Cycloid psychoses. A case report

H. Dolengevich Segal and J. Saiz Ruiz

Psychiatry Service. Hospital Ramón y Cajal. University of Alcalá. Madrid. Spain

Psicosis cicloide. A propósito de un caso

Summary

Cycloid psychoses, described by Leonhard, have a sudden onset, unstable polymorphic delusion symptomatology, labile state of consciousness, lack of physical symptoms, quick remission with no residual mental abnormalities and normality between episodes. Leonhard distinguished three clinical forms: anxiety-happiness psychosis, excited-inhibited confusion psychosis and hyperkinetic-akinetic motility psychosis. The essential characteristics of this clinical subtypes are: polymorphism, global disturbance of psychic life, acute appearance of symptoms, total insomnia 3 days before onset of symptomatology, intra and interepisode lability, polar structure, tendency to repetition of episodes (phases) and a good long-term prognosis.

We present a patient's clinical history and evolution that illustrate the characteristics of this kind of endogenous psychoses.

Key words: *Cycloid psychosis.*

Resumen

Las psicosis cicloides, descritas por Leonhard, se caracterizan por un comienzo repentino, sintomatología delirante polimorfa e inestable, variación importante del estado de conciencia, ausencia de síntomas físicos, remisión rápida con restitutio ad integrum *y normalidad intercrítica. Leonhard clasificó estas psicosis en tres grupos: psicosis de angustia-felicidad, psicosis confusional (incherente-estuporosa) y psicosis de la mortilidad (acinética e hipercinética). Los rasgos esenciales de las psicosis cicloides son: polimorfismo, alteración global de la vida psíquica, agudeza en la aparición de los síntomas, imsomnio total 3 días antes de la aparición de los síntomas, labilidad intra e interepisódica, tendencia a la alternancia (estructura polar), tendencia a la repetición de los episodios (fases) y buen pronóstico a largo plazo.*

Presentamos el cuadro clínico y la evolución de una paciente que cumple las características de este tipo de psicosis endógenas.

Palabras clave: *Psicosis cicloide.*

INTRODUCTION

Under the name of acute and transient psychotic disorders (F23), the ICD-10 includes a series of pictures characterized by: *a*) acute onset (of less than 2 months); *b*) presence of typical syndromes, and *c*) presence of acute stress.

However, it is correctly stated that the three characteristic mentioned do not have to occur to reach an adequate diagnosis. The fundamental fact is found in the condition acuity in the sense that a florid psychotic picture may appear in a few hours and, in the second place, this picture is made up of typical and characteristic symptoms, such as consciousness, affective and psychomotility disorders.

Of all the group, the cycloid psychoses are certainly the essential picture that the ICD-10 calls «acute polymorphic psychotic disorder». Although the picture may arise as a consequence of stress situations, the disorder sometimes appears without the concurrence of precipitating factors. Finally, it must be stated that the condition's relative benignity is characteristic, since, in a short time, the patient returns to psychic normality in most of the cases, which contrasts with the usual malignity of the schizophrenic conditions. The DSM-IV does not recognize this picture's independence and the patients who suffer this disorder are included in the schizophreniform disorder or in a brief psychotic disorder[1].

Based on the previous considerations, we present the following clinical case followed by an analysis of the symptoms, proposing cycloid psychosis as the diagnosis.

PRESENTATION OF THE CLINICAL CASE

This case deals with a 38 year old woman who was brought to the Emergency Service with a knife wound in the upper hemiabdomen on the epigastrium level due to a suicide attempt within a psychotic episode.

She had no significant medical-surgical background. As psychiatric background, she had a psychotic picture

Correspondence:
Helen Dolengevich Segal
Servicio de Psiquiatría
Hospital Ramón y Cajal
Ctra. Colmenar, km 9,100
28034 Madrid (Spain)
e-mail: edolen@ya.com

with schizophreniform characteristics when she was 17 years old, that lasted one and a half months. It was treated with psychodrugs and with *ad integrum* recovery. In a short period of time (1 to 2 days), she began to behave «strangely», speaking with incoherences and with mood status fluctuations. She made constant reference to deaths and had false recognitions. After this picture, she began with depressive symptoms, with feelings of sadness and disability, partial anhedonia condition, hypobulia and difficulty in initiating sleep, which remitted without treatment after approximately 1 year.

One year before her present disease, she suffered depressive symptoms again. She felt sad and pessimistic, tired, with non-refreshing sleep and floating anxiety. After 3 months, treatment was prescribed with paroxetine 20 mg 1-0-0 and bromazepam 1,5 mg 0-0-1 for 4 months. The symptoms disappeared and treatment was discontinued. She remained stable for 6 months, until she began to commit minimum errors in the work area, which made her excessively concerned about each work detail. She could not concentrate or maintain her attention beyond a few minutes, had feelings of sadness, disability and guilt because «she could not fulfill the expectations of the others». She arrived home concerned, with obsessive ruminations about these questions, and could not rest, her anxiety increasing slowly.

As family background, her older sister died at 42 years of age due to ACVA and she has an 18 year old nephew diagnosed of delusional dysmorphophobia.

Regarding her previous personality, she describes herself as very perfectionist, although flexible, intelligent, sensitive, hard-worker and impatient. He is very self-demanding, generally underestimates her achievement and greatly needs others' recognition. She is non-practicing catholic and does not consider the subject of religion as important. She commonly practices yoga, likes movies, reading and writing.

Her present disease began a week before admission to hospital, the already previously established depressive symptoms becoming worse. She reported low mood with anxiety. She slowly began with psychomotor uneasiness, which led her to stay at home, constantly moving, but without performing any task, which increased her feelings of uselessness. She reported difficulty to fall asleep, reaching global 4 insomnia days before admission. Thoughts entered her head rapidly and she thought «all this has to have a solution». She felt responsible for her family's misfortunes. She had mystic-religious type intuitions that overwhelmed her and made her understand things, as a type of revelation: «It is God who gives order to life, one cannot overlook the rule of life.» In recent days, she was confused, she lived a dream-like state, and it was difficult for her to know what was real and what was not. «It was as if I were living in a movie and I was part of the script.» Her behaviors became extravagant and senseless. Her mood state fluctuated, going from anxiety to happiness from one moment to the next, without apparent cause, many times inappropriately. The day she was admitted to hospital, she had a sensation of constant strangeness. She had the delusional perception that only she could understand that «that seen on the TV referred to a situation of insanity in all the world», and she felt that she had been chosen to «help everyone». Without any apparent precipitating factor, she took a knife and stuck it into her abdomen, with the sensation that «all was unreal». She was calm, but when they tried to help her, she had significant anguish and psychomotor agitation, requiring physical restraint. She was brought to the hospital in an ambulance. Once in the emergency service, assessment by psychiatry was requested to sedate her.

In the psychopathological examination, she was conscious, and orientation was not evaluable. Approachable, although she offered null collaboration. Absent contact, occasional perplexity. At times suspicious, mistrustful due to mechanical restraint. Coherent speech, although sometimes incongruent, vague and circumstantial, with continuous references to death and verbalization of a vague fear of being harmed. Concern about solving family problems. Oneiroid delusional ideation, at times confusing. False recognitions. No evidence of sensoperceptive disorders. She alternates moments of anguish-happiness, that are inappropriate and insipid. Global insomnia and hyporexia. Null awareness of disease. The physical examination reveals an incisional wound in epigastrium of approximately 4 cm which is not penetrating on examination. Abdomen normal to palpation without pain. BP: 110/70; HR: 1,001 lbm; temp: 37 ºC.

During her stay in the emergency service, she was mechanically restrained and sedated. The abdominal CT scan showed «incision of the wound in anterior abdominal wall. Increased right psoas muscle size, with small linguae of liquid and frayed surroundings». Abdomen plaque shows «small pneumoperitoneum». Complete blood count with leukocytosis 21,000 (90 N), rest normal. She remained under observation and with baseline treatment of haloperidol 10 mg/day, biperiden 2 mg/day and clonazepam 4 mg/day.

The patient was evaluated 2 days after admission, while hospitalized in the surgery service. She was conscious and oriented on the three spheres, calm, mildly somnolent. She performed a partial criticism of the event. No delusional ideas or sensorperception disorders were seen. Euthymic mood, with mildly affective, although appropriate, flattening. Without suicidal ideation nor self or heteroaggressiveness. Increased sleep and she began to tolerate oral food.

Treatment was adjusted, decreasing clonazepam to 2 mg/day. In surgery, she evolved without complications and was discharged. Evolution was favorable for psychiatry, without daytime somnolence and she was increasingly conscious of the episode. Considering the absence of psychotic or confusional symptoms, as well as the excellent family support, it was decided to discharge the patient for out-patient follow-up. Complementary tests performed revealed: TSH, toxics in urine, B_{12}. Normal folic acid. Brain CT scan: normal.

After being discharged, weekly out-patient follow-up was maintained. At the beginning, the patient had low

mood, little initiative and it was difficult for her to perform her daily activities. She had decreased attention and concentration. Furthermore, she had daytime anxiety with obsessional rumiations on the psychotic episode that caused anguish and concern regarding the possibility of a new episode. As she became aware of the episode, she showed guilty feelings and feeling of responsibility regarding what had occurred. With fractioned, little refreshing sleep. She reported a sensation of psychomotor uneasiness that made it impossible for her to be still in one place, which was interpreted as akathisia. Up to 40 mg of Paroxetine was added to the treatment and haloperidol was slowly decreased and then substituted by olanzapine 5 mg at night. Thus, biperiden was discontinued and clonazepam maintained only when necessary.

After approximately 4 weeks, her mood stage began to improve, anxiety disappeared and her sleep was adequate. She was more sure of herself, could stay alone and take care of her children. She showed a desire to work, feeling increasing more capable of carrying out a totally integrated life on both the family as well as work level.

DISCUSSION

Cycloid psychoses, elaborated by Leonhard, come from the development of fundamental approaches of Magnan in France and Wernicke and Kleist in Germany[1]. Magnan[2] and Legrain[3] described some acute psychoses, that were called *bouffées délirantes* characterized by a sudden onset, without precipitating factor, polymorphic and unstable delusional semiology, important variation of consciousness stage, absence of physical symptoms, rapid remission with *restitutio ad integrum* and intercritical normality.

Kleist[4], in turn, with the influences of Wernicke in the beginning and then of Westphal and Schroder, elaborated the notion of «marginal psychoses» (*randpsychsen*), that is thus named because they were practically related with all the endogenous psychoses of the Kraepelin classification[5], but only in regards to symptoms, since it established that they were autochtonous and independent psychoses. The five groups that Kleist distinguished were: cycloid psychoses, psychosis of self, paranoid psychoses, epileptoid psychoses and psychosis of quality of relationship[6].

Based on the investigation of Kleist, Leonhard proposed the name of cycloid psychosis to refer to the totality of the pictures[7]. Leonhard classified these psychoses into three groups: anxiety-happiness psychosis, confusional psychosis (incoherent-stuporous) and motility psychosis (akinetic and hyperkinetic)[8]. The characteristic of these pictures is the lability state, a syndromic mixture appearing both within the same phase (intraphasic lability) as well as from one phase to another (interphasic lability). Cabaleiro considered that anxiety psychosis and happiness do not make up a unit, but rather are both marginal syndromes: the former of manic depressive or thymopathic circle and the latter is identified with Kleist's acute expansive psychosis of inspiration[9].

The essential traits of cycloid psychoses are: polymorphism, global alteration of psychic life, acuity in appearance of symptoms, total insomnia three days before the appearance of the symptoms, intra- and interepisodic lability, tendency to cycling (polar structure), tendency to repetition of episodes (phases) and good long term prognosis[10].

The patient that we present fulfills the ICD-10 criteria for acute polymorphic psychotic disorder without schizophrenia symptoms[11] as well as those of the DSM-IV for brief psychotic disorder[12]. However, when it is taken into account that she had a first episode at 17 years of age, characterized by mood state fluctuation, reference to deaths and false recognitions, with complete recovery and a second episode in the fourth decade of life, having similar characteristics, cycloid psychosis must be considered as a diagnosis. Considering the characteristics of these pictures, the patient fulfills the necessary conditions to integrate the diagnosis: global insomnia days before eclosion of the psychotic symptoms, in form of mystic-religious delusional intuitions, constant reference to deaths, false recognitions, fluctuating mood from anxiety to happiness and oneiroid state, a transformation of the psychic life of the patient being observed. For an exact diagnosis, the onset must be acute, several types of hallucinations or delusional ideas must be present, the type and intensity varying from one day to the next or within the same day. There must be a changing emotional state, although, in spite of the variety of the symptoms, none occurs with sufficient consistency to satisfy the schizophrenia guidelines or manic or depressive episode ones[6].

Our patient favorably responded to drug therapy with neuroleptics, the psychotic symptoms completely disappearing after three days. This is important in regards to treatment, since although Leonhard opposed chronic treatment of cycloid psychoses, there are other authors who support the use of antipsychotics with or without antiepileptics both for rapid remission of the acute episodes as well as regarding prevention of relapses[13,14]. We decided to maintain the treatment for at least three months with low doses of olanzapine and to add paroxetine to treat the depressive symptoms, which had a good clinical response and excellent tolerability.

There are authors who consider cycloid psychosis as an atypical form of affective psychosis[15,16]. Furthermore, grouping of similar or shared symptoms has received different names, such as reactive psychosis[17], schizoaffective psychosis[18], bouffée délirante[19], atypical psychosis[20] or puerperal psychosis[21]. Leonhard's classification of the endogeneous psychosis and the approach to the cycloid psychoses as an independent nosological category, different from manic-depressive disorder and schizophrenias, coincides with other authors[22-24] and has been very useful in recent years, since it makes it possible to more appropriately classify pictures such as that present in the communication. Leonhard's original idea on cycloid psychoses has been widely verified by the present re-

search[25-28]. In fact, the changes to this concept, above all those tending towards simplification, have led to loss of its heuristic value. A renewed emphasis on the exact characterization of individual manifestations and syndromes, as described by Wernicke, Kraepelin, Kleist and Leonhard in their studies is very promising as a way to revive progress in the scientific understanding of the etiology, genetics, prognosis and treatment of the different endogenous psychoses.

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