Dead men walking

Reflections on Cotard's syndrome and homelessness

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> The homeless live in virtually every city and town around the globe, representing a sixth of humanity—or about a billion souls. Like ghosts they haunt the busy thoroughfares of the world. And like the lepers of old . . . the homeless are outcasts, almost nonpeople.
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> —Wayne Teasdale[1p113]

Over the course of the past two decades, multiple well-designed studies have documented the human tragedy of individuals with psychiatric disorders who wander city streets and precariously nest in the public niches of the urban landscape. Recent reports conservatively estimate that over one million people are homeless at any given time in the United States.[2] Of this figure, approximately one-third to one-half suffer the effects of a serious and persistent mental disorder and/or substance abuse.[3] Indeed, severe and debilitating mental illness can be both cause and consequence of an existence defined by extreme material poverty, emotional deprivation, and unremitting social isolation.

In 1880, Jules Cotard, a renowned Parisian neurologist, first described an unusual delusional syndrome as *delire des negations* in a lecture to the Société Médico-Psychologique.[4] In this rare psychotic disorder with multiple etiologies (severe depression, schizophrenia, multiple sclerosis, and trauma, for example), a constellation of symptoms are spun into a core delusion of nihilism, in which the person denies his own existence or holds to the belief that he or she is dead. In one of Cotard's final lectures prior to his death in 1889, he reiterated his belief that the "Cotard delusion" developed from an extreme form of depressive hypochondriasis and melancholia.[4] Although this syndrome is not frequently encountered in contemporary psychiatric practice, during my years of working with the homeless I have treated at least two individuals who have held firmly to the belief that they have died and are no longer part of the physical world.

Michael was a young man in his late 20s who was brought to our shelter-based homeless psychiatric clinic by his case manager. He had made his way to the shelter after being discharged from jail on a trespassing charge, a not uncommon occurrence for those who live on the streets and seek makeshift shelter in abandoned buildings or within the outside nooks of commercial businesses. He was disheveled, covered in feces, and smelled of urine. According to his case manager, he refused to leave his shelter bed and was eating and drinking only what was brought to him by the staff or other homeless clients. When asked how he was doing, his reply was direct and chilling, "I'm dead." Gently coaxing additional information, he related in a flat and monotonal voice, "There's nothing left inside me. My insides are gone. My brain is dead. I'm dead." When questioned about how he could be walking and talking in the world if he was dead, he responded, "There's nothing there. There is no world."

The rest of the day was spent trying to arrange an admission to a psychiatric hospital capable of providing a full medical work-up, ongoing psychiatric care, and even electroconvulsive therapy if needed to treat Michael's devastating delusional disorder. Not surprisingly, no takers could be found. Being homeless, Michael lacked funds and insurance. He had no means to negotiate his own way through a payer-driven health care system. Antidepressant and antipsychotic medications were initiated on an outpatient basis and, over the course of the following week, the local academic hospital eventually agreed to accept Michael on a "compassionate" basis. Within a few weeks, after fairly intensive and successful treatment, Michael was discharged and is now living in the community in stable housing. The last time he was seen in the aftercare clinic, he acknowledged recalling very little from that

Photo by Frank Windgassen

harrowing time of psychological death.

This past month, I was asked to see a homeless man recently found in nearby woods. Jerome was an elderly man who looked much younger than his chronological age, even though he had spent several months in a camp pitched under a stand of spindly pine trees. He was tearful and racked by roller coaster-like emotions at the beginning of the psychiatric evaluation. When asked what was causing him so much pain, he choked out, "I'm dead . . . I need to be in a casket." He stated that he knew he was from "the other world" because "this world" no longer existed. He reported having been "dead" for some time, but had not yet been put into a casket, which would allow him to cross over to "the other world," a place beyond the here-and-now where he knew he truly belonged.

Gathering additional information from the case managers, it appeared Jerome had been treated in the past for psychiatric disorders, but had lived a fairly quiet, stable life with his mother in the community. Tragically, his mother had recently died and Jerome, losing what was most likely his existential anchor in life, slowly drifted into homelessness, depression, and delusional thinking. His disconnect from the human community led to a solitary life in the woods, and the ever-growing belief that he, like his mother before him, had passed from this physical world. Jerome entered into treatment with a combination of shelter, medication, and supportive, grief-oriented therapy. Progress has been slow, but steady. He now can acknowledge that he is not truly "dead," but mournfully admits that a part of him did, indeed, "die" with his mother.

Although both these men met the clinical criteria for severe depressive disorders with psychotic features, one cannot help but believe that the nature of their shared core delusion (nihilism) was profoundly shaped by their experiences of being homeless. For both of them, their state of homelessness ruptured their fragile connections to the world and led to the eventual disintegration of their identities and the spiral into existential nothingness.

Clearly, Jules Cotard was not writing about homeless individuals when he described his *delire des negations*, but if ever there was a type of delusional disorder which would, paradoxically, make the most sense for a homeless person to cultivate, it would be Cotard's Syndrome. Consider: Is it such a momentous leap into psychotic depression for a homeless person in our society, whose everyday life is overlooked, ignored, and forgotten by others, to cultivate an unshakable belief that he or she is "dead"? Moreover, viewed from the tragic perspective of one who spends countless hours in social isolation and wrenching solitude, Cotard's syndrome can be understood as a psychotic defense against accepting the reality of an outside world that consistently denies the reality of the homeless person's existence. What better way to deal with this overwhelmingly painful reality than to posit a belief system that, in essence, denies the existence of a rejecting world?

In the book, *Homelessness in America*, Kim Hopper and Jim Baumohl speak clearly to the existential reality that lies behind the very concept of the term "homeless":

> Americans have used the word "homeless" in something like its modern sense for roughly 150 years. Most often, its meaning is literal and prosaic: the absence of a domicile. Thus, we employ it to describe those sleeping outdoors in any of a variety of makeshifts, or residing in temporary accommodations like the police-station lodgings of earlier generations or the emergency shelters of the present day. But we also invoke the word to indicate something poignant and diffuse: the absence of belonging, both to a place and with the people settled there. In this sense, we sometimes call homeless those who are just passing through, or who, like exiles . . . are never quite at home where they live.[5p3]

One can only surmise that the development of Cotard's syndrome in these two homeless men took root in their interior states of grinding desolation and depthless loneliness. "Death" and nothingness became both a defense and an escape for each of them. Michael and Jerome truly were the "walking dead," nonpersons who were without identity, voice, or connectedness. Only after being carried into a community of other-directed concern and compassion, within a context of humane medical care, did they begin the slow process of rehumanization.

Physicians are incredibly privileged to be in a position to heal, to relieve suffering and even to delay death. But how fortunate can one be to also witness a "resurrection" of the "dead"?

References

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