

Case Report

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The Living Being Dead: Cotard Syndrome Presenting as a Dead Spirit


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Abstract

Jules Cotard described a syndrome with melancholic anxiety, delusions of possession, ideas of suicide and, thoughts of the non-existence of their own body and/or soul. 'Perethaya' is a greedy dead spirit recognized in Sri Lankan culture who expresses a dangerous longing for food until their subsequent incarnation. A 68-year-old female previously diagnosed with depressive disorder stated she is deceased and turned to a 'perethaya'. She ate from garbage bins and attempted to consume water from toilet bowls as a 'perethaya' would do. A 42-year-old male diagnosed with recurrent depression stated he has died and is now a 'perethaya'. He believed any person who would talk to him is dead as well. These reports present a culturally unique way of Cotard syndrome in Sri Lanka.

Keywords: Depression; Cotard syndrome; nihilistic delusions; Sri Lanka; transcultural psychiatry.

INTRODUCTION

Jules Cotard described a syndrome with melancholic anxiety, delusions of possession, ideas of suicide and, thoughts of the non-existence of their own body and/or soul [1]. In this clinical condition hypochondriac and nihilistic delusions are prominent and classically patients would present with statements such as "I am dead," and "my internal organs do not exist" [2]. They are likely to express an anxious and depressed mood. Furthermore, delusions of possession and immortality may be present. Suicidal and self-mutilating behaviours may pose a threat to life [2]. Cotard syndrome is not listed at present as a specific disorder in the Diagnostic and Statistical Manual of Mental Disorders. This clinical syndrome is typically viewed as a part of other underlying psychiatric and neurological disorders [3]. It is believed that specific underlying psychopathological mechanisms are present in the Cotard syndrome and

a sound understanding would facilitate effective therapeutic interventions for each patient.

Many psychiatric disorders have culturally variable presentations and there have been unique reports from Sri Lanka. For examples, depressive disorder is known to present as a burning sensation of the body [4]. High functioning autism spectrum disorder in children has presented to services as stories of past lives and reincarnation [5]. Moreover, well recognised mental disorders may present in unusual ways in non-western settings. In relevance to Sri Lanka, a middle-aged female was diagnosed with depressive disorder after presenting with recent onset voyeuristic behaviour and an adolescent with high functioning autism after he was discovered having sexual intercourse with a heifer [6, 7]. In this context, we report two patients with Cotard syndrome presenting as a 'perethaya', a greedy dead spirit recognized in Sri Lankan culture who has a dangerous longing for food until their next incarnation [8].

CASE REPORT

The first is a 68-year-old married retired schoolteacher. She had been diagnosed to have recurrent psychotic depression for 7 years and had been stable on mirtazapine and aripiprazole. She developed orofacial dyskinesia and treatment was cross tapered from aripiprazole to quetiapine. After the psychopharmacological modification, she presented with a depressed mood and was constantly preoccupied about having an oral carcinoma, without any related symptoms. Her mood gradually worsened over two weeks and she was admitted for inpatient management. She stated that she was dead, and that her internal organs had ceased to function. She demonstrated agitation and disorganised behaviour. She intermittently removed all clothes in public and claimed she could feel an iron rod being inserted to her vagina. She believed she deserved to be tormented and raped, and that this would purge her from her sins. She was convinced that she was a greedy dead spirit or 'perethaya,' and ate garbage from dustbins in the ward and attempted to drink water from the toilet bowls. The patient remained alert and oriented with regards to time, place and person during the inpatient stay, with no features of delirium and the cognitive assessments including a Mini Mental State Examination and lobe functions were normal. Further, all neuroimaging, haematological, endocrinological and biochemical investigations were within normal limits. She responded to a course of electroconvulsive therapy and a combination of mirtazapine, venlafaxine, quetiapine and lithium carbonate.

The second patient is a 42-year-old married man. He had been diagnosed to have recurrent depressive disorder for the last 10 years. He presented with a relapse after defaulting psychopharmacological treatment. He was severely distressed in the context of a property dispute. He claimed that he could hear his deceased father asking people to bury him as he is dead. He firmly believed his relatives were plotting against him, despite no evidence. He was diagnosed with psychotic depression and admitted for inpatient management as he gradually deteriorated. He firmly believed that he was dead, and his current existence was of a greedy dead spirit 'perethaya' and the rest of the world had ceased to exist. He believed that others who spoke to him including doctors were also dead, as only the dead could speak to the dead. He stated he deserved his current plight due to his past sins and a soothsayer predicted his impending demise long

before. His neuroimaging, haematological, endocrinological and biochemical investigations were normal. He responded effectively to a combination of venlafaxine and risperidone.

DISCUSSION

We reported two patients with psychotic depression presenting with Cotard syndrome. They both stated they had died and now exist as greedy dead spirits called 'perethaya'. Buddhism was established in Sri Lanka in the third century BC and even after centuries of Portuguese, Dutch and British colonisation, Theravada Buddhism continues to remain the predominant religion. In Theravada Buddhism, supernatural powers are not given any prominence as a solution for life's suffering and there is no omnipotent creator God [9]. It is described that dangers of life's desires are not confined to the mortal world but may continue in a dead spirit born in a lower realm, called a 'perethaya,' who is greedy for food. Traditionally, oily and sweet food would be placed in a specific place in funerals to be consumed by the 'perethaya'. The mourners would give merit by almsgivings for the deceased to obtain a righteous rebirth [8]. It is believed that a person who desires too much during the human life would be born a 'perethaya' and is considered to represent an extremely unfortunate outcome for a Buddhist, that requires sympathy from the living [10]. This belief aligns with the nihilism described in severe depressive disorder and Cotard syndrome [3].

A culturally variant presentation of Cotard syndrome has been reported from Iran. A 42-year-old woman believed she was executed by a female ghost with long nails, dishevelled hair, and enormous eyes. In Persian folk lore, this is known as 'Aal', a female mythical creature who troubles postnatal women [11]. Further, a Koro like presentation has been reported with the Cotard delusion in a male from Italy diagnosed with depressive disorder [12]. Furthermore, a 62-year-old Spanish male with psychotic depression, parkinsonism and cognitive impairment has been diagnosed to have Cotard syndrome and Koro [13]. Koro is a culture-bound syndrome usually reported from Sri Lanka and other Asian countries where the individual has a distressing and frightening fear of shrinkage and retraction of his penis into the abdomen [14].

Compared to other medical specialities, psychiatry has a considerably intense relationship with the local culture. This is predominantly demonstrated in culturally variant presentations of familiar psychiatric phenomena. The cases of Cotard syndrome described here, occurring in the context of depressive disorder, shows how a clinical entity well known in the West has presented uniquely in Sri Lanka. Therefore, the development of cross-culturally comparable diagnostic interviews that would be conveniently accessible to the clinicians of a country, could help to increase the diagnostic accuracy in psychiatry [4, 15].

Author declarations

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Author contributions

MC and KALAK, both were responsible for the concept, design and writing of the manuscript. PKDHJLDSR was responsible for the clinical assessments. CK was responsible for the literature review.

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Informed written consent was obtained from all patients

Competing interests

Authors declare that there is no conflict of interest.

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