Case Report

Thalassophobia in a case of schizophrenia: a case report

Leena Dhakne[1], Sagar Karia[2], Avinash De Sousa[3]

[1]Resident Doctor,
[2]Assistant Professor,
[3]Research Associate and Consultant Psychiatrist,
[1,2,3]Department of Psychiatry, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai.
Corresponding author: Sagar Karia
Email – kariabhai117@gmail.com

ABSTRACT

Thalassophobia is the intense fear of deep bodies of water, such as the ocean, sea, or large lakes. It often involves anxiety about what might be lurking beneath the surface, the vastness of the water, or the inability to see the bottom. Some common triggers include deep-sea images, dark water, or even just thinking about deep water. Here we present the case of 45 years old male with schizophrenia that developed thalassophobia during his illness.
Key words: schizophrenia, thalassophobia.

(Received – 20th October 2023, Peer Review completed – 10th November 2023, Accepted – 20th November 2023)

INTRODUCTION

Thalassophobia is the intense fear of deep bodies of water, such as the ocean, sea, or large lakes. It often involves anxiety about what might be lurking beneath the surface, the vastness of the water, or the inability to see the bottom [1]. Some common triggers include deep-sea images, dark water, or even just thinking about deep water [1]. Thalassophobia can vary in severity from mild discomfort to extreme panic. There have been cases reported where the individual may have extreme panic while swimming or images of the deep sea and creatures may cause fear. Even playing video games that involve underwater imagery may cause the anxiety [2]. Here we present the case of a 45 years old male that developed thalassophobia in relation to major depression.

CASE REPORT

A 45 years old right handed Hindu Marathi speaking male studied up to 10th standard (failed) and working in a courier service, married but separated from his wife, residing at Antop Hill came with sister and nephew to the psychiatric outpatient clinic with sadness of mood, lack of interest in doing things previously pleasurable to him, muttering and gesticulating to self, irrelevant talk, easy irritability with anger outbursts, feeling scared of going to washroom as he would feel waves of sea coming on to him, sleep disturbances, erectile dysfunction, suspiciousness that people are going to hit him and forgetfulness all since 2 months prior to presentation.

The patient was apparently alright 4-5 years prior to presentation, when his family members noticed a change in his behaviour in the form of muttering and gesticulating to self, irrelevant talk and paranoia. When family members asked with whom he was talking he would get irritable and would have anger outbursts towards them. He also had pervasive sadness of mood, loss of interest in doing work or previously pleasurable activities and sleep disturbances like having difficulty in falling asleep, early morning awakenings and suspiciousness that people talking ill about him and going to hit him. For all these complaints, the patient was brought to Sion Hospital by his sister and nephew in our outpatient department and was diagnosed as

Major Depressive Disorder with Erectile Dysfunction and was started on medication. He was started on Tab. Amitryptiline 25 mg at night and Tab Escitalopram 5 mg twice a day and the relatives were advised to watch for the psychotic symptoms and to follow up regularly.

The patient was on regular compliance and had subsequent follow ups but developed psychotic features like seeing his dead father and hearing of voices inaudible to others, gesticulating with a tightened fist trying to hit someone and continuous thoughts would give him uncontrollable urges to abuse his dead father. He was then started on Tab. Haloperidol 5 mg twice a day, Tab. Trihexyphenydyl 2 mg twice a day along with Amitryptiline 25mg at night and Mirtazapine 15mg at night. He was also started on Tab Tadalafil 10mg for his erection problems. The patient was also having obsessive-compulsive features like rearranging things repeatedly and prolonged handwashing and repeated rinsing of his mouth. Hence, he was started on Tab. Clomipramine 25 mg at night which was gradually titrated to 75 mg at night along with Haloperidol, Trihexyphenydyl, Mirtazapine and Tadalafil. The patient developed tremors due to the Haloperidol and presented with an extrapyramidal reaction and hence the same was stopped.

Later, the patient started having complaints like getting scared of going to the washroom as he had thoughts that waves of the sea were coming towards him and he would drown in that/ Hence he had fearfulness about going to the washroom and towards using tap water. Due to this fearfulness, he started consuming alcohol in the form of around 90 ml of country liquor intermittently. He also had sexual thoughts and the urge for anal sexual intercourse with any female. He was then started on Tab Trifluoperazine 5mg twice a day and Tab Trihexyphenydyl 2mg twice a day with Tab Quetiapine 100mg at night, Tab Topiramate 25mg twice a day and Tab Amisulpride 100mg at night. This was supplemented by Tab. Escitalopram 10mg at night. He was well maintained on the above medications with regular follow-up. But on follow-up, the patient had complained of fearfulness in going to the bathroom as he was afraid that the sea waves would drown him.

There was no history of any over-familarity, overspending, restlessness or panic episodes in the past.

There was no history of substance use, major medical or surgical illness in the past. The patient had no suicidal ideations, or suicide attempts in the past. There was no history of head injury, fever or seizure disorder in the past. There was family history suggestive of any psychiatric illness.

On personal history, his birth and delivery were normal and childhood and developmental history was uneventful. He got married 20 years ago but his wife had left him immediately after 10 days of marriage. He is currently separated but not divorced. He stays with his sister and her family. Social support is poor. He has always been short-tempered, responsible, obedient, introvert by nature and religious.

His general examination and vital parameters were in normal range. Systemic examination revealed no abnormality. On mental status examination, he was thin built, well-kempt, groomed and sat quietly through the interview. He was conscious, cooperative and communicative. Eye to eye contact was initiated and maintained. Rapport was well established and maintained. Active attention was arousable and sustained while passive attention was normal. Mood was conveyed as sad, and affect was congruent to mood and stable. His speech was continuous, coherent, relevant with appropriate rate, rhythm, tone, volume and output. On though assessment he revealed delusions of reference, continuous thoughts about waves of sea and drowning leading to anxiety. Perceptual abnormalities in the form of visual hallucinations of sea waves was presented. There were no suicidal thoughts and ideas. He was oriented to time, place and person. His immediate, short term and remote memory were normal. He possessed average intelligence. His test and social judgement were normal, and he had grade IV insight. He was diagnosed as Schizophrenia with Thallasophobia and Erectile Dysfunction. On last follow up he was better and maintained on Tab. Olanzapine 10mg at night, Tab. Paroxetine 25mg at night, Tab Trihexyphenydyl 2mg at night and Tab Clonazepam 0.5mg SOS when anxious or panicky. He had also been advised Tab. Tadasure 10 mg tab half hour prior to sexual intercourse.

DISCUSSION

Thalassophobia is a rare condition in clinical practice. Therapy includes Gradual Exposure Therapy (Desensitization) where the patient would start by looking at images of deep water in a controlled, safe environment. Then one may progress to watching underwater videos or movies featuring the ocean and followed by a visit a beach or lake, staying on dry land at first. One could move into shallow water before

considering deeper areas. One could also try Cognitive Behavioral Therapy (CBT) where the therapist challenges irrational fears and negative thoughts about deep water. The aim is to replace fearful thoughts with rational, calming affirmations (e.g., "The water is not dangerous; I am safe here"). This could be combined with the practice of deep breathing exercises to manage anxiety when exposed to triggers [3]. Progressive muscle relaxation can help reduce physical tension. Meditation and mindfulness can create a sense of control over fear. Some therapists use Virtual Reality (VR) to help expose patients to deep water scenarios in a safe, controlled way. VR simulations can mimic underwater exploration to help desensitize fears [4]. Education and rational understanding like learning about the ocean, its creatures, and underwater environments can reduce irrational fears may help. Understanding how rare deep-sea dangers are, may help ease anxiety. There is also a role of support groups and self-help groups [5]. A combination of medication and psychotherapy work best in the management of thalassophobia. It is a rare phenomenon, but clinicians must nevertheless be aware of the same.

REFERENCES

1. Jamieson AJ, Singleman G, Linley TD, Casey S. Fear and loathing of the deep ocean: why don't people care about the deep sea?. ICES Journal of Marine Science 2021;78(3):797-809.
2. Der Rowe V. Assessing university Students' abilities and challenges while learning to swim. J Sports Phys Educ Stud 2023;3(1):8-18.
3. Huppert JD, Roth DA, Foa EB. Cognitive-behavioral treatment of social phobia: new advances. Curr Psychiatr Rep 2003;5(4):289-96.
4. Freitas JR, Velosa VH, Abreu LT, Jardim RL, Santos JA, Peres B, Campos PF. Virtual reality exposure treatment in phobias: a systematic review. Psychiatr Quart 2021;92(4):1685-710.
5. Rapee RM, Abbott MJ, Baillie AJ, Gaston JE. Treatment of social phobia through pure self-help and therapist-augmented self-help. Br J Psychiatry 2007;191(3):246-52.

****

Acknowledgements – Nil
Conflict of Interest – Nil
Funding – Nil