	Excited delirium
All five criteria required:	Based on perceived abnormal behavior and suggested six out of 10 criteria:
• Disturbance in attention—reduced ability to direct, focus, sustain, and shift attention and awareness	• Pain insensitivity • Superhuman strength
• The disturbance develops over a short period of time (usually hours to a few days), representing an acute change from baseline attention and awareness and tending to fluctuate in severity during the day	• Tachypnea • Sweating
• An additional disturbance in cognition, i.e., memory deficit, disorientation, language, visuospatial ability, or perception	• Agitation • Tactile hyperthermia
• The disturbances are not better explained by a preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma	• Police noncompliance • Lack of tiring
• There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect	• Inappropriately clothed • Mirror/glass attraction

and insensitivity to pain, deflects from appropriate ways to manage agitated people with delirium safely. The term may evoke racist and stigmatizing stereotypes that dehumanize the person, furthering the perception that they are violent threats instead of people in need of emergency care.[6] Thus, rather than invoking deescalating life-saving response that minimizes risk to all, "excited delirium" evokes a perception of severe threat while eliciting a response involving extreme force. Such force can result in harm, even death, to the agitated person.

"Excited delirium" can be a default "diagnosis" in the field—typically in cases of acute substance intoxication during physical restraint by law enforcement. This presumption can result in emergency responders in the field overlooking alternative life-threatening conditions causing extreme agitation, such as acute mania, hypoxia, brain injury, and thyroid storm. When this presumed diagnosis is conveyed to the emergency department (ED), it could delay accurate diagnoses and corresponding treatment.

ISSUE #3: SOCIAL INJUSTICE

The features of "excited delirium" justify use of tasers and potentially lethal force by law enforcement. The purported high mortality associated with "excited delirium" provides post hoc, alternative explanations for deaths resulting from law enforcement use of extreme force. The term is invoked in legal defense cases involving law enforcement, even in the absence of drugs in a person's system or alternate explanations that could medically explain behavior. This term and its purported features including presumed high mortality shields police from accountability in these deaths that often involve Black men,[4,5] by defending police action including extreme use of force in the face of purportedly unmanageable violence.

AN ILLUSTRATION: THE DEATH OF DANIEL PRUDE

The following account based on grand jury testimony surrounding the death of an unarmed Black man illustrates how "excited delirium" dehumanizes people and elicits violent law enforcement responses, even when the person is unarmed and offers little resistance while simultaneously shielding police from accountability.

Mr. Daniel Prude's family called 911 when he ran naked into the streets. A police officer broadcasted "… this guy is supposed to be on PCP if they run into him." When asked why he issued this broadcast, the officer who was involved in restraining Mr. Prude stated… "that people under the influence of PCP can be very erratic and display extreme strength." Although Mr. Prude showed minimal resistance, police cuffed him, placed a spit hood over his head, forcibly restrained him face down, threatened him with a taser, and twice applied hypoglossal pressure, i.e., painful manual pressure under the jaw. Minutes later, he stopped breathing.[7] The medical examiner ruled his death a homicide, listing cause of death as complications of asphyxia in the setting of physical restraint, excited delirium, and acute phencyclidine intoxication. An emergency medicine medical expert disagreed, testifying that Mr. Prude died from "excited delirium," not from police restraints.[7] The grand jury failed to indict the police involved.

The NY Attorney General's report and sworn testimony offer evidence that "excited delirium" contributed to the death of Mr. Prude, but not in way the medical expert testified. Mr. Prude likely died from asphyxiation from force used by police who apparently believed Mr. Prude possessed extreme strength from PCP invoking "excited delirium." One could ask whether Mr. Prude was harmed by police who restrained him based on the concept or term of excited delirium. Would they have acted similarly absent the concept given PCP's reputation for resulting in extreme behaviors? Although these are reasonable

questions, in this case the harm of the concept of "excited delirium" rested primarily in the citation of low-quality data underlying the term's claimed effects to exculpate the officer. Notably, the medical expert testified that Mr. Prude died from "excited delirium" caused by PCP, making it impossible to separate these intertwined beliefs.

Police are only human and rely upon medical experts and respond to what they believe to be true. The medical expert's testimony retrospectively confirms the belief that "excited delirium" justified police actions. An officer when encountering a violent individual intoxicated with PCP might await medical personnel, who could offer an assessment of appropriate medical response and medical restraint that could yield an opportunity to treat the underlying intoxication. Sometimes this will not be possible—violent behavior has inherent risks and medical personnel may not be able to quell a person safely in the field.[8] There is much to learn about these dynamics and there is a great deal of public discourse on these subjects that should be informed by ongoing medical evidence and improved practices in the field.

CONCLUSION: RECTIFYING THE HARMS OF EXCITED DELIRIUM

Words matter. As suggested by an AMA and AAMC *Guide to Language, Narrative and Concepts*, dehumanizing language, false narratives, and erroneous concepts can harm people and contribute to health inequities.[9] While safety on the scene and in EDs for all involved is critical, use of force should be limited without assuming from the get-go that it will be needed. To prevent needless death and tragedy, avoid litigation, and ensure justice, terminology must conform to current evidence and avoid dehumanizing people most in need of care.

We generally support the 2021 ACEP recommendations for management of hyperactive delirium.[10] We encourage emergency medicine and ACEP to reconsider its 2009 position statement on "excited delirium" based on current evidence, potential for unintended harm to Black patients, and potential for reinforcing racial injustice and also injustice for people with behavioral health disorders. Academic journals are well positioned to encourage adoption of humanizing language and to challenge false narratives and erroneous concepts among those working in emergency medicine and first responders. This can be done during medical education including case conferences and through community trainings for emergency medical services and law enforcement. Most importantly, language that points to traditional appropriate medical interventions can enhance out-of-hospital treatment, while humanizing, language, and scientifically valid concepts can be promoted by example and through informal conversations when inappropriate terms are used. These humanizing steps will promote health equity in emergency medicine.

CONFLICT OF INTEREST

The authors declare no potential conflict of interest.

AUTHOR CONTRIBUTIONS

Kevin Fiscella, Debra A. Pinals, and Cleveland G. Shields each contributed to drafting the manuscript and critical revision of the manuscript to ensure important intellectual content.

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