Two Case Reports of Confusion Psychosis: Should We Reevaluate the Place of Cycloid Psychoses in Modern Psychiatry?

To the Editor: In practicing inpatient psychiatry, my colleagues and I often encounter cases of psychosis with acute onset and polymorphic symptomatology that include confusion, a mixture of psychotic and affective symptoms, the absence of an identified stressor, and a favorable response to treatment. These conditions usually fall into *DSM-IV* categories of brief psychotic disorder, schizophreniform disorder, or even psychotic disorder not otherwise specified (NOS). However, these diagnostic categories do not have any significantly distinctive features except the duration criterion.

The diagnostic concept of "cycloid psychoses" is not part of the current *DSM* system but should be considered for inclusion as it has identifiable criteria for both the diagnosis and the duration of the clinical event. Cycloid psychoses are divided into 3 forms: "anxiety-elation psychosis," "confusional psychosis," and "motility psychosis."[1,2]

These 2 cases of psychosis were formally diagnosed as brief psychotic disorder and psychotic disorder NOS (*DSM-IV* criteria), but have very certain characteristics of Leonhard's "confusional psychosis." However, I believe that the clinical characteristics of these cases would be better diagnosed using the concept of cycloid psychosis of the confusional form.

Case 1. Ms A, a 39-year-old unmarried white woman with a previous history of bipolar disorder, was picked up by the police in 2009 and brought by ambulance to the local emergency department exhibiting erratic and bizarre behavior. She was found wandering in her neighborhood confused, disoriented, and unable to answer questions. In the emergency department, she continued to be disorganized to the point of being noncommunicative. The patient was medically cleared for psychiatric admission. Her blood work showed no significant abnormalities, and the toxicology screen was negative.

During transport to the psychiatric unit, the patient suddenly became agitated and combative. She thought that she was in a doorway to hell or heaven and that the psychiatric unit was a torture chamber. She started to quote the Bible and to sing, in order to avoid hell. She required chemical and physical restraints for safety and received an injection of haloperidol, lorazepam, and diphenhydramine. After the injection, she slept through the night and most of the next day. In the late afternoon of the next day, the patient was able to provide some information about her psychiatric history, but had some amnesia regarding the events on admission.

The patient's psychiatric history was remarkable for similar short psychotic episodes in the past. She was diagnosed with bipolar disorder years before, and she also had a history of cutting herself as an adolescent. Her medical history was positive for mitral valve prolapse. Substance abuse history was negative. The patient reported that she was prescribed lamotrigine and quetiapine but had not taken them for few weeks. She appeared somewhat perplexed but oriented and appropriate. The patient's fiancé reported that prior to the hospitalization, the patient's anxiety had been increasing and she had been sleeping poorly for the past 3 or 4 days. The patient lived out of the area and had rejoined her fiancé just 10 days prior to the admission.

The patient's medications were restarted in low doses, as her outpatient psychiatrist was not available. The patient proceeded to full recovery by day 3 after admission. She was successfully discharged in psychosis-free condition on the sixth day.

Case 2. Mr B, a 21-year-old Creole man, was brought into the emergency department in 2009 by the police, having been found in a local library to be behaving in an inappropriate and bizarre manner, harassing people and trying to strip himself naked. He was uncooperative and confused. In the emergency department, he mumbled to himself and seemed preoccupied with whether people were men or women. His answers to questions were non sequiturs, such as "Am I in a cocoon?" and "Is this the ocean?" Later, he misperceived a psychiatrist and a social worker for his mother and father. He was suspiciously looking around the examination room, appeared frightened, and was responding to internal stimuli. He received an injection of haloperidol and lorazepam. Initially confused, distracted, and agitated, he became cooperative and compliant. The patient's physical examination, laboratory values, and brain computed tomography scan revealed no abnormalities. His toxicology screen was negative.

In the psychiatric unit, treatment with olanzapine was initiated. The patient responded well. By the second day, his psychotic presentation cleared with an exception of mild residual perplexity and pressured speech. He became able to provide information about himself, his medical and psychiatric history, and substance abuse history. He reported occasional cannabis use, but no prior psychiatric issues or medical history. By the fourth day of olanzapine treatment, his residual symptoms disappeared, and he was successfully discharged home.

In my opinion, these 2 clinical presentations are consistent with Kleist-Leonhard's idea of "confusion psychosis."[2–4] By further developing the ideas of Wernicke's "motility psychoses," Kleist introduced "revelation and confusion psychoses" and "autochthonous degeneration psychoses."[5] Later, he united them into a concept of "cycloid psychoses."[6] After Kleist died, his concept was expanded further by Leonhard, who added the anxiety-elation psychosis. According to Leonhard, the conception of cycloid psychosis includes 3 entities: "anxiety-elation psychosis," "confusional psychosis," and "motility psychosis."[1,2] Each of these forms involves acute onset, cyclic course with full recovery in between, intense involvement of anxiety, psychomotor agitation, affective dysregulation, polymorphous delusions, and hallucinations.[2,4,7] Leonhard emphasized the independence of cycloid psychoses from other psychotic and mood disorders.[1,2] The diagnostic criteria for cycloid psychoses were further developed by Perris and colleagues.[8–11] The most recent research and way of thinking about cycloid psychoses were impeccably summarized in the review by Salvatore and colleagues.[12]

In spite of extensive research and publications, cycloid psychoses currently do not have a place in the *DSM* system. Now, while the *DSM-5* is in process, should we go back and reevaluate a place for cycloid psychoses in modern psychiatry?

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