



special articles

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HARVEY GORDON, MIKE KINGHAM AND TONY GOODWIN

Air travel by passengers with mental disorder

Air travel is a rapid and efficient mode of travel nationally and internationally. People with a psychiatric disorder can usually travel safely, but may at times require an escort. People whose mental state or behaviour are disturbed are not fit to travel until stability has been achieved. Suicidal or homicidal behaviour by those so disposed are fortunately rare, but can be catastrophic in outcome. Careful assessment is necessary, and psychiatrists are advised to be more aware of the possibility of liaison with airport medical services when appropriate.

Despite a recent reduction in the number of passengers on commercial aircraft following acts of terrorism, war in Iraq, communicable diseases such as severe acute respiratory syndrome (SARS) and a downturn in the global economy, air transportation continues to convey millions of people each year across the world. Among this multitude of air passengers are an unknown number of people with mental disorder. Aspects of air travel relevant to psychiatric evaluation are reviewed here.

Prior to departure

Fitness to travel

Most people with pre-existing medical or psychiatric conditions are able to fly on a commercial aircraft without difficulty. 'Fear of flying' courses run by the major airlines may be helpful for some. All travellers should preferably be fully vaccinated, covered by insurance, and prepared for the demands of the journey and of their destination. Assessment of fitness to travel is advisable following recent illness, hospitalisation, injury, surgery or instability of an acute or chronic condition, or where special services are required such as oxygen, use of a stretcher, or authority to carry or use accompanying medical equipment. Passengers with mental illness are required to be in a stable condition to travel alone. In other cases an appropriately trained health professional – usually a nurse, but sometimes a doctor – should be provided as an escort, with access to medication to calm the patient if necessary. Liaison with the airport medical services may be under-utilised and should be encouraged where appropriate.

Reasons for travel by air

People who are mentally disordered may, like any citizen, want to travel for reasons of vacation, recreation, business or visiting friends or relatives, or at times for pilgrimage to places of religious or spiritual focus. Additionally, people may occasionally travel for reasons activated by an abnormal mental state (Miller & Zarcone, 1968). Psychiatric patients may be transferred from the unit to which they were admitted back to their catchment area unit (Favazza & Schaefer, 1970); sometimes the air carrier that brought the patient may be obliged to take them back. The trip might be made for rehabilitation or compassionate reasons during the person's inpatient stay, with potential adverse media publicity in forensic cases (Gekosi & Sayed, 2003). Repatriation of patients to their country of origin may occur under section 86 of the Mental Health Act 1983, for people categorised as mentally ill, detained on a treatment order and with the approval of a mental health review tribunal, although voluntary arrangements are more common (Green & Nayani, 2000). Deportation under immigration legislation is also undertaken when ordered by a court or the Home Office, and psychiatrists may be requested to advise on the mental health aspects of such proposed decisions.

Airport syndrome

Miller & Zarcone (1968) described a small number of cases of people who were found in a psychiatrically disturbed state at San Francisco airport, some of whom required admission to the local psychiatric hospital. In some of these cases the person had gone to the airport without attempting to travel; in other cases the person was removed from an aircraft just before departure, or had just landed at the airport, sometimes as a stopover between connecting flights. The majority of these people were found to suffer from a psychotic illness and travel to the airport was in some way a product of this illness, with a tendency in some cases for repeated visits. Subsequent studies have indicated similar findings (see, for example, Wiesmann et al, 2001). 'Airport wandering' is rare, but should be recognised as a possible manifestation of severe mental illness.



In flight

In-flight medical or psychiatric emergencies

In a study by Matsumoto & Goebert (2001), only 3.5% of all medical in-flight emergencies in the USA were categorised as due to psychiatric illness. In 90% of the latter, the diagnosis was that of an anxiety state, and in only 4% was it a psychotic disorder. For anxiety states, the onset is usually prior to boarding and continues throughout the flight, with more reports of anxiety on longer flights. One unusual case has been described of a man complaining of physical ill-health, which resulted in diversion of the plane for his hospitalisation, the subsequent diagnosis being 'jet-set Munchausen syndrome' (Addison & Talan, 1974). None the less, patients with psychiatric disorders whose behaviour is regarded as unpredictable, aggressive, disorganised, disruptive or unsafe are felt unsuitable for travel by air (Aerospace Medical Association, 1996). Patients with alcohol or drug dependency problems should have completed detoxification before travelling to avoid in-flight withdrawal reactions (Goodwin, 2000). Statistics pertaining to problems associated with illegal drug use on aircraft are not available, but such substances may at times contribute to in-flight emergencies (Lyman & Mohler, 1985).

Although the frequency of psychiatric emergencies is much lower than that of other medical emergencies in-flight, the public is likely to be less tolerant of such incidents, and indeed the control of disturbed behaviour in an aircraft poses much greater potential hazards than on the ground. Seriously dangerous incidents in the air are fortunately statistically rare, but have a high public impact.

In cases in which comorbid physical illness is also present, psychiatric patients will need to heed advice on its management. Patients and their escorts should have their medication readily accessible in their hand luggage, rather than packed in a suitcase.

Suicide and homicide

Suicidal ideation may occur during flight in people who are mentally unwell (Miller & Zarcone, 1968; Wieshmann *et al*, 2001). On rare occasions, the aircraft itself is used as the means of suicide. Lester (2002) described two instances of commercial aircraft crashing as a result of a suicidal passenger killing the pilot and co-pilot, with the subsequent death of all the passengers. In each case the perpetrator had purchased life insurance, presumably to benefit his family. The use of private aeroplanes for suicide by the pilot has also been noted (Jones, 1977). Maulen & Faust (1990) estimated that 2–3% of all aviation accidents may be due to suicide. Maulen (1993) felt that suicide in aviation was determined by factors similar to other suicides, but that grandiose and narcissistic elements were also prominent. The crash of flight EgyptAir 990 in October 1999, about half an hour after take-off from New York to Cairo, was felt on inquiry to have possibly been caused by a suicidal pilot

(Langewiesche, 2001). In December 2000, British Airways flight 2069 from London to Nairobi was caused to dive thousands of feet by a man thought to be suffering from schizophrenia who entered the cockpit and tried to seize the controls; he was subdued after a violent struggle (Harris, 2001). Within such cases of psychosis, any grandiose or histrionic elements might be related to the publicity consequent to precipitating the crash.

According to Merari (1999), 13% of all hijackings of aircraft between 1947 and 1996 were caused by people who were mentally disturbed; however, no definition of 'mental disturbance' was given. Most hijackings were the result of terrorism, which accounted for most of the fatalities. Hoffman (1999) noted that the placing of bombs on aircraft did not originate with terrorism, but continued a series of incidents beginning in 1933 that were motivated by the criminal motive of collecting insurance on family members. Suicide bombing of aircraft came to prominence following the events of 11 September 2001 in the USA (Gordon, 2002). Suicide is a core aspect of psychiatric practice, yet it is probable that the episodes of suicide–homicide carried out by terrorists have no psychopathological basis. Excessive anger and the support of the community to which the person is affiliated may, however, be relevant psychological and social factors (Silke, 2003).

The rarity of suicide or homicide–suicide by aircraft renders such incidents virtually impossible to predict. However, psychiatric evaluation should take into account the presence of either suicidal or homicidal ideation when assessing patients undertaking journeys by air.

Air rage

Passenger misconduct of an aggressive nature during air travel has become a matter of considerable public concern, and has been increasing in frequency (Fine, 2002). Such behaviour may occur either in the airport or in flight; with estimates of some 12 000 episodes of disruptive passenger behaviour in 2000 (Anonymous & Thomas, 2001). Alcohol consumption is associated with air rage in about a third of cases, with smoking-related issues in about another third (Moffatt, 2002). Although occasional instances may be ascribed to mental illness, the main factors associated with air rage are alcohol misuse, 'no smoking' rules, arguments with flight attendants, drug abuse (Fine, 2002), environmental crowding on the aircraft, delays and lack of information.

At the destination

Jet lag

Jet lag is caused by the desynchronisation between various body and environmental rhythms (Herxheimer & Waterhouse, 2003). Jet lag needs to be distinguished from the effects of travel fatigue, which is common on long-haul flights. Katz *et al* (2002) found that jet lag can induce relapse in an existing psychiatric illness. Whether this is due to the change in time zones or to the effects



of sleep disruption is not entirely clear (Arehart-Treichel, 2002).

Nature of the destination

Some Israeli psychiatric authors have described the 'Jerusalem syndrome' (Bar-El et al, 2000). Other Israeli colleagues dispute that this is a specific syndrome; instead, they consider it to be a variant of a schizophrenic illness (Kalian & Witztum, 2000), and point to examples of pilgrimage to Jerusalem over many centuries made by people for whom the journey was not the trigger for this psychosis (Kalian & Witztum, 2002). Nonetheless, some people with pre-existing psychosis might become overwhelmed psychologically by places with strong emotional association. A similar phenomenon may be that of 'Stendhal syndrome', in which an acute psychotic reaction occurs in art-loving tourists visiting Florence (Magherini, 1992). Psychiatrists therefore need to take account of the nature of the patient's destination and factors there that might contribute to any relapse. Sufficient supplies of medication should also be carried, in case of unexpected delay in the return flight. Account should also be taken of any interpersonal emotional factors that the patient might experience during the visit.

Conclusions

Most people with mental disorders travel uneventfully, but in some cases psychiatric evaluation is necessary. Airport medical services may be able to provide valuable assistance.

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- *Harvey Gordon Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust, Denis Hill Unit, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent BR3 3BX, Mike Kingham Specialist Registrar in Forensic Psychiatry, Broadmoor Hospital, Crowthorne, Berkshire, Tony Goodwin Airport Medical Services, Horley, Surrey
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