



OLGU SUNUMU / CASE REPORT

When the fear of cold becomes uncontrollable: two cases of frigophobia

Soğuk korkusu kontrol edilemediğinde: frigofobisi olan iki olgu

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Abstract

The aim of this study is to consider cultural and behavioural factors of frigophobia development by examining undeclared frigophobia cases in Turkey. This report discusses two cases of a specific phobia (frigophobia) determined during home visits. The study suggests that raising awareness at all levels of the healthcare services in this respect and approaching the field in a multi-disciplinary team work in identifying and treatment of cases would improve the lives of individuals suffering from such phobias.

Key words: Frigophobia, somatisation, culture-bound syndrome.

Öz

Somatizasyon değişik olgularla ilişkilendirilmekte, bu alanda yapılan çok sayıda kültürel çalışma somatik belirtilerin ruhsal hastalıkların dışavurumu olduğunu ve kültüre bağlı olarak şekillendiğini göstermektedir. Frigofobi, soğuk almaktan aşırı korkma olarak tanımlanmakta ve kültürle ilişkili özel bir sendrom olarak kabul edilmektedir. Bu makalede ev ziyareti sırasında belirlenen iki frigofobi olgusu sunulmuştur. Ancak, yaşam kalitesini önemli ölçüde düşüren ve sosyal izolasyona neden olan bu durum özgül fobi olarak tanı almamıştır.

Anahtar kelimeler: Frigofobi, somatizasyon, kültürel ilişkili sendrom.

INTRODUCTION

Fear is an emotional response to a perceived or real threat. People can feel anxious about certain activities in daily life¹. Phobia refers to an excessive and persistent fear of objects and situations that do not pose a real threat^{1,2}. Several psychological approaches have been developed and used to understand and explain such human emotions and behaviours. Biological approaches suggest that fears emerge out of a fundamental instinct intended to protect the organism from dangers, and that the formation of fear is associated with perception and memory³.

The behavioural approach advocates the view that phobias are behaviours learned through conditioned reflex. According to the psychoanalytical approach, on the other hand, phobias reflect oppressed instincts disguised in a new form. This condition is associated with intense feelings of anxiety that

interfere in one's daily activities and quality of life⁴⁻⁶.

Phobias, which are among the most frequently seen psychological disorders, have attracted considerable attention in recent years. While, according to the American Psychiatric Association, the incidence rate of specific phobias, defined as the experience of extreme and groundless fears of certain objects or situations, amounts to 12.5 per cent throughout life, studies have found that in Turkey its prevalence in general is 4.2 per cent and that of specific phobias within the entire spectrum was found to be 2.7 per cent. Women seem to be 2.5 times as vulnerable to phobias as men^{2,7}. Previous research has demonstrated that specific phobias originally emerge in early childhood and the individuals in question do not generally notice that a phobia is the course of development in them⁷. From a psychological point of view, upbringing is of great importance. The behavioural approach in particular suggests that learned behaviours and culture plays an important role in the upbringing and development of children

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and have a significant effect on the development of phobias^{8,9}. Recent anthropological research has revisited the concept of culture and brought new insights into cultural psychiatry. Previously, the notion of culture was examined only based on values and beliefs, but it also arises out of daily life activities, determining and forming the social relations based on common sense, interactions with other people, and the rhythmical ups and downs of social life and shared symbolic tools (language, aesthetic sensibility, value judgments etc.). Considering this new set of values in relation to diseases, we conclude that diseases are a cultural category, like languages. Biological parameters have as much effect on diseases as local social phenomena. Therefore, trans-cultural psychiatry is a field that examines the internal associations between the social world and diseases, based on the results of such an examination and the fact that the body is a rich source of symbols in almost every society⁹⁻¹¹.

Defined as pa-len or wei-han (a morbid fear of catching a cold) by Chinese psychiatrists, Frigophobia is accepted as a syndrome specific to Chinese culture. Five cases were reported by Chang and his colleagues for the first time in 1975¹¹. Recently, a series of case reports from Sri Lanka has joined the literature on frigophobia patients¹².

According to traditional Chinese philosophy, the imbalance between Yin and Yang is the mainspring of illness. It is believed that the consumption of cold food and cold air leads to an imbalance of Yin and weakness and illness occur¹¹⁻¹³. Fear of catching cold may usually develop as a reaction to a crisis or an important loss that can result in situations which can make them feel insecure. Frigophobia patients may fear that the cold will lead to weakness, physical illnesses, sexual weakness and even death. Overprotected and dependent personality traits are seen in these patients at early stages of life^{9-11,13}.

Perera and his colleagues determined that patients' sensitivity relates to the extremities at first, and then the fear is generalised. In addition, patients ask for medical help only when the symptoms get more serious or the fear of death increases. Furthermore, training about the illness, removing doubts and the use of anxiolytics and supportive psychotherapy are effective in the management of the illness¹².

The purpose of this study is to argue for cultural and behavioural factors in frigophobia development by going through undiagnosed frigophobia cases in

Turkey. At the same time, it aims to direct the attention of readers to the diagnosis and treatment of this specific phobia, which affects the quality of life.

CASES

Case 1

Mr T is 89 years old and, with only a primary school education and is a retired truck driver. He is 1.65cm tall and he weighs 62 kg. He is married, and he has four children. Mr T. stated that he started smoking when he was 15 and quit at the age of 30. He lost his mother when he was 35, and his father when he was 46. As the fourth of six siblings (female, male, male, Mr T, male, male), Mr T was circumcised at the age of five and had pneumonia at the age of eight. He got married when he was 28 and had pneumonia a month after he got married. He had hepatic cyst surgery many years earlier and cataract surgery in 2005. He is currently using eye drops (1 mg/ml nepafenac) given after the cataract surgery and, for a couple of months, he has regularly been taking multivitamins prescribed by the family physician mentioning weakness.

He is not diagnosed with any chronic illness. He is currently suffering from dizziness, backache, and pain in both knees, seems to be extrovert and to enjoy about talking. His wife says, he was in the habit of overdressing when they got married. After had pneumonia he started to sleep in separate beds by saying "I get sick". His overdressing behaviour escalated after retirement. He was jealous of her and he had used physical violence towards her until a few years ago. He is said to have a bath right before bedtime once every 15 days in winter time, and once a week in summer time. Either his wife or his grandchild bathes him. Moreover, the bathroom is heated with an electric heater in summer and winter and he uses hot water while performing his ablutions.

During the interviews done in April, Mr T. was sitting in the sun-soaked couch of the room having a towel placed on his back, a belt around his waist in addition to nine layers of clothes on his upper body when the outer temperature was 18 °C and room temperature was 25 °C. He was wearing five layers of trousers and a pair of prayer socks over two layers of normal socks. He had three layers of hats on his head and a coat and blanket on him. He

wears four layers of clothes on the upper and four layers on the bottom part of his body and four layers of caps. In winter time, he has a woollen quilt and a blanket on, and only a quilt in summer time.

Mr T. reported that he consumes fruit and water at room temperature, after getting them heated on the heater. He has not been out for two years. When asked if he had any fears, he replied as "I am only afraid of catching a cold". He can meet his needs to use the bathroom and feed himself. He can perform his ablutions and prayer.

In a physical examination, he was reported to have moist and warm skin, his blood pressure was 120/50 mmHg, his pulse 66/min, and respiration 30/min. He got 6 points from Geriatric Depression Scale (6 and above is accepted as depression), 27 points from Standardised Mini Mental Test (SMMT), (24-30 points are accepted as normal). No abnormal value was detected in Mr T.'s biochemical, hormone and hematology tests (routine biochemical blood count, TSH, FT3, FT4, Ferritin, VitB12, sedimentation) apart from total cholesterol (213 mg/dL), and RBC (4570).

Case 2

Ms R., 77 years old, with only a primary school education. She is 1.68cm tall and weighs 76 kg. She is a widow with two sons. Her parents are closely related to each other and because of her father's alcohol addiction they got divorced. Then she was raised by her grandmother from the age of three. Mrs R. lost her elder brother a year ago and her husband six years ago. She claimed that her mother had mental problems that she did not know about and stayed in a psychiatric hospital. She reported that she had a very difficult childhood. She also stated that her step-grandfather encouraged her to cover her head and did not let her go to school after primary school. Ms R. stated that she occasionally had a sore throat when she was a child, as well as mumps and measles, and that her grandmother used to overdress. Mrs R. got married at the age of 19, gave birth to her first child at the age of 21 and to the second at 26. Her older son is a widower and has been living with her for seven years and he is addicted to alcohol.

In her early 30s, when she went to the dentist, she was unable to open her mouth adequately; then through examination and imaging, she was diagnosed with Eagle Syndrome (elongated hyoid

bone). It was suggested that she should have surgery, but she refused as she was afraid, and she avoided cold weather in order not to become ill. Her son reports that she had problems after the birth of his brother (anxiety about not being able to take care of two children). Thus, Mr S. was sent to his grandfather to be looked after. Mrs R. was diagnosed with atypical psychosis and has been using olanzapine 20 mg (1x1) for seven years, as was learned from her medical records. Her son reports that she was taken to the psychiatrist after constantly groaning and having disturbed sleep. Mrs R. has been taking her medicine regularly, but she has not had check-up since she started taking it. She has felt better since she started taking medicine. She has dentures but does not wear them as they give her tightness in the chest.

In the physical examination, she was reported to have moist and warm skin; her blood pressure was 150/90 mmHg, and her pulse 80/min (while her blood pressure was being measured, she was nervous and anxiously asked what the score was). She reported that she currently had no complaints apart from fatigue. She got 8 points from Geriatric Depression Scale and 28 points from SMMT. She is physically independent, and she can meet her daily needs. She can cook and wash the dishes. However, the hygienic condition of the house seemed poor. She stated that she spends most of her day in bed and stays there until her son gets up. She has two meals a day.

On the day of interview, the outside temperature was 38 0C. It was observed that Mrs R. tightly wrapped her scarf around her neck and covered her head with another scarf. She was wearing a dress which leaves the neck and arms partially open and another undercoat and pajamas beneath. She was also wearing two pairs of thick socks and a pair of slippers. She said that she has been wrapping her neck for years because her hyoid bone is long, and she believes that if she feels cold, she will get ill and even get throat cancer. She has been wearing thick socks since she was young to avoid irregular vaginal bleeding and illnesses. She has stated that she wears a woollen cap day and night and when it is cold, she never goes out in order not to get cold. She said, "If I go out in cold weather, I fall to the ground, tip over and faint". Mrs R. reported that she never has cold drinks or food and she has her water heated in a special metal cup. She has a bath once in every 15 days in summer and once a month in winter, and

spends the whole winter in the kitchen.

She does not go out for fear of getting cold, has said, "I do not always go out in hot weather for fear that I may have a stroke" when she was invited to go out to the garden. The only nearby relatives are his brother's wife and her children who live next door.

DISCUSSION

The most common amongst the anxiety disorders, specific phobia, is defined as an excessive fear and anxiety of a certain situation or object¹. Specific phobias can develop against to certain animal, high places, darkness, lightening, elevators, closed spaces, blood, injections and specific objects. Encountering this object or situation leads to symptoms of panic in the patient. Therefore, the person avoids the feared object or situation and feels anxious about the possibility of encountering it^{14,15}

Although specific phobias are manageable, they may get in the way of daily life¹⁶. According to the American Psychiatric Association, there are five characteristics of specific phobia. These are: constant and excessive fear of any subject or situation and their reminders, anxiety triggered by phobic warning, excessive and illogical fear, avoiding phobic warnings and the things related to them, impaired functionality of victim^{1,2,17}. The people presented above have an excessive and unreal fear of catching cold even in hot weather, and they keep away from cold weather, water and foods. They use the warmest place in the house for all daily activities, eating, sleeping, bathing in the same room. In fact, they cannot go out, which continues for a long time. The female case said that she had panic, tachycardia, and syncope when going out in cold weather. According to cognitive vulnerability theory developed for explaining the aetiology of specific phobias, stimulants such as fear or disgust triggers are perceived as uncontrollable and unpredictable depending on personality traits and learning experience. When fast, automatic effective reactions (tachycardia, sweating etc.) are developed by triggering of a stimulus, they create a slower cognitive response, which represents the fear and repulsion caused by the stimulus and associates it with different situations. The patient cognitively perceives the possibility of encountering this unpleasant stimulus as a threat and tries to avoid all situations and objects relevant to stimulus¹⁷.

In the cases discussed above, patient stories show that phobic reactions about cold or catching a chill started in their childhood. The female case developed a fear based on her vulnerable personality caused by her traumatic family story and is associated with the health problems of childhood (pneumonia in the male case, sore throat in the female case) for both cases.

The anxiety seen in the elderly is related to the presence or perception of age related problems such as weakness, physical health loss, care insecurity, forthcoming death. Also, it is known that specific phobias fluctuate over lifetime. In both cases, avoiding behaviour and anxiety related to cold have been reported to get worse over the years. It was thought that this could also be related to physical, psychological and social changes brought on by the ageing process.

The prevalence of specific phobias in the elderly has been reported to vary between 1-25 per cent¹⁸. Kırmızıoğlu et al. found the prevalence of specific phobia among people 65 years and older to be 11%⁷. Structural clinical interviews are useful for diagnosis of specific phobias in elderly individuals. There are also diagnostic tools available for screening, such as the Fear Survey Schedule-II for Old Adult (FSS-II OA), which includes age-specific fears developed by Kogan and Edelstein². Specific phobias in elderly outpatients can be diagnosed using this screening tool. Even though specific phobias lead to significant problems affecting the life quality of people suffering from them it is an area that has attracted the attention of few researchers in Turkey. Individuals had been presented in this article have not been diagnosed with phobia despite they have experiencing a disturbing situation for a long-time cause of phobia. Only the female case received psychiatric counselling when she was taken by her children, but she never went back. The reason for not being diagnosed can be the frigophobia itself. Because of frigophobia, the person hesitates to leave the house and does not apply for health service. Another reason why these people are not diagnosed can be cultural or depending on your learning experience¹⁰⁻¹³. The behaviours of avoidance from cold are widespread among people in Turkey; in fact, such behaviours are encouraged from childhood. The behaviour pattern of avoiding cold weather is frequently reflected in many recommendations from people such as "one should not drink cold water

when sweaty”, “one should keep the feet warm” or “do not stand in places with a draught”. From this point of view, we can say that frigophobia is a condition that can appear normal within the cultural context of this society, as a manifestation of intrapsychic conflicts, a disadvantageous condition whose diagnostic characteristics may end up being disregarded. The fact that frigophobia is linked to a physical illness, as in our cases, and that this phobia is not recognised by family members as a health issue can also be a reason for not going to a doctor. In this respect, frigophobia is different from other specific phobias and is culturally acceptable and can be nourished by society. Therefore, it is more likely to be remain untreated. In this case, the importance of regular follow up of elderly people in their own home by primary health care workers is clear. Indeed, these cases were detected during home visits by public health nurses.

Specific phobias are among the most treatable disorders but only a small proportion of patients with specific phobia seek therapy. The first choice in the treatment of specific phobia is behavioural therapy. One aspect of behavioural therapy is exposure treatment which has different modalities and the other is cognitive therapy 19,20. Cognitive therapy and exposure therapy can also be used in combination 18-20. Antidepressants, tranquilisers and beta blockers are also used in combination with cognitive-behavioural therapy. It is known that drug therapy alone is not sufficient, and the treatment of phobia must be supported by behavioural treatment procedures 19-22.

This study is the first in Turkey to define the fear of catching cold as a specific phobia, and little research is available investigating frigophobia at the international level. The two cases addressed in the present study have important implications for further studies and discussions based on scientific data regarding frigophobia. The study suggests that raising awareness at all levels of the healthcare sector and approaching the field with a multi-disciplinary team work in identifying cases and their treatment would improve the lives of individuals suffering from phobia.

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