Delirium Misdiagnosed as Depression: A Critical Source of Mismedicine in Geriatric Care.

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Introduction

What happens when a medical emergency is mistaken for a chronic mood disorder? This is the reality for 69% of older adults presenting with acute behavioural and cognitive changes. Delirium is a common, acute neuropsychiatric condition experienced by hospitalized elderly patients, clinically recognized as a medical emergency due to its association with high morbidity and mortality (Emekli & Alici, 2025). Despite its prevalence, delirium is commonly underdiagnosed, partly due to its comorbidity with depressive symptoms. Major Depressive Disorder (MDD) often manifests atypically in older adults, with prominent somatic symptoms, withdrawal and apathy rather than overt sadness or guilt, closely resembling hypoactive delirium (Howland et al., 2025). This diagnostic overlap contributes to mismedicine, a term coined by Dr. Pooya Beigi, the founder of the Misdiagnosis Association and Research Institute (MARI). Mismedicine encompasses a broad spectrum of errors in the diagnosis, treatment, and communication that result in preventable harm or substandard care (Blissy, 2024). In this context, misdiagnosis represents a critical and potentially life-threatening form of mismedicine. This paper examines delirium and its overlap with MDD, the consequences of misdiagnosis, and potential strategies to reduce diagnostic errors in older adults.

Challenges in Distinguishing Delirium from Depression

As stated above, the primary cause underlying the frequent misdiagnosis of delirium and MDD is their overlapping symptomatology. Hypoactive delirium and MDD are characterized by psychomotor slowing, agitation, sleep-wake cycle disturbances, reduced motivation, impaired concentration, and apathy (Howland et al., 2025). Depression has been identified as both a risk factor for and potential consequence of delirium, further highlighting their interconnected nature (O'Sullivan et al., 2014). Physicians and non-psychiatric healthcare professionals often attribute these nonspecific symptoms solely to MDD, relying heavily on brief, cross-sectional assessments rather than longitudinal observation (O'Sullivan et al., 2014).

Delayed psychiatric consultation further increases the likelihood of misdiagnosis. Emekli and Alici (2025) found a positive correlation between consultation delays and missed delirium diagnoses; the longer clinicians wait to seek psychiatric input, the greater the likelihood of a diagnostic error. These delays often stem from failure to recognize delirium early and initiate timely referrals, resulting in the underdiagnosis of delirium and the overdiagnosis of MDD.

When older adults present with delirium-related symptoms, they are frequently dismissed as manifestations of "normal aging" or misattributed to psychiatric illness. Formal cognitive or attentional assessments are often omitted, with clinicians inferring a psychiatric explanation for behavioural changes. Consequently, key features of delirium, such as acute onset and fluctuations in mental state, are misinterpreted as mood-related disengagement (Howland et al., 2025). Addressing this issue requires the systematic use of standardized screening tools and clinical training.

Clinical Consequences of a Misdiagnosis

The misdiagnosis of delirium as MDD, or vice versa, carries serious consequences for older adults. As delirium is a medical emergency, failure to identify it promptly can result in severe complications including persistent cognitive impairment, weakness, dementia, and pneumonia (Cleveland Clinic, 2023; Emekli & Alici, 2025). Delayed recognition often results in postponed treatment, functional decline, and prolonged hospitalization and institutionalization (Emekli & Alici, 2025). Extended hospital stays impact patients' physical and psychological health and resources.

Misdiagnosis may also lead to patients failing to receive appropriate medical care. For instance, patients may not be taken in for medical workups or psychiatric evaluations to examine their condition. Delirium, unlike MDD, requires immediate intervention; delays in care significantly increase the risk of irreversible cognitive and physical decline (Howland et al., 2025). Inappropriately diagnosing delirium as MDD can expose patients to harmful pharmacological treatments. Antidepressants, antipsychotics and mood stabilizers have been associated with an increased risk of delirium onset or symptom exacerbation when used improperly (Huang et al., 2024).

Conversely, patients with MDD who are wrongly diagnosed with delirium face the absence of appropriate psychiatric care, increasing their risk of worsening symptoms. MDD in older adults is associated with impaired immune function, reduced treatment adherence, increased mortality, and significantly higher suicide rates (Gintner, 1995). The lack of a diagnosis, or a misdiagnosis, can leave patients feeling misunderstood or dismissed, further aggravating psychological distress and delaying recovery. Given the morbidity associated with both conditions, accurate and timely diagnoses are critical to improving patient outcomes

Systemic Approaches to Prevent Misdiagnosis

The first step in addressing the misdiagnosis of delirium as MDD is the implementation of standardized diagnostic tools alongside clinical training for non-psychiatric healthcare professionals. For instance, the 4-AT test is widely recognized as a reliable and valid screening tool for delirium. Tieges et al. (2020) reported that the test correctly identified 88% of delirium cases while ruling out non-delirium cases, demonstrating high sensitivity and specificity. Importantly, the test's diagnostic accuracy was consistent across diverse clinical settings, languages, and populations, showing high cross-cultural validity. Incorporating brief, reliable tools like the 4-AT into the routine clinical assessments of older adults can significantly reduce diagnostic uncertainty, misdiagnosis, and broader mismedicine errors. These tools can help clinicians identify the condition early, contributing to reduced morbidity, shorter hospitalization times, and better outcomes.

Beyond routine delirium screening, it is equally crucial to rule out psychiatric disorders. Educating non-psychiatric professionals on psychiatric versus medical symptom etiology, and when and how

to apply delirium screening tools, can facilitate timely diagnosis and treatment implementation (Henrique et al., 2017). Standardized training protocols that emphasize longitudinal monitoring and integrated psychiatric evaluations can enable clinicians to assess patients for both disorders in a single encounter (O'Sullivan et al., 2014). Professionals must also prioritize key delirium symptoms, such as fluctuation in mental state and attentional impairments, rather than relying on mood symptoms to make a diagnosis (Howland et al., 2025). Dr. Pooya Beigi emphasizes the importance of identifying the root cause of symptoms to avoid mismedicine errors, which should guide diagnostic practices in these cases (Blissy, 2024).

From the patients' perspective, reporting symptoms comprehensively, with transparency can substantially improve diagnostic accuracy and reduce the risk for mismedicine (Blissy, 2024). Dr. Beigi recommends patients and caregivers to remain vigilant regarding medication use and adherence, as mismedicine errors may persist even in outpatient settings (Blissy, 2024).

Conclusion

The misdiagnosis of delirium as MDD in older adults represents a critical and preventable form of mismedicine with severe consequences. Symptom comorbidity, atypical presentations, and reliance on cross-sectional assessments contribute to inaccurate diagnoses, increasing patients' risk of morbidity and mortality. Standardized screening tools and improved clinical education for all healthcare professionals are essential steps in closing these gaps. Recognizing delirium as a medical emergency is critical to preventing irreversible decline and promoting recovery in older adults with neuropsychiatric symptoms.

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