

Delirium Versus Dementia Versus Psychosis

A plain-English guide for you and your family

WHAT IS HAPPENING

Your brain runs on a careful balance of chemical messengers — neurotransmitters like acetylcholine, dopamine, and serotonin — that keep your attention sharp, your memory working, your mood steady, and your sense of what's real accurate. Think of it like the volume knobs on a soundboard: each one has to stay in the right range or the whole mix goes off. Delirium happens when something sudden — an infection, a new medicine, dehydration, low oxygen — knocks those knobs way out of balance in hours or days. Attention breaks first: the person can't focus, drifts in and out, may see things that aren't there, gets very confused, and swings between agitated (can't sit still, yelling) and drowsy (barely awake). The good news: if you find and fix the trigger fast, the brain usually resets and the person gets back to normal. Dementia is different — it's a slow, permanent loss of brain cells over months to years, so memory fades, thinking gets harder, and personality changes, but attention stays okay early on and the confusion is steady, not flipping on and off. Psychosis means the dopamine and reality-checking circuits malfunction, so the person hears voices, believes things that aren't true (like someone is spying on them), and can't tell it's not real — but attention and memory can still work fine. None of this is the person's fault or a character flaw. It's the brain's wiring and chemistry struggling under stress, illness, or damage. Life stressors — isolation, poverty, trauma, lack of sleep — make every one of these worse because stress chemicals hurt the same circuits. Treating the medical problem without addressing the life problem means it often comes right back. If someone suddenly gets confused, check for infection (especially urine or lungs), new medicines, dehydration, constipation, pain, or low oxygen first — those are the most common delirium triggers and you can reverse them. Keep the person safe, keep the room quiet and lit during the day, and get medical help fast.

What you might feel

- Delirium: confusion that starts suddenly (over hours or a few days)
- Delirium: attention jumps around; the person cannot focus or follow a conversation
- Dementia: memory and thinking decline slowly (over months to years)

- Dementia: the person stays alert and aware of their surroundings (until very late stages)
- Psychosis: seeing, hearing, or believing things that are not real (hallucinations or delusions)
- Psychosis: thoughts may be disorganized or speech may jump from topic to topic without a clear link
- Delirium: the level of alertness swings — sometimes drowsy, sometimes agitated — within the same day
- Dementia: personality or behavior changes (apathy, irritability, losing social manners) develop over time
- Delirium: sleep-wake cycle is reversed or completely disorganized
- Psychosis: lack of insight (the person does not recognize that their perceptions or beliefs are false)

Call the doctor right away if...

- Sudden confusion with fever, low oxygen (blue lips or fingertips), very high or very low blood sugar, or a new medicine — suggests delirium and needs urgent work-up (blood tests, urine culture, chest X-ray, medication review) to find and fix the cause before the brain is permanently harmed
- Hallucinations or delusions with commands to hurt self or others, or the person cannot care for themselves safely (not eating, wandering into traffic, responding to voices) — needs immediate psychiatric evaluation and may need inpatient admission to keep the person and others safe
- Rapid memory loss over weeks (not years) with headache, seizures, fever, or new weakness on one side — may signal a brain bleed, tumor, herpes encephalitis, autoimmune encephalitis (like anti-NMDA receptor), or prion disease (Creutzfeldt-Jakob) rather than typical dementia, and requires urgent brain imaging (MRI) and lumbar puncture
- Delirium that does not improve after 72 hours of treating the cause (antibiotics for infection, stopping the offending drug, correcting electrolytes) — consider a second hidden cause, medication toxicity, or an unrecognized structural brain problem

What the care team will do

- Check vital signs, oxygen saturation, and fingerstick blood glucose immediately to find life-threatening causes of confusion
- Review the medication list with the provider and stop or reduce any medicines known to cause delirium—especially opioids, benzodiazepines, anticholinergics, and sleeping pills
- Reorient the patient every time you interact: use their name, tell them where they are, what day and time it is, and explain what you are doing in simple words

- Keep the room quiet, well-lit during the day, and dark at night; open curtains in the morning and encourage the patient to get out of bed and sit in a chair
- Bring in family members, familiar objects from home like photos, and the patient's glasses and hearing aids so they can see and hear clearly
- Assess for pain every shift using a pain scale, and treat pain with the lowest effective dose of non-sedating medicine like acetaminophen
- Monitor intake and output closely, encourage oral fluids if the patient can swallow safely, and give IV fluids if the patient is dehydrated
- Avoid physical restraints and minimize sedating medicines; if the patient is agitated and a danger to themselves, try one-to-one observation first and use the lowest dose of an antipsychotic like haloperidol only as a last resort

Medicines you may be given — and why

Haloperidol (first-generation antipsychotic, for severe agitation in delirium when safety is at risk)

Haloperidol sits on dopamine D2 receptors in the brain and blocks them. Dopamine is a messenger chemical that helps brain cells talk to each other; in some circuits, it acts like a 'go' signal. When delirium makes the brain misfire and send too many 'go' signals, the person becomes restless, confused, and sometimes combative. Blocking some of those signals calms the storm so the person feels less overwhelmed. Think of it like turning down the volume on a speaker that's blasting too loud.

Olanzapine (second-generation antipsychotic, alternative for agitation in delirium)

Olanzapine blocks two types of receptors at once: dopamine D2 receptors (which calm the overactive 'go' signals) and serotonin 5-HT_{2A} receptors (which help steady mood and perception). Serotonin is another messenger chemical in the brain; too much activity at certain serotonin receptors can twist how you see and feel things. By blocking both dopamine and serotonin, olanzapine reduces agitation and confusion with a bit less muscle stiffness than haloperidol, though it brings its own risks—mainly drowsiness, weight gain, and blood sugar problems.

Donepezil (cholinesterase inhibitor for Alzheimer dementia)

Donepezil blocks acetylcholinesterase, the enzyme that normally breaks down acetylcholine after it's used. Acetylcholine is a messenger chemical the brain uses to pass signals between nerve cells, especially in memory and attention circuits. In Alzheimer disease, nerve cells that make acetylcholine die off, so there's less of it available. By stopping the enzyme that chops up

acetylcholine, donepezil lets each molecule last longer in the synapse (the tiny gap between nerve cells). More acetylcholine hanging around means signals pass more easily, so thinking and memory work a little better—like keeping the mail carrier on the route longer so more messages get delivered.

Memantine (NMDA receptor antagonist for moderate to severe Alzheimer dementia)

Memantine partially blocks NMDA receptors, which are gates on nerve cells that open when glutamate (an excitatory messenger chemical) arrives and let calcium rush into the cell. Calcium is needed for normal signaling, but in Alzheimer disease the system goes haywire: glutamate floods the brain and opens too many gates, letting in a constant, toxic wave of calcium that damages and kills nerve cells. Memantine sits in the gate just enough to block the harmful flood but still lets normal, brief glutamate signals through. Think of it like a screen door that keeps bugs out but lets fresh air in—it filters out the bad while preserving the good.

Antipsychotics (for primary psychotic disorders: schizophrenia, schizoaffective disorder, severe psychotic depression or mania)

Antipsychotics reduce psychosis—hallucinations (seeing or hearing things that aren't there), delusions (false, fixed beliefs), and disorganized thinking—by blocking dopamine D2 receptors in the mesolimbic pathway. The mesolimbic pathway is a deep brain circuit that handles emotion, reward, and motivation. When this circuit becomes overactive and pumps out too much dopamine, it creates false perceptions and beliefs: voices that aren't real, ideas that don't match reality, thoughts that jump and scatter. Think of dopamine as an amplifier turned up too loud in that circuit; the antipsychotic turns the volume down so the person can tell what's real again. Second-generation drugs also block serotonin 5-HT_{2A} receptors, which may help mood and cause fewer movement side effects, though they bring higher risk of weight gain and metabolic problems.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022)
- American Geriatrics Society Clinical Practice Guideline for Postoperative Delirium (2015, reaffirmed 2023)
- National Institute on Aging Alzheimer's and Related Dementias Resources
- American Academy of Neurology Practice Guideline Update: Mild Cognitive Impairment (2018)

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