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Original Article - Case Report

Treating Cotard's Syndrome Following Bereavement Without ECT: A Case Study

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ABSTRACT

Cotard's syndrome is an uncommon neuropsychiatric disorder marked by nihilistic delusions that include the denial of one's existence or body parts. It is most often linked to severe major depressive disorder with psychotic symptoms, and it constitutes a significant risk because of self-neglect, refusal of food, and suicide. Early diagnosis is essential, since the illness is often misdiagnosed and underreported. We report the case of a 52-year-old man with a history of recurrent depression, who presented with severe depressive symptoms, nihilistic delusions, refusal of food and fluids, psychomotor retardation, and mutism after the death of his spouse. Mental status examination revealed depressed mood and blunted affect, without hallucinations. He was diagnosed with major depressive disorder, severe with psychotic features, presenting as Cotard's syndrome. The patient were treated with escitalopram, low-dose lorazepam, and intensive supportive inpatient care. Gradual but complete resolution of nihilistic delusions and functional improvement occurred without the use of antipsychotics or electroconvulsive therapy. This case highlights bereavement as an important precipitating factor for Cotard's syndrome and demonstrates that early, targeted antidepressant therapy combined with supportive inpatient care may lead to full remission of nihilistic delusions without electroconvulsive therapy in selected patients.

Keywords
cotard's syndrome, psychotic depression, nihilistic delusions, bereavement, electroconvulsive therapy, mutism

Abbreviations
Beck Depression Inventory (BDI-II); Cotard Syndrome Rating Scale (CSRS); Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5); Electroconvulsive therapy (ECT); International Classification of Diseases, 10th Revision (ICD-10); Mental Status Examination (MSE); Positive and Negative Syndrome Scale (PANSS); Selective serotonin reuptake inhibitors (SSRIs).

INTRODUCTION

Cotard's syndrome is a rare neuropsychiatric condition characterized primarily by nihilistic delusions, in which patients believe they or parts of their body don't exist, are dead, or have lost vital organs[1]. Such delusions often occur with severe mood disorders, particularly major depressive disorder with

Table 1. Chronological order of disease progression

Time point	Clinical events	BDI-II Score	Key clinical observations
6 months prior	Death of spouse	N/A	Acute grief reaction
Following weeks	Depressive symptoms, withdrawal	N/A	Social isolation, anhedonia
3 months prior	Mutism, refusal of food and fluids	N/A	Weight loss, dehydration
Admission	Severe depression with nihilistic delusions	41	Complete mutism, refusal to eat or drink, passive suicidal ideation
Day 1-7	Escitalopram + lorazepam + supportive care	38	Minimal improvement, still refusing oral intake, requires encouragement
Day 8-14	Continued treatment with intensive treatment	29	Gradual resumption of oral intake, partial improvement in psychomotor retardation
Discharge	Resolution of delusions, improved function	21	No longer expresses nihilistic delusions, able to perform basic self-care and insight improving

psychotic features[1]. They may also be seen in other psychiatric or neurological conditions[2]. Patients often present with severe psychomotor retardation, social withdrawal, refusal to eat, self-neglect, and high suicide risk. This stems from beliefs that their body doesn't exist or lacks meaning[3]. This case report presents a male with severe major depressive disorder and classic Cotard's delusion following a bereavement. The case highlights the clinical features, diagnostic challenges, and therapeutic response contributing to the growing understanding of this rare but important psychiatric condition.

Even though Cotard's syndrome has been mentioned in various psychiatric and neurological disorders, bereavement as a trigger is comparatively underreported in the literature[4,5]. Here, the fact that losing the spouse is a psychological stress which can trigger severe depressive episodes with psychotic features, including nihilistic delusions[6,7]. A literature review suggests that there are only a few cases where bereavement was clearly identified as the triggering event of the syndrome, the underlying cause for most of the cases is due to primary mood disorders, schizophrenia or other brain conditions[8,9,10]. Such a gap in the literature indicates the need for detailed case reports exploring the bereavement-depression-psychosis association, especially when conservative treatment approaches lead to favourable outcomes.

CASE PRESENTATION

A 52-year-old male with a 12-year history of recurrent major depressive disorder treated intermittently with selective serotonin reuptake inhibitors (SSRIs) and psychotherapy, with partial response, presented to the clinic with severe depressive symptoms and profound nihilistic delusions over 6 months, following the bereavement of his spouse. There was no history of psychosis, substance use, neurological illness, or cognitive decline.

There was no family history of psychotic disorders. Premorbid personality and functioning were reported as stable.

Clinical Findings

Mental Status Examination at admission showed that the patient was pale, thin, and had severe psychomotor retardation. He was alert and well oriented to person, place, and time. Mood was depressed, and affect was blunted. The patient also had an expression of hopelessness. Speech was slow, low volume, and monosyllabic. Thought content mainly included nihilistic delusions ("I am dead", "my brain is rotting", "my heart does not beat"). There was no report of hallucinations. There was

severe impairment of insight and judgement. It was also noted that he had passive suicidal ideation, but no active plan. The timeline of the clinical course is mentioned in **Table 1**.

Diagnostic Assessment

The patient met DSM-5 criteria for major depressive disorder, severe with psychotic features, with nihilistic delusions consistent with Cotard's syndrome. Diagnosis was based on longitudinal mental status examination and semi-structured clinical interviews. The Beck Depression Inventory (BDI-II) assessment was done on the patient and resulted in the severe range (scoring > 30). No laboratory or neuroimaging abnormalities were identified, and there was no evidence of delirium or dementia.

Therapeutic Intervention

During the 14-day stay, the patient was managed pharmacologically with Escitalopram (20mg/day) as the primary drug due to its minimal side-effect profile, proven efficacy and the patient's previous partial response to SSRIs. The patient was also given Lorazepam at a low dose (1mg/day) because of its rapid action, easy dose titration and its efficacy in the management of anxiety, which is often associated with psychotic depression alongside supportive care (nutritional support and hydration), which significantly improved the patient's condition and led to the resolution of nihilistic delusions. There was partial resolution of psychomotor retardation; he resumed oral intake and was able to perform basic self-care.

Follow-Up and Outcomes

The patient was advised to follow up as an outpatient: Weekly for the first month, biweekly for the second month, and monthly thereafter. The follow-up plan included Escitalopram (20mg/day), supportive psychotherapy focusing on coping strategies and grief and psychoeducation for the patient and family

After the 1st month of appointments, the patient reported that he "no longer felt dead" and stated a gradual return of emotional awareness and motivation. His BDI-II score decreased to 16 (mild range). After 3-months, he was back to most daily activities, re-engaging socially with family, and reported improvements in both sleep and appetite. At the 6th month, he was fully back to his daily and social activities. He stated that grief had played a major role in his illness and was willing to continue his treatment.

The patient was also monitored for relapse and suicidal ideation during the follow-up period. The prognosis is reported to be good with appropriate treatment. The follow-up course is summarized in **Table 2**.

Table 2. Post-discharge follow-up course

Time point	BDI-II Score	Clinical status	Interventions
1-month post-discharge	16	No nihilistic delusions, improved mood, good medication adherence	Weekly follow-up, continued escitalopram 20 mg/day
3-month post-discharge	12	Returned mostly to daily activities and social re-engagement, better sleep and appetite	Biweekly follow-up, grief-focused psychotherapy
6-month post-discharge	8	Returned back fully to his daily and social activities.	Monthly follow-up, continued maintenance therapy

DISCUSSION

Cotard's syndrome was first described by Jules Cotard in 1880 as the "delusion of negations." It is a rare and unique disorder in which individuals imagine themselves as dead, non-existent, or without any vital bodily parts[4, 5]. It is also known as the "dead man walking" disease because it is a physical contradiction of Descartes' cogito ergo sum[4, 6]. The most common symptom is the denial of one's own existence. However, the clinical picture has been far more complex in the past, including sadness, assertions of immortality, and emotions of damnation[4, 6]. Though often linked to severe depression, it can also occur in the setting of schizophrenia or organic neurological disorders, including stroke, encephalitis, and brain tumors[6, 7]. This case focuses on the role of grief, which plays an important role in the development of Cotard's syndrome.

Cotard syndrome caused by bereavement has been reported in a limited number of case reports[6,8]. The

psychological trauma of loss of a spouse can trigger severe depressive episodes with psychotic features, including nihilistic delusions[7]. This case report is an addition to the small but growing body of evidence and shows the importance of recognizing grief as a major stressor in the pathological development of Cotard's syndrome. This is particularly important in clinical settings where patients may present with atypical depressive symptoms following major life events.

Cotard's syndrome is difficult to diagnose since it is not currently recognized as a distinct illness in either the ICD-10 or DSM-5[4,11]. Psychiatrists must use interviews to identify basic nihilistic illusions about the body, soul, or the universe[7, 9]. Timely and proper inpatient care and management are crucial because these delusions can lead to life-threatening refusal of nutrition and hydration, as exhibited by the patient[4, 6, 9]. People frequently divide the condition into three groups: Type I (pure nihilistic delusions), Type II (a mixed group with anxiety and hallucinations), and Type III (psychotic depression)[4, 6, 9]. This patient exhibited symptoms of nihilistic delusions, without hallucinations and thus aligns with the "pure" presentation of the syndrome, which is rarely seen in modern clinical practice. Hence, the patient was diagnosed with Major Depressive Disorder with severe psychotic features manifesting as Cotard's Syndrome, according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria[11].

The Mental Status Examination (MSE) was performed through longitudinal, clinical observation and semi-structured interviews[12]. His clinical state was consistent with the 'Severe' range (scoring > 30) of the BDI-II[13]. This clinical assessment served as the basis for monitoring recovery during the inpatient stay. However, the absence of a specific instrument to measure nihilistic delusions during the inpatient stay serves as a limitation of this study. For the future cases, we recommend the use of the Cotard Syndrome Rating Scale (CSRS) or the Nihilistic Delusions subscale of the Positive and Negative Syndrome Scale (PANSS) for more objective and systemic monitoring of symptom evolution[14].

Treatment and care must be adjusted to the underlying cause, whether it is a primary personality disorder or due to any brain lesion[4, 6, 15]. Electroconvulsive therapy (ECT) is widely accepted as the gold standard therapy, especially in patients with treatment resistance, catatonia, or life-threatening feeding refusal[6, 9]. ECT is the preferred therapy because many case reports show rapid and significant remission of nihilistic delusions. However, dependence on ECT may partially indicate reporting bias towards severe or refractory patients, with the lack of controlled studies to inform stepped-care approaches[4, 6, 15]. We understand that one case report alone fails to challenge the current therapeutic standard, and the results we report should be viewed as a recommendation for a possible alternative treatment option for selected patients instead of questioning the proven efficacy of ECT.

Pharmacological strategies sometimes include combinations of antipsychotics (e.g., risperidone or olanzapine) and antidepressants (e.g., fluoxetine or amitriptyline)[4, 6, 15]. It was noted that the patient demonstrated gradual but meaningful improvement with SSRI therapy, low-dose benzodiazepine use, and intensive supportive care, without the use of antipsychotics or ECT. The remission of nihilistic delusions with escitalopram and supportive measures alone is noteworthy, since it contrasts with the often-reported need for ECT in similar cases. This finding indicates that, in some instances, early identification and swift implementation of antidepressant treatment may be enough. Similar outcomes have been reported, particularly in patients with psychotic symptoms that are mood-related and intricately associated with a depressive episode[1,3,6]. However, the potential role of ECT in cases of relapse or non-response remains significant and must be included in future care strategies.

The patient's prognosis is positive, since current research indicates that Cotard's syndrome is recoverable with prompt care. Several clinical features may have contributed to the favorable result in this case, including the absence of hallucinations, absence of a prior psychotic disorder, preserved state of orientation and cognition, and the clear emotional alignment of the nihilistic delusions. Structured monitoring using validated tools like the Beck Depression Inventory-II also made it possible to objectively evaluate the severity of symptoms and recovery, which supported for the decisions about inpatient treatment[12]. His quick recovery is consistent with accounts of full remission once the underlying depression is addressed[4]. These factors point out the need of personalized treatment planning instead of spontaneous escalation to ECT in every instance of Cotard's syndrome[4, 6, 15]. However, a persistent depressed state requires regular monitoring to avoid

relapse or self-starvation[6].

Even though the prognosis observed is favourable, Cotard's syndrome could still be life-threatening because of the risks of self-neglect, starvation, and suicide. Regular outpatient follow-up, relapse monitoring, and psychosocial support, especially grief-focused psychotherapy, are the critical components of long-term treatment[6]. Although ECT continues to be an essential therapeutic option for severe or refractory cases, this case contributes to an emerging collection of data advocating for a more refined, structured approach to treatment according to clinical subtype, severity, and early response.

CONCLUSION

This case adds to the limited literature on bereavement-induced Cotard's syndrome that points out the importance of considering this diagnosis in patients with severe depressive symptoms and unusual nihilistic delusions specially when the major stressor is bereavement. The patient's positive clinical response with SSRI monotherapy and supportive care alone without the use of antipsychotics or ECT. Suggesting that this type of management will be helpful in selected patients with type 1 (pure) Cotard's syndrome, especially when identified earlier, and if delusions are mood-congruent.

The main contributions of this case are: (1) reporting a positive response with conservative management alone in Type 1 Cotard's syndrome following bereavement, (2) highlighting the role of grief-focused interventions in the management of depression with psychotic features, and (3) providing a detailed timeline of recovery to inform clinicians about realistic expectations for treatment response.

Future research should include: (1) comparative studies of SSRI versus ECT responses in clinical subtypes of Cotard's syndrome, (2) use of dedicated rating scales for monitoring nihilistic delusions in clinical practice, and (3) future studies of the bereavement-depression-psychosis association to identify risk and protective factors. Such cases can increase clinical awareness and help in improving diagnostic accuracy and management methods for such rare psychiatric conditions.

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This study was prepared according to the CARE guidelines[16]. This study's final manuscript was approved and reviewed by all the authors and take full responsibility for its accuracy and integrity. All data used and viewed during this study are included in this published article. Ethics committee approval is not applicable to this single-patient case report according to the institutional regulations. Written informed consent was obtained from the patient for the publication of this study.

Autor contribution

MMC worked on the introduction and conclusion, AKPP compiled the case presentation and abstract, CGC worked on the case discussion and KTM aided in supervision and editing of the final draft. All authors have read and approved the final manuscript.

Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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