

Psychological Health

International travel is often a stressful experience. Travellers face separation from family and familiar social support systems, and must deal with the impact of foreign cultures and languages, as well as bewildering, unfamiliar threats to health and safety. Coping with high levels of stress may result in physical, social and psychological problems. Those who encounter a greater range of stress factors may be at greater risk for psychological problems. Under the stress of travel, pre-existing mental disorders can be exacerbated. Furthermore, for those people with a predisposition towards mental disorder such a disorder may emerge for the first time during travel.

Physicians caring for people in their home country or overseas should be aware of the differences (both within and among countries) in the availability of mental health resources (for example, emergency facilities, staff, beds, investigative facilities, as well as the type and quality of medication). Culturally compatible clinicians and support staff may be rare or non-existent, and they may not understand the native language of the traveller, so access to interpreters may be necessary. The legal environment within which a clinician practises may also vary widely. Laws dealing with the use of illicit substances vary considerably and penalties may, in some countries, be quite severe. As a result of these differences in the infrastructure for providing mental health care and in the legal system, the first decision a clinician may have to make is whether the traveller's care can be managed at the travel destination or whether the traveller requires repatriation.

Mental disorders and travel

Mental disorders are not rare among travellers. Overall, mental health issues are among the leading causes of ill health among travellers, and “psychiatric emergency” is one of the most common medical reasons for air evacuation, along with injury and cardiovascular disease.

Prevention of mental disorders

Although some of the events that cause stress cannot be predicted, taking precautions may reduce travel-related stress. Travellers should gather proper information before travel (for example, on the nature of their journey, such as the mode of travel or the length of the journey, or on the characteristics of their destination and the expected difficulties); this will enable them to maintain their self-confidence and to cope with the unfamiliar. It also allows them to develop strategies to minimize risks. Gathering information before travel helps to reduce the risk of suffering psychological disturbances or aggravating a pre-existing mental disorder.

Patients with a history of neuropsychiatric disorder, including psychosis, depression, seizures or generalized anxiety disorder should not be prescribed Mefloquine but an alternative regimen.

Travellers subject to stress and anxiety, especially concerning air travel, should be helped to develop coping mechanisms. Individuals who are afraid of flying may be referred to specialized courses run by airlines, if available.

Given the potential consequences of a psychiatric emergency arising while travelling overseas, enquiry into psychiatric history or treatment should be a standard part of any pre-travel consultation. Travellers with a significant history of mental disorder should receive specific medical and psychological advice. Those using psychotropic medication should continue the medication while travelling. In certain countries it is a criminal offense to carry a prescription psychotropic medication (for example, benzodiazepine) without proof of prescription. It is thus highly advisable that travellers carry a letter from a physician certifying the need for drugs or other medical items, or both, as well as documents about their clinical conditions and details about treatment, such as copies of prescriptions. All these documents should be in a language that is understood in the country of travel. If travellers will be abroad for long periods of time (for example, if the traveller is an expatriate or a business traveller), they can be taught self-monitoring techniques and stress-reduction strategies before departure or during their stay. If drug misuse is suspected, the large variation in the legal status of drug misuse among countries should be emphasized.

If the appropriate precautions are taken, most people affected by a mental disorder whose condition is stable and who are under the supervision of a medical specialist are able to travel abroad.

Mental disorders

Anxiety disorders

In a study by Matsumoto and Goebert, about 3.5% of all medical in-flight emergencies in the United States of America were categorized as being caused by mental disorder. In 90% of the in-flight emergencies caused by mental disorder, the diagnosis was an anxiety state, and in only 4% was it a psychotic disorder.

Phobia of flying. Extreme fear of flying may be a symptom of a specific phobia. A specific phobia is an intense, disabling fear of something that poses little or no actual danger. Specific phobias are characterized by marked fear of a specific object or situation or marked avoidance of such objects or situations. In specific phobias, significant emotional distress is caused by these symptoms or avoidance of the situation as well as by the recognition that these feelings or actions are excessive or unreasonable. People with phobia of flying usually dread or avoid flying, and may have anxious anticipation when confronted with vivid descriptions of flights, the need to fly, and the preparations necessary for flying. This fear may severely limit a person's ability to pursue certain careers or enjoy leisure away from home. Phobia of flying may coexist with other specific phobias. Additionally, anxiolytic medication or alcohol are often used to cope with this fear.

The phobia of flying responds well to exposure-based psychological treatment. Before starting treatment, the person may need to be educated about aircraft technology and maintenance, control of airspace, or pilot training; worries about these issues may make him or her vulnerable to fears of possible disasters. In a typical 2-day treatment regimen, the emphasis focuses exclusively on identifying the anxiety hierarchy and practising desensitization. New virtual reality technologies that allow therapists to create more realistic environments for desensitization aid this brief approach. However, the equipment to support this approach may not be available in most countries. Other techniques that may help passengers overcome their fear of flying are based on self-control, relaxation and challenging negative thoughts. These techniques may be learned from cognitive behavioural self-help books or from psychotherapists trained in cognitive behavioural therapy.

Panic attacks. Anxiety that is intense enough to lead to an emergency room visit has been noted frequently among psychiatric emergencies occurring in travellers. Panic attacks are characterized by an abrupt onset of intense anxiety with concomitant signs and symptoms of autonomic hyperactivity. Associated feelings of shortness of breath, chest pain, choking, nausea, derealization, and fear of dying may be present. The attack peaks within 10 minutes, sometimes much more quickly, and may last for 30 minutes. These attacks may occur as a part of a panic disorder or as a result of substance abuse, such as during cannabis use or alcohol

withdrawal. Panic attacks may also occur in those with a phobia of flying. People who experience panic attacks may feel more comfortable in an aisle seat when travelling by plane.

The onset of panic attacks often occurs during or following periods of increasingly stressful life events, and these events may be related to travelling. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders, they should be avoided by people suffering severe anxiety.

Mood disorders and suicide attempts

Depression. The stressors of international travel or overseas residence, isolation from family and familiar social support systems, and reactions to a foreign culture and language may all contribute to depression, at least in people who are susceptible. Uncommon but serious problems associated with depression are the risk of suicide or the occurrence of psychotic symptoms, or both.

Depression is characterized by persistent depressed mood or lack of interest occurring over a number of weeks. People who are depressed tend to be relatively inactive, anergic and unmotivated. Associated symptoms may include difficulty sleeping and loss of appetite and weight (occasionally people may sleep or eat more), feelings of worthlessness and hopelessness, suicidal ideation or thoughts of death, and poor concentration and memory impairment. Some people may have psychotic features, such as delusions or hallucinations, which are usually consistent with their mood. Depressive episodes may occur as a single episode, as recurrent episodes, or as part of bipolar affective disorder. Treatment, if indicated, should be initiated and monitored by a trained clinician.

Suicide risk. People who are depressed should be assessed in terms of the frequency and persistence of suicidal ideation, their plans for a suicide attempt, whether they have easy access to lethal means for an attempt, the seriousness of their intent, their personal history of suicide attempts (for example, the potential lethality, the chance of discovery), whether there is a family history of suicide or suicide attempts, whether they have psychotic features or are misusing substances, or both, whether they have had major recent adverse life events, and their socio-demographic details (for example, their sex, age, and marital and employment status). If the risk of suicide appears to be substantial, immediate hospitalization or evacuation to the nearest adequate facility may be the best option. If these options are not immediately available, clinicians should try to implement suicide prevention measures; these may include arranging for a 24-hour attendant (for example, a family member, private duty nurse, etc.), removing any obvious means

of suicide (for example, firearms, medications, knives, toxic chemicals, etc.), and checking frequently on the person's status. Access to alcohol and other psychoactive substances should be reduced, and an evaluation for withdrawal symptoms should be undertaken. Suicidal individuals who exhibit psychotic features or severe problems with substance misuse should be referred to a specialist. Of note, survivors of suicide attempts may require legal assistance in those countries where attempting suicide is illegal.

Mania. Although relatively uncommon, mania may pose an emergency overseas. The manic state is seen as part of a bipolar affective disorder in which people also have depressive episodes. A manic episode is characterized by an abnormally elevated, euphoric or irritable mood that persists for days or weeks. People with mania frequently present with inflated self-esteem, abundant energy, a decreased need for sleep, heightened libido and negligible insight into the nature of their disorder. These symptoms may lead to poor judgement that affects decisions in various spheres of life (for example, financial, sexual, career, or in terms of substance use). Occasionally, patients develop psychotic symptoms, such as incoherence, delusions and hallucinations. Hypomanic states are less serious versions of mania that usually do not require hospitalization. It is common to find travellers who have initiated a trip because of their elevated mood.

Treatment delivered overseas is frequently aimed at either hospitalization, if possible, or stabilization pending medical evacuation or repatriation. Committing a person to care under the criterion of posing imminent danger to self or others is not always possible, and the person's lack of insight may make voluntary consent to treatment difficult to achieve. Frequently, some sort of leverage from family or a sponsoring organization is necessary to obtain the person's cooperation. Physicians should carry out a medical evaluation that includes assessment and tests for substance misuse (for example, the use of amphetamines or cocaine) since misuse can cause manic symptoms.

Psychotic disorders

A psychotic state is characterized by delusions, hallucinations, thought disorder or severe changes in behaviour (for example, severe self-neglect or catatonia). Psychosis is a state that may occur in many different mental disorders, including mania, depression and many substance use disorders. The presence of psychosis, especially in a person who is not suffering from a chronic mental disorder, or who has never had prior episodes, represents a psychiatric emergency.

Acute and transient psychotic disorder. Acute and transient psychotic disorder is characterized by rapid onset of symptoms of psychosis and a relatively brief

duration (≤ 3 months). Given the known association between stress and acute and transient psychotic disorder, it is not surprising that such disorders have been described in relation to travel stress. It is hypothesized that the isolation of long-distance travel, substance misuse, irregular food and fluid intake and insomnia may contribute to their occurrence. On the other hand, cultural and individual factors may also be important from the etiological perspective. Some psychotic manifestations may be related to places with historical, artistic or religious significance. A traveller may become overwhelmed at pilgrimage centres such as Mecca, Jerusalem, and Santiago de Compostela, as well as at a variety of holy places in India, among others. In many cases reported from these and other specific sites, the psychotic state evolved rapidly; there was no prior history of such problems; and symptoms resolved quickly with treatment. However, it should be recognized that some people who seemingly develop psychosis in these specific situations might be experiencing an exacerbation or recurrence of pre-existing psychoses, such as schizophrenia.

Management depends upon accurate diagnosis. Since psychotic states may occur as a result of mood disorders, substance use disorders (involving, for example, cannabis), schizophrenia and general medical conditions (for example, cerebral malaria) or medications (for example, mefloquine), these must be excluded. Due attention should be paid to the risk of violence or suicide. If hospitalization and referral to a specialist is not possible, then the clinician should use a safe, contained environment that allows for frequent monitoring.

Schizophrenia. Reports of finding travellers with schizophrenia at international airports or at embassies when in need of assistance are by no means rare. Travellers with schizophrenia may be arrested by police for “very strange” or “suspicious” behaviour, and police or family members may contact the embassy. Schizophrenia is characterized by psychotic symptoms that can wax and wane over time. (Symptoms may remit for extended periods, especially with treatment.) Negative symptoms, such as flat affect, lack of motivation, and poverty of thought and speech, are also present for extended periods of time, even in the absence of psychosis. Schizophrenia often begins in the teens or early adulthood. Given the chronic nature of the disorder and the relatively early age of onset, it is unlikely that travel in itself can be considered a causative factor. Individuals with schizophrenia often misuse substances and may have coexisting substance use disorders.

Disorders due to psychoactive substance use

A wide variety of disorders of differing severity are attributable to the use of psychoactive substances. Misuse of all substances is encountered among the population

of international travellers. In a study of 1008 young backpackers (aged 18–35 years), Bellis et al. reported that more than half of the sample (55.0%) used ≥ 1 illicit drug when backpacking. Individuals showed a significant increase in the frequency of alcohol consumption in the country in which they were travelling compared with their behaviour in their home country. The proportion of individuals drinking ≥ 5 times per week almost doubled, from 20.7% to 40.3%.

Dependence on psychoactive substances is characterized by craving (a strong desire or sense of compulsion to take the substance); difficulties in controlling substance-taking behaviour (in terms of its onset, termination, or levels of use); physiological withdrawal state (or use of the same or a closely related substance for relieving or avoiding this state) when substance use has ceased or been reduced; tolerance (increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses); progressive neglect of alternative pleasures or interests because of the use of the psychoactive substance (an increased amount of time is necessary to obtain or take the substance or to recover from its effects); and persisting with substance use despite clear evidence of overtly harmful consequences. Travel is unlikely to be a key determinant of the development of substance dependence. However, being in new and sometimes exotic places and freed from the familial and social restraints of home, as well as having easy access to cheap substances may trigger a relapse in individuals who are in remission.

People with substance dependence who plan to travel sometimes carry small doses of the substances (or a substitute such as methadone) to avoid withdrawal syndrome. Psychoactive substance possession or use is considered a serious crime in quite a few countries. Travellers should be treated for withdrawal and dependence before departure. Travellers who misuse substances may present or be brought to health-care professionals abroad due to intoxication or with withdrawal syndromes.

Intoxication. Acute intoxication is a dose-related transient condition that occurs following the administration of alcohol or another psychoactive substance, resulting in disturbances in level of consciousness, thought processes, perception, affect, behaviour, or psychophysiological functions. Almost always, alcohol intoxication (that is, drunkenness) by itself does not become a psychiatric emergency, unless the person becomes violent or suicidal. However, intoxication with stimulants, hallucinogens, phencyclidine, inhalants, and cannabis more commonly result in psychotic states that may present as a psychiatric emergency. Given the complexity of treating these states of intoxication, hospitalization or treatment in an emergency room over the course of hours may be preferred.

Withdrawal. Withdrawal states may also present as psychiatric emergencies. Withdrawal from alcohol or sedatives or hypnotics is usually characterized by autonomic hyperactivity, tremors, insomnia, anxiety and agitation. But occasionally it may be associated with seizures or delirium tremens, a condition marked by delirium, severe autonomic hyperactivity, vivid hallucinations, delusions, severe tremors and agitation; delirium tremens is associated with significant mortality. People presenting with withdrawal should always be evaluated for concurrent medical conditions and for the use of other substances that might complicate management or diagnosis.

Even brief contact with patients following the detection of substance misuse offers the health-care professional opportunities to intervene to reduce harm. The person should be given advice about reducing or stopping the consumption of substances, on how to obtain clean injecting equipment, on safer sexual behaviour, and on risk factors for accidental overdose. Some people presenting with intoxication, and most people presenting with withdrawal, are likely to be dependent on the substance. They should be advised to obtain long-term treatment in their country of origin.

Other relevant areas of concern

Rage. Passenger misconduct of an aggressive nature during travel has become a matter of considerable public concern, and it seems to be increasing in frequency, although it is still not very common. Rage may vary from verbal threats aimed at crew and fellow passengers to physical assault and other antisocial behaviour. Some physical aggression has been common in air rage but serious injuries have not been frequent. Air rage – like road rage – is predominantly attributed to young males. Although occasional instances may be ascribed to mental disorder, the main factors associated with rage are alcohol and substance misuse (for example, intoxication or withdrawal), arguments with travel attendants, crowding, delays and lack of information about problems with the journey. Prevention efforts may involve training transport staff.

Culture shock and reverse culture shock. Travel often leads to encounters with a new culture that necessitates adjustment to different customs, lifestyle and languages. Adapting to the new culture is particularly important when travelling for a long period (such as during expatriation or migration). Major cultural change may evoke severe distress in some individuals and is termed culture shock. This condition arises when individuals suddenly find themselves in a new culture in which they feel completely alien. They may also feel conflict over which of their

lifestyles to maintain or change, or which new lifestyle to adopt. Children and young-adult immigrants often adapt more easily than middle-aged and elderly immigrants because they learn the new language and continue to mature in the new culture. If a person is part of a family or a group making the transition and the move is positive and planned, stress may be lower. Furthermore, if selected cultural mores can be safely maintained as people integrate into the new culture, then stress will be minimized.

Reactive symptoms are understandable and include anxiety, depression, isolation, fear, and a sense of loss of identity as one adjusts. Self-understanding, the passage of time, and support from friends, family members and colleagues usually helps to reduce the distress associated with adapting to new cultures and unfamiliar experiences. Distressed individuals who present to health professionals may be helped to understand that experiencing these reactions is natural and that distress will subside as they adapt to the new culture. Joining activities in the new community and actively trying to meet neighbours and co-workers may lessen culture shock.

Returning home may also be a psychological challenge for people who have been travelling and living abroad for a prolonged period of time, especially if overseas travel has been particularly enjoyable or if their future life is expected to be less exciting and fulfilling. In some younger or long-term travellers, a strong desire to remain within the new culture and a dread of returning home may be seen. In others, a sense of loss and bereavement may set in after the return, when travellers and their relatives realize that things have changed, and that through their differing experiences they have grown further apart. This may lead to feelings of surprise, frustration, confusion, anxiety and sadness. This is often termed reverse culture shock. Sometimes friends and relatives may themselves be hurt and surprised by the reaction of those who have returned. Self-understanding and the ability to explain the situation may help all parties restore healthy reactions and relationships.

Further reading

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