

The Health of the Older World Traveller (Part VI)

Psychological Aspects of Global Travel and Older People

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Global travel is part of life style for many older people. A sizeable proportion of the population however, both old and young, are fearful of travelling by air, under and over water, a prerequisite for those departing from Britain. The phobic may exhibit avoidance behaviour and refuse to contemplate leaving the UK to the disadvantage of spouse and partner. Recent climatic, terrorist and financial events have made all forms of transportation a more worrying experience adding to common fears of travel in a ship, aircraft, or through a long tunnel.

Realistic concerns about aeroplane mechanical failure do not now predominate as in early days of air-craft travel, but recent well publicised events have enhanced worries about this mode of transportation. The financial recession has resulted in airline economies bringing decline in customer care and failure to address passenger's legitimate anxieties regarding airport congestion, luggage loss, flight delays, cancellations and rerouting.

Air travel is regarded as the most dangerous and anxiety provoking travel option by the general public.¹ Flight anxiety is an emotional state of worry triggered by an appreciation of risks usually disproportionate to the actual risks involved in air travel. Recent media reports of thousands of travellers marooned for days in airports in Britain and Europe has altered public perception of risk relating to air transportation and focused it on airports.



Phenomenal loss of luggage, cancelled flights, rerouting and stranding has however brought anxieties about this travel mode more in line with the proportionate risk of an unwanted event occurring to the traveller. Paradoxically as the risk of mechanical aeroplane failure and physical danger has waned the likelihood of major psychological trauma in air travel has increased markedly. Major delays, prolonged waits in packed airline lounges, vast queues in air-ports and the uncertainty of arrival and departure have impacted on the public psyche. Land and sea transport has not been exempted from weather and terrorist anomalies, with passengers marooned on motorways and rail lines and in terminals.

These events are bringing behavioural change, particularly in seniors. The old are more psychologically vulnerable to uncontrolled situations. Common features of old age such as indecisiveness, slower problem solving, inflexibility in purpose, poorer memory and cognitive decline aggravate personal reaction to the frenzied environment in airports and rail stations, when all onward movement abruptly ceases. Pre-flight worries and anxieties are added to the concerns older travellers have of actually flying. Their cumulative effect can promote tension and angst with the psychological effects resulting in adverse physiological responses, cardiac stress and possible heart attack and stroke.

There has been a fall in air travel in 2010 disproportionate to that relating to financial recession. Saga travel, an operator specialising in elderly travel, reports a coinciding increase in passengers seeking to avoid the fly part of the cruise experience by use of UK ports for arrival and departure. The Passenger Shipping Association reports that 650,000 passengers shunned airports and set sail from a UK port in 2010, 10% more than in the previous year. Older people who are not time-pressured like the young, are avoiding potentially stress-provoking airports.

Older people also often have a wealth of travel experience of adverse events relating to air travel which may generate fears and anxieties, not affecting the phlegmatic young with less exposure to air travel and unaware of potential travel problems. Younger people are more likely to consider adversity an adventure.

Flight anxiety is one of the most debilitating experiences for air travellers. Flight anxieties are common phenomena observed in 10-40 % of air travellers dependent on pre-flight and in-flight situations.² This proportion is likely to have increased with the deleterious change in the pre-flight experience and terrorist threat to aircraft. They can result in undesirable consequences. Flight anxiety may predispose passengers to stress-related illnesses and cardiological problems, which may result in-flight emergencies.³ Apart from potential health damaging effects, it may have an adverse effect on social interaction.⁴ Stress of air travel has been found to disrupt passengers' behaviour.⁵ Stressed and anxious passengers may become more demanding, dissatisfied and easily agitated in communication with the crew or other passengers. Fatigued and overwrought they can exhibit disruptive behaviour ranging from verbal aggression to severe physical aggression.

Air transport related anxieties may be enhanced in anxiety prone personalities, the vulnerable old and be affected by cultural values and external environmental influences.⁶ All shape the subjectively experienced cognitive and emotional impact of the overall flying experience. Airport environments and flights often pose novel situations where personal control is limited and bureaucracy, overt and covert regulation and rules add to frustrations.⁷ Attribution of blame and satisfactory redress from front line staff, which might diffuse build-up of stress rarely occurs, as they too have scant control over the predicament. The air travelling public people are reacting to these psychological pressures by changes in behaviour, belatedly being recognised by the transport industry.

Travel related stress in older travellers starts before departure with change from home- established routines. The land journey can be affected by adverse road/rail conditions and the traveller can be stressed by time of arrival at the departure terminal. Stress mounts incrementally with progression through airport security, now a major source of psychological disturbance for passengers. There is invasion of individual privacy with potential embarrassment on the luggage search, enforced taking off of shoes, belts and body frisking. Authoritarian demands of security staff are objectionable and the process an unwelcome reminder that the aeroplane may be blown-up in en route. Restriction on hand luggage is an additive irritant for most travellers, adding to the increasing frustration engendered by passage to the aeroplane. The passenger has been reduced to a mere seat number in an uncaring bureaucratic process.

Communication failures are tension-causing when systems collapse under overload. The procedural process is annoying, diminishing and demeaning and added to inevitable flight delays and failures, continued frustration brings increasing stress, tension and aberrant behaviour in airport or the air and physiological change which may endanger health.⁶

In a study undertaken at Heathrow airport in 2007, passengers had heart and finger monitors fitted to record blood pressure and pulse rate while in the air-port en- route to flight departure. Skin conductance-a reliable measure of stress- was also measured. Readings were correlated with the amount of psycho-logical stress they experienced.⁷

Passengers passing through the airport, who were healthy and not exercising, showed monitored stress levels equivalent to on-duty riot police. During the test, there were marked physiological changes. ECG and BP monitors showed immediate and sustained changes:-Within minutes of entering the terminal, heart rates had increased from 55 beats per minute to over 70 per minute in the non-exercising state.

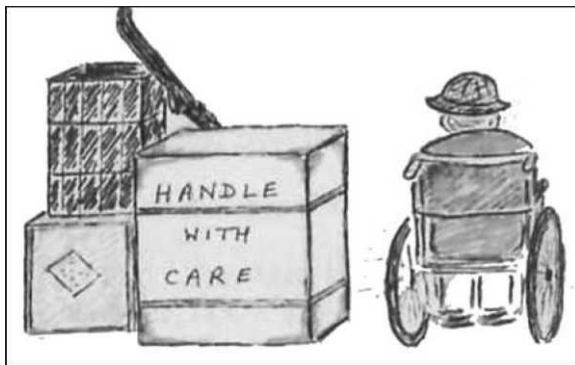
In the average 4 hours it took to board the aircraft, rates continued to rise to more than 200 beats per minute in transit with a rise also occurring in blood pressure.

Queues at check-in and security increased blood pressure levels from average of 123/81 mm Hg to 170/99mm Hg. There was a marked increase in skin conductance with a rise 100 times that in a relaxed state. Associated stress levels peaked four times but were sustained at a high level overall.

Causes of peaking were queues, unfriendly, unhelpful staff, lack of or misinformation.

Monitoring on the return journey revealed that return transit through the airport was almost as stressful as departure, primarily because of queues at immigration, security channels and lost luggage.

A similar study on passengers travelling by, road and train confirmed the stress felt by delayed passengers. Pulse rate of train passengers increased with the queue for departure and while the train was in the Channel tunnel. Car drivers were stressed on board-ing the ferry and adapting to foreign driving. Only coach passenger remained relaxed during travel.⁸



A study of 1009 passengers transiting an airport reported that 69% stated that rude staff were a contributory problem to stress with 52% considering this a major cause of travel related stress.⁹ Behavioural responses are also evident with 42% of travellers admitting to repeatedly checking travel documents prior to the flight and international journey, with these obsessive compulsive tendencies greater in women. A third admit they check passports at least five times from arrival at the departure point to boarding, although they do not normally exhibit obsessive behaviour.

Coping strategies for Air Travel Anxieties

Half of all worried travellers do nothing to minimise their anxieties. Many admit behavioural responses.¹⁰

Several coping strategies are adopted by passengers for air-travel worries:

- 9% avoid flying if possible
- 16% use relaxation and distraction techniques
- 13% use alcohol drinking for relaxation in flight
- 6% resort to sedatives

Virgin Atlantic now offers in-flight audio meditation programmes with tips on relaxation from a psychotherapist to help diminish passenger stress. Many travellers resort to cognitive strategies to diminish and deal with the travel experience and affluent older passengers particularly can reduce the effect of adverse circumstances by travelling in first class.¹¹

Coping strategies or mechanisms are thinking pat-terns and cognitive frameworks that individuals use when stressed and aroused, in order to regulate their emotional state and alleviate anxieties. Passengers distract themselves by reading, writing, utilising relaxation techniques or other activity

which directs attention from flight or pre-flight experience. Music listening can induce calmness. Alcohol, smoking and tranquilliser pills are also used to handle stress.

Younger air travellers are most likely to minimise the seriousness of their flight experience, reflect on personal fears and anxieties over flying and remind themselves of pleasant experience, either relevant or irrelevant to the flight situation, as strategies to cope with current distress. Insistently thinking about the risks of flying, picturing the worst possible scenario to minimise one's fear and blaming other people are the least frequently utilised strategies. However many older people admitted to brooding over worst scene scenarios as day of departure approached.¹⁰

New coping strategies are being developed in passengers exposed to airport environmental challenge, but they are however limited in potential adaptation manoeuvres. Weight restrictions limit food, drink and pastimes to be taken airside to ameliorate prolonged waiting and make it almost impossible to prepare for prolonged delay or a night or two spent on a departure lounge floor. Maladaptation results in aggressive behaviour and has brought a resultant increase in reported police intervention at major airports.¹²

Passengers are now adopting the classical response to potential stressful situations - avoidance. They are seeking alternative means of reaching destinations. Long distance train companies report increased business with more well used and more trains. Ferry companies to the continent are attracting more travellers. The cruise lines diligently survey regular and potential passengers and they report an increasing demand for UK port to port cruises. The arrival of fly cruising 20 years ago had driven these from the scene, but they are regaining popularity.

Intending passengers approach health professionals for anxiolytics and sleeping pills to reduce travel anxieties but their prescription should be resisted. The latter may result in deep vein thrombosis on long flights due to limb immobility and cognitive behavioural techniques are advised rather than anxiolytics in older people who may already be on other drug medication and risk adverse drug interaction.¹³

The travel health professional should have an understanding of passengers' subjective experiences and anxieties over flying and the use of coping strategies. Adequate knowledge on psychological aspects of air travel and specifics of worry experience, along with anxiety provoking situations should inform management and direct pre-travel advice to minimise psychological and physiological stress.

Coping strategies for air travellers

- Use alternatives to air transport when possible. Book into airline courtesy lounges.
- Travel in best affordable class.
- Book into local hotel accommodation, the night prior to departure.
- Assume delay and take reading material, games, emergency food and water, a ground sheet and small pillow.
- Avoid air travel in winter, the strike season and round public holidays.

Travel related phobias

Flying phobias and fear of tunnels are common and affect old and young. They can inhibit sufferers from undertaking global travel. With good management, disabling fear, disturbed conditioned responses and frantic avoidance behaviour can be replaced by rational activity.



Anticipation, apprehension, fear and phobia

Typically, the older phobic presents to the family doctor a few days before a long planned flight, traverse of the Channel Tunnel or ship passage to a popular holiday resort. Months previously the family have convinced grandmum or dad that they can overcome reluctance to fly or sail and the vacation is arranged. As the time for departure draws ever closer, apprehension increases with anticipation and shortly before the dread day it becomes apparent to the patient that he or she cannot face the perceived ordeals of an air, sea or tunnel passage. An acute anxiety state results which reaches crisis proportions as the family becomes teed up for departure. This presents as a specific phobia which may be associated with panic reaction.¹⁴

The majority of phobics appear to be women although women may be more likely to report their fears than men. Travel phobias represented 2.81 per cent of phobias reported by women in surveys.^{15,16} In a 10 per cent random sample of 7,074 patients in general practice based on a structured questionnaire listing 13 common fear-provoking objects or situations, 16 per cent admitted to having a phobia and 13 per cent of this sub-group reported fear of flying with a female to male preponderance of 2:1.¹⁷

Disproportionate reaction

Fear is of course a normal and essential condition for everyday living. It is a response to a real or imagined threat with a behavioural element which is often pronounced. Minor fears are within the cultural norm and there is a continuum between mild and intense fears with the latter usually described as phobia. This is considered *a morbid response disproportionate to the causative stimulus*. Sufferers often structure their lives to avoid fear-provoking situations.

In a Phobia:

The degree of anxiety and fear is: out of all proportion to evoking situation. cannot be explained or reasoned away. beyond voluntary control. leads to avoidance.

Definition

The phobic reaction is totally out of proportion to the situational trigger, is involuntary and cannot be explained or reasoned away by the individual involved. It leads to incapacitating avoidance behaviour and it is likely that there are many more people with flying phobias than the statistics suggest, as most simply avoid any likelihood of exposure to air travel. Those with such a condition have an irrational, uncontrollable fear resulting in avoidance behaviour which may disturb their lifestyle.

To understand the phobic's reactions one has to consider the cognitive, physiological and behavioural components involved. The *psychic element* appears as overt anxiety and an exaggerated arousal response when exposed to the feared situation or even consideration of exposure, e.g. as the day of the dreaded flight draws closer. The *physiological response* results in a sweating, tremulous, palpitating and breathless patient with assorted pains from muscle tension. The primeval fight or flight reflexes poorly prepared such people for today's flight demands. *Avoiding behaviour* by the travelling executive or salesman, or the house-wife's refusal to contemplate air travel thus depriving her family of a holiday in the sun, introduces a *social element* which often finally forces the patient to seek professional help.

The phobic cycle is open to curative intervention at three levels through different components.

Relaxation can be taught to control physical symptoms.

Cognitive therapy helps control and change fear-provoking thoughts.

Exposure treatment can help overcome the restrictions in lifestyle.

In most cases it is not known how a phobia has developed. Sometimes there is a clear cut trigger such as an unhappy incident occurring on a flight or to an aircraft before or after travel. Some are simply conditioned fear reactions. It is likely that we are more genetically predisposed to make fearful links with some situations and objects than with others; as humans we are phylogenetically prepared to learn certain stimulus responses than alternatives. A Freudian approach to the condition would accept that, when someone shows fear of something he knows to be harmless, then the phobic object or situation is associated with or symbolises something else that is genuinely dangerous. Freud believed that the inner conflict in such a case is then repressed and repressive aspects of it are displaced on to alternative external objects symbolising the repressed complex.

Components occurring in phobic states

Cognitive element - person is subjectively afraid

Behavioural response - avoidance of feared situation

Physiological Manifestation - tachycardia; hyperventilation which often lead to:

A social component - disruption of normal living

Therapeutic approach

Given time, therapy can usually bring alleviation of symptoms and cure and, even at the eleventh hour, patients can be helped towards and along the frightening path from airport to aircraft and on with the flight. A phobia specific to flying can be dealt with most easily but air travel involves more than boarding the aeroplane. Crowded departure lounges will disturb the agoraphobic, the closed inescapable environment of the jet-liner frightens those with a fear of closed spaces, climbing the steps to the doorway of a jumbo jet towering above will upset those with a fear of heights, and the necessity to eat in public will give anxiety to those with a social phobia. All these possibilities must be kept in mind when preparing to treat the patient who wants to make the feared flight and the even more dreaded return.

Approached at the last moment a harassed family physician, battling through a busy surgery, will probably reach for the prescription pad and prescribe a tranquilliser. This hurried response might get the patient on to the aeroplane where, with the added boost of recourse to in-flight duty free alcohol, the flight might just be made tolerable. The prescribed drug does nothing to cure the underlying condition, however, and merely treats the symptoms with the risk of initiating dependence upon anxiolytic drug therapy. Other therapies are available which can usually cure the patient. When drugs are used they ought to be prescribed for the very short term.

Benzodiazepines¹⁸ are given for general anxiety, with higher dosage in anticipation of the phobic event, and the patient advised to refrain from taking alcohol or a hypnotic on the flight. Beta-blockers are used to control peripheral sympathetic responses such as palpitations. In entrenched agoraphobia with travel phobic manifestations there is some evidence that clomipramine has an antiphobic effect but it has to be given in high dosages. Any anti-depressant may well lift a specific phobia which has been a symptom of an underlying depression.

Behaviour modification

Given time before the need to travel, behaviour modification is widely used in clinics to treat phobics.¹⁹ The principal is to expose the patient to the situation which causes distress until he gets used to it and attempts are then made to extinguish the fear by relating it to a pattern of response which provokes no anxiety. The problem behaviour needs detailed study in order to arrive at a hypothesis about its genesis and identify appropriate intervention.

Desensitisation¹⁹ consists of ***two features; muscle relaxation and reduction of anxiety and the construction of a graded hierarchy of aversive stimuli*** from information provided by the patient. Such a hierarchy for a flying phobia would consist of arrival at the air-port, proceeding to the departure lounge, walking on to the plane, experiencing take-off and landing. The hierarchy can be

presented to the patient, either in imagery or in reality, and film and tape recordings can be used effectively in desensitisation. Treatment can be assisted by vicarious or participant modelling. Here the therapist approaches the feared object or situation and demonstrates his confident response to it before asking the patient to do likewise. This procedure has three functions; the model encourages new patterns of behaviour to be adopted, unnecessary responses are inhibited or disinhibited and the expression of already established responses can be facilitated.

Desensitisation works well with social and specific phobias and British Airways and several universities and hospitals have run courses for phobic travellers with success. These often culminate in a short flight round the local town to demonstrate to the sufferer that the phobia has been extinguished. The disadvantage is that the process is time-consuming and often requires many sessions. Desensitisation can be carried out, however, with minimal therapist contact using tape recordings and book instruction on relaxation and desensitization procedures.

The use of hypnosis for phobias²⁰ borrows both from behaviour modification and desensitization but therapy is facilitated by induction of a trance state.

Teaching the patient auto-hypnosis, whereby at a coded signal he can recreate the relaxed state acquired at earlier sessions, decreases the risk of dependence and diminishes the time required for therapy. Graded desensitisation and flooding are both practicable within the trance states and visual imagery and vicarious modelling can also be used. A modified flooding technique is used and it is very effective for specific phobias such as flying.²¹

One of my patients, who had patiently built up his business, had a unique opportunity presented to his firm for advancement and profit in the Far East, but he had long had a phobia for air travel. Unable to resist the opportunity for expansion he made his plans, bought his tickets, and the day before departure succumbed to panic and terror at the thought of many hours incarcerated in an aircraft. In the surgery he was in a state of agitation but refused to consider a drug prescription as he wished to be mentally fit for tough business negotiations upon arrival in Hong Kong.

He accepted the offer of hypnotherapy with alacrity and, providing to be good subject, was quickly in a trance and relaxed. Soon he was able to create a visual image of himself boarding and sitting in the aeroplane and, with continued suggestion of calmness, muscle and mind relaxation and freedom from tension, he was able to fantasise himself through a prolonged exposure to the feared situation. Given post-hypnotic suggestions that he would remain calm throughout the flight, and that the standard pre-take off and recorded music would relax him, he went off to make a successful return flight and business deal. Even when the jet-liner was buffeted badly by turbulence and suddenly dropped 500 feet, with the dramatic appearance of personal passenger oxygen masks from their overhead stowage, he was able to keep calm. Now after a decade and many air trips he remains undisturbed by his once disabling phobia.

"Gentle words, quite words are after all the most powerful words. They are more convincing, more compelling, more prevailing and successful," an elderly lady wrote to me on return from her first successful air trip after years of phobic avoidance. However the removal of psychosomatic symptoms before the patient is ready, and has built up more socially satisfactory defences, can precipitate more serious difficulties and therapists have to keep this in mind. It seems likely, however, that desensitisation can be carried out with little therapist contact using tape recordings to carry out relaxation and desensitisation procedures, and these are certainly a useful adjuvant in desensitisation and hypnotherapy. Book and computer instruction courses offering graded and detailed programmes of relaxation and exposure are available, and have proved of value to many phobics.

Conclusion

Although phobias of air travel and flying are common and likely to become more prevalent, the phobic air traveller need not despair as there are thriving phobic societies and several books and many therapists available to proffer support and guidance. With good management, the disabling fear, disturbed conditioned responses and frantic avoidance behaviour can be replaced by rational activity and more normal, socially acceptable reactions and conditioned responses.

BEHAVIOURAL DISTURBANCE

Air Rage. Elderly people are not immune to the behavioural disturbance referred to as *air rage*. A build-up of fatigue, frustration and anger can result in verbal and physically aggressive behaviour to fellow travellers and staff. Over indulgence in alcohol drinking and medication interaction can result in behavioural misconduct and they should be aware of this risk. Alcohol intake on long flights is best avoided by those on routine medication and affected by a measure of kidney failure - a consideration for many older travellers as a third of those over 80 will be affected by grade 3a chronic kidney disease.

Early Alzheimer's disease can be seen in the aberrant behaviour displayed by some elderly vacationers.¹³ Sometimes solo travellers they can be seen wandering round cruise ships and getting lost from tour groups. Their fellows are usually tolerant and supportive but they put themselves at health risk on ships and in road traffic. Unaccustomed surroundings and travel related stressors add to their confusional states.

They are particularly likely to become disorientated in airports. In 40% of these early cases some measure of agitation, sleep disturbance, wandering, increased irritability and aggression are apparent.¹³

Locational change tends to increase their mental stability and they should be discouraged from participating in holidays with an ever changing environment such as cruise, coach or, train tour. If they do travel anti-psychotic medication should be reviewed before departure. They should travel with a companion and provisional plans should be in place for unwanted illness in the accompanying person.

Case History

A 75 year old man had travelled alone to Australia despite a diagnosis of senile dementia. His visit to family was successful but on the return, tired, dehydrated and confused he became disturbed and wandered around Heathrow for many hours while transferring aeroplanes. Totally disorientated he missed his onward flight and was only identified as ill and lost by a patrolling policeman after the last flight of the day had departed. He never fully recovered his former cognitive state and was institutionalised when he finally arrived in his home town.

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