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Beat-1 with Chris Lawrence

01/20/2006

CHAS'REVIEW COMMENTS:
KUDOS to Chris Lawrence! His research into the reasons why some individuals seem to have support for arguing that "excited delirium" doesn't exist because it isn't an "officially recognized" disorder, is RIGHT ON!!! Excited Delirium IS a legitimate medical disorder – even if it isn't included in the psychiatric conditions "Bible" (the DSM). After all, ANY illness or injury that causes an altered level of consciousness, COULD also cause a state of excited delirium. It isn't only "psychiatric" problems or disorders that cause excited delirium!]

PoliceOne Exclusive: Excited Delirium and its medical status

I recently spoke with a person at a national police association headquarters about excited delirium (ED), and was "reminded" that there are some people who do not like the term because it is not "officially recognized." Depending on what you consider as "official recognition," this person has an arguable point.

Some reports include comments from critics who claim that ED is not real, but rather the product of poor police performance, a term used to hide police brutality, or cover for improper training (*60 Minutes II, 2003; Parenti, 1999*).

Other reports point to the fact that ED is not listed in the "DSM" and therefore not a recognized medical or psychiatric condition (*Benner & Isaacs, 1996*), an admittedly dated yet still valid point.

A more recent comment raised the question of whether or not ED exists at all (*Paquette, 2003*).

Why do these points keep cropping up in discussions relating to sudden unexpected deaths?

Here are the facts, as I understand them.

"DSM" is an acronym used for a text published by the American Psychiatric Association (APA), which lists the criteria used by medical practitioners when diagnosing people believed to be experiencing some form of mental illness. The full name of the text, according to the front cover is the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision." This text is 980 pages long, includes 11 appendices, and was last published in 2000 (my copy was printed in June 2004). The DSM-V is in the works.

The process of how the DSM came into existence is documented within the front portion of the text. For the purposes of this column, the DSM is the product of an evolution over 50 years old, while the interest in categorizing mental health issues is much older than that. In sum, the purpose of the DSM is to provide a thorough and consistent guide to assist the medical community in diagnosing mental health illness.

An ability to make a diagnosis is dependent on information derived from three sources: patient records, informants, and interviews with patients themselves (*Morrison, 1994*). I'll come back to this point later.

There is a parallel text, referred to as the ICD or the International Classification of Diseases. Published by the World Health Organization (an on-line version is available), it is currently in its 9th variation and is the "official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States" (*World Health Organization*). Even this document is being revised (*U.S. Department of Health and Human Services, 2004*). The ICD also excludes "excited delirium" from its text.

So where does the term "excited delirium" come from?

If you go to the website known as PubMed, a service provided by the National Library of Medicine and the National Institutes of Health, you can find the answer.

This online service includes over 15 million entries from a number of life science and medical journals dating back to the 1950's. If you type in "excited delirium" as the search term you will find, as of December 19, 2005, 18 articles listed. The earliest entry using the term excited delirium is a publication by Wetli and Fishbain (1985), "Fatal cocaine intoxication presenting as an excited delirium is described in seven recreational cocaine users" (p.873). As you can see the first use of the term is descriptive of the behavior, not a diagnosis.

According to PubMed, the next documented use of the term occurred eight years later in a paper by O'Halloran and Lewman (1993) where they provided 11 case reports concerning "the sudden death of men restrained in a prone position by police officers." "All subjects were in an excited delirious state when restrained" (p.289) again, using ED as a descriptive term rather than as a diagnosis.

Two years later, Stratton, Rogers, and Green (1995) wrote a case report describing two incidents where "the cause of death was determined to be positional asphyxiation during restraint for excited delirium" (p.710). This would seem to be the first occasion where the term ED was changed from an adjective, describing an event, to a noun where it became a symptom cluster. This cluster was defined in 1997, when Farnham and Kennedy described ED as "a state of mental and physiological arousal, agitation, hyperpyrexia (high temperature) with epiphoria (tearing of the eyes), and hostility."

To better understand why the DSM does not list ED, I suggest critics turn to the Introduction on page xxiii.

The APA states that the utility and credibility of the text require that it be supported by an extensive empirical foundation (*American Psychiatric Association, 2000*). That usually means that someone has conducted research to test a hypothesis. As mentioned by Dr. Christine Hall (*Manojlovic et al., 2005*) "there is currently no prospective scientific evaluation outlining historical features of excited delirium and retrospective reviews are fraught with selection and reporting bias…" (p.38). In other words, to date, research associated with ED is sparse.

The limited research required into ED precludes its inclusion in the DSM. In fact, the DSM states, "New diagnosis will only be included after research has established that they should be included rather than being included to stimulate that research" (p.xxviii). It only makes sense that a malady not subject to research and clarification will not be included in the ICD either.

Having said that, it would be unfair not to point out that the current version of the DSM was prepared on the basis of literature dating up to 1996 and involved the efforts of "more than 1000 people" (p.xix). Any compilation of this magnitude will incorporate a systemic lag resulting from continued research, which cannot be incorporated in the revised edition. Add to this point, the fact that 15 of the 18 ED related articles found on PubMed were written after 1996, the cutoff date for inclusion in the DSM literature review.

The DSM editors acknowledge that with the generation of new knowledge through research or clinical experience, new disorders may be identified while some are removed.

Efforts are underway to establish research protocols to study subjects experiencing ED. There is a long way to go before we have any answers on that front. A huge barrier is a lack of funding for investigating this problem. Another barrier is the presentation of ED itself. As Dr. Hall has said, during a number of presentations we have mutually been involved in; it is difficult to study a problem where the presenting symptom is death.

One other point needs addressing. My experience over the past six years leads me to wonder if medical specialization may be hampering the appreciation of ED and sudden deaths. I have looked into the potential causes and features of ED and spoke with physicians from many different fields. What I have learned is that specialization can lead to a silo approach to a problem. For example, pathologists don't usually go to psychiatric conferences and cardiologists tend not to read neurology texts.

As I stated earlier, an ability to make a diagnosis is dependent on information derived from three sources: patient records, informants, and interviews with patients themselves (*Morrison, 1994*). People experiencing ED often arrive with few, if any patient records, (medical) informants are either non-existent or are untrained lay persons who lack an appreciation of the significance of the information they may or may not have, and talking with the patient during the event is essentially impossible.

The psychiatrist cannot interview him until she is able to carry on a conversation with the subject, while the emergency room physician is faced with treating an aggressive, resistive patient unable to provide a case history. When an excited, delirious patient dies before reaching hospital he - it's a man in 97% of the cases (*Lawrence, 2005; D. L. Ross, 1998*), is subject to autopsy. If the subject dies in Emerg, treatment stops and the case moves to the pathology department.

I'm not criticizing physicians, or anyone else for that matter, for the situation as I describe it. Medicine is becoming more complex everyday. My point is that a broader appreciation of ED may be subject to society's demand for medical specialization, which is the current trend. When the opportunity to bring a collection of specialists together arises, as occurred in Victoria, British Columbia, the resulting synergy is both remarkable and illuminating (*Office of the Police Complaint Commissioner (BC), 2005*).

If these types of gatherings could reoccur I think the understanding of ED that should result might narrow the debate, broaden our perspectives and inform the public about how much, and how little, we know about ED.

"Excited delirium is not a clinical entity of its own, but a constellation of symptoms from a varied and severe underlying process" (*Manojlovic et al., 2005 p.38*). while the American Medical Association does not recognize ED as a medical diagnosis or psychiatric condition, the National Association of Medical Examiners has recognized ED (*Stephens, Jentzen, Karch, Wetli, & Mash, 2004*) for more than a decade (Wetli, 2006). One text has been written specifically on the problem, Excited Delirium Syndrome by Theresa and Dr. Vincent DiMaio (2005).

I recommend two other books for the consideration of anyone interested in learning more about ED or sudden unexpected deaths: Karch's Pathology of Drug Abuse, Third Edition (*Karch, 2001*), and Sudden Deaths in Custody, edited by Professor Darrell Ross and Dr. Ted Chan (2006). My copy arrived last week.

The future will determine if proposed research is actually conducted, and whether or not ED "officially" makes it into a future version of either the DSM or the ICD. Until then the debate will continue.

The views expressed are those of the author and do not reflect the official position or policies of the Ministry of Community Safety and Correctional Services or the Ontario Police College

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with Chris Lawrence

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Chris' teaching experience started in 1983 and includes training related to his assignments, including 4 years as adjunct faculty at Sheridan College in Brampton, Ontario and 10 years as a consultant in the security industry. He became a full-time staff instructor at OPC in 1996.

Chris has a Master of Arts degree in Leadership and Training from Royal Roads University in British Columbia, and is a Technical Advisor to the Force Science Research Center, Minnesota State University-Mankato. He has testified regarding use of force training and subject control in Canada and the United States and has published and presented on the subject of police use of force and sudden deaths throughout North America and in Australia.

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