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ORIGINAL RESEARCH

Experiences of international travel in patients with psychotic illness: a case series

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Objectives. To identify factors influencing successful international travel among patients with psychotic illness.

Methods. Eight individuals participated in a semi-structured interview of 15–20-minute duration with a clinician in relation to their recent experience of international travel. Clinical files were reviewed and a case series was compiled.

Results. Four individuals engaged in international travel without any adverse effects. Four other individuals experienced significant psychotic and/or affective symptoms while travelling. Treatment non-adherence, a lack of awareness of how to obtain support and limited or no pre-travel planning were noted in these individuals.

Conclusions. Pre-travel counselling, treatment adherence, provision of information packages relating to their mental illness and having contact details of their treating mental health team increase the likelihood of successful international travel in patients with psychotic illness. Travelling with a companion may reduce fear of relapse.

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Introduction

International travel has been identified as a risk factor for relapse in individuals with psychotic illnesses (Felkai & Kurimay, 2017). Several factors, including disturbance of the sleep-wake cycle, poor self-care while travelling, increased alcohol and drug use and poor pre-departure medication planning, have been suggested as contributing to this risk (Vermersch *et al*., 2014). Travelling to certain destinations of high cultural or spiritual value has also been associated with an increased risk of relapse of psychosis. For example, psychotic illnesses appear to account for an unusually high percentage of referrals to mental health services among tourists in Jerusalem, although it is unlikely that the 'Jerusalem Syndrome' represents a unique clinical entity (Airault & Valk, 2018). Travelling to such destinations may also be a symptom of active mental illness, such as disinhibited behaviour or grandiosity, in individuals already in the midst of a relapse. In addition, medications prescribed for prophylaxis (e.g. mefloquine utilised for prophylaxis of malaria) when travelling to endemic areas may either precipitate psychotic symptoms or a psychotic relapse in individuals with a pre-existing history of a psychotic illness (Nevin & Byrd, 2016).

A relapse of a psychotic illness when travelling is associated with significant difficulties. These include accessing appropriate mental health supports and, where mental health care is accessed, management strategies are impaired due to the individual with psychosis being unknown to the treating mental health team. Experiencing a relapse of psychosis is distressing for an individual and his or her family members, with this distress increased in magnitude due to the unfamiliar environment the individual is in. In addition, psychiatric illness (including psychotic relapse) is one of the three most common reasons for repatriation of an international traveller, with associated organisational and financial consequences (WHO, 2012).

To date, published review articles and case reports have predominantly described the difficulties that some individuals with psychotic illnesses experience when travelling (Flinn, 1962; Streltzer, 1979; Hennequin *et al*., 1994; Alkan *et al*., 1999; Linton & Warner, 2000; Beny *et al*., 2001; Katz *et al*., 2001; Tran *et al*. 2006; Ringqvist *et al*., 2015; Simpson & Pasic, 2016; Felkai & Kurimay, 2017). There are little data on pre-travel strategies that can be employed to increase the probability of

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a positive experience of international travel. Consequently, in this case series, we conducted semi-structured interviews with eight individuals with a diagnosed psychotic illness who recently engaged in international travel to examine the negative and positive experiences and the various factors associated with these experiences.

Methods

Eight individuals with a psychotic illness (schizophrenia, schizoaffective disorder or bipolar 1 disorder) over the age of 18 currently attending mental health services in Ireland and who recently returned from international travel were invited to participate in this study. Individuals were excluded if they had an intellectual disability (IQ < 70), a co-morbid diagnosis of dementia, were experiencing a current relapse of psychosis or were unable to provide written informed consent.

Each individual participated in a semi-structured interview of 15–20-minute duration with a clinician (SM, ZM, BH) in relation to their recent experience of international travel. The interview schedule was designed by SM, ZM and BH (see Appendix A), with consensus reached in relation to the information to be attained at interview. Data collected included the destination of travel, duration of travel, if travel was engaged with other individuals, treatment adherence while travelling, engagement in pre-travel planning arrangements with their local mental health service, use of psychoactive substances when travelling, factors that individuals noted that supported or hindered their travel experience and individuals' views on future travel given previous experiences of travel. Informed consent was obtained from all participants, and all participants allowed the researchers (SM, ZM, BH) to access their clinical notes for pertinent additional demographic and clinical data (e.g. clinical diagnosis, medication regime, additional data pertaining to their travel experiences and pre-departure preparations engaged by treating community mental health team).

Case 1

AB is a 27-year-old individual, unemployed and in a long-term relationship. AB developed a first manic episode with psychotic features in 2015 when they travelled alone to a yoga retreat in the Canary Islands. Prior to travelling, AB had no prior history of mental illness.

On the third day of the retreat, AB developed symptoms consistent with a manic episode, including insomnia, irritability, pressure of speech, poor concentration and disinhibition, which caused significant disruption for their fellow retreat members. AB was accompanied to a primary care practice by two organisers of the retreat where the organisers (but not AB) were interviewed by a general practitioner, and a 2-day course of a benzodiazepine was prescribed with no referral to local mental health services. Given ongoing concerns, an organiser of the retreat contacted AB's partner who flew over and accompanied them back to Ireland. AB required additional diazepam to support their travel back to Ireland, due to AB's ongoing disinhibited behaviour. AB was provided with no written information pertaining to their manic episode (associated with grandiose delusions) by the general practitioner. On returning to Ireland, AB was brought to an emergency department and was subsequently admitted for a four-week period to the acute psychiatric inpatient unit. They were treated with olanzapine and reducing doses of clonazepam. Since that episode, AB continues to engage with the local mental health services and has travelled abroad again on two occasions without difficulty for up to two weeks.

AB describes the experiences of the holiday in the Canary Islands as 'frightening and confusing', and the experience on arrival back to Ireland as 'distressing'. Subsequent successful trips associated with no mental health difficulties were attributed by AB to treatment adherence and a greater awareness of their mental health disorder (bipolar disorder), having had extensive psychoeducation from their mental health team. AB has had a contact number for a community mental health nurse in Ireland, for these recent successful international travels which AB describes as 'a significant comfort'.

Case 2

DF is 35 years of age, single, unemployed and diagnosed with schizophrenia in 2014 with co-morbid harmful use of cannabis. Since DF's first psychotic episode requiring involuntary admission in 2014, DF has been admitted on four occasions (twice formally under the Mental Health Act 2001) to their local psychiatric inpatient unit. DF is treated with oral olanzapine which has been supplemented with clonazepam during periods of relapse of psychosis. DF's episodes of relapse have been related, according to both DF and their clinical team, as secondary to treatment non-adherence and/or cannabis misuse.

In 2016, DF travelled alone to a Mediterranean island for a two-week holiday. Before being diagnosed, DF had enjoyed similar trips where they travelled alone. On the flight from Ireland DF became highly fearful of the cabin crew. The crew were alerted to their abnormal mental state as DF was speaking in a loud and threatening manner. On arrival at the destination airport, DF was escorted by waiting police officers to a

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local inpatient psychiatric inpatient unit where DF was involuntarily detained. On review, DF was noted to be experiencing persecutory delusions. Four days after this, a family member was alerted to DF's admission by staff at the acute psychiatric inpatient unit and the following day DF's family member travelled to support DF. DF was discharged from hospital three days later without any documentation pertaining to their hospital admission and travelled back to Ireland, where DF was reviewed by their treating community mental health team and subsequently admitted voluntarily to their local psychiatric inpatient unit for four weeks with ongoing persecutory delusions. Since that admission DF has been treated with the antipsychotic medication olanzapine in depot formulation (405 mg IM fortnightly), and has had no subsequent psychiatric inpatient admissions.

DF described the travel experience as 'horrific', stating 'I was in fear' and described receiving intramuscular medication under restraint on a number of occasions. DF self-reports other physical restraint procedures including being 'tied to my bed'. DF admitted to treatment non-adherence prior to travelling. DF has not engaged in any travel outside Ireland since this episode, with a fear of a similar experiences occurring, a predominant reason for this decision, and plans no further travel in the future, despite their now-stable mental state.

Case 3

HG is 25 years old, single, unemployed individual with a diagnosis of schizophrenia (first psychotic episode in 2017) and co-morbid epilepsy. HG had been engaged with an Early Intervention in Psychosis (EIP) service since their initial presentation but admits to partial adherence with their prescribed olanzapine. In December 2017, HG travelled to visit a family member in Southeast Asia, without informing their treating EIP psychosis team.

While on holiday, HG developed new persecutory delusions and suicidal ideation. HG's family member describes HG becoming more fearful and irritable and was alarmed by HG's paranoid ideation. They accompanied HG to their GP where HG was prescribed diazepam. The family member contacted the EIP team in Ireland who offered advice and support. HG's family member accompanied HG on a flight back to Ireland (HG required additional diazepam to facilitate this journey back to Ireland) and was reviewed the day after arrival to Ireland by their treating EIP team, and outpatient support was attained with an ameliorating effect on HG's psychotic symptoms.

HG believes that their holiday was 'ruined' due to a relapse of symptoms and that this episode of illness has negatively impacted on HG's relationship with their family member. HG believes that the 'long distance they travelled' was the reason for a worsening of their mental state. HG also admits to limited adherence with olanzapine in the two weeks prior to travelling. HG has not travelled out of Ireland since this episode and is very hesitant about the idea of future travel, particularly if the location is a long distance from Ireland, even though they are now treatment adherent and have a stable mental state.

Case 4

BF is a 22-year-old third-level student, diagnosed with schizophrenia (first episode in 2016), with symptoms predominantly related to persecutory and referential delusions. Due to variable adherence, BG was commenced on a depot medication (aripiprazole 300 mg) in January 2017, particularly as psychotic symptoms (albeit not overly intense or intrusive) recurred secondary to partial non-adherence with oral aripiprazole. BF informed their community mental health team of a planned trip to mainland Europe for 10 weeks between June and August 2017. A decision was made to discontinue their depot antipsychotic medications, given the complexity of organising this when travelling and BF was switched to oral medications 2 weeks prior to travelling (aripiprazole 15 mg). During the period of travel, there was no contact between BF and the local community mental health team in Ireland.

BF stated that although the trip was enjoyable, they experienced psychotic symptoms *at times, including delusions of a persecutory nature. For example, BF believed that harm might come to BF and BF's travel companion from people in one town where they stayed. BF's travel companion was unaware of their existing mental illness and although they noted that BF was more withdrawn than usual during some periods of travel, they were unaware of the presence of psychotic symptoms. Psychotic symptoms were more intense and correlated with times that BF had relatively poor adherence with aripiprazole. Since returning to Ireland, BF has been re-established on aripiprazole in depot formulation (400 mg IM monthly), with no psychotic symptoms now evident.

BF found the development of psychotic symptoms when travelling 'upsetting' and although travelling (for most but not all the holiday) with a friend, felt 'isolated' at times. BF was aware that improved adherence with medication ameliorated their symptomotology. BF has engaged in two briefer trips out of Ireland (without any mental health sequelae) since this time but these both were of shorter duration; BF received their depot antipsychotic medication before

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and after returning to Ireland with no associated periods of treatment non-adherence. BF plans to travel again in the future and has agreed to bring documentation from the treating community mental health team pertaining to their mental illness, will inform any travel companion of having mental health difficulties and will endeavour to have improved treatment adherence with oral medication if organising depot antipsychotic medications is not feasible. BF is confident that future travel experiences, even if of longer duration, will be successful and are happy to follow the plan outlined earlier.

Cases 5 and 6

DB is a 48-year-old individual with schizoaffective disorder first diagnosed more than 20 years ago, and is the principal carer for a family member who suffers dementia. DB's mental state has been stable on clozapine 600 mg nocte for many years, and is treated with sodium valproate for prophylaxis of seizures due to their relatively high treatment dose of clozapine. DB experiences overvalued persecutory ideas at times, but these do not impact on their functionality. They frequently visit religious sites abroad with their local church group and have been on many trips with them. Most recently, in June 2018, they travelled to Medjugorje, and DB found the trip very enjoyable. One of their travel companions, PM, is also a patient of the clozapine clinic.

DB stated that they found it comforting to have a companion on the trip, in part because PM is a fellow service user who could relate to their concerns but particularly as they are a 'supportive friend'. DB has not experienced a deterioration in their mental state while travelling. DB always informs the clozapine team of their intention to travel, and they provide them with a letter detailing their condition and treatment which they could present to local mental health services should they become unwell. DB has sufficient medications for their periods of travel although on some initial travels, they had concerns that their medication would be seized in the airport.

DB states that they would encourage other patients with psychosis to travel. DB admits some reluctance to travelling alone, due to concerns regarding disorganisation in relation to travel arrangements but not related to concerns of a relapse of psychosis. DB believes that close engagement with clozapine staff prior to travel and having contact telephone numbers of two staff members of the clozapine service is of significant support to them. DB plans to travel with their church group on an annual basis and is optimistic that such international trips will not be associated with a relapse of psychosis.

PM is a 54-year-old, unemployed individual with a history of paranoid schizophrenia who has been treated with clozapine for 17 years. PM's initial illness course was characterised by frequent relapses, with symptoms including auditory hallucinations and delusions of a persecutory, religious, referential and less frequently nihilistic nature. PM continues to experience auditory hallucinations of lesser intensity, which no longer are distressing for them. PM's treatment currently consists of clozapine 275 mg daily, amisulpiride 600 mg nocte and clonazepam 5.5 mg daily.

PM has travelled with DB a number of times recently, including to Medjugorje in 2018. Like DB they are supplied with a letter explaining their illness history and current medication from their local clozapine service. PM reports travelling with DB is of significant support. PM reports that their auditory hallucinations are of low intensity when travelling and have not adversely impacted on their travel. PM plans to travel again but similarly to DB would be reluctant to travel alone, stating that this predominantly relates to organisational issues relating to travel rather than their mental illness. PM plans to engage in further travel and is optimistic about the success of further travel.

Case 7

JJ is a 53-year-old unemployed, individual with a diagnosis of schizophrenia, for 31 years and treated with clozapine for 21 years. JJ experiences some ongoing low-intensity psychotic symptoms including delusions of reference and thought broadcasting, which are not overtly distressing. JJ's treatment consists of clozapine 525 mg daily which is augmented with amisulpiride 400 mg daily and clonazepam 1 mg daily.

JJ has travelled annually for over 10 years to Lourdes with a church group and recently travelled with two family members for the first time to the United States of America(U.S.A.). Prior to travelling, JJ attained psycho-education from clozapine staff in relation to managing their medications, and obtained a letter detailing their condition and treatment which they could present to mental health services should they become unwell. JJ's medication was kept in their hand luggage to ensure they had this treatment available to them on arrival in the U.S.A. JJ enjoyed their trip to the U.S.A. and stated that they had no deterioration of their mental state and 'felt really safe', on holiday.

JJ stated that they would encourage other individuals with schizophrenia to travel, although JJ admits that on initial periods of travel, that they had anxiety regarding travelling and suffered a relapse of psychosis. JJ's positive experiences of travel have significantly reduced this anxiety and now JJ enjoys travelling, albeit JJ does not travel alone stating a lack

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of confidence as the main reason: 'you need someone with the confidence to ask for directions'. JJ also says that they would prefer to travel with someone who knew about their diagnosis of schizophrenia so that they could help them to recognise if things were 'getting bad'. JJ plans to travel on an annual basis either to Lourdes or to other locations and is optimistic about the success of further travel.

Case 8

BB is a 43-year-old unemployed individual with a diagnosis of schizoaffective disorder, who has been stable from a psychosis and affective perspective for several years. Treatment consists of clozapine 200 mg nocte and lamotrigine 150 mg nocte due to previous experiences of depressive episodes. BB, in addition, has a co-morbid diagnosis of alcohol dependence syndrome, currently abstinent for over two years. Recently, BB engaged in travelling for the first time in many years with a group of friends to Eastern Europe.

BB liaised with clozapine staff in their local mental health service ensuring they had sufficient medication for their travel experience. BB experienced no symptoms when travelling, and relates same to treatment adherence and not consuming alcohol despite some of their travel companions engaging in alcohol consumption. One other colleague was also abstinent from alcohol, which was particularly supportive for BB. The holiday was very enjoyable for BB, and after this positive experience, BB hopes to engage in further travel, but stated that travelling with at least one companion would be preferable to travelling alone, predominantly for organisational reasons, 'I'd feel safer if I was with someone, getting thorough airports on my own, getting the right gate'.

Discussion

This qualitative study is limited by its small size and the limited diagnostic range of the participants. Furthermore, within the interview protocol, participants were not asked directly about previously described risk factors; rather they were given an opportunity to focus in on factors they felt were important. While this approach is valuable in identifying novel factors, the study is subsequently limited in its ability to assess the contribution of factors the patients felt were less important or did not wish to discuss – direct questioning about the impact of jet lag and drug use may, for example, have been useful. There is, in fact, a lack of qualitative data in the literature on the effects of identified risk factors on the relapse rate while travelling. However, despite its limitations, this case series demonstrates that individuals with mental health disorders, including individuals with treatment-resistant psychotic illnesses, were able to engage in overseas travel without experiencing relapses or exacerbations of their psychotic illness.

Four individuals in this case series who were treated with clozapine for treatment-resistant schizophrenia or schizo-affective disorder travelled abroad (cases 5–8) without any adverse sequelae. Factors associated with these positive experiences included pre-travel education/counselling, the provision of specific information packages by mental health staff prior to travel in case they required input from mental health services, treatment adherence when travelling (including having sufficient medications for the duration of their period of travel) and contact details for a staff member at their treating mental health service. This cohort of patients who had long-standing contact with often-consistent mental health staff members were potentially more likely to have developed good therapeutic alliances with their treating team and thus discussed any potential travel plans. In addition, patients on clozapine have been reported to have greater adherence to antipsychotic medication compared to other cohorts of psychotic patients (Higashi *et al.*, 2013).

It is also notable that the patients who had good travel experiences had longer durations of illness, travelled for shorter time periods and travelled in the company of others. The shorter travel period may be accounted for by the fact that patients on clozapine require regular blood monitoring and longer trips would require arrangements to ensure blood monitoring occurred at their travel destination. Individuals with longer duration of illnesses have also been reported to have greater treatment adherence (Tarutani *et al.*, 2016), with poor or partial treatment adherence noted in cases 2–4.

Of further interest is the fact that the patients who had successful journeys reported reluctance to travel alone. Travelling in a group or with a companion was noted by these patients as more optimal in relation to their management of the practical issues regarding travel including following directions, or ensuring that correct transport was taken on arrival at their holiday destination. While these thematically similar worries could represent greater insight into negative symptoms of psychotic illness which truly limit the ability to cope in a foreign country, they could equally represent co-morbid anxiety symptoms (Kalin *et al.*, 2015; Temmingh & Stein, 2015; Worswick *et al.*, 2018). Social isolation is an additional risk factor for relapse

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in psychotic illness (Bowtell *et al.*, 2018), and it is perhaps unsurprising therefore that many of these insightful patients choose to go on group holidays rather than travelling alone.

While psychotic illnesses may occur *de novo* when travelling and are consequently difficult to predict or manage (case 1), individuals with established mental illness in this study (cases 2–4) may potentially have had better travel experiences if different strategies were employed, including better treatment adherence, better engagement with their mental health team prior to travel and non-use of psychoactive substances. Difficult travel experiences were associated in some cases (2 and 3) with a significant reluctance to engage in further travel, which was significantly different to the views of individuals with psychotic illnesses of similar severity who had positive travel experiences. It is possible that timely and patient-authorised communication between the traveller's treating mental health team and travel medicine physician would help anticipate potential travel maladjustments and serve to safeguard the patient's mental health in an unfamiliar overseas environment.

Conclusion

This study demonstrates that individuals with significant psychotic illness, including treatment-resistant illness, were able to benefit from positive travel experiences. Those who had successful trips abroad all planned to or have subsequently completed further travel. Appropriate pre-planning was associated with an increased chance of a positive travel episode. This included pre-travel education, the provision of specific information packages by mental health staff prior to travel in case they required input from mental health services, treatment adherence when travelling and having contact details of a staff member(s) from their community mental health service. The information provided typically included diagnosis, medications and contact details of a member of the treating team. Appropriate pre-travel communication between mental health teams and travel medicine physicians may also benefit travellers with psychotic illness.

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Conflict of Interest

The authors have no conflicts of interest to report.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. Ethical approval was obtained prior to the commencement of this study from the Clinical Research Ethics Committee of Galway University Hospitals. Informed consent was obtained from all participants. The initials of each participant have been changed and their gender withheld to maintain anonymity.

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Appendix A – Questions Utilised in Semi Structured Interview

1. Have you had previous experience of travel?
2. What concerns did you have in relation to travelling abroad (on this occasion) regarding the management of your illness?/In your opinion were there barriers to you travelling?
3. Did you think you would be able to access services while abroad?
4. Did you have any concerns about accessing services if required and how might this impact on your mental health? Do you think the lack of access to services would affect your mental health?
5. Were you supported by your mental health team preparing for your trip? Who specifically was involved, and what preparations were undertaken? Did you have contact with your mental health team when travelling?
6. Did you encounter any specific difficulties while abroad? Describe these.
7. Do the potential difficulties around following a treatment care plan result in non-adherence?
8. Have you previously travelled abroad? What worked well in relation to your travel experience, and what would you advise other people going to travel abroad?
9. Were your family aware of any potential difficulties?
10. Were any emergency supports required?
11. Do you plan to travel again? And explain reason for this answer.
12. Any other points you would like to make regarding your travel experience?

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