Cycloid Psychoses

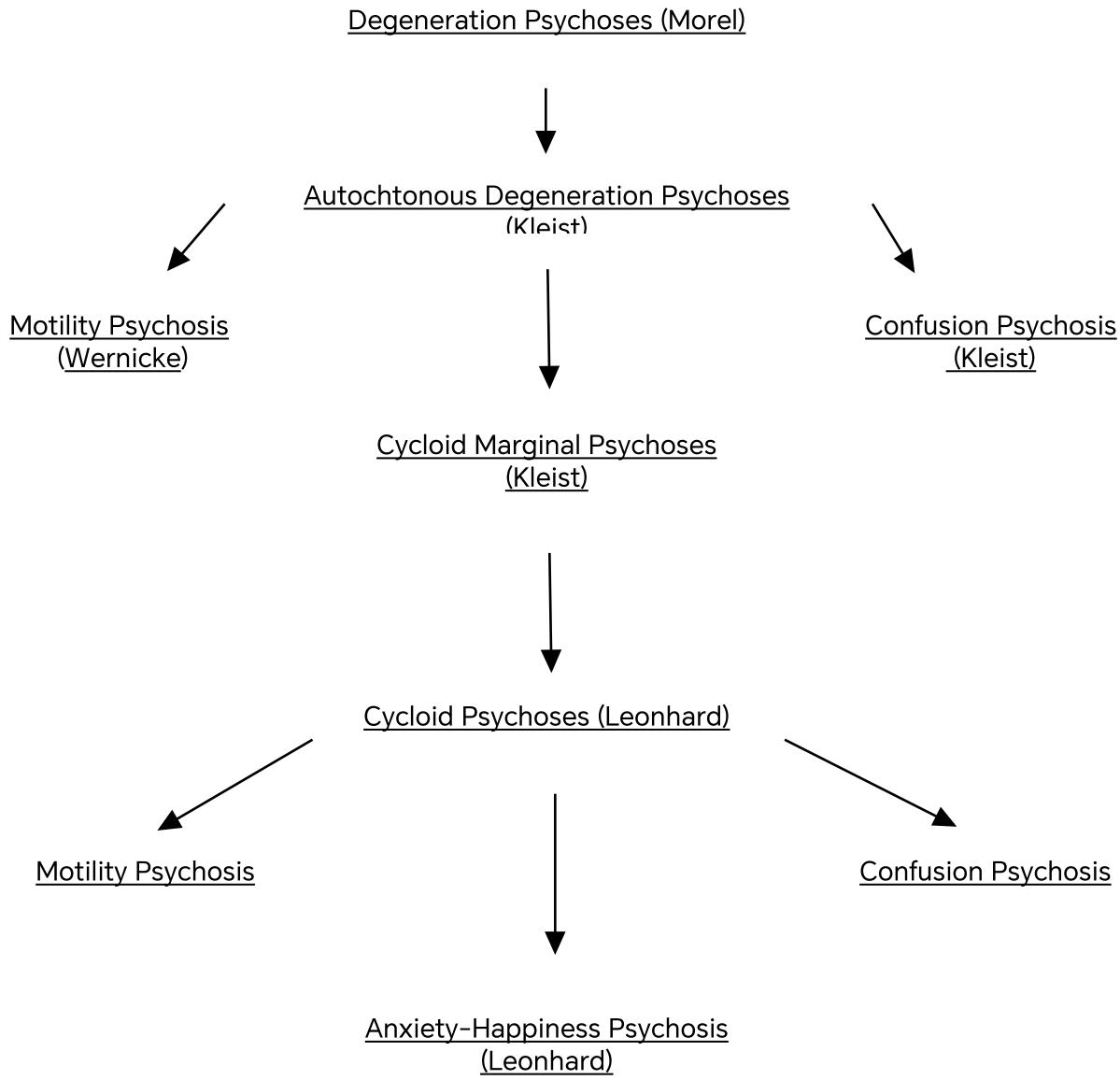
Recognition of the difficulties encountered in the separation of "affective" and "schizophrenic" psychoses yielded the identification of "cycloid psychoses." In his textbook *The Classification of Endogenous Psychoses* Leonhard (1957) pooled together three different forms of psychoses: motility psychosis (Wernicke, 1894, 1900; Kleist, 1972; Funfgeld, 1936), confusion psychosis (Kleist, 1928) and anxiety-happiness (elation) psychosis (Leonhard, 1934, 1939) under the heading of cycloid psychoses. He separated cycloid psychoses from the phasic and schizophrenic psychoses and defined them as a group of remitting bipolar disorders which resemble the phasic psychoses in their course and the nonsystematic schizophrenic psychoses in their content. Leonhard (1960) noted the great similarity in contents between the nonsystematic schizophrenias and cycloid psychoses. He also emphasized, however, the essential difference between these two groups of disorders. Only cycloid psychoses displayed complete recovery from each phase. In this respect they resemble phasic (affective) psychoses to the extent that if full recovery is not achieved the possibility of misdiagnosis needs to be considered. Chronic courses are exceptionally rare. If they occur, however, cycloid psychoses "lose their tension" after repeated periods of hospitalization.

Conceptual development of cycloid psychoses dates back to the work of the 19th century French school (Fish, 1964; Brockington, Perris and Meltzer, 1982). Legrain (1886) and Magnan (1893) recognized that within Morel's (1860) "degeneration psychoses" (psychoses that are the result of a degenerative process within a given family) there were illnesses with an acute or subacute onset (Legrain, 1886), which followed a phasic, episodic course (Magnan, 1893) with a full remission between episodes. The concept was further elaborated by Schroder (1926) who referred to this group of disorders as "metabolic psychoses" in order to highlight their episodic nature. Gaupp (1926) called them "mixed (combinierten) psychoses" because of the mixture of "schizophrenic" cross-sectional psychopathology with a longitudinal -course resembling manic-depressive illness.

The separation of two distinct illnesses from this mixed group of psychoses, motility psychoses (Wernicke, 1894) and confusion psychosis (Kleist, 1928), yielded the concepts of "autochotonous degeneration psychoses" and "cycloid marginal psychoses" (which include both motility and confusion psychoses) in the work of Kleist (1921, 1928). Subsequently, the identification of a third distinct illness, anxiety-happiness psychosis (Leonhard, 1934), resulted in the present concept of cycloid psychosis which includes motility, confusion and anxiety-happiness psychoses (Leonhard, 1957) (Figure 10), (see Appendix X, Tables I-III).

In his lecture at the Royal Edinburgh Hospital for Nervous and Mental Disorders on the 27th of June 1960, Leonhard (1961) defined cycloid psychoses, as a group of acute, reversible psychoses which do not fulfill the criteria of schizophrenic or manic-depressive illness. He reasserted that cycloid psychoses appear in three different bipolar forms of illness, motility psychosis, confusion psychosis and anxiety-happiness psychosis, each consisting of contrasting clinical states which may occur at different times but are never present simultaneously. Thus, the prevailing manifestations of motility psychosis are hyperkinesia or akinesia. In contradistinction to periodic catatonia, however, there is never an admixture of hyperkinesia and akinesia. Confusion psychosis in the excited phase is characterized by incoherent thinking, misidentifications and pressure of speech. In the inhibited phase pressure of speech is replaced by a decrease in verbalization. The third disorder, anxiety-happiness psychosis, is manifest with prevailing anxiety or elation (happiness).

Figure 10



Cycloid psychoses: development of the concept.

A desire to make others happy is pathognomonic of happiness psychosis. In cycloid psychoses there is no overlap between the two opposite poles in any one of the three illnesses. On the other hand, the three cycloid psychoses are not sharply separated from each other. The same applies to the differentiation of cycloid psychoses from the non- systematic schizophrenias: motility psychosis from periodic catatonia, confusion psychosis from cataphasia and anxiety-happiness psychosis from affect-laden paraphrenia. Not infrequently the final diagnosis must be withheld and decided upon on the basis of the outcome of the illness, i.e., full recovery in cycloid psychoses and partial remission in the nonsystematic schizophrenias (Table XX).

The concept of cycloid psychosis was further elaborated in the work of Perris (1973, 1974) who put forward an operational definition for this diagnosis. According to Perris, to qualify for a diagnosis of cycloid psychosis, the patient must have affective symptoms (mood swings) associated with confusion, delusions of reference, motility disturbances, ecstasy and/or pan-anxiety. He shifted the emphasis from paranoid anxiety or motility extremes to acute onset, polymorphic (multiform) symptomatology and confusion. Of particular importance is the polymorphic clinical picture with all sorts of symptoms jumbled, suggesting the presence of several different disorders, none of which is dominant or persistent. The clinical picture may shift from one syndrome to another, and there is never a fully developed stable manic, depressive, or paranoid syndrome.

The shift of emphasis in the definition of cycloid psychosis is possibly responsible for the difference in reported prevalence rates between Leonhard's (1957) study carried out in Frankfurt from 1938 to 1942 and subsequently in Berlin and the study of Cutting, Clare

Table XX

First Dimension Psychopathology (Symptomatology) Cross sectional	Hyperkinesia or akinesia Incoherent thinking Pressure of talk with misidentifications Retardation with ideas of reference Anxiety with ideas of reference and/or significance Elation (happiness) with expansive ideas and the desire to make others happy
Second Dimension Onset – Etiology	Endogenous with acute or subacute onset
Third Dimension Course of Illness	Episodic-remitting Bipolar
Fourth Dimension Outcome Picture	Full recovery

Leonhard's (1969) diagnostic criteria of cycloid psychosis.

and Mann (1978), carried out in London on patients admitted to the Maudsley professorial unit from 1955 to 1964. In the Frankfurt-Berlin study (Leonhard's criteria) out of 1537 patients 837 were schizophrenic, 282 manic-depressive and 418 cycloid. In the London study (Perris' criteria) out of 2500 admissions only 73 or 3% of all admissions and 8% of all psychotic admissions were cycloids. Cycloid psychosis was the fourth most common psychotic diagnosis in the Maudsley series, after depressive psychosis (18%), schizophrenia (16%) and organic conditions (10%). The different definitions, used in the two cohorts, might also explain why in the German sample the most frequently occurring cycloid disorder was anxiety-happiness psychosis (178 patients) followed by confusion psychosis (142 patients) and motility psychosis (98 patients), while in the British sample the least numerous subgroups were the ones with manifestations of ecstasy (7 patients) and pan-anxiety (30 patients).

In spite of the differences in the frequency of occurrence in the two studies, results of the survey carried out by Cutting, Clare and Mann (1978) favor Leonhard's contention that cycloid psychosis is a nosologically distinct category within the endogenous psychoses. In a follow-up examination of 90% of their 73 cycloid patients, they found that compared with other psychoses, the cycloids had the highest recovery rate (90%), the highest proportion of patients with at least one remission and the highest admission and episode rates (.28 and 0.30/year, respectively). They spent more time in hospitals than depressed or manic patients (.86 months/year, compared with .24 and .46 respectively), but much less than schizophrenic patients (2.52 months/year). The distinctiveness of cycloids on outcome measures was also substantiated in the study of Brockington et al (1982). In a series of 233 patients, they found that 90% of 30 cycloids fully recovered, while only 67% of the whole group showed a similar response. When compared with schizophrenia, the cycloids fared even better; 92% of the 24 cycloids given a CATEGO diagnosis of schizophrenia made a full recovery compared with the 59% in the 102 non-cycloid CATEGO schizophrenics.

In the DCR (Pethö, Ban, Kelemen et al., 1984) substantiation of a diagnosis of cycloid psychosis is based on the evaluation of 16 variables. The diagnosis is essentially made on the basis of Leonhard's principles, although Perris' criteria, such as acute or subacute onset, polymorphic-fluctuating symptomatology, mood swings and thematic incoherence, are also considered. Attention is focused on the presence of protopathic change of Gestalt, in spite of the recognition that in Conrad's (1958) work this is pathognomonic of schizophrenic psychopathology and not of cycloid psychos is. Furthermore, insofar as outcome is concerned personality changes are considered to be an acceptable alternative to full recovery.

Cycloid psychosis is not an accepted diagnostic category either in ICD-9 or in DSM-III. Contrary to the common belief that patients with this diagnosis are subsumed under schizophrenic disorders, schizoaffective type in ICD-9 and schizoaffective disorder in DSM-III, there is substantial evidence to believe that this is not the case. However, there is a fair concordance between cycloid psychoses in two series of patients, i.e., 134 patients in the Hetherne series (Cooper et al., 1972) and 119 patients in the Camberwell series (Wing et al., 1968) and Kasanin's (1933) acute schizoaffective psychosis (Kappa = .42 and .37 respectively). However, Brockington et al. (1982) found that of the 108 patients meeting Kendall's study criteria for schizoaffective psychosis (Kendell and Brockington, 1980), only 20 patients. (19%) met Perris! (1974) criteria for cycloid psychosis. On the basis of these findings Brockington, Meltzer and Perris (1982) asserted that "it is obviously a mistake to regard cycloid psychosis as a synonym for schizoaffective disorders." The same applies to manic-depressive psychosis. In spite of all the similarities between cycloid and manic-depressive psychosis, "there was a negligible overlap between these two disease concepts" in the Netherne series.

In two clinical studies in which the correspondence between cycloid psychoses and hospital diagnoses was explored, no consistent relationship was found. In the clinical study of Cutting, Clare and Mann (1978) the hospital diagnosis (based on ICD-9) of 73 cases of cycloid psychosis were: schizophrenia in 33, schizoaffective in 20, affective in 11 and atypical psychoses in 9 patients. Similarly, the diagnosis of 30 cycloid patients in the clinical study of Brockington et al. (1982) were schizophrenia (including schizoaffective schizophrenia) in 18, mania in 7, depressive psychosis in 4 and puerperal psychosis in 1 patient. In the same study, CATEGO classification was S+ in 18, M+ in 5, 0+ in 3, P+ in 3 and D+ in 1 patient. RDC diagnoses were schizoaffective depression in 11, schizoaffective mania in 6, both in 1, schizophrenia in 7 and mania in 5 patients; and DSM-III diagnoses were depression with mood incongruent psychotic features in 10, with mood congruent features in 6, schizophreniform psychosis in 5 and schizophrenia in 2 patients. On the basis of these findings Brockington et al. (1982) conclude that "in terms of the ICD and CATEGO systems, a majority had some form of schizophrenia, while in terms of the two American systems a majority had mood-incongruent or schizoaffective depression or mania."

Finally, it should be noted that Fish (1964) considered cycloid psychosis as one of four different kinds of atypical psychoses. The other three are atypical manic-depressive psychoses, psychogenic reactions and epileptoid psychoses. He contends that the differentiation of cycloid psychoses from the other forms of atypical psychoses is an essential prerequisite for meaningful research on these disorders.

Differential characteristics of the three cycloid psychoses were described by Leonhard (1957, 1961), Fish (1962, 1964) and Pethö, Ban, Kelemen et al. (1984).