

Cotard's Delusion or Syndrome?: A Conceptual History

G.E. Berrios and R. Luque

This report offers an account of the historical construction of Cotard's syndrome showing that by *délire des négations* the French author meant a subtype of depressive illness. Subsequent debate led first to the belief that it was just a collection of symptoms associated with agitated depression (anxious melancholia) or general paralysis, and later to the view that it might after all constitute a separate entity. At the present moment, and impervious to the fact that the French term *délire* means far more than "delusion," some

authors use Cotard's syndrome to refer to the belief of being dead and suggest that such a delusion might have a specific brain location. From the clinical and evolutionary perspectives, it is unclear why a delusion should merit, simply because of its "nihilistic" content, a special brain location or presage chronicity. It is suggested here that before neurobiologic speculation starts, efforts should be made to map out the clinical features and correlations of the *délire des négations*.
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THERE HAS BEEN some interest of late in English-speaking psychiatry in the clinical¹⁻³ and neurobiologic⁴⁻⁶ aspects of the so-called Cotard's syndrome. A tendency can also be detected in American literature to use "Cotard's delusion" for the "delusional belief of being dead," irrespective of clinical context.⁴ It is not yet clear whether this departure from historical and clinical usage constitutes a scientific advance or is a mere misreading of the original literature and of the conceptual context in which Cotard performed his studies. "Nihilistic delusions" but not Cotard are mentioned in DSM-III-R (p. 220)⁷; neither term appears in ICD-10.⁸ This report reviews the original French sources for Cotard's syndrome and its conceptual construction between 1880 and World War II. A separate report offers a statistical analysis of 100 cases and outlines the clinical features of this phenomenon.⁹

JULES COTARD AND HIS TIME

Jules Cotard was born on June 1, 1840, in Issoudun, France, and studied medicine in Paris, where he was a student of Broca and Vulpian; he became interested in the pathology of the nervous system while working under Charcot. His first substantial report was *Études physiologiques et pathologiques sur le ramollissement cérébral*,¹⁰ he obtained his doctorate in 1868 with an *Étude sur l'atrophie partielle du cerveau*.¹¹

From the Department of Psychiatry, University of Cambridge, Addenbrooke's Hospital, Cambridge, UK.

Address reprint requests to G.E. Berrios, M.D., Department of Psychiatry, University of Cambridge, Addenbrooke's Hospital (Box 189), Hills Road, Cambridge, UK.

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After seeing the great Lasègue interview a patient at the *Préfecture de Police*, he turned to psychiatry. In 1874, Lasègue introduced Cotard to Jules Falret, and these two men formed an enduring partnership at the Vanves asylum. His untimely death on August 19, 1889, followed an attack of diphtheria caught from his daughter.

Cotard was influenced by Condillac, Cabanis, Destutt de Tracy, Maine de Biran, and Comte, and wrote on hypochondria, abulia, and the "psychomotor origin" of delusions.¹² At his funeral, Jules Falret described him as "a profound and original thinker, given to paradox, but guided by a robust sense of reality."¹³ This original bent of mind is illustrated in an early report on *Folie*,¹⁴ where Cotard explored the difficulties posed by adopting ordinary terms into the scientific language of psychiatry, and rejected the principle of etiologic classification of mental disorder.¹⁵ Based on the belief that knowledge about the brain was insufficient to support causal explanations, he proposed a symptomatic classification.¹⁴ Original thinking also led him to suggest that disturbances of affectivity might be "the grounds on which delusions germinate."¹²

THE ORIGINAL SOURCES

On June 28, 1880, in a meeting of the *Société Médico-Psychologique*, Cotard read a report on *Du délire hypochondriaque dans une forme grave de la mélancolie anxieuse*¹⁶ detailing the case of a 43-year-old woman who believed that she had "no brain, nerves, chest, or entrails, and was just skin and bone," that "neither God or the devil existed," and that she did not need food, for "she was eternal and would live forever." She had asked to be burned alive and had made various suicidal attempts.

Cotard was aware of the fact that similar cases had been described before, and quoted Esquirol,¹⁷ Macario,¹⁸ Leuret,¹⁹ Morel,²⁰ Krafft-Ebing,²¹ and Baillarger,²² the last of whom had 20 years earlier reported similar cases in the context of general paralysis. Cotard diagnosed his patient as suffering from *lypémanie* (an Esquirolean category only partially related to “psychotic depression episode”).²³ Cotard explained that *délire hypochondriaque* resulted from “an interpretation of pathological *sensations* often present in patients with anxious melancholia.” He suggested that a similar form of *délire* might have given rise to the myth of the “wandering Jew”²⁴ and to cases of so-called *démonomanie*. He believed he had found a new type of *lypémanie* characterized by anxious melancholia, ideas of damnation or possession, suicidal behavior, insensitivity to pain, delusions of nonexistence involving the whole person or parts thereof, and delusions of immortality. These were the original features of the complete Cotard’s psychotic state (*délire de Cotard*).

Two years later, Cotard returned to the topic and introduced the term *délire des négations* (translated since then as nihilistic delusions): “I would like to venture the term *délire des négations* to refer to those cases . . . in which patients show a marked tendency to denying everything.”²⁵ Carried to its extreme, this negating attitude led the patient to denying the existence of self or world, and such delusions may be the only symptom left during the chronic state of melancholia. To make sense of this new symptom cluster in the context of French nosology, Cotard compared it with the *délire de persecution* (persecutory syndrome), which since the time of Lasègue had been central to French psychiatry.²⁶ In clinical practice, *délire des négations* may be found alone, as a manifestation of general paralysis, or associated with anxious melancholia.

In 1884, Cotard reported a case of melancholia with nihilistic delusions who complained of an inability to “visualize the features of his children.” Recalling a case of Charcot’s who had also “lost the capacity to visualize absent objects,” Cotard went on to suggest that nihilistic delusions might be secondary to a “loss of mental vision,” an incapacity to evoke mental representations of objects not present to the

senses.²⁷ A few days before his death, he modified this view by suggesting that the primary disorder was a reduction in “psychomotor energy” (*la diminution de l’énergie psycho-motrice*) leading both to psychomotor retardation and loss of images (the latter causing the *délire des négations*.)¹²

A digression is now required concerning the major difficulty posed by the translation of *délire*, which is usually rendered as delirium or delusion. These terms only manage to convey fragments of its French meaning. *Délire* is not a state of delirium or organic confusion (in French, *délire aigu*²⁸ and *confusion mentale*²⁹) or a delusion (in French, *idée or thème délirante*³⁰)—it is more like a syndrome that may include symptoms from the intellectual, emotional, or volitional spheres.³¹ Hence, translating *délire des négations* as nihilistic delusion gives the wrong impression (caused by the intellectualistic semantics attached to the term delusion in English) that it exclusively refers to a thought. As clearly described in his 1882 report, Cotard never meant it to be a thought, but instead a symptom cluster. So, to talk about the delusion of being dead as Cotard’s delusion^{6,32} makes little sense, for *délire des négations* also entails the presence of anxiety, severe depression, and other attending delusions.

THE NAMING OF THE SYNDROME

In 1893, Emil Régis coined the eponym Cotard’s syndrome,³³ and the term was made popular by Jules Séglas, who reported the case of a man with “intermittent anxious melancholia” with delusions of absence of organs and of negation, damnation, and immortality. In opposition to Cotard, Séglas proposed that nihilistic delusional states did not constitute a distinct clinical entity, but only a severe form of anxious melancholia (*une forme particulière de mélancolie anxieuse . . . une sorte d’aggravation de la maladie*) (pp. 66-67).³⁴ Three years later, Séglas hypothesized that the condition was analogous to “secondary paranoia,” i.e., a terminal state of “that clinical condition that foreign authors have called *Secundare Verrücktheit* (p. 419).³⁵ In later reports, Séglas went on to classify nihilistic ideas according to whether their content involved the body, people and objects of the external world, or intellectual faculties and

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