

Delirium Is Not Primary Psychosis

ABSURD HEALTH INSTITUTE · 2026-10-16 · Established clinical diagnostic distinction

Abstract

Delirium is an acute disturbance of attention and awareness caused by diverse medical, toxic or physiological insults. It can produce frightening hallucinations, bizarre statements, emotional volatility and agitation. Misclassifying delirium as primary psychosis risks overlooking an immediately treatable cause; mislabeling a stable primary psychiatric disorder as delirium can also distort care. The defining question concerns the overall pattern of cognition and consciousness, not merely the content of unusual beliefs.

The distinguishing features

Delirium commonly develops over hours or days and fluctuates. Inattention, disorientation, sleep-wake disturbance and changes in arousal are central features. Hyperactive delirium may look like severe agitation or psychosis; hypoactive delirium may be mistaken for depression or apathy. A person with schizophrenia may also develop delirium, so preexisting psychiatric diagnosis does not immunize against new medical illness.

Why medical causation is heterogeneous

Infection, hypoxemia, medication toxicity, withdrawal, metabolic abnormalities, organ failure, surgery, severe pain and sleep deprivation can precipitate delirium. A single neurotransmitter explanation is inadequate; systemic illness interacts with neural networks, vulnerability and environmental stressors. The correct assessment does not automatically invoke rare causes before evaluating common and dangerous ones.

Oxalate in its proper place

Severe oxalate nephropathy could contribute to renal dysfunction, and severe renal dysfunction may be associated with encephalopathy. That is a conceivable indirect pathway. The presence of delirium, however, does not justify searching for dietary oxalate as a default cause, nor does elevated urinary oxalate prove that it caused the mental-state change. Kidney chemistry, fluid status, infection and medication exposures offer more immediate and generally more probable targets for evaluation.

Consequences of the distinction

Delirium can be a medical emergency requiring prompt identification and treatment of underlying contributors and careful supportive care. Sedating an agitated patient without investigating the underlying cause may conceal clinical deterioration. Yet behavioral safety can require simultaneous symptomatic management. The right response is integrated medicine, not the artificial opposition of psychiatry and general medical care.

Conclusion

Delirium illustrates why a psychiatric-looking symptom is not always a psychiatric syndrome. It also illustrates why the search for biological causes must be broad enough to consider ordinary disease before selecting a favored speculative explanation.

Selected readings

- Dalmau et al., Neurological syndromes presenting with psychiatric features
- Bhat et al., Severe postpartum psychiatric differential