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Research Paper

Delirium in an Older Adult Male: A Clinical Psychology Case Report from a Biopsychosocial Perspective

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ABSTRACT

Delirium is a common neuropsychiatric condition among elderly individuals, characterized by an acute onset of confusion, memory impairment, and fluctuating levels of consciousness. Early identification and multidisciplinary management are essential to reduce associated morbidity in geriatric populations. Older adults experiencing reduced family interaction, social isolation, and caregiving deficits are often vulnerable to psychological and cognitive disturbances. Clinical observations in geriatric care settings indicate that emotional disconnection, anxiety, poor supervision, and disrupted support systems may intensify confusion, stress, and cognitive instability among older adults. Such psychosocial vulnerabilities become increasingly significant in contemporary aging societies where changing family structures, migration of adult children, and reduced intergenerational co- residence may affect emotional security and caregiving availability among older adults. These factors may indirectly influence cognitive stability, emotional resilience, and recovery outcomes in geriatric populations. This case report describes the assessment and psychological management of a 73-year-old male diagnosed with Delirium not induced by alcohol or psychoactive substances. A comprehensive clinical interview and mental status examination were conducted. Psychological interventions included psychoeducation, cognitive orientation techniques, and family-based supportive strategies. The client presented with sudden memory loss, excessive sleep, confusion, and gait instability. Following structured psychological intervention and collaborative care, gradual clinical improvement was observed over the treatment period. This case underscores the importance of timely psychological assessment and individualized interventions in the management of geriatric Delirium. Integrating family support and cognitive orientation strategies may improve functional outcomes and quality of life in elderly patients. The case is also interpreted within the context of changing family caregiving structures and psychosocial vulnerabilities in later life.

Keywords: *Delirium, Geriatric Mental Health, Psychological intervention, Cognitive orientation, Case report, Clinical Psychology*

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Delirium in an Older Adult Male: A Clinical Psychology Case Report from a Biopsychosocial Perspective

Older adults are increasingly vulnerable to cognitive and emotional disturbances caused by a mix of physical and psychosocial issues. Delirium is a serious condition that features sudden changes in attention, awareness, and cognition, with symptoms that fluctuate over time (American Psychiatric Association [APA], 2022). This disorder is common in elder care, frequently leading to longer hospital stays, worsened overall health, and higher mortality (Oh et al., 2017). Because these signs are often mistaken for normal aging or depression, especially in hypoactive cases, the condition frequently goes undiagnosed (Tieges et al., 2021). Therefore, multidisciplinary teams must quickly identify and treat it to protect patient health.

Older adults face a higher risk of delirium due to physical aging, multiple medications, chronic illnesses, sensory loss, metabolic issues, and a weaker ability to adapt. Because the aging brain is prone to inflammation and neurochemical imbalances, minor medical stressors like infections, unstable diabetes, electrolyte changes, or hospital stays can easily trigger the condition (Maldonado, 2013; Inouye et al., 2014). Although physically or neurologically driven, delirium often causes psychological and behavioral problems, including altered awareness, poor focus, mood swings, sleep disruptions, and anxiety (APA, 2022). These issues highlight the need for clinical psychologists to run thorough testing, differentiate diagnoses, educate families, and use non-drug therapies to stabilize emotions and thinking. Modern clinical guidelines strongly advocate for multidisciplinary, diverse care frameworks that incorporate environmental changes, cognitive orientation tactics, psychotherapy, and family support to manage the disorder (National Institute for Health and Care Excellence [NICE], 2010; Hshieh et al., 2015).

In addition to biological vulnerabilities, psychosocial determinants play a meaningful role in shaping geriatric mental health outcomes. Older adults experiencing loneliness, emotional neglect, reduced family interaction, prolonged inactivity, social withdrawal, and caregiving instability may demonstrate increased vulnerability to emotional distress and cognitive dysfunction (Berkman et al., 2000). Emerging literature in geriatric mental health increasingly recognizes that psychosocial stabilization, emotional reassurance, and continuity of supportive relationships may positively influence cognitive functioning, emotional regulation, and adaptation during periods of illness. Within this context, Social Support Theory provides an important framework for understanding how emotional, instrumental, and familial support function as protective psychosocial resources during later life. Supportive caregiving relationships may buffer stress, facilitate coping, and enhance psychological resilience among older adults experiencing health-related vulnerability (Cohen & Wills, 1985). Therefore, the presence or absence of meaningful social support may influence symptom experience, recovery trajectories, and psychosocial functioning among older adults experiencing neuropsychiatric disturbances.

On a broader level, social changes have transformed traditional aging and care systems, making sociocultural factors increasingly important in geriatric mental health. According to Modernization Theory, shifts like urbanization, migration, industrialization, and moving from joint to nuclear families have weakened the historic family care systems that used to support older adults (Cowgill & Holmes, 1972). Living apart from adult children, facing emotional distance, and changing family care setups can cause social isolation and psychological vulnerability among seniors, especially in fast-changing nations like India (Lamb, 2013). Additionally, the Biopsychosocial Model shows that mental health issues in later life develop from an ongoing interaction between biological risks, psychological processes, and social surroundings (Engel, 1977). Instead of looking at cognitive issues purely from a medical

angle, this view highlights the need to understand how continuous care, emotional bonds, and social stress actively shape the lives and daily functioning of older adults.

While clinical research extensively covers the medical treatment of delirium, little focus is placed on structured psychological testing and customized, non-drug therapies for non-substance-induced cases in older adults, especially within a biopsychosocial framework. There is a clear necessity to document how clinical psychology supports multidisciplinary elder care and to view neuropsychiatric symptoms through a wider psychosocial lens. To address this gap, this case report details the psychological evaluation and non-pharmacological treatment of a 73-year-old male with delirium not caused by alcohol or drugs, evaluating his condition within the broader realities of old-age vulnerability, psychosocial health, and shifting family care dynamics.

Epidemiology

Delirium occurs frequently among older adults, especially within acute care environments. Research shows that roughly 10% to 30% of elderly patients experience delirium when admitted to the hospital, and that number can rise to 50% or more during their stay, particularly if they face severe medical illnesses or undergo operations (Oh et al., 2017; Tieges et al., 2021). In intensive care units, rates can climb past 70%, which highlights how vulnerable critically ill older adults are. In India, epidemiological data remains scarce, but new evidence points to a similar clinical burden that is worsened by slow diagnosis and a shortage of mental health resources. Because the condition leads to higher mortality, more complications, longer hospitalizations, and permanent cognitive loss, it stands as a major public health issue in elder mental health that demands fast identification and broad treatment.

Beyond medical risk factors, psychosocial determinants such as social isolation, reduced supervision, caregiver burden, and weakening intergenerational support systems may further increase vulnerability among older adults. In rapidly aging societies such as India, changing family dynamics and migration-related separation may intensify these psychosocial risks.

CASE PRESENTATION

1. Identification Data

Mr. R.P. was a 73-year-old married man from Ernakulam district of Kerala. He belonged to a middle socioeconomic class and completed his formal education up to the fifth standard. Currently unemployed, he relied completely on his family members for financial support. He lived in a household with his wife and extended family. Despite living with family, reports indicated that he experienced a lack of emotional engagement, extended periods of inactivity, and social withdrawal over several years. Experts note that these specific psychosocial factors frequently cause emotional vulnerability and a lack of psychological stimulation in older adults [1]. His native language was Malayalam, which was the only language he spoke. His son brought him in for his psychological consultation, and his wife acted as the primary informant. Ultimately, the information provided by his wife was deemed both reliable and sufficient.

2. Presenting Complaints

The client was brought in with the following complaints:

- Sudden onset of memory impairment for the past three weeks
- Confusion and difficulty recognizing familiar individuals for the past three weeks
- Unsteady gait for the past three weeks

- Generalized weakness and fatigue for the past three weeks
- Excessive sleep for approximately seven years
- Persistent tension and anxiety for nearly twelve years

The recent cognitive symptoms were reported to have an abrupt onset with a fluctuating course.

3. History of Present Illness

The client presented with complaints of persistent tension and anxiety for approximately twelve years. Initially, these symptoms were perceived by family members as possibly related to hypertension. Over the subsequent years, he developed excessive sleep and decreased energy levels, which persisted for nearly seven years.

Approximately three weeks prior to the current consultation, the client developed sudden cognitive disturbances characterised by memory impairment, confusion, difficulty recognising familiar persons, and episodes of disorientation. Family members also reported unsteadiness while walking and occasional altered awareness.

Medical evaluation during this period revealed episodes of electrolyte imbalance and poorly controlled diabetes mellitus. Although electrolyte levels were medically corrected, symptoms such as confusion, excessive sleep, and generalized weakness persisted, leading to referral for psychological assessment.

4. Past Psychiatric History

The client had a history of depressive symptoms and anxiety approximately twelve years earlier, for which he received psychiatric treatment. There was no reported history of psychiatric hospitalisation.

5. Substance Use History

There was a history of chronic alcohol consumption. The client reportedly discontinued alcohol use ten years ago and has maintained abstinence since then.

6. Medical History

The client was a known case of diabetes mellitus. Recent medical records indicated episodes of electrolyte imbalance. There was no reported history of head injury, seizures, or other major neurological illnesses.

7. Personal History

The client's developmental milestones were reported to be within normal limits. He completed formal education up to the fifth grade and was previously engaged in occupational activities. At present, he is unemployed and dependent on family members for daily living activities. Reduced occupational engagement and increasing dependency in later life may contribute to diminished social participation and perceived loss of role identity.

8. Mental Status Examination

- **General Appearance and Behaviour:** The client was an elderly male of average build, appropriately dressed, and moderately groomed. He appeared fatigued and demonstrated reduced eye contact. Psychomotor activity was decreased.
- **Speech:** Coherent and relevant, though reduced in spontaneity and mildly slowed.

- Mood and Affect: The client subjectively reported feeling "tired." Affect was constricted but appropriate to the context.
- **Thought Process:** Thought form was goal-directed, though psychomotor slowing was evident. No formal thought disorder was observed.
- **Thought Content:** No delusions, obsessions, or preoccupations were elicited.
- **Perception:** No hallucinations or perceptual abnormalities were reported during the assessment.

Cognitive Functions:

- Orientation: Partially impaired, particularly with respect to time and place.
- Attention and Concentration: Impaired.
- Immediate and Recent Memory: Impaired.
- Remote Memory: Relatively preserved.
- Insight: Level III – Awareness of being sick, but attributing illness to external factors, on external factors or organic factors.
- Judgment: Social judgment appeared mildly impaired.

Table No: 1 Timeline of Symptom Progression

Duration	Clinical Features
12 years	Persistent tension and anxiety
7 years	Excessive sleep and reduced energy
3 weeks	Sudden memory loss, confusion, gait disturbance
Recent	Electrolyte imbalance and poor glycemic control

Diagnostic Formulation

In consideration of the client's age, acute nature, and recent cognitive disturbances, the condition was highly suggestive of an acute confusional state. The results obtained from the Mental Status Examination also confirmed this, as the client was found to have disturbed attention, awareness, and cognition.

The acute confusional state was evident, as the client was demonstrating an acute and fluctuating clinical course, as opposed to a chronic condition such as a neurocognitive disturbance. Additionally, the underlying medical condition, such as the client's electrolyte imbalance, was also suggestive of an acute confusional state.

Considering the client's condition and the criteria for an acute confusional state as per the ICD-10 classification, the provisional diagnosis was that of delirium not induced by alcohol or other psychoactive substances (F05). The diagnosis was also consistent with the DSM-5 criteria, as the client was found to have disturbed attention and awareness, an acute and fluctuating condition, and an underlying medical condition.

Assessment Tool

Delirium in the present case was assessed using the Confusion Assessment Method (CAM), a standardized, clinician-administered instrument specifically designed to identify delirium in medical and geriatric settings. The CAM is widely regarded as a reliable and valid tool, demonstrating high sensitivity (94–100%) and specificity (90–95%) across diverse clinical populations.

The instrument operationalizes delirium diagnosis based on four core clinical features: (1) acute onset and fluctuating course, characterized by a sudden change in mental status with symptoms that vary in severity over time; (2) inattention, reflected in difficulty focusing, sustaining, or shifting attention; (3) disorganized thinking, evident through incoherent or illogical thought processes; and (4) altered level of consciousness, ranging from hyperalertness to lethargy or reduced responsiveness.

According to the CAM diagnostic algorithm (Inouye et al., 1990), delirium is identified by the presence of features (1) and (2), along with either (3) or (4). In the present case, the patient demonstrated an acute onset of cognitive disturbance with a fluctuating course, marked inattention, and episodes of disorganized thinking, thereby meeting the criteria for delirium as per CAM guidelines.

The use of the CAM facilitated systematic clinical assessment, supported differential diagnosis from conditions such as dementia and depression, and provided a structured framework for monitoring symptom progression and response to intervention. Its brief administration time and applicability in bedside settings further enhance its utility in routine clinical practice.

Differential Diagnosis

- Delirium vs Major Neurocognitive disturbance (Dementia):

Although there was a cognitive disturbance, dementia was ruled out due to the acute and fluctuating course of symptoms, which differ from those seen in dementia, such as a gradual and progressive course.

- Delirium vs. Depression:

Depression can sometimes present with cognitive disturbances, especially among older adults. However, depression was ruled out due to a lack of symptoms such as persistent low mood, anhedonia, and depressive cognition, and the presence of symptoms such as impaired attention and fluctuating levels of consciousness.

- Delirium vs Substance-Induced Disorders:

Substance-induced delirium was ruled out due to a lack of symptoms related to substance use or withdrawal, supporting an organic medical cause for the client's condition.

Interventions and Management

Management of the client was guided by an evidence-based, non-pharmacological delirium care framework, primarily based on multicomponent interventions recommended in geriatric psychiatry and consultation-liaison models (Inouye et al., 1999; NICE, 2010). The approach was multidisciplinary, structured, and family-oriented, focusing on addressing modifiable risk factors and supporting cognitive recovery.

Treatment Framework and Structure:

The intervention was implemented over 2 weeks using a structured, non-pharmacological approach. The schedule of sessions was as follows:

- Daily brief sessions with the client (20–30 minutes), focusing on cognitive orientation, reassurance, and supportive interaction.
- Alternate-day sessions with family members (30–45 minutes), aimed at psychoeducation, caregiving guidance, and skill training.

- Weekly follow-up sessions to monitor cognitive status, behavioural changes, and overall progress.

The intervention was guided by principles derived from the Hospital Elder Life Program (HELP) and established non-pharmacological delirium management protocols that emphasize orientation enhancement, environmental modification, and active caregiver involvement (Inouye et al., 1999).

1. Psychoeducation (Family-Based Intervention)
Psychoeducation was delivered through 2–3 structured sessions (30–45 minutes each) with the primary caregivers. The intervention aimed to enhance understanding of the condition and improve caregiving practices.

The psychoeducation focused on explaining the nature and typically reversible course of delirium, the role of underlying medical factors (such as electrolyte imbalance) in the onset of symptoms, and the condition's fluctuating pattern, including variations in attention, awareness, and cognitive functioning.

In addition, caregivers were educated about the importance of consistent supervision, reassurance, and appropriate communication strategies to manage confusion and behavioural disturbances.

This intervention is grounded in caregiver education models within delirium management frameworks, which emphasize the role of informed caregiving in reducing family distress and improving patient outcomes (National Institute for Health and Care Excellence [NICE], 2010).

Family-based reassurance and psychosocial stabilization were considered clinically important in reducing confusion, emotional distress, and behavioural disorganization. Strengthening caregiver involvement and maintaining emotional familiarity may support cognitive orientation and emotional regulation among elderly patients.

2. Cognitive Orientation Intervention
Cognitive orientation strategies were implemented daily through brief structured interactions, which included repeated orientation to time, place, and person, the use of orientation aids such as clocks, calendars, and familiar objects, and the establishment of a consistent daily routine; this approach is based on reality orientation therapy, which is commonly used in the management of delirium and cognitive impairment (Spector et al., 2000).

3. Supportive Psychotherapy
Supportive sessions (15–20 minutes daily) were conducted, focusing on emotional reassurance, reducing anxiety, and encouraging simple communication. These interventions drew on principles of supportive psychotherapy adapted for medically ill patients with impaired cognition (Kaplan & Sadock, 2015).

4. Environmental Modification Protocol
A structured environmental plan was implemented and monitored daily, which included maintaining a low-stimulus and well-lit environment, ensuring the presence of consistent caregivers, and minimizing noise and unnecessary interruptions; such environmental

modifications constitute a core component of multicomponent delirium prevention and management models (Inouye et al., 1999; National Institute for Health and Care Excellence [NICE], 2010).

5. Sleep–Wake Cycle Regulation

A behavioural sleep protocol was implemented, which included encouraging daytime wakefulness, reducing daytime napping, and maintaining regular sleep–wake timing. Such sleep regulation strategies are supported by delirium care guidelines to help reduce cognitive fluctuations (National Institute for Health and Care Excellence [NICE], 2010).

6. Multidisciplinary Coordination

Regular coordination with the treating physician was maintained to address the underlying medical condition. This reflects a biopsychosocial model of care that integrates medical and psychological management.

CASE-BASED DISCUSSION

Discussion

This case report details a 73-year-old male who demonstrates fluctuating neurocognitive impairments of sudden onset, fulfilling the clinical criteria for a diagnosis of delirium (ICD-10: F05). His prominent clinical symptoms which include memory deficits, disorientation, and compromised attentiveness correspond directly with standardized diagnostic frameworks that characterize delirium as a rapidly evolving disturbance in an individual's cognition, attention, and environmental awareness (American Psychiatric Association, 2022).

Theoretically, delirium is classified as an acute neuropsychiatric syndrome driven by temporary brain dysfunction, occurring through pathophysiological routes such as neuroinflammation, neurochemical imbalances, and metabolic disturbances (Maldonado, 2013). Clinical models emphasizing these specific pathways highlight that the syndrome typically features a fluctuating trajectory and potential reversibility. The clinical presentation of the current patient strongly aligns with this established theoretical framework; his symptoms manifested suddenly alongside concurrent diabetes mellitus and electrolyte derangements, both of which serve as classic precipitating triggers. These observations mirror findings documented by Inouye et al. (2014), who corroborated that metabolic abnormalities serve as primary drivers for the onset of delirium in geriatric cohorts.

In actual clinical practice, delirium often presents with a highly diverse set of symptoms that can easily be missed, especially when it takes a hypoactive form. For this specific patient, the lack of overt psychotic features like agitation or hallucinations risked causing his state to be misattributed to simple exhaustion or underlying depression. This phenomenon aligns closely with observations made by Meagher et al. (2011), who noted that the understated presentation of hypoactive delirium frequently leads to widespread diagnostic confusion with depressive disorders. This discrepancy underscores the pronounced divide between textbook descriptions and bedside medicine, reinforcing the critical need for comprehensive cognitive screening paired with thorough collateral histories from family members to map out an accurate baseline timeline (Hosker & Ward, 2017).

The client's history of anxiety and past depressive symptoms may have increased vulnerability to cognitive disturbance, consistent with the stress–vulnerability model. However, the absence of longitudinal data limits the ability to establish a causal relationship, indicating the need for

cautious interpretation. Additionally, the absence of current substance use supported the diagnosis of non-substance-induced delirium.

This specific case underscores the broader significance of psychosocial well-being within geriatric mental health (World Health Organization, 2023). Geriatric individuals who experience minimal emotional connection, social isolation, long-term dependency, and volatility in caregiving arrangements may exhibit heightened vulnerability to both cognitive impairments and psychological distress. Even though delirium is fundamentally triggered by underlying medical etiologies, an individual's psychosocial environment can heavily modulate their emotional adaptation, symptom severity, and overall recovery trajectory (Inouye et al., 2014).

Modern aging societies—most notably in India—are experiencing a profound shift away from multi-generational living due to evolving family structures and the outward migration of adult children (Ugargol & Bailey, 2020). These societal changes are dismantling traditional family-based caregiving arrangements, which heavily impact regions like Kerala (Kalavar et al., 2020). Consequently, such shifts can degrade an older individual's sense of emotional safety, limit their social ties, and weaken their psychological resilience. This evolving landscape underscores why geriatric healthcare must pivot toward a comprehensive biopsychosocial model rather than relying solely on biomedical treatments (United Nations Population Fund, 2023).

This case reflects broader sociological shifts occurring within modern Indian family structures and caregiving systems. Even though delirium is fundamentally triggered by underlying medical etiologies, elements like caregiving availability, emotional continuity, and social connectedness significantly modulate symptom expression and recovery trajectories among geriatric patients. Evolving trends such as rapid urbanization, the outward migration of adult children, and the proliferation of nuclear families have steadily eroded traditional, intergenerational care arrangements in India, frequently culminating in diminished daily supervision and emotional involvement for the elderly. These demographic transitions weaken informal care networks that historically served as crucial protective mechanisms for older adults (Lamb, 2013; Patel & Prince, 2001). In this specific scenario, the patient's low levels of emotional engagement and extended periods of inactivity—despite sharing a household with family—could reasonably be linked to his overall emotional well-being and cognitive performance. While direct causal links cannot be definitively proven, these specific psychosocial parameters can alter emotional resilience and adaptability during acute illness. Consequently, from a sociological viewpoint, recovery from delirium depends not just on biomedical stabilization, but also on the presence of consistent caregiving, active emotional reassurance, and stable, supportive family dynamics.

The client's long-term inactivity, financial reliance, and minimal social involvement can be analyzed using sociological theories on aging and social role transitions. The sociology of aging establishes that older adults frequently navigate significant role loss due to retirement, shrinking productivity, restricted social circles, and rising dependency. These shifting dynamics can negatively alter self-perception, emotional stability, and cognitive engagement during late life (Cumming & Henry, 1961; Hooyman & Kiyak, 2011). While direct causal relationships should not be conclusively assumed, his extended inactivity and reliance on others likely stem from a lack of opportunities for purposeful social interaction and cognitive exercise. Viewed through this lens, the progress he showed during treatment might not purely

result from medically correcting his electrolyte levels. Instead, it highlights the critical impact of psychosocial containment, organized family participation, emotional validation, and continuous personal interaction in fostering recovery and psychological stability in older patients.

Despite a successful clinical outcome, several distinct limitations must be acknowledged:

- Assessment Tools: Standardized cognitive screening instruments—such as the MMSE or MoCA—were not administered, which restricts the objective measurement and replication of these results.
- Follow-Up Timeframe: The abbreviated observation window limits our insight into the patient's long-term prognosis and his prospective risk for future delirium episodes.
- Diagnostic Differentiation: Structured diagnostic protocols were absent, reducing definitive diagnostic certainty when trying to isolate delirium from emerging dementia or depressive pseudodementia.
- Generalizability: Because this study details a single case report, the specific observations and clinical findings possess restricted broader generalizability.

Ultimately, this case underscores the necessity of merging academic theory with actual bedside practice. Academic models frequently stress complete reversibility and straightforward diagnostic parameters; however, real-world scenarios demand meticulous evaluations, interdisciplinary cooperation, and tailored treatment plans. Closing this divide is vital for managing delirium successfully, particularly within elderly demographics where symptoms are regularly atypical. This case positions delirium as an acute, potentially reversible condition in older cohorts, underscoring the urgent need for prompt detection, rigorous screening, and clear differentiation from alternative neurocognitive disorders (American Psychiatric Association, 2022). The patient's clinical improvement validates the use of multi-component, non-pharmacological protocols combined with standard medical stabilization (Inouye et al., 2014; National Institute for Health and Care Excellence, 2010). In conclusion, this case demonstrates the necessity of unified, multidisciplinary, and patient-centered treatment models, while reinforcing the indispensable value of clinical psychologists in driving assessments and providing caregiver counseling.

Ethical Considerations

The present case report is based on clinical observations and psychological interactions undertaken as part of the researcher's supervised internship training in a hospital setting in Kerala, India. The case was selected for academic and scholarly purposes due to its clinical relevance in understanding the psychological assessment and management of Delirium among older adults. Institutional permission was obtained from the concerned hospital to utilize anonymized clinical information for educational and publication purposes in accordance with professional and ethical standards governing internship-based clinical documentation.

To ensure confidentiality and protect the identity of the client, all personally identifiable information, including names, locations, institutional identifiers, and contextual details that could reveal the identity of the individual or the clinical setting, have been removed or modified. The case has been presented solely for academic purposes, with emphasis on preserving anonymity while maintaining clinical accuracy and relevance.

The preparation of this report adhered to ethical principles of confidentiality, professional responsibility, and respect for patient dignity commonly upheld in clinical psychology and

mental health practice. As this report is based on a retrospective clinical case encountered during supervised internship practice and does not involve experimental intervention or direct patient recruitment for research purposes, the case is presented as a clinical case report rather than an empirical research study.

Patient Consent Statement

The present case report is based on anonymized clinical information collected during the author's supervised clinical internship. Clinical assessment and intervention were conducted as part of routine service delivery, and institutional procedures governing confidentiality, documentation, and educational use of anonymized case material were followed. All personally identifiable information has been removed or modified to protect the client's identity and privacy.

RESULTS AND OBSERVATIONS

Results

The client was monitored over a period of 4 weeks, with assessments conducted at baseline, mid-intervention (2 weeks), and follow-up using clinical interviews, Mental Status Examination (MSE), and caregiver reports, which are commonly used in delirium assessment in clinical settings (American Psychiatric Association [APA], 2022).

At baseline, the client exhibited impaired orientation (time, place, and person), reduced attention and concentration, and significant deficits in recent memory, along with confusion and excessive sleep. By the end of the second week, partial improvement was observed, particularly in orientation to person and place, while orientation to time remained inconsistent.

At the end of 4 weeks, the client demonstrated marked improvement in cognitive functioning, with near-complete restoration of orientation to time, place, and person, improved attention, and a significant reduction in memory impairment as observed through MSE assessments. Episodes of confusion showed a notable decrease in frequency and duration, consistent with recovery patterns described in delirium literature (Sharon K. Inouye et al., 2014).

Behavioural improvements were also observed, including reduction in excessive sleep and stabilization of the sleep–wake cycle, which are considered important indicators of recovery in Delirium (National Institute for Health and Care Excellence [NICE], 2010). Functional outcomes also improved, with better gait stability and increased independence in activities of daily living.

Caregiver reports indicated that the client became more responsive, less confused, and more engaged in social interactions, reflecting improvement in overall cognitive and behavioural functioning. No new behavioural disturbances or perceptual abnormalities were noted during the follow-up period. Improvement in social responsiveness and emotional engagement further suggests the importance of psychosocial support and family interaction in promoting recovery and functional stabilization among older adults.

Overall, the pre–post clinical comparison indicates significant improvement across orientation, attention, memory, sleep regulation, and functional abilities, supporting the effectiveness of combined medical and psychological interventions, as recommended in multicomponent delirium care models (Inouye et al., 1999; NICE, 2010).

CONCLUSION

The case report illustrates the assessment and psychological management of an elderly male client diagnosed with Delirium not induced by alcohol or psychoactive substances. The case demonstrates that Delirium, though distressing and acute in presentation, can be effectively managed through early identification, psychoeducation, cognitive orientation strategies, and strong family support. Psychological interventions in Delirium primarily focus on supportive care rather than structured therapy. In this case, providing accurate information to family members, maintaining a structured environment, and ensuring regular follow-up contributed significantly to the client's recovery. The gradual improvement observed reinforces the importance of a multidisciplinary approach combining medical and psychological management.

The case also highlights the importance of psychosocial well-being in geriatric care. Emotional reassurance, social connectedness, family involvement, and supportive caregiving environments may significantly influence the psychological adjustment and recovery outcomes of older adults. Integrating psychosocial approaches into geriatric mental health care becomes increasingly important in the context of changing family structures and evolving caregiving patterns. From an academic perspective, this case highlights the valuable role of clinical psychology interns in geriatric mental health settings. It emphasizes the need for careful assessment, empathetic family support, and collaboration with medical professionals to manage neurocognitive disturbances. The experience gained through this case contributes to a practical understanding of Delirium and its holistic management.

Beyond its clinical implications, the present case also underscores the importance of understanding geriatric neuropsychiatric conditions within broader psychosocial and sociocultural contexts. While Delirium is predominantly precipitated by acute medical and neurobiological factors, the case suggests that social environments, caregiving continuity, emotional connectedness, and opportunities for meaningful engagement may shape vulnerability, recovery experiences, and functional outcomes in later life. In rapidly aging societies such as India, changing family structures, migration-related separation, and the gradual weakening of traditional intergenerational caregiving systems may present additional psychosocial challenges for older adults. However, caution is warranted in establishing direct causal relationships between social circumstances and clinical presentation within a single-case design. Rather, the present findings highlight the value of adopting a biopsychosocial and interdisciplinary lens that situates geriatric mental health not solely within individual pathology, but also within the wider social realities that influence ageing, care, and psychological well-being. Future research employing longitudinal and multidisciplinary approaches may further clarify the interaction between psychosocial conditions and neuropsychiatric outcomes among elderly populations.

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Conflict of Interest
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