PREPARING FLIGHT ATTENDANTS FOR IN-FLIGHT PSYCHIATRIC EMERGENCIES: A TRAINING MANUAL

A dissertation submitted to the Wright Institute
Graduate School of Psychology, in partial fulfillment of the
requirements for the degree of Doctor of Psychology

by
REBECCA E. GRAS
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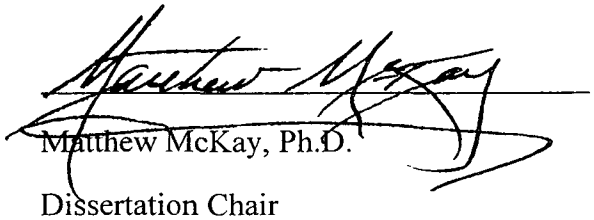
CERTIFICATION OF APPROVAL

I certify that I have read PREPARING FLIGHT ATTENDANTS FOR IN-FLIGHT PSYCHIATRIC EMERGENCIES: A TRAINING MANUAL by Rebecca E. Gras, M.A. and that in my opinion this work meets the criteria for approval of a dissertation submitted in partial fulfillment of requirements for the degree of Doctor of Psychology at the Wright Institute Graduate School of Psychology.



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While in-flight psychiatric emergencies occur at a lower rate than other medical emergencies (Matsumoto & Goebert, 2001), they tend to cause a higher degree of disruption for passengers (Gordan, Kingham, & Goodwin, 2004). However, flight attendants often receive training that is too basic, minimal, and insufficient to effectively manage psychiatric emergencies when they occur during commercial air travel (Duqeutte, as cited in Meyers, 2008; Flight Safety Foundation, 2002; Meyers, 2008).

This study reviews various elements inherent in the process of commercial air travel that may increase the likelihood that a passenger will have a psychiatric emergency in-flight. The following factors are examined: environmental conditions on a commercial aircraft, stressors involved in the process of air travel, the implication of a passenger's purpose of travel, and the effects of substance used while traveling. Additionally, there is a review of the effects of Jet Lag on a passenger's mental health, the impact of air travel on psychotropic medications, and individual passenger risk factors. This study also critiques the current training system and explores various training models and suggestions that are presented within crisis intervention literature.

The results of this study include a manual which employs an understanding of the relationship between air travel and mental illness while drawing upon recommendations and best practice models offered within the field of crisis intervention. Through the utilization of clear behavioral indicators, flight attendants are taught to recognize a range of psychiatric emergencies which may occur on a commercial aircraft. Additionally, the manual offers attendants specific behavioral recommendations which can be used when attempting to defuse a crisis situation. Lastly, the manual focuses on the mental health of flight attendants; attendants are taught to recognize their own indicators of anxiety and offered a variety of tools to decrease their own crisis responses. The goal of this manual is to better prepare flight attendants to identify and handle a full range of in-flight psychiatric emergencies thereby creating a safer flying experience for passengers and flight attendants alike.

ACKNOWLEDGMENTS

In ordinary life we hardly realize that we receive a great deal more than we give,
and that it is only with gratitude that life becomes rich.
-- Dietrich Bonhoeffer

This dissertation is not the product of my labor alone, but rather the culmination of many individual's efforts. I would like to thank my committee members, Dr. Matt McKay and Dr. Karen Davison whose patience and encouragement guided me through each step of this process. I also honor my family and friends who have offered countless hours of support, listening to me vent with regard to this topic. I imagine that most of them know more about the airline industry that they had ever imagined that they would! Specifically, I am thankful for my dear friend Batya who lent me her artistic talents and brought my visions to life and my father who offered editing suggestions and kind words of encouragement and support throughout this process. Last, but certainly not least, I full heartedly thank my husband: Benny, your kind and supportive words guided me out from the trenches on more than one occasion.

DEDICATION

To the young man traveling from San Francisco to New York: witnessing your pain and struggle inspired me to reach out to other travelers with mental illness.

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Chapter One: Introduction

Background

Air travel is no longer a mode of transportation reserved only for the elite. More manageable prices have made air travel accessible to the masses (Bor, 2004). In fact an estimated one billion people worldwide make at least one airplane trip a year (Bor). According to the Bureau of Transportation Statistics, as listed on the U.S. Department of Transportation's website (n.d.) in the United States alone, 680 million passengers flew on a commercial airline in 2008. This is a 2.9% increase from 2007 when a reported 661 million passengers flew.

While in-flight psychiatric emergencies occur less often than other medical emergencies (Matsumoto & Goebert, 2001), they tend to cause a higher degree of disruption for passengers (Gordan, Kingham, & Goodwin, 2004). In extreme cases, the disruption may even pose a safety threat to all passengers (Gerwen, n.d.; Pierson, Power, Marcus, & Dahlberg, 2007; Rhoden, Ralston, & Ineson, 2008) and flight crew on board (Rhoden, 2008). The manner in which crewmembers and fellow passengers manage the individual who presents with a psychiatric emergency in-flight, determines the extent of injury that the "disruptive passenger" receives (Pierson et al.). In severe cases, the mishandling may even result in the death of the disruptive passenger (Pierson et al.). Following the events of 9/11, air travel for individuals who suffer from mental illness has become even more dangerous as crewmembers may easily misinterpret a passenger's intentions and accidently mistake them for a terrorist (Meyers, 2008).

Flight attendants are often the first responders to passengers who are in the midst of a psychiatric emergency in-flight, however their training tends to be too basic,

minimal, and insufficient (Flight Safety Foundation, 2002; Meyers, 2008). Furthermore, Kern (2003) notes that inadequate training of air crew seems to negatively impact their ability to successfully diffuse and recognize passengers that may be potentially disruptive. These observations support the need for a new training manual which will better prepare flight attendants to manage in-flight psychiatric emergencies.

Assumptions and Rationale

The process of determining appropriate mental health interventions depends largely on a clinician's diagnostic impression of the patient's difficulties. While flight attendants must choose appropriate types of interventions during a crisis situation, they are not legally permitted to diagnose a passenger. Given the importance of properly assessing an individual's type of presentation in order to determine appropriate responses, the proposed manual utilizes behavioral descriptions of various mental health disorders and teaches attendants how to determine appropriate intervention styles, without needing to determine an exact diagnosis.

There are a variety of models and orientations that are currently used in the field with regard to training professional to manage individuals who are in a state of psychological crisis. Given the nature of a flight attendant's qualifications and duties, the proposed manual draws on models used to train professionals who are not in the field of mental health care. Additionally, the suggestions offered within the proposed manual reflect an understanding of the unique and specific environment created on an airplane.

Statement of the Problem

While the frequency of in-flight psychiatric emergencies is reported at a lower rate than other medical emergencies, the public seems less tolerant of psychiatric emergencies than they are of medical emergencies (Gordan, Kingham, & Goodwin, 2004). Psychiatric emergencies that occur in-flight often create a stressful atmosphere for passengers and flight attendants alike. In fact, research demonstrates that such incidents threaten the emotional and physical well-being of all passengers on board (Gerwen, n.d.; Pierson et al., 2007; Rhoden, 2008). When not managed correctly a psychiatric emergency may result in injury or death for the passenger who presents in a state of psychological distress (Murr & Hosenball, as cited in Pierson et al.). This issue has been compounded post 9/11 as airline personnel are trained to practice with greater alertness with regard to potential security threats (Frank, 2005; Meyers, 2008). As a result travelers with severe mental illness have been treated as terrorists when personnel misinterpret their intentions.

Despite the critical role which flight attendants play as first responders during an in-flight crisis situation, the Federal Aviation Administration (FAA) allows each airline to use their discretion when determining the depth of training given to flight attendants with regard to managing disruptive passenger behavior (Barron, 2002). Moreover, although the mismanagement of psychiatric emergencies in-flight has been determined to have detrimental effects on individuals with mental illness, the American Psychological Association (APA) has yet to approve any manuals that could be used to train flight attendants to appropriately prepare for and manage in-flight psychiatric emergencies.

These observations support the need for a comprehensive manual that will incorporate theoretical and empirical research findings with regard to the specific nature of air travel, the relationship between air travel and psychological illness, and the limitations of flight attendants. The manual will teach attendants appropriate ways to approach, assess, and manage a passenger who is in the midst of having a psychiatric emergency while in-flight on a commercial airline.

Purpose

This study supports the creation of a manual that trains flight attendants working for commercial airlines within the United States with regard to the assessment and management of psychiatric emergencies as they arise in-flight. Preparing flight attendants with adequate training will enable them to manage such emergencies with greater confidence and effectiveness. Additionally, attendants will develop a more comprehensive understanding with regard to intervention options which utilize spoken de-escalation techniques. By learning de-escalation techniques attendants will extend their repertoire of tools beyond the conventional use of physical restraints, which have been implicated as potentially harmful for passengers.

Moreover, as attendants increase their knowledge base regarding mental illness, in general, they may begin to challenge some of the stereotypical beliefs which are often held with regard to mental health disorders.

Preview

The next chapter will include a review of the factors inherent in literature review process and the elements which inform the final product of this research (the training manual). Specifically, there will be a discussion of the integration of literature taken from

the field of clinical psychology, aviation, and news media. The methodology section will review the ways in which these empirical data sources have been synthesized and are integrated in the manual, which is presented in the results section of this study.

Chapter Two: Methods

An integration of the available literature on the topic of in-flight psychiatric emergencies is presented in three sections to support the development and production of the final product, a training manual. The first section creates a context for psychiatric emergencies as they occur in-flight by examining relevant literature regarding the rates of occurrence, the safety risks of such incidents, the effects that 9/11 have had on air travel for individuals with mental health challenges, and the role that physicians play during such emergencies. The second section examines the relationship between psychiatric emergencies and air travel by examining specific factors that seem to contribute to and increase the likelihood of a psychiatric emergencies occurring in-flight. The third section reviews some of the current training standards, while identifying some of the inadequacies of the current training system. The final chapters of this study present the training manual and offer a discussion regarding the implication and limitations of this study and suggestions for future research.

Literature Review Process

The literature is integrated using a Bio-Psycho-Social model, as there is an integration of biological, observable behaviors and psychological dynamics within the context of social factors. The final product reflects this integration as attendants are trained to examine and address each of the aforementioned factors in an effort to appropriately diffuse a psychiatric emergency in-flight.

In an effort to define the scope of the literature review, key words and the inclusion criteria utilized are examined. Because the terms psychiatric emergency and psychological emergency are not standard key words used within aviation or

psychological literature, the literature review process investigated other related terms, such as: Disruptive Passenger Behaviour or Behavior, Air Rage, Unruly Passengers, Travel Syndromes and Medical Emergencies In flight. Other search terms used include: Psychiatric Emergencies in Flight, Stress and Air Travel, Emergencies in Air, Anxiety and Air Travel, Training Criteria for Flight Attendants and Flight Crew, Training for psychiatric emergencies, Disruptive Passenger Behaviour or behavior, Air Rage, Unruly Passengers, Travel Syndrome, and Medical Emergencies In-flight. Additionally, in an effort to gather data with regard to recommendations and best practice models for crisis intervention, the following search terms were used: Non-violent Crisis Intervention, Mental Health Crisis Management, Crisis Intervention Guidelines, Risk Management, Managing Urgent Mental Health needs.

The search fields utilized in this study determine the scope and range of the research that is referenced. Given the interdisciplinary nature of this research project, literature was gathered from an array of sources, including: the field of aviation psychology, governmental agencies within the commercial aviation industry, and peer reviewed psychological journals. Additionally, given the fact that commercial air travel was studied, newspaper and magazine articles were referenced to capture the full range of perspectives relevant to this project. Moreover, while the proposed training manual will be geared towards training flight attendants in the United States, the limited amount of data on the topic necessitated the inclusion of any related journal article, regardless of the country of publication.

Towards the Development of a Comprehensive Training Manual

Due to the lack of international standards with regard to training of cabin crew (Abeyratne, 2007; Barron, 2002), it is up to airlines to determine the extent of their training. As a result, each airline has its own set of manuals and standards. Given the proprietary nature of the training materials, the actual manuals were not available to be critiqued. Thus, this study draws upon the critiques offered by scholars and researchers within the field of clinical and aviation psychology. The final product of this research synthesizes the literature regarding techniques commonly taught to non-psychological professionals while also adapting the training to the specific stressors, situations, and the environment particular to a commercial aircraft.

Chapter Three: In-flight Psychiatric Emergencies: A Contextual Review

Rates of In-flight Psychiatric Emergencies

Within the literature, there are limited references to psychiatric emergencies as they occur in-flight. While some seminal studies have been conducted that examine this issue, the available statistics likely underestimate the extent to which these incidences occur (Flight Safety Foundation, 2002; International Transport Workers' Federation, 2000). First, this section will offer a general definition for the term psychiatric emergency. Next, there will be an examination of current statistics on the incidence rates of in-flight psychiatric emergencies. Additionally, factors will be proposed that may contribute to the difficulty in adequately assessing how often psychiatric emergencies occur. Finally, in the latter portion of this section, this researcher will attempt to categorize the types of psychiatric emergencies that have been reported in the literature with respect to the following variables: gender, socioeconomic class, type of mental illness, and history of prior mental health diagnosis.

Definition of Psychiatric or Psychological Emergency

For the purposes of this study, Psychiatric or psychological emergencies include any incident in which a passenger is in a state of psychological distress that may result in harm to that individual or to others. Psychological distress may include experiences of altered reality and hallucinatory episodes. The experience of altered reality may be due to a range of factors including: substance use, medical conditions, or a psychotic break (Flight Safety Foundation, 2002).

On an aircraft, psychological distress may manifest in one or more of the following ways: psychosis, anxiety reaction, panic response, and substance use or

withdrawal. Additionally, the behavior of a passenger experiencing psychological distress may be deemed disruptive, unruly, or an act of "air rage" (Flight Safety Foundation, 2002). While the aforementioned terms for passenger behavior are used quite frequently there are no established definitions or standards within the field of aviation psychology for these terms.

Estimated Rates

According to The Office of NASA Aviation Reporting System (ASRS, 2000) in 1999, "passenger behavior problems" were the most frequently reported incidences to ASRS by cabin crew personnel. However, it is not clear what behaviors were included within "passenger behaviors." In an effort to quantify the occurrence rates of in-flight psychiatric emergencies, Matsumoto and Goebert obtained information from MedLink, a 24-hour medical consultation service that is used by nine commercial domestic and international carriers. According to Matsumoto and Goebert, MedLink estimated that they provided service for 24% of domestic flights within the United States during the 1997 calendar year. Matsumoto and Goebert's results indicate that of 1,375 in-flight calls made on commercial flights in 1997, 3.5% were categorized as psychiatric or psychological emergencies.

In terms of the occurrence of "air rage," which in some cases may be considered psychiatric in nature, it seems that airlines are more likely to report such incidences when they occur. For example, Barron (2002) examined the incidence rates of worldwide reports of air rage from the Air Transport Association (ATA). According to ATA (as cited in Barron) 1,132 incidences were reported in 1994 while 5,416 were reported in 1997. This tremendous increase may be a reflection of the increase in rates of air rage

have risen or may indicate the airlines increased efforts to emphasize the importance of reporting such incidences. Barron (2002) also found increases in reported incidences of air rage in a review of data of two major Australian airlines that first began to record incidence of air rage in 1998. More specifically, during 1998 thirty incidences had been reported, whereas by 1999 there were 650 reported incidences (Barron). Furthermore, other airlines demonstrated similar growth patterns. For example, Barron cited a Japanese airline and Calder (as cited in Barron, 2002) noted that during one full year in the United Kingdom, 1,200 incidences of "air rage" had been reported. More specifically 70 of these "air rage" incidents were deemed "most serious."

Similarly, The Department for Transport (n.d.) found that in 2006-2007 there were 2,219 incidences of disruptive passenger behavior which occurred on British aircrafts, as reported to the Civil Aviation Authority. This finding was nearly double the 1,303 reports made during the previous year, according to The Department for Transport.

Lack of Uniform Definition within the Literature

Psychiatric emergencies may be under-reported and under-represented within the literature, as the events become subsumed under the heading of different categories. The following terms exist within the literature and likely represent events which emanate from psychological difficulties: "passenger misconduct," "passenger behavior problems," "unruly passenger behaviors," "air rage," "disruptive passenger behavior," "travel syndrome," and "travel fatigue." Additionally, the aforementioned events may be included within the category of "medical emergencies." For example, Matsumoto and Goebert (2001) noted that within the some of MedLink's medical categories (e.g. Cardiac, Neurological, and Respiratory) there are likely psychiatric incidences that have

been wrongly categorized. Furthermore, Pierson et al. (2007) note that although the Federal Aviation Administration (FAA) and The National Aeronautical and Space Administration (NASA) each have reporting systems, much of the disruptive passenger incidents are usually categorized as "medical emergencies" and often are managed by healthcare personnel.

Moreover, psychiatric emergencies may be handled as legal offense requiring the involvement of law enforcement. For example, Pierson et al. (2007) noted that the rates of in-flight psychiatric emergencies are inaccurate, as behavior problems that result from psychosis, personality disorders, substance withdrawal and intoxication are often managed by the legal system and not categorized or reported as psychiatric emergencies. Furthermore, Pierson et al. noted that such behavior is usually subsumed under the category "passenger misconduct." Additionally, Matsumoto and Goebert's (2001) posited that the limited accounts of psychotic episodes and the lack of reports of disruptive passengers in their sample may be due to the fact that such cases are handled through legal means, with consultation likely initiated with the FBI (Matsumoto & Goebert).

Lack of One Comprehensive International Database

The field of aviation lacks a single comprehensive reporting database that may host reports of in-flight emergencies as they occur internationally (Anglin, Neves, Giesbrecht, & Kobus-Mathews, 2003). Thus, no one database is currently utilized by all airlines to receive and provide reports of psychiatric emergencies (Rayman, 1997). Currently, there are multiple databases used to host an airline's reports of incidences that occur in-flight. Some of the databases that are currently used in the field include, Aviation Safety Reporting System [ASRS], Aircrew Incident Reporting System [AIRS],

The Civil Aviation Authority [CAA], Aviation Safety Action Program [ASAP], and MedLink. All of the aforementioned databases rely on the self-reports of crew members, pilots, or ground staff. Pierson et al. (2007) asserted that the reported rates of passenger misconduct are often inaccurate and incomplete. Pierson et al. attributed this inaccuracy to the lack of standardized reporting. Moreover, Kern (2003) noted that with regard to air rage, actual reporting practices seem to vary between governmental agencies and individual airlines. Additionally, Kern asserted that it is difficult to gain a clear understanding of how and why incidents of air rage occur as reports often omit important demographic or situational details.

Lack of Emphasis of Importance of Databases and Reluctance to Report

The inaccurate rates of reported occurrence of in-flight psychiatric emergencies may also be a reflection of a lack of emphasis by commercial airline companies to keep such records or a result of reluctance by crew members to make such reports. While airlines are encouraged to report safety incidences as a way to help the airlines to notice safety trends and issues, the airlines are not mandated to report (Bor, 1999). Bor noted that the emphasis on the importance of keeping official records of incidences of air rage is a recent occurrence. Thus, it is difficult to gauge the historic progression of such occurrences. Additionally, Bor (as cited in Barron, 2002) explained that underreporting may be due in part to reluctance or hesitation on the part of the reporting crew member or the disruptive passenger.

Profile and Scope of Incidences

Gender differences. There are inconsistencies with regard to gender differences seen in individuals who present with a psychiatric disturbance while on board an aircraft.

Calder (as cited in Barron, 2002) describes a "classic" demographic profile for air rage: a male, aged 20-35, traveling with others for leisure purposes. Furthermore, according to The Department for Transport's data, on board United Kingdom aircrafts in 2007- 2008 year, 74% of reported incidences of "disruptive passenger behaviour" involved male passengers. However, it is possible that this data is skewed by reporting bias, as a crew member might feel more threatened by a male passenger who is traveling as part of a group. In contrast, an individual traveling alone may be perceived by crew members to be a more manageable threat. With regard to other types of psychiatric emergencies, research supports a range of ages and genders (Barron, 2002). For example, according to Juahar and Weller's (1982) sample, the majority of individuals diagnosed with schizophrenia (59%) were male, whereas the gender difference was almost undetectable in those diagnosed with an affective illness, as males appeared only slightly more often (52 %). Whereas, within Bar-El et al.'s 1991 study, gender was not found to be a significant factor at all.

Socioeconomic differences. Based on limited data, class or socioeconomic differences were not consistently evident in those who presented with a psychiatric incident in-flight. For example, Independent (as cited in Barron, 2002) found that passengers traveling within business class where just as likely to cause disruption as those traveling in economy class. In fact, according to Independent (as cited in Barron, 2002) in one year, 40% of business travelers had witnessed some sort of verbal or physical abuse of a fellow passenger or crew members. It seems that acts of disruptive passenger behavior occur somewhat frequently in business class cabin. *Asiaweek,* November 26,1999, (as cited in Anglin et al., 2003) featured the results of a poll of 3,000 frequent business travelers,

21% reported witnessing verbal abuse of a passenger towards flight crew, 19% witnessed "drunk and disorderedly conduct," 13% witnessed illegal smoking, 13% witnessed abuse of another passenger, and 2% experienced flights plane diversion due to air rage.

Type of mental illness. The literature presents a range with regard to the types of mental illness reported by airline passenger. This section will review some of the seminal studies that have examined the occurrence of psychiatric emergencies during travel with respect to specific types of mental illness. One of the difficulties inherent in attempting to compare the following studies is the authors' neglect to operationally define terms, such as Psychosis or Anxiety. Such terms may describe a range of possible psychiatric presentations and are not necessarily correlated with a clinical diagnosis. Additionally, the authors relied on different sources for their information, such as self-reports offered by crew members to an incident reporting system and post-treatment files of individuals, who had been admitted to a psychiatric hospital. Thus, comparisons between these studies are made cautiously with the knowledge of the aforementioned limitations.

Matsumoto and Goebert (2001) found that anxiety accounted for 90% of the emergency calls made to MedLink in 1997. Whereas, Psychosis was reported in 4% of the cases, disruptive passengers not deemed to be psychotic also encompassed 4% of the reported cases (Matsumoto & Goebert). On the contrary, Jauhar and Weller (1982) found that a diagnosis of schizophrenia was relevant for 50% of all admissions whereas only about 28% of the population sample presented with an affective disorder (Jauhar & Weller). Within Streltzer's 1979 study of the features of individuals who were admitted to a psychiatric hospital during their visit to Hawaii, Schizophrenia was the most common diagnosis in the sample (n=35). In addition, 21 patients presented with alcohol

use or dependence, and 8 individuals presented with substance use or abuse issues (Streltzer). The smallest group for classification purposes in Streltzer's sample, was individuals who presented with a dissociative disorder of disorientation (n=9) (Streltzer). Streltzer noted an age trend, as younger individuals within the sample tended to present with dissociative symptoms while the older adults had been classified as having "acute organic brain syndrome (p. 467)."

Bar-el et al. (1991) examined 83 foreign tourists (32 women and 57 men) who had been admitted to Kfar Shaul Psychiatric Hospital in Jerusalem. In accordance with earlier studies of a similar nature, the most common diagnosis reported by Bar-el et al. (1991) was Schizophrenia. Other common diagnoses (in descending order of frequency) were: Acute Psychosis, Affective Psychosis, personality disorder, and Dementia (Bar-el et al., 1991). Following their research, Bar-el et al. (1991) generated a demographic profile of a type of traveler who requires psychiatric services: male or female, aged 20-30 years, with above average education. Bar-el et al.'s research found that while half of the travelers had a profession, only a quarter of them were employed at the time of travel. Psychotic symptoms were found in approximately 80% of the sample, while the remaining individuals' were diagnosed with personality disorders or other psychological challenges (Bar-el et al.). Bar-el et al. (1991) noted that this data concurred with Shapiro's (1976) findings.

Shapiro's (1976) research explored the occurrence of mental health challenges by individuals who were in the process of air travel. More specifically, Shapiro examined the types of individuals who presented with psychiatric disturbances while at an airport. Shapiro examined the records of patients who had been admitted to Queens Hospital

Center in NY from the years 1968-1973. Shapiro found that 359 out of a total of 21,025 individuals', who had been admitted to the psychiatric emergency room, had been referred from Kennedy International Airport. Shapiro's (1976) study also included individuals who were found wandering within the airport in addition to those individuals who had psychiatric difficulties while in-flight. Shapiro found that 74% of the individuals presented with or were found to have a diagnosis of Schizophrenia with the predominant clinical features of grandiosity or persecutory delusional thoughts that revolved around or were related to some aspect of travel (e.g. the airport, or a plot that they believed they were specifically involved in or had intentions to thwart). This data might be skewed, as air travelers manifesting psychological difficulties, such as Schizophrenia, which has features that may appear more aberrant thereby attracting the attention of law enforcement agents. Whereas, more passively distraught passengers, such as those with mild anxiety or panic disorder may go unnoticed and may not be recognized as having mental health issues by authorities.

In another seminal study, Young (1995) included 30 subjects within his sample who had traveled to Honolulu from 12 different countries. Within Young's sample 19 had arrived on westbound flights, while 11 of the subjects had arrived on eastbound flights. Young's subjects were patients admitted to Queen's Medical Center between August 1990 and January 1991 who had been treated for psychosis. Young found that 18 of the travelers (60%) were not perceived to be "acutely ill" at the time of departure based on self-reports and collateral information, whereas 11 individuals (36%) were identified as being ill before their plane departure. Additionally, Young found that nine patients (30%) reported prior or current substance abuse. Three of Young's sample subjects tested

positive in their urine for traces of ethanol. Young (1995) failed to state who the "collaborators" were who provided the researchers with information nor was it clear what factors were used to evaluate whether a traveler was presenting with a psychiatric disturbance.

Weishmann, Anjoyeb, and Lucas (2001) explored the incidence rates of individuals who have mental health issues in airports. While Weishmann et al. does not include individuals with in-flight difficulties or those dealt with by "passenger services" such as flight attendants, the results of their research illustrate the scope of psychiatric illness within air travel. Weishmann et al. found that among those detained in the airport for mental health purposes, individuals with a diagnosis of Schizophrenia and Schizotypal Personality Disorders were represented most in the reported sample (compared to other disorders and conditions). These results should be interpreted with caution as it is possible that those who presented with more manageable symptoms or disorders, such as anxiety, were less likely to be detained. Whereas with regard to disorders, such as Schizophrenia, which may manifest with more severe behaviors, airline personnel may more readily interpret their behaviors as dangerous.

Safety Risks Associated with In-flight Psychiatric Emergencies

The unique environment on a plane, which restricts passengers to the confines of an aircraft without access to an immediate exit, can make the experience of an individual undergoing a psychiatric emergency frightening and potentially dangerous to all individuals on board the air-craft (Barron, 2002). Additionally, Gerwen (n.d.) notes that such occurrences can be costly for airlines as they may lead to emergency landings. This section will explore the potential safety risks that in-flight psychiatric emergencies pose

on flight crew members, passengers, and the individual who is presenting with psychological distress.

Psychiatric emergencies that occur in-flight may create a stressful atmosphere for passengers. In fact, a psychiatric emergency may actually threaten the emotional or physical wellbeing of all passengers on board (Gerwen, n.d.; Pierson et al., 2007; Rhoden, 2008). In extreme situations where the "disruptive individual" attempts or commits suicide using the plane, all passengers are at risk, which will be further explored in the section regarding passenger suicide. Additionally, when a psychiatric emergency escalates, it may require the attention of many flight attendants thereby rendering them unable to assist other passengers who may be experiencing difficulties.

The impact that in-flight psychiatric or psychological emergencies have on flight crews has not been directly explored in the literature. Although, the literature does describe related terms such as "disruptive passenger behavior" which may include incidences that are psychiatric in nature. In addition, there have been many incidences in which flight attendants have reported experiencing direct physical assault by a distressed passenger (Rhoden, 2008) or emotional abuse such as name-calling and insulting comments which target the attendant's physical appearance or intelligence (Abeyratne, 2007). Furthermore, Rhoden (2008) noted that flight attendants are at risk when their attempts to manage a disruptive passenger's behavior are ineffective. In fact, according to Gerwen (n.d.) in the Netherlands, 18% of cabin crew members had sought out medical care for treatment of mental health issues such as anxiety and depression. Gerwen cautioned the reader that while disruptive passenger behavior is not solely responsible for these mental health issues in crew members, it may play a significant role.

Moreover, a situation that cannot be controlled solely by the flight attendants may require the assistance of a pilot. For example, within *Callback*, a monthly safety bulletin published by The Office of the NASA Aviation Safety Reporting System (ASRS, 2000), behavioral incidence reports in 1998 were reviewed. According to the ASRS, 43% of disruptive passenger behavior caused disruption to both the cabin and the cockpit crews. It is ultimately the pilot who is responsible for deciding how to proceed during any emergency situation (Rosenberg & Pak, 1997). In fact, in 22% of the reported cases a pilot had to leave the cockpit in order to assist crew members in managing a disruptive passenger. ASRS also found that when pilots became involved in the management of disruptive passenger behavior, other passengers and crew were at higher risk of serious incident because of the pilot's distraction from their flying duties.

The literature overlooks the extent of damage that may be experienced by the individual who presents in a state of psychiatric emergency, while on an aircraft. An individual, who is in the midst of having major psychological distress, may accidentally or intentionally inflict harm on themselves. This possibility increases if the cabin crew fails to appropriately manage the psychological emergency. Furthermore, when the intentions of a disruptive passenger are not fully understood the crew may respond with undue force which may result in serious injury. Such was the case with Rigoberto Alipizar, a man diagnosed with Bi-polar Disorder who was killed after being mistaken for a terrorist (Morrissey, 2005). Additionally, Pierson et al., (2007) noted that when other passengers involve themselves in an attempt to manage a disruptive passenger's behavior the situation may escalate and result in unnecessary violence towards the disruptive passenger. In the most severe cases, the aggressive attempts of fellow passengers to

manage the disruptive passenger resulted in the deaths of the disruptive passengers (Murr & Hosenball, as cited in Pierson et al.). Furthermore, beyond the physical injury that may be sustained, there exists the potential for psychological trauma, shame, and emotional turmoil that a distraught passenger may retain after the psychiatric emergency itself has been resolved.

The Effects of 9/11 on Air travel

Since the terrorist events of 9/11, air travel for individuals who struggle with mental illness has become more dangerous than ever, with psychiatric and psychological incidences being mistaken for acts of terrorism (Meyers, 2008). Frank (2005) wrote, "In the post-9/11 world, such behavior draws increasing scrutiny from flight crew. As the U.S. aviation system has become more security-conscious, it has also become less tolerant of strange behavior by passengers (p.1)." Two recent examples demonstrate this occurrence, in September 2008, Carol Anne Gotbaum became frantic after missing a connecting flight on route to a treatment facility (Bardach, 2007). According to Bardach, the police inappropriately placed her alone in a holding cell, where she accidentally strangled herself. Also, in 2005, Rigoberto Alipizar, an individual diagnosed with Bipolar disorder, was incorrectly identified as a terrorist (Morrissey, 2005). In fact, according to an eye witness, Alpazar's wife attempted to communicate to air marshals that he had a mental illness "She was running behind him saying, 'He's sick. He's sick. He's ill. He's got a disorder (Morrissey, p1)." However, despite her warnings, Federal Marshals shot and killed [Alpazar] as he ran frantically off the parked plane onto the tarmac (Morrissey). Both of these incidents illustrate a misunderstanding of the intentions and needs of air travelers who present with a psychiatric illness. Airline personnel struggle to differentiate

between passengers who have the intent to perpetrate acts of terror from those individuals who may act out due to mental illness.

Meyers (2008) notes that while post 9/11 has seen a rise in overall security training, airplane personnel are not being trained to more accurately assess the mental state and intentions of passengers. Ron Honberg, JD, the national director for policy and legal affairs at the National Alliance on Mental Illness (NAMI), states: "There's been so much focus on terrorism that responding to people in psychiatric distress is not even on the radar (as cited in Meyers, p. 37)." Moreover, Mary T. Zdanowicz (as cited in Wald, 2005), the executive director of the Treatment Advocacy Center, an organization that acts as advocates for those with mental illness, noted that post 9/11 flying has become increasingly dangerous for those who suffer from mental illness.

Physician's Role with Regard to In-flight Psychiatric Emergencies

When a medical emergency occurs in-flight on a commercial aircraft, flight attendants are encouraged to request assistance from any medical doctor who is also traveling on board. During a medical emergency, a physician is warranted to request a diversion of the plane, use of the medical kit provided on each plane, or reduced flight altitude (Rosenberg & Pak, 1997). Dowdall (2000) noted that in most cases when physicians intervene, "confirmation of the diagnosis and reassurance are often all that is required (p. 2)." Although, Dowdall is unclear as to whether the physicians were actually reassuring the passengers or the flight attendants. While a physician may be able to offer attendants some support during a psychiatric emergency, a psychologist or psychiatrist would be better qualified to offer assistance with regard to mental health issues. Despite this, it has been a standard within the field to ask for the assistance of a physician.

Physicians also play a large role prior to air travel as they may identify individuals for whom flying may exacerbate existing mental health issues. Young (1995) discussed the importance of a physician's role in pre-flight advisement. Treating physicians should assess whether their patient who intends to travel has any history of psychiatric difficulties that occurred during past travel. Additionally, Young noted that clinicians should advise patients of the potential risks involved in traveling across time zones as well as the impact that travel may have on their medications. Specifically, prescribing physicians may stress the importance of medication compliance, which includes advising travelers to take medications along with them on the plane (Rosenberg & Pak, 1997; Young). Additionally physicians may warn travelers of the potential negative impact that air travel may have on medications and the potential need to adjust medications or dosages, if there is a change in time zones (Rosenberg & Pak). Moreover, Young advises physicians to consider the possibility of increasing psychotropic medications prior to travel.

Linton and Warner (2000) urge health care providers to become aware of the risks that elderly patients face when traveling, especially for those with a history of mental illness. Furthermore, Linton and Warner suggested that psychotropic medication be prescribed as a prophylaxis for those who may have a history of "travel related affective episodes (p. 1071)." While pre-screening and advisement of passengers is an ideal preventative measure, airlines cannot guarantee that a passenger will visit his or her physician prior to embarking on a plane.

Summary and Preview

This chapter identified a context in which the occurrence of psychiatric emergencies may be better understood, by defining terms and rates of occurrence. Additionally, this chapter examined the potential safety risk that in-flight psychiatric emergencies pose for passengers' and crewmembers, and the role that physicians may play during an in-flight psychiatric emergency. With the context well established, the next chapter surveys elements of commercial air travel that contribute to the likelihood that a passenger may have a psychiatric emergency while in-flight.

Chapter Four: Factors that Contribute to In-flight Psychiatric Emergencies

Environmental Conditions on a Plane

During air travel, passengers must contend with the environment of an aircraft, often for extended periods of time, without the possibility for immediate exit. While there is some research with regard to the relationship between an aircraft's environment and its possible effects on the mental health of passengers, this area is generally under-researched. The available research will be reviewed below.

Cabin Pressure, Air-quality, and Noise

Researchers have found that the cabin pressure in an aircraft may induce stress in some travelers (Aerospace Medical Association Medical Guidelines Task Force, 2003; Rayman, 1997; Shand, 2000). Additionally, an aircraft's traveling altitude and lowered oxygen levels may act as another set of possible stressors for passengers (Aerospace Medical Association Medical Guidelines Task Force; Rayman).

With regard to "air rage," Anglin et al. (2003) noted that air quality may aggravate passengers, thereby increasing the possibility for aggressive behavior. Additionally, Anglin et al. noted that poor air quality can worsen the effect that alcohol, tobacco deprivation, and mental illness have on those who experience air rage. Similarly, Bell, Greene, Fisher and Baum (as cited in Barron, 2002) discuss the possible effect that the dry, pressurized environment on an aircraft may have on a traveler's mental health. Specifically, Bell et al. (as cited in Barron) noted that the stress and irritation caused by the air quality on a plane may increase the likelihood that a traveler may have a lapse in judgment and might commit unruly or disruptive behavior. Moreover, Fairechild (1998) quotes Vincent Mark, M.D., an environmental physician, who supported her theory

regarding the link between air rage and decreased oxygen levels, Mark states; "Curtailment of fresh air in airplanes can be causing deficient oxygen in the brains of passengers, and this often makes people act belligerent, even crazy. I'm positive about this, and it can be proven with a simple blood test."

A passenger may also perceive the noise on an aircraft to be excessive (Air Transport Association of America, as cited in Rayman, 1997). Abeyratne (2008) notes that engine noise and vibrations may increase a passenger's anxiety levels.

Cramped Conditions

Airlines are making concerted efforts to remain competitive within their market while also maintaining and maximizing their profits. Thus, in an effort to maintain decreased fare rates, many airlines have increased their passenger load (Harkey, 1999). Thus, crowding on commercial flights is not an uncommon experience. With more seats on each flight, passengers are forced to sit within closer proximity to one another (Rayman, 1997). The increase in passenger load also contributes to the immobility of passengers (Rayman). Thus, passengers may remain seated for hours in confining and uncomfortable chairs.

Shand (2000) notes that the prolonged immobility that usually accompanies commercial air travel should be considered as a factor that might increase the likelihood of a health condition developing mid-flight. Similarly, Aerospace Medical Association Medical Guidelines Task Force (2003) acknowledges the mental health risks of cramped seating on an aircraft. Moreover, McIntosh et al. (1998) noted that for a traveler with claustrophobia crowded seating conditions will surely negatively impact the passenger's mental health functioning. In fact, some authors have found cramped seating to be a

factor that contributes to the occurrence of "air rage" (Abeyratne, 2008; Birkland & Mapes, as cited in Barron, 2000). Additionally, Anglin et al. (2003) noted that cabin crowding can worsen the effects that alcohol, tobacco deprivation, and mental illness have on those who experience "air rage."

Societal Factors

During the early years of air travel, the venue was both luxurious and reserved for the elite (Bor, 2004). However, while the mechanical aspects of airplanes have become more sophisticated and accessible to more travelers, many aspects on board are less accommodating for passengers. Robort Bor (2004), a clinical psychologist and licensed pilot, noted that since commercial air travel has become more accessible to a broader range of socio-economic classes, there has been a decrease in the level of comfort and amenities that are offered. This may result in traveler disappointment or lack of preparation. More specifically, inexperienced travelers may hold the naïve expectation that air travel will be an easy, effortless process (Anglin et al., 2003; Bor, 2004). Feelings of disappointment may increase anxiety for those travelers who are already in a state of heightened emotional sensitivity (Bor).

This issue has become heightened given the recent shift in the economy as many airlines have begun cutting back on amenities that were previously standard fare, such as: entertainment, food, and beverages. Additionally, some airlines have added surcharges for luggage and seat choice (Kirby, 2008). According to Kirby, there has also been a decrease in the quality of service, as flights are being delayed or cancelled at higher rates. In fact, in June 2008 alone, 30 % of all flights were late or cancelled and average delays were reported to be at least 62 minutes (Kirby). In addition to the expected frustration

that often results when ones plans are disrupted and altered unexpectedly, these delays and cancellations ultimately contribute to increased congestion in airport terminals. As a result, more passengers are spending time in the airport anxiously awaiting the departure of their flights and managing shifts in their travel itineraries. Thus, it is not surprising that Khan (as cited in Barron, 2000) posited that delays and overbooking both contributed to the likelihood of passenger misbehavior.

Given the decrease in amenities and the frequency of delays and cancellations, the need for a positive customer service experience has likely increased. However, customer service has suffered as many airlines have cut positions for economic reasons (Kirby, 2008). Kirby noted that according to a study published by J.D. Power and Associates in June 2008, customer satisfaction with North American airlines fell to a three year low and customer service was the service area of greatest complaint.

Process of Travel

Stress exacerbates symptoms of mental illness, especially for individuals who have a history of mental health difficulties. This section will review the factors inherent in the process of air travel that may induce stress in a passenger, thereby increasing the likelihood that they may have a psychiatric emergency while in-flight.

Airport Stressors

Many authors note that the stress of travel begins long before an individual actually boards the aircraft (Abeyratne, 2008; Aerospace Medical Association Medical Guidelines Task Force, 2003; Bor, 2004; Harkey, 1999; Rayman, 1997; Shand, 2000). In particular, generating a flight itinerary and purchasing a ticket requires patience and a significant financial commitment (Bor, 2004). Additionally, travel often involves

separation familiar surroundings, objects, and loved ones (Bor; Wehr, Sack & Rosenthal, 1987) which can be quite emotionally triggering for many travelers.

Once at the airport, an individual must navigate through an intricate maze of gates and counters under tight schedule pressures (Harkey, 1999). Airport stressors include navigating traffic congestion leading to the myriad of terminals (Harkey), parking issues (Aerospace Medical Association Medical Guidelines Task Force,2003; Harkey, 1999), contending with crowds of fellow travelers (Rayman, 1997), crowded terminals (Shand, 2000), long check in-lines (Aerospace Medical Association Medical Guidelines Task Force; Harkey; Rayman), as well as physical stressors due walking a long distance to a gate (Harkey; Rayman) often with heavy luggage in tow (Aerospace Medical Association Medical Guidelines Task Force; Shand).

Additionally, the quantity of information air travelers are subject to may be overwhelming (Harkey, 1999; Rayman, 1997). This includes: confusing announcements, last minute gate changes, and unexpected flight cancelations (Aerospace Medical Association Medical Guidelines Task Force, 2003; Harkey; International Transport Worker's Federation, 2000). Furthermore, airport security can be quite stressful, especially in cases that require invasive searches of passengers or their belongings (Aerospace Medical Association Medical Guidelines Task Force). Passengers may perceive the airport security process as "intrusive or threatening" (Harkey). Moreover, a survey by McIntosh et al. (1998) found that customs processes and retrieving baggage upon arrival were a source of anxiety for one third of respondents.

Stressful Elements during Air Travel

Change in routine may have a significant effect on the mental states of travelers according to Bar-el, Kalian & Eisenberg (as cited in Bar-el et al., 2000). Moreover, disruption of a passenger's usual routine can lead to feelings of boredom (Calder, as cited in Barron, 2000) and inactivity that may precipitate disruptive passenger behavior (Flinn, 1962; Singh, as cited in Bar-el et al., 2000).

Upon boarding the airplane, individuals' are restricted with regard to the types of coping techniques that they are permitted to employ. More specifically, some individuals may be denied the use of their usual coping techniques, including excessive use of alcohol, nicotine, or illegal substances (Bor, 2004). When passengers' are denied a needed source of comfort, they may become agitated (Bor).

During air travel a passenger must contend with a rapid change in environmental factors, which may create a "severe crisis situation" for a traveler (Hiatt & Spurlick, as cited by Katz et al., 2001; Streltzer, 1979). Elements such as unfamiliar surroundings, contact with strangers or foreigners, a sense of isolation, and cultural differences were considered factors which increase the probably that an individual may have a psychiatric emergency during air travel (Flinn, 1962; Singh as cited in Bar-el et al., 2000). Shand (2000) also speaks to culture shock experienced by some travelers. This experience of culture shock may begin during a flight as travelers are surrounded by other passengers and crew members who speak a language foreign to them. In fact, language and communication difficulties were posited as factors that contribute to disruptive passenger behavior, according to the International Transport Worker's Federation (2000) survey results.

The Aerospace Medical Association Medical Guidelines Task Force (2003) identifies other in-airplane stressors, which include uncomfortable crowded seats, extended time spent taxiing on the runway, turbulence, airsickness, and inconvenient or delayed access to toilet facilities. Take-off and landing have also been identified as stressful events for passengers (Abeyratne, 2008; McIntosh et al., 1998). Additionally, disruptive passenger behavior has been linked to unavailability of meal choice, seat assignment issues, and disputes with regard to carry-on luggage (International Transport Worker's Federation, 2000). Other general inconveniences associated with airline travel that have been linked to a potential stress response in passengers, include: as lost luggage, weather delays and cancellations, and pressures related to flight connections (Aerospace Medical Association Medical Guidelines Task Force, 2003). In fact, according to a survey by McIntosh et al. (1998), flight delays, were considered a source of anxiety for 50% of respondents.

Purpose of Travel

Travel purpose may influence the likelihood of an in-flight psychiatric emergency. This section will examine the relationship between chosen fight destination and the reason a passenger chose to travel with those who have in-flight psychiatric emergencies. There will also be an examination of the phenomenon of individuals who travel with the sole purpose of committing suicide.

There is a relationship between traveling for religious or mystical purposes and mental health issues (Bar-el et al., 1991; Gordon et al., 2004). Cohen (as cited in Bar-El et al., 2000) describes an "existential mode of traveling," in reference to a religious pilgrimage that modern tourists may make at some point in their lives. For example, Bar-

El et al., (2000) documented Jerusalem Syndrome, a response seen in passengers traveling to Israel. In the service of studying and defining this syndrome, Bar-El et al. (2000) analyzed data collected from 1200 tourists over the course of a 13 year period (1980-1993). Another Bar-el et al. (1991) study included 83 foreign tourists, 32 women and 57 men, who had been referred to the Kfar Shaul Mental Health Centre located in Israel, for mental health treatment and were identified as having "severe Jerusalem-generated mental problems (pg. 86)." While the authors failed to note when the "mental issues" were first noticed, it is likely that many travelers had symptoms while en route to Israel.

Within Bar-el et al.'s (2000) sample of hospitalized individuals who presented with a history of mental health disorder, patient motivations to travel to Jerusalem included: psychotic identification with a biblical character; psychotic intent to act on a religious or political idea in Jerusalem; motivation to secure healing by traveling to Jerusalem, and resolution of personal family issues by traveling to Jerusalem. Bar-el et al. (2000) noted that similar syndromes have not been documented in other holy sites. However, with regard to individuals traveling to specific destination as part of a personal quest, Magherini (as cited by Bar-el et al., 2000) documented Stendhal Syndrome, a condition seen in some art connoisseurs who visit Florence, Italy.

An individual may travel to an exotic destination with the sole purpose if escaping the difficulties that they have been experiencing at home with hopes of discovering a better life for themselves at their new destination. For instance, Hiatt and Spurlick (as cited by Bar-el et al., 1991) identified a sub-group of individuals with mental

illness who travel to Hawaii with the sole purpose of finding "a geographical solution to internal problems (Bar-el et al., 1991, p. 238)."

Streltzer's (1979) study of travelers to Hawaii also identified a group of travelers who venture to Hawaii with hopes of escaping their troubled lives at home. He labeled this group "transients" as opposed to the "tourists" who arrived in Hawaii with the purpose of visiting (Streltzer). Price (as cited in Jauhar & Weller, 1982) refers to this same phenomenon as "move on depression," a tendency for individuals who have been diagnosed with a mental illness, especially depression, to feel motivated to travel as a way to escape the adversity of their current situation. Jauhar and Weller found that individuals within this group tended to be unmarried, younger, unemployed and with a history of previous psychiatric illness; many noted that a lack of a support contributed to their difficulties.

Additionally, Langen, Streltzer, and Mutsuoki (1997) documented "honeymoon psychosis," a condition seen in Japanese tourists visiting Honolulu, Hawaii. Psychiatric episodes occurred at a higher rate in Japanese individuals who traveled to Hawaii for the purpose of honeymooning, when compared to Japanese travelers in general (Langen, Streltzer & Mutsuoki). The authors posited that most of the travelers had a predisposition to mental illness and/or a history of psychiatric illness that was likely re-triggered by the stresses involved in adjusting to a new marriage, traveling, and adjusting to Hawaiian culture. An element also noted within Langen et al.'s study is that the majority of subjects (n=10) who had a history of psychiatric illness had not disclosed their psychiatric history to their partner prior to marriage. Additionally, the authors noted that of 9 of 16 marriages were arranged, which may have contributed to mental health disturbances

during the honeymoon. The authors caution that this should not be generalized to honeymooners from other countries, as there is no evidence yet to support such a trend (Langen, Streltzer & Mutsuoki).

Other reasons for travel that may increase an individual's level of vulnerability towards having an in-flight psychiatric emergency include holiday travel, family matters (Roger, as cited in Rosenberg & Pak, 1997), business travel (Roger as cited in Rosenberg & Pak), and travel for the purpose of relocation (Lucas, as cited in McIntosh et al., 1998). Travel related to the death of an acquaintance, friend, partner, or family member increases vulnerability as well (Wehr, Sack & Rosenthal, 1987). Surprisingly, leisure travel is also considered a stressful life event (Holmes & Rahe as cited in Langen, Streltzer & Kai). In fact, many leisure travelers may not be mentally and emotionally prepared for their trip (Holmes & Rahe, as cited in Langen, Streltzer & Kai, 1997). Plane travel may also be required for individuals with a psychiatric disorder who must transfer from one facility to another, require non-local rehabilitation, require repatriation to a country of origin, or must be deported under immigration legislation (Gordon et al., 2004).

Airplane Used for Suicide

While the act of suicide on an aircraft is uncommon, the act can have serious and potentially dangerous consequences that extend beyond the suicidal passenger. Maulen and Faust (as cited in Gordon et al., 2004) estimated that suicide is a direct cause of 2-3% of all aviation accidents. Possible scenarios include suicide by a pilot on a commercial flight (Bills, Grabowski, & Li, 2005), army jet, or a private plane (Jones, as cited by Gordon et al., 2004). With regard to suicide by a passenger, there is a growing body of

literature regarding acts of terrorism on board aircrafts. Gordon et al. (2004) notes that while the act of suicide, in general, may be understood to signify and originate from a degree of mental illness or psychopathology; this may not be the case with those who use suicide as an act of terrorism. There are other explanations for terrorist behavior aside from psychopathology, such as cultural factors, poverty, and religion.

Gordon et al. (2004) noted that the uncommon use of an aircraft for the purposes of suicide has made it difficult to understand the full scope of the issue and the factors that may predict such incidences. However, Maulen (as cited by Gordon et al., 2004) maintained that the factors that cause suicide on an aircraft are similar to the factors typically implicated in predicting suicide in general. For example, Maulen (as cited by Gordon et al., 2004) found a preponderance of grandiose and narcissistic personality traits prominent in those who did attempted suicide.

There are various methods used by passengers' to attempt suicide on an aircraft which include forcefully taking over control of the plane, jumping from an emergency exit mid-flight, using a bomb, or starting a fire. A passenger may be motivated to commit suicide on an aircraft for one or a combination of reasons including life insurance benefits, narcissistic and grandiose thoughts, delusions of grandeur, and other delusional fears or hopes of obtaining fame. Moreover, there have been cases of suicidal behaviors occurring during an episode of mania that occurred in-flight.

Substance Use or Withdrawal

This section will review the relationship between substance use during air travel and in-flight psychiatric emergencies. This section includes alcohol use and withdrawal

symptoms, as well as a review of the impact that nicotine withdrawal may have on air travelers.

Alcohol Consumption

Alcohol is readily available during most phases of commercial air travel, in terminals and on board aircrafts (Anglin et al., 2003). In fact, many travelers begin drinking prior to boarding the plane and often continue drinking throughout the duration of the flight (Aerospace Medical Association Medical Guidelines Task Force, 2003; Anglin et al.). For example, Flinn (1962) observed that amongst soldiers who presented with "travel syndrome," many had consumed considerable amounts of alcohol prior to embarking on their trip. Once on board an aircraft, passengers may use alcohol as a way to relax and manage their fears of flying (Anglin et al., 2003; Bor, 2004; Harkey, 1999). In fact, alcohol was amongst the most frequently used coping technique for anxious travelers (McIntosh et al., 1998).

Alcohol has been linked strongly to incidences of "air rage" and disruptive passenger behavior (Anglin et al., 2003; Barron, 2002; Department for Transport, n.d.). In fact, Young (1995) speaks directly to the effect that excessive substance use plays with regard to the development of psychotic features during and after travel. Results of a survey disseminated by the International Transport Worker's Federation (2000) indicated that according to representatives from 64 international airlines, alcohol is the most highly reported cause of disruptive passenger behavior. Moreover, according to a 2001 study by Bor et al. (as cited in Anglin et al., 2003), 88% of respondents from 206 airlines, believed that alcohol was considered a primary cause of "air rage." This is supported in the literature, as research demonstrates that alcohol can trigger and intensify violent episodes

in those who have certain predispositions to psychotic disorders (Smith & Hucker, as cited in Anglin et al.; Crowley et al., as cited in Anglin et al., 2003; Swartz et al. as cited in Anglin et al.).

Furthermore, a passenger's mental state can be negatively impacted when alcohol is mixed with certain medications (Anglin et al., 2003). For example, on May 06, 2009 United Airlines had to divert a plane bound for London due to a disruptive passenger who had allegedly combined sleeping pills with alcohol (Johnsson, 2009). Additionally, the effects of substances, such as alcohol and recreational drugs, may become more pronounced during air travel due to the increase in altitude and the drop in air pressure inside the cabin (Harkey, 1999; International Transport Worker's Federation, 2000). The intensification of the effects of alcohol may contribute to aggressive behavior and poor judgment (Cooper, as cited in Anglin et al., 2003) as well as dehydration (Anglin et al.).

Aerospace Medical Association Medical Guidelines Task Force (2003) also recognized the possibility for a passenger to experience withdrawal symptoms while in-flight. For example, a passenger who is in the process of recovering from an addiction to alcohol may find themselves in considerable discomfort as they are constrained in an environment where alcohol is made readily available (Aerospace Medical Association Medical Guidelines Task Force, 2003).

Nicotine Use and Withdrawal

Cigarette smoking was banned on domestic and international flights in 1987 (Aeronautics and Space, Act 14). Cigarette smoking and nicotine withdrawal have been linked to many reported events of "passenger misconduct" (Barron, 2000; International transport Worker's Federation, 2000), "unruly passenger behavior" (Pierson et al., 2007),

and incidents of "air rage" (Anglin et al., 2003). In fact, International transport Worker's Federation noted that "Physiological and psychological evidence also points to the stressful effect that not being able to smoke can have on some passengers, and in certain situations nicotine denial is known to cause disruptive behaviour (p.10)." Similarly, Aerospace Medical Association Medical Guidelines Task Force named nicotine withdrawal as a potential health difficulty. Furthermore, Harkey (1999) noted that when a passenger is denied nicotine as a source of comfort they may respond in agitation and may potentially cope with their cravings by consuming large amounts of alcohol.

Jet Lag

This section will explore Jet Lag, an air travel specific condition that has been found to have a relationship to mental illness. Within this section, Jet Lag will be defined and there will be an exploration of the relationship between Jet Lag and mental health disorders, in general. Additionally, there will also be an examination of the particular factors that determine the degree and type of impact that Jet Lag has on travelers with mental illness including the direction traveled, age of the traveler, and history of prior mental health diagnosis.

Definition of Jet Lag

According to Waterhouse et al. (2007), Jet Lag is a condition which occurs when an individual travels across three or more times zones. A rapid change in time zones produces a lack of synchronization between the passenger's internal body clock and the new time in the travel destination (Waterhouse et al., 2007). When the body clock does not adjust immediately to the destination's time zone, the experience of Jet Lag occurs with symptoms that include difficulty sleeping, change in eating habits and digestion

difficulties (Waterhouse et al., 2007). Also, Jet Lag may produce marked difficulties in the performance of mental and physical tasks, an increase in the occurrence of headaches, and an increase in irritability (Waterhouse et al., 2007).

The sleep-wake process is governed by the body's internal clock which is controlled by zeitgebers (time-givers); environmental indicators, including clocks; contact with natural sun light; and social indicators from others (Aerospace Medical Association Medical Guidelines Task Force, 2003). According to several studies, the symptoms of Jet Lag dissipate as the body's internal clock adjusts to the new time zone (Haimov & Arendt; Meir; Parry; Waterhouse, Reilly, & Edwards, as cited in Waterhouse et al., 2007).

Relationship between the Biological Aspects of Jet Lag and Psychobiological Features of Mental Health Disorders

In an effort to examine the relationship between the biological aspects involved in Jet Lag and mental health disorders, the biological elements involved in circadian rhythm regulation will be explored. The role that desynchronization plays in mental health disorders will also be discussed.

The suprachiasmatic nuclei, which is located in the hypothalamus region of the brain, has been found to be the main center responsible for the regulation of the body's internal clock (Klein et al., as cited in Katz et al., 2001). Katz et al. (2001) asserted that of the external cues that are utilized by the internal clock for the purposes of regulating the body's circadian rhythms, light and dark have been most strongly indicated and control the release of the hormone melatonin. More specifically, the retina picks up the external lightness or darkness cues, and transmits the information to the pineal gland by way of

the suprachiasmatic nuclei and the sympathetic nervous system (Brizizinski, as cited by Katz et al., 2001). Penav (as cited by Katz et al., 2001) noted that melatonin also plays an important role in the regulation of cortisol and temperature levels, which normally takes place on a 24 hour schedule.

Affective disorders. Affective disorders are mental health disorders in which an individual presents with a pervasive alteration in mood that negatively impacts their thoughts, emotions, and behaviors. The following disorders are commonly referred to as affective disorders: Major Depressive Disorder, Generalized Anxiety Disorder, Anxiety Disorders including phobias and panic, Bi-polar Disorder, and Cyclothymic Disorder. Disturbances in circadian rhythms, dysrhythmia, have been linked to neuropsychological shifts in cognition, motivation levels, and affect (Healy, as cited in Katz et al., 2001).

With regard to depression, Katz et al. (2001) noted that the relationship between desynchronization and depression varies. An overlap between the symptoms of Jet Lag and that of Major Depressive Disorder has been observed (Arendt, as cited by Katz et al., 2001). For example, both conditions may manifest with sleep disturbance, irritability, heightened anxiety, and somatic complaints (Healy et al., as cited in Katz et al., 2001). Additionally, there is evidence that individuals who present with Major Depressive Disorder have been found to have abnormalities in their melatonin secretion patterns (Zetin & Potkin, as cited in Katz et al., 2001).

For individuals that have been diagnosed with Bi-polar Disorder, there is a high co-occurrence of sleep sensitivities (Wehr, as cited in Wehr, 1991). Moreover, for individuals who have been diagnosed with Bi-polar Disorder, sleep deprivation has been found to acts as a catalyst for mania (Wehr, Sack, & Rosenthal, 1987; Wu & Bunney, as

cited in Katz et al., 2001). Thus, there seems to be a bi-directional relationship between mania and sleep deprivation; loss of sleep contributes to episodes of mania while individuals who present with mania are also less likely to maintain healthy sleep habits and as a result often deal with the effects of sleep deprivation (Wehr, Sack & Rosenthal).

Additionally, it has been hypothesized that an individual's recovery of sleep in the day or night following travel-induced sleep loss can actually precipitate depressed mood. In fact, Wehr (1991) observed that during the period of sleep that followed a night of sleep deprivation patients' spent the majority of their sleep in cycle-2, thereby not entering the REM cycle. Thus, it seems the non-REM portion of sleep acts as a mood depressant with anti-manic properties (Wiegand et al., as cited by Wehr, 1991). Katz et al. (2002) cited a study by Wirz-Justice and Van den Hoofdakker in which treating sleep deprivation in depressed patients' yielded euthymia. Furthermore, Wright (as cited in Katz et al., 2001) reported a case of psychotic mania that emerged after a night of sleep deprivation in a patient who had no history of previous psychosis.

Similarly, Leibenluft, Albert, Rosenthal, and Wehr (1996) obtained data from patients at the National Institute of Mental Health with rapid cycling Bi-polar Disorder. Data demonstrated a relationship between sleep and mood; a decrease in hours of sleep seemed to predict the patient's self-report of hypo-manic mood the following morning (Leibenluft et al.). Leibenluft et al. also found that manipulating the wake-up time of an individual who have been diagnosed with Bi-polar Disorder played a large role in predicting the individual's mood. This consideration is relevant for overnight flights in which an individual may experience disruption in their usual sleep-wake cycle, specifically, effects on their wake-up time.

Schizophrenia. The relationship between circadian rhythm abnormalities and Schizophrenia and Schizophreniform Psychosis is under-researched and the findings seem somewhat limited and inconsistent (Katz et al., 2001). Van Cauter (as cited in Katz et al.. 2001) found that while the pituitary-adrenal gland and circadian rhythms were normal in schizophrenic men, their prolactin secretion was hyper-responsive to physiological shifts associated with sleep. In contrast, Jang (as cited in Katz et al., 2001) hypothesized a direct link between abnormalities in melatonin metabolism and the pathogenesis of schizophrenia. Katz et al. (2001) noted Jang's assertion has yet to be empirically supported, but if empirical evidence was made available, then Katz et al. (2001) assert that Jet Lag may be viewed as a trigger for the manifestation of psychotic states in individuals who have been diagnosed as having Schizophrenia or other Schizophreniform Disorders.

Factors That Impact the Relationship between Jet Lag and Mental Illness

The direction that a plane is traveling may play a role in determining the manifestations of symptoms that may result from Jet Lag. Monk, Buysse, Carrier, and Kupfer (as cited in Katz et al., 2001) demonstrated that eastbound flights produce higher levels of Jet Lag than westbound flights. Additionally, Waterhouse (2007) found that those traveling eastbound had greater difficulty falling asleep at night whereas those on westbound flights demonstrated greater difficulty with early wakening. Mcfareland (as cited in Rayman, 1997) noted that in general, most travelers recover more quickly from Jet Lag if they were traveling on a plane that was headed west whereas those who were heading east seemed to have longer recovery periods.

Researchers have found that the direction traveled does seem to have an impact on the nature of mental health symptoms of airline travelers. For example, Young (1995) found that westbound travelers were significantly more likely to present with symptoms or manifestations of depressed affect whereas those individuals who traveled eastwardly demonstrated significant levels of mania. However, Young (1995) recognized that in this study there was no way to experimentally control for travel directions, which may be a confound. Furthermore, Young's (1995) sample size of 30 was limited, despite being the largest study in the literature on the psychological effects of time zone travel.

Jauhar and Weller (1982) found similar results, in those who traveled westbound, with a time zone change of at least 2 hours. In particular, airline passengers traveling westbound were more likely to present with depression whereas those who traveled eastbound presented with hypomania. In a related study, Wehr, Sack and Rosenthal (1987) discussed and reviewed four specific case studies highlighting air travel induced symptoms. One case involved a woman who traveled overnight on a transatlantic flight from the United States to Europe. She slept very little and upon arrival the following morning, awoke with hypo-manic symptoms (Wehr, Sack & Rosenthal, 1987). This is in accord with Jauhar and Weller's and Young's findings that mania tended to occur in those traveling from west to east.

Similarly, Oyewumi (1998) reviewed a case of an individual whose Jet Lag triggered a relapse of psychosis. Oyewumi concluded that westward travel to Lebanon seemed to have exacerbated the passenger's pre-existing condition of psychosis thereby necessitating an increase in dosage of the individual's anti-psychotic medication, Clozapine. Whereas the patient's dosage of clozapine required a reduction during the

eastward bound portion of his journey. Oyewumi noted that this may indicate that westward travel in particular acts to exacerbate symptoms. However, more information regarding the patient's travel history, ethnicity, purpose for travel and country of origin would be necessary in order for the reader to determine causality in this incident.

Impact of sleep deprivation or Jet Lag on those with a previous mental health diagnosis

With regard to the impact of Jet Lag on individuals who have a history of mental illness, Katz et al. (2002) noted that this area is under-researched. Some studies identified Jet Lag as a possible triggering factor in mental illness relapse, while other studies do not seem to name the particulars of the travel process that may have led to the relapse. However, it is possible to infer that based on the fact that the individual had traveled across multiple time zones, that Jet Lag is a probable causative factor.

Flinn et al. in 1959, (as cited in Flinn, 1962) documented that over a three year period, 22 cases of "travel syndrome" were documented at one air force base. According to Flinn, many similarities existed amongst the documented cases; they often suffered from symptoms of insomnia and psychiatric symptoms, which included hallucinations, delusions, and ideas of reference that usually appeared after two or three days of travel. Most Travelers were admitted to the hospital after they expressed fear for their safety and requested protection from a perceived, delusional threat. After treatment, most individuals recovered within a week. While Flinn's 1959 study did not explicitly mention the term Jet Lag, it may be implied through the records that Jet Lag or a diagnoses of Post-Traumatic Stress disorder (PTSD) was likely implicated (as cite in Flinn, 1968). However, it is also possible that many of these individuals were likely returning from

serving active duty and as a result, may have presented with premorbid levels of anxiety and/or depression prior to embarking on their journey.

Katz et al. (1999) documented a case of a 30-year-old male with no history of previous psychosis who was hospitalized two days following an eastward bound flight, with a time zone change of eight hours. Hospitalization was warranted due to psychotic responses, as indicated by "elevated affect, hallucinatory behavior, loose associations, and grandiose delusions (Katz et al., 2000, p.558)." Symptoms resolved within five days of treatment with penthixol, oxazepam and melatonin. Furthermore, Katz et al. (1999) described a second case in which a 43-year-old woman with no history of psychosis was admitted to a hospital after an eastbound flight with a time change of 10 hours. After a three day delay following the flight, the woman demonstrated a "florid psychotic state" which was resolved after taking melatonin for four days (Katz et al., 1999).

Katz, Knobler, Laibel, Strauss and Durst (2002) examined the psychiatric features of Jet Lag using subjects from the Kfar Shaul Hospital, which automatically receives any travelers that arrive to Israel and experience a psychotic breakdown. Data was collected from 1993-1998. In an effort to isolate time change as the variable responsible for the mental health break-down, Katz et al.(2002) used external sources to verify whether the patient had any preexisting mental health issues and only used patients whose psychotic symptoms emerged within seven days of landing in Israel. Additionally, the researchers accounted for demographic, religious background, travel history and psychiatric diagnosis. Katz et al. (2002) found a connection between a subjects relapse from a pre-existing psychotic or affective disorder and Jet Lag. Similarly, Tec (1981) reported a case example of an individual whose depression relapsed as a result of Jet Lag.

Impact of Age on Jet Lag

Despite the increasing numbers of older airline travelers, there is a lack of research regarding the impact that travel has on the elderly (Monk, 2005). While passenger age has been listed as a possible factor that may influence the severity of Jet Lag, there is little information regarding the differential impact of Jet Lag on older adults (Monk; Rosekind, as cited in Aerospace Medical Association Medical Guidelines Task Force, 2003). Furthermore, Linton and Warner (2000) note that there is little data regarding the ways that Jet Lag impacts older adults with a history of mental illness.

In an effort to explore the impact of Jet Lag on older adults with a history of mental illness, Linton and Warner (2000) cite three case studies. In each case, a psychiatric disturbance occurred within two weeks after returning home from travel. In two cases, the women were diagnosed with a relapse of Bi-polar Disorder in the manic phase, with symptoms of disrupted sleep and eating habits that were likely the result of Jet Lag (Linton & Warner, 2000). Linton and Warner urged clinicians to be aware of the risk that elderly clients may have when traveling, especially those with a history of mental illness. Furthermore, Linton and Warner suggested that psychotropic medication should be prescribed as a prophylaxis for those who may have a history of "travel related affective episodes (p. 1071)."

Other Factors

Several authors noted that other factors may influence the severity of Jet Lag including the number of time zones crossed during the course of travel (Aerospace Medical Association Medical Guidelines Task Force, 2003; Waterhouse et al., 2007) and

the amount of sleep loss (Graeber et al., Moline et al., Pennybaker, & Rosekind, as cited in Aerospace Medical Association Medical Guidelines Task Force, 2003).

Impact of Air Travel on Psychotropic Medications

Individuals who are being treated for a psychiatric condition may be prescribed medications that act to stabilize mood or to decrease the severity of their symptoms. The process of air travel may negatively impact the effectiveness of a psychotropic medication. This section will review elements of air-travel which negatively impact the effectiveness of psychotropic medications thereby increasing the likelihood that an individual with a mental health disorder will have a psychiatric emergency while on board an aircraft.

Young (1995) hypothesized that non-compliance to psychotropic medications may be a precipitating factor in the development of psychotic features during or after air-travel. Young studied 30 passengers who were hospitalized for a psychiatric condition after air travel to Honolulu, Hawaii. Within the sample, 50% of the sample (n=15) had been prescribed psychotropic medication. However, only 40% (n=6) of individuals reported that they had taken their medication as it was prescribed to them. In an effort to offer possible explanations for decreased medication compliance, Young noted that during travel there is a disruption of normal routine and increased possibility that medication may be misplaced or lost. Additionally, Young suggested that a traveler may feel happy during travel, thereby causing them to believe that they no longer need their medications. This factor was also observed in Streltzer's (1979) study, in which individuals who expressed a belief that moving or traveling to an exotic destination, like Hawaii, would release them from their mental health issues.

Given the stressors involved in commercial air travel, a traveler's dosages of psychotropic medication may need to be adjusted. In fact, Oyewumi (1998) documents a case example of a patient whose psychotropic medications required an adjustment due to air travel. Young (1995) also advised physicians to consider the possibility of increasing medication dosages prior to travel. Specifically, he noted that anti-depressants should be prescribed for westbound flights while anti-manic medications should be prescribed for those traveling eastwardly. Moreover, according to Young physicians should stress the importance of medication compliance, which included advising travelers to take medications along with them on the plane.

Aerospace Medical Association Medical Guidelines Task Force (2003) cautioned physicians that many of the medications that are often prescribed for psychiatric disorders cause anticholinergic effects, which may result in the slowing of digestive processes. These symptoms may become aggravated at higher altitudes and ultimately cause the buildup of intestinal gas formation. Additionally, alcohol, which is readily available on-board an aircraft, may negatively mix with psychotropic medications causing the medications to be ineffective (Aerospace Medical Association Medical Guidelines Task Force).

Significance Attached to Airport and Air Travel for Individuals with Mental Illness

Individuals with mental illnesses may be specifically attracted to air travel (Miller & Zarcone, as cited in Young, 1995; Shapiro, 1976). Shapiro was an early investigator of the relationship between mental illness and air travel and examined patients who had been admitted to Queens Hospital Center in NY from 1968-1973. Shapiro found that 74% of this sample had a diagnosis of Schizophrenia; the predominant clinical features were

grandiose or persecutory delusional thoughts related to some aspect of travel, or a plot that required the patient's involvement. More than half of Shapiro's sample had a psychiatric history which included one or more previous hospitalizations.

Shapiro (1976) found a relationship between an individual's actual attraction to the airport and their ideations that revolved largely around issues dealing with separation, abandonment, and wishes for reunification. Shapiro explained that the airport seemed to represent safety and was imbued with hopes of reunification or reattachment to a loved one. For example, many of the individuals in Shapiro's study directly referenced a hope to see family members, especially mothers. Shapiro noted that this was especially true when the separation had occurred over an extended period of time. Some individuals demonstrated a tendency to return to the airport during times of mental health decomposition. Shapiro stated:

> Apparently the airport, in time of crisis and psychotic disorganization, had come to represent concretely the focus from which time and space could somehow suddenly be bridged and the safety and security, and reassurance of reattachment to love ones might be established. (p. 455)

Hence, Shapiro concludes that the airport was experienced as a transitional object for some travelers within this sample.

Passenger Factors

This section will review various aspects of pertaining to individual features of a passenger which may increase the likelihood that they could experience an in-flight psychiatric emergency.

Passenger Nationality

On board an airplane, nationality seems to play a large role in determining the level of expectation that a passenger may have with regard to service (Kim & Prideaux,

2003). Kim and Prideaux analyzed the results of surveys that were given to flight attendants who worked for Korean Air International. Flight attendants were asked to rate their experience working with customers of three different nationalities: Japanese, Korean, Chinese, and American. Results indicated that nationality did seem to play a role in determining the level of demanding behavior that the passenger exhibited and the level of expectation that the passenger seem to have held with regard to service.

Passenger Fears

In 2006, 40% of the 2.1 billon of individuals who traveled by plane had reported some fear of flying (Abeyratne, 2008). Fear of flying, fear of crowds, and fear of enclosed spaces may contribute to a passenger's sense that they have surrendered all control to the aircraft and that they no longer have control over their well-being (Harkey, 1999). With regard to fear of flying, Abeyratne noted:

> Fear of flying is a specific phobia, not so much caused by a clear and present danger, but rather mostly caused by anxiety, as to what might happen even under the most normal circumstances. The response to this anxiety could be a totally uncontrolled and irrational act that could jeopardize the safety of the aircraft and others on board. (p. 46)

An individual's ability to tolerate anxiety will play a role in determining the extent to which they might be negatively impacted by their fear of flying (Abeyratne, 2008). Abeyratne noted that fear of flying may increase the likelihood that an individual may act out in a fit of "air rage" even in passengers who did not have any prior difficulties with aggression. Siomkos (2000) noted that a passenger's heightened sense of concern and anxiety with regard to the possibility of an airline accident may precipitate unruly passenger behavior.

Pre-existing Disorders

Air travel may aggravate a preexisting condition, causing a traveler to become increasingly disoriented and agitated while on board an aircraft (Aerospace Medical Association Medical Guidelines Task Force, 2003). Frank (2005) noted: "In most cases, disruptive passengers have a physical or mental problem that clouds their judgment." For example, Frank cited an event that occurred on March 2000, Peter Bradley, a man who suffered from a rare brain infection, was subdued by passengers and crew after he pulled out a pocket knife and threatened the cockpit.

Moreover, Green and Mooney (as cited in Aerospace Medical Association Medical Guidelines Task Force, 2003) noted that passengers who present with neurological or psychiatric disorders may become "very upset by changes to familiar routines, confusion over procedures, enforced crowding with stranger, or lack of privacy (p. A13)." Similarly, Aerospace Medical Association Medical Guidelines Task Force cautioned that some passengers may function reasonably well at home, in their familiar environment, but may decompensate psychologically on board an aircraft. For example, air travel for passengers who have tendencies towards claustrophobia or other air travel related phobias or anxieties may be particularly at risk for having an in-flight psychiatric emergency (Aerospace Medical Association Medical Guidelines Task Force).

Furthermore, certain medical conditions may have psychotic features that could be triggered in-flight. For example, "sun-downing," a condition which worsens during the nighttime could be triggered during an evening flight (Aerospace Medical Association Medical Guidelines Task Force, 2003). Moreover, impaired cognitive abilities due to conditions such as progressive dementia and Alzheimer's disease may increase the

likelihood that a passenger might become disoriented during a flight (Aerospace Medical Association Medical Guidelines Task Force).

Summary and Preview

This past chapter reviewed a myriad of factors inherent in the process of commercial air travel that increases the likelihood that a passenger may have an in-flight psychiatric emergency. Some critical factors included: the occurrence of Jet Lag when traveling across multiple time zones, the stressors that accompany the travel process, use of substances, and a passenger's purpose for travel. While chapter three established the context for which we may understand the occurrence of in-flight psychiatric emergencies and this chapter has explored the relationship between factors involved in commercial air travel and in-flight psychiatric emergencies, the next chapter will examine and critique some of the current flight attendant training standards with regard to the management of passengers who have an in-flight psychiatric emergency.

Chapter Five: Training

Critique of Current Flight Attendant Training

For individuals who suffer from mental illness, air travel can be especially dangerous. Flight attendants receive minimal and insufficient training as to how to manage psychiatric emergencies when they emerge in the air (Flight Safety Foundation, 2002). Meyers (2008) states that although the FAA requires each airline to have some procedures in place to manage psychiatric emergencies, he cites Alison Duqeutte, a spokeswoman for the FAA, who noted that each airline is permitted to develop their own training programs and that training is often quite basic. There is no uniform standard for training of crewmembers with regard to the management of disruptive passenger behavior (Abeyratne, 2007; Barron, 2002). The Federal Aviation Administration's Advisory Circular (October, 18, 1996), loosely advised airlines that training is required, but does not add much specificity as to the nature of the training:

> Air carriers should provide training for crewmembers and other responsible personnel for handling passengers who interfere in the performance of crewmember duties... regardless of how training is provided, it should include information which will help the crewmember recognize those situations which may, when combines with the traits of some passengers, create stress. (Section 6, p.3)

The depth of the training, and the definition and categorization of "disruptive passenger behavior" are both discretionary, as it is stated within the FAA's Advisory Circular (October, 18, 1996), "... an air carrier can develop its own methods of defining these occurrences (Sections 3.b., p.1)." Thus, Barron (2002) noted that the lack of specific laws has led airlines to deal with each occurrence in the way that they see fit. Barron notes that a training standard is necessary as crew members often have to make quick decisions in

the moment which follow with immediate action. Additionally, Corey Caldwell, a spokeswoman for the Association of Flight Attendants (as cited in Meyers, 2008), noted that training tends to focus on broad topics such as handling an intoxicated passenger, while neglecting to train attendants in techniques that may be used to help identify and appropriately sooth a passenger with a mental illness.

Flight Safety Foundation (2002) cited a chapter in the book "Mental Health: Pre-flight and In-flight" by Lucas (2002), to illustrate that civil aviation regulations in several countries require that flight attendants have some level of training on how to handle in-flight psychiatric emergencies. However, there does not seem to be a specific universal standard for the level of training required. David Streitwieser, M.D. (as cited by FSF Editorial, 2002) discussed the limitations that flight attendants must contend with because they are unable to diagnose passengers and thus must rely on the (often limited) medical information that they do have. Additionally, he notes that medical advice is not often sought until after a passenger has put forth a disruptive action. Training flight attendants to consult with services such as MedLink, when they are suspicious of an individual's presentation, may help them to avoid an incident.

Moreover, in 2002 Streitwieser (as cited by Flight Safety Foundation, 2002), argued that additional training would help flight attendants to more carefully consider their initial responses to individuals who may be presenting with a psychiatric disorder. An increase in training would also help flight attendants to feel more competent when attempting to assess and deal with in-flight emergencies which in turn would help them to manage the escalation in their own emotional responses. For instance, Streitwieser (as cited by Flight Safety Editorial Staff) suggests that in a situation where a passenger is

suffering from a psychiatric condition and presents with anger, a flight attendant may in turn respond with anger. However, the flight attendants anger may actually exacerbate the passenger's symptoms. Instead, attendants may be taught "techniques for defusing aggressive behavior." Having a greater understanding of psychiatric symptomatology, in general, would help flight attendants to distinguish the behavior of an aggressive passenger from that of an individual who is struggling with a psychiatric disorder. Furthermore, the Flight Safety Foundation noted that flight attendants are trained to physically restrain passengers that seem to pose a threat to themselves or others, there seems to be a lack of training with regard to stopping other disruptive behavior that may surface once the passenger has been restrained.

Moreover, Zdanowicz (as cited in Wald, 2005) noted that the tactics commonly used to manage disruptive passengers are not the correct tactics to use with the mentally ill. With regard to law enforcement, Zdanowicz stated,

> Typically when they are trying to subdue someone whose behavior is escalating, they pump themselves up, making themselves big, get in their face and try to overpower them... that kind of behavior will more often lead a person with mental illness to get worse.

Thus, it seems crew members would benefit greatly from receiving more in depth training with regard to more accurately identifying and dealing with passengers who present in the midst of a psychiatric emergency.

Matsumoto and Goebert (2001) found that in 1997 the treatment most commonly recommended by MedLink was the administration of supplemental oxygen to passengers. In 19% of the cases MedLink officials instructed flight attendants to reassure passengers, letting them know that everything would be "o.k." and 15% of cases were told to breath into a paper bag. The results of these interventions seemed successful as 86% of

passengers appeared to improve following the oxygen or ventilation into a paper bag. Matsumoto and Goebert (2001) noted in the discussion that having a passenger breath into a paper bag actually increases their carbon dioxide levels. In fact, Perna, Bertini, Arancio, Ronchi, and Bellodi (as cited in Matsumoto & Goebert, 2001), found that for individuals who present with panic disorder, Carbon Dioxide actually increased their anxiety levels and increased the occurrence of panic attacks. Furthermore, the authors cite Zun (1997), who suggests that when working with passengers who present with respiratory disease or cardiac arrest, it is best to reassure them that everything is going to be "o.k." while guiding them to take slow, normal breaths. The article failed to note the outcome for those passenger who were simply reassured that everything was going to be "o.k." It is probable that breathing assisted passengers who presented with anxiety. However, it is unlikely that in more complex psychiatric cases, simply guiding the passenger to breath was sufficient.

Additionally, Barron (2002) noted that a common response used by crew members is to rely on the use of restraints to manage passenger behavior (restraints may be fashioned from seatbelts or cords from head-sets). Barron (2002) notes that restraining a passenger can result in tragedy, especially when tranquilizers are used. Tribune News Services (1998) documents a specific case of an unruly traveler who was traveling from Budapest to Bangkok. Following the passenger's display of aggressive and disruptive behavior, crew members strapped him to his chair. A fellow traveler who was a doctor was also asked to intervene, in an effort to calm the passenger down, the doctor injected the individual with a tranquilizer. Ultimately, the unruly passenger died as the tranquilizer did not mix well with the alcohol that the individual had consumed during

and before the flight. Similarly, Roche (2000) reported an incident in which an unruly passenger on a domestic flight died after being restrained and subdued by eight passengers. His autopsy revealed that he had sustained bruises and scratches from hits to his face, neck and torso. These results helped to link this passenger's death directly to the trauma that he underwent on the plane, while being restrained.

Thus, it seems restraint is not always the best option to use when dealing with a passenger who is in the midst of a psychiatric emergency. The proposed training manual will expand a flight attendants repertoire to include other approaches and techniques that may be used to de-escalate a passenger's behavior before the attendant resorts to the use of physical means of restraints.

Survey of Training Elements

There is a scarcity of research with regard to the development and use of mental health interventions by non-mental health care professionals. This section will survey the available literature while addressing the ways in which these data inform the creation of the training manual proposed in Chapter Six. General tips and suggestions will be reviewed first followed by a discussion of specific treatment recommendations that depend on the type of psychiatric emergency. This section will end with an examination of elements which will make a flight attendant most effective as a responder.

General Tips and Suggestions

Clinicians and researchers present general suggestions and guidelines to be used when addressing an individual in the midst of psychological distress. For example, Crisis Prevention Institute (CPI) (1995) in the training manual titled "Non violent crisis intervention: a practical approach for managing violent behavior" emphasized the

importance of establishing a good rapport with the individual who is in a state of crisis. A crucial element involved within the process of developing rapport, is the practice of empathic listening. CPI offers the process of empathic listening as a means which may help the responder convey a sense of care and interest while attempting to build rapport with the individual who is in distress. The process of empathic listening is described as a non-judgmental form of listening in which the responder offers undivided attention and allows moments of silence for reflection.

CPI (1995) addresses the importance of understanding the precipitating factors involved in acting out behavior. CPI notes that if the responder can come to an understanding of the factors which are causing the individual to act out, then the responder may be less likely to believe that they are the cause for these behaviors (a process known as depersonalization). Moreover, by understanding specific behavioral descriptions of various disorders, the responder will be able to make a more informed decision when choosing an intervention approach. This researcher supports the assertion that in order to achieve a level of understanding regarding a passenger's state of distress, an attendant will benefit from basic knowledge of various mental health diagnoses and the variations in symptom presentations. Dorfman and Walker (2007) in their book titled "First responders' guide to abnormal psychology" offer detailed descriptions of various psychological disorders in terms of their presentation, occurrence rate and cultural elements. For the purposes of training flight attendants more basic, shortened descriptions are necessary. Thus, the proposed manual relies upon descriptions found in the DSM-IV-TR (American Psychiatric Association, 2000) and attempts to describe the symptoms of various mental health disorders in clear behavioral terms.

Foxman (1990) in his book titled, "A Practical Guide to Emergency and Protective Crisis Intervention" reviews some key elements which should be used when working with an individual who presents in a state of psychiatric crisis. In particular, Foxman notes that individuals who experience mental health issues are often extra sensitive to perceived or real acts of rejection or criticism. Thus, Foxman asserts that all interventions should be done in a respectful and caring manner. For example, Foxman stresses the importance of preparing a patient for any procedures that may follow. Additionally, Foxman speaks to the importance of abandoning an overly authoritative or directive role in favor of the practitioner seeing themselves as a guide, "leading the [passenger] from a state of high stress to [one of] low stress." (p.49)

Individuals who are in a state of psychiatric or psychological crisis often feel quite powerless over their symptoms and experiences (Foxman, 1990; U.S. Department of Mental Health and Human Services, 2009). Thus, in an effort to give the individual back a sense of control, Foxman suggests interventions that place the distressed individual in a position of control. A responder may achieve this by asking the distressed individual weather they are interested in receiving aid and by soliciting the individual's preferences and needs. By doing so, Foxman asserts that a clinician may avoid enactment of a savior/healer relationship. This shifting of dynamics is meant to empower the distressed individual by giving them a sense of agency and power in a situation which may be causing them to feel powerless. Moreover, The U.S. Department of Mental Health and Human Services (2009) emphasize the importance of working collaboratively along with the individual in a state of crisis rather than performing the intervention *to* them. Additionally, the literature (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; U.S.

Department of Mental Health and Human Services, 2009) stress the importance of viewing the patient as a credible source of information. The proposed manual draws on these techniques and attempts to impress upon flight attendants the importance of working in a patient-centered manner, respecting the passenger and avoiding actions which are meant to decrease the passenger's sense of control.

CPI (1995) notes that certain crisis situations will benefit from a team approach. Foxman (1990) outlines the appropriate ways in which a team of individuals should approach a crisis situation. For example, when a team of individuals is intervening it is important that all participants remain somewhat active. Individuals may do so by making minor supportive comments or by stating their intentions in a clear manner. Foxman cautions that remaining a silent observer may allow the distressed individual the opportunity to interpret the silence as an indication of rejection or judgment, such as: "she is silent because she thinks I'm crazy" or "he doesn't like me, he thinks that I am a hopeless case." This recommendation is accounted for in the proposed manual, as flight attendants will often rely on a team approach when intervening with a distressed passenger.

Foxman (1990) and CPI (1995) both discuss the importance of setting appropriate limits and boundaries with regard to acceptable behavior during a psychiatric crisis. Particularly, Foxman notes that creating very clear guidelines of what will and will not be allowed lends structure to the interaction. Foxman maintains that an individual can be assertive without being aggressive and specifies that the manner in which the passenger is notified of the rules should depend on their presentation. Furthermore, CPI recommends that when setting limits a responder should state positive choices and consequences first

("If you hand me that sharp object then I can get you a cup of water"). CPI warns that starting with a negative consequence will likely put the distressed individual on the defensive ("If you don't hand me that sharp object I will have to notify the officials immediately"). Moreover, CPI cautions that placing negative consequences first may be received as a challenge or ultimatum. CPI also stresses that limits are most effective when they are: "Simple and clear, reasonable, [and] enforceable" (p. 57). The proposed manual incorporates these techniques when teaching Flight Attendants the most effective means of communicating limits to passengers in distress.

Many of the recommendations featured within this section are also supported by the research of Allen et al. (2003) who explored the preferences and needs of individuals who had presented at a hospital during a psychiatric emergency. The results of their research outlined elements that patients found especially helpful when reflecting on the way in which their behaviors were managed during a psychiatric crisis. Specific experiences that were found to be favorable, according to the consensus include: having staff listen to their version of their story or the course of how events transpired and being asked for feedback regarding what treatment they wanted. Moreover, patients reported that they appreciated when the worker helped the client to try and calm down before resorting to physical techniques. Lastly, patients noted that they appreciated being asked which treatments were most and least helpful for them during past psychiatric emergencies. The proposed manual offers strategies and tips which take into account the aforementioned preferences.

With regard to creating a new training standard, The Flight Safety Foundation (2002) suggests using methods that are used to train physicians who treat patients that are

agitated and present with un-stabilized psychiatric disorders in a hospital emergency setting. While many of the suggestions offered by researchers and clinicians in this section draw upon hospital emergency experiences, caution is used when applying these techniques in the creation of the proposed manual. In particular, this researcher wonders how training techniques intended for an emergency room setting would translate to the vastly different setting found on a commercial plane. For example, individuals who are working within a hospital environment have security measures in place which flight attendants lack, such as access to an immediate exit and immediate availability of security personnel. Additionally, a hospital attendant has access to medications and mental healthcare professionals. Thus, this manual draws upon other training recommendations in addition to the training elements derived from a hospital emergency setting.

Specific Responses Based on Type of Incident

Psychotic Episodes

With regard to managing psychotic episodes, Foxman (1990) notes that the sensory response system of an individual presenting in the midst of psychosis are amplified, causing the individual to feel a sense of overwhelm and stress. These elements can make it quite difficult for an individual to concentrate and relate to others within their environment. The manual attempts to give attendants a sense of the type of distress that a passenger who is in the midst of a psychotic episode experiences so that attendant may understand the need to reduce external stimulation. For instance, attendants are instructed to move the individual to a quieter, less crowded area on the plane. Additionally, flight attendants are taught appropriate ways to approach a distressed passenger in a manner

which will not overwhelm the; speaking slowly in a soft voice and repeating statements when necessary, giving the passenger the opportunity to have a few moments of pause to process statements before generating a reply, giving the passenger personal space, and asking for permission prior to touching them.

Moreover, with regard to managing psychotic episodes, Langlands, Anthony, Kelly, and Kitchener (2008) utilized the Delphi Method (a technique of soliciting a consensus from within a group or groups of experts) in order to gather the recommendations of 157 mental health consumers, carers (care-givers), and clinicians. The results of their investigation informed the production of guidelines which set a standard of training for individuals who do not work in the mental health care sector ("first aiders"). These guidelines are organized by topic and span many different areas. The following areas were selected as they were deemed most relevant to interventions made by flight attendants: How the First Aider should approach someone who may be experiencing psychosis; How the first aider can be supportive; How the first aider should deal with delusions and hallucinations; How the first aider should deal with communication difficulties; How the First Aider should respond when the person has become acutely unwell; What should the first aider do if the individual becomes aggressive.

Each area offers specific recommendations such as, "If the person is showing aggression, the first aider should stay calm and avoid nervous behavior" (p.442); "If the person is showing aggression, the first aider should avoid raising their voice and should not talk too fast" (p. 442);"The first aider should evaluate the situation by assessing the risks involved" (p.441) (that the person may harm themselves or others); "The first aider

should avoid using patronizing statements when interacting with a person who may be experiencing psychosis" (p. 440). These standards provide a useful guide which is used to inform many of the interventions offered within the psychosis section of the proposed manual.

Panic Attack

Kelly, Jorm, and Kitchener (2009) through the use of a panel of "experts" generated the following list of guidelines which the public may follow in order to assist an individual who is in the midst of a panic attack. The guidelines instruct first aiders to validate the experience of panic symptoms while also acknowledging that the feelings are temporary and not life threatening or dangerous. The first aider should also reassure the individual that they are safe. These guidelines provide a standard for critical elements which should be included during an intervention with an individual in the midst of a panic attack and will be implemented in the manual's section regarding panic attacks. While the First Aid Guidelines offer a standard of care for non-mental health care professionals, the suggestions require modifications in order to be adapted for the training of flight attendants. Additionally, further research would be beneficial to demonstrate that such interventions by a member of the public (without real clinical or professional training) are actually effective at managing a mental health emergency.

Self-harm and Suicide

With regard to self-harm behaviors and suicide, Foxman (1990) speaks to the importance of not engaging a suicidal individual in any sort of power struggle. For example, offering the individual an ultimatum may be interpreted by the patient as a challenge, in which case they may choose to act of their threat as a means of proving that

they can. Alternatively, Foxman notes the importance of giving the distressed individual choices, so that they may realize that they are in control of their own behaviors and therefore also responsible for the consequences of their behaviors. Additionally, the distressed individual may come to recognize that the individual who is intervening is not claiming the ability to control their behavior. Instead, the suicidal individual is given an opportunity to make an informed decision. The manual incorporates these suggestions within the section which addresses management of suicidal and self-harm behaviors.

Role of the Flight Attendant as a Responder

The literature examines ways in which individuals who are responding to psychiatric emergencies can be most effective when attempting to de-escalate a crisis situation. For example, the literature (CPI, 1995; Foxman, 1990; The U.S. Department of Mental Health and Human Services, 2009) addresses the importance of a practitioner learning to check-in with themselves in order to recognize and respond to their own feelings of stress during a crisis situation. Foxman specifically notes the importance of checking-in, and listening to one's own body cues; learning to pay attention to their own bodily indicators of stress. Additionally, Foxman speaks to the process of learning to be in control of one's own affective states so that the responder may more effectively think, plan, and organize their thoughts during a psychiatric emergency.

CPI (1995) note that although the responder may not be able to control the precipitating factors leading up to the acting out behavior and the individual who is acting out, the responder can learn to control their own responses. CPI also stresses the importance of normalizing the fear and anxiety response for those who are intervening.

The manual proposed in Chapter Seven will strive to impress upon attendants the normal nature of their emotional responses which may be triggered during a crisis situation.

While many of the sources discuss feelings of anxiety that may arise, this researcher maintains that an individual may have a range of emotions in response to a crisis situation, such as: anger, sadness, guilt, frustration, fear. The proposed manual presents this range of emotional responses while attempting to prepare attendants for those responses while also normalizing the range of possible responses to crisis situations.

CPI (1995) differentiates between productive and non-productive responses. For example, CPI teaches the responders to utilize their surge of adrenaline to be more effective during a crisis situation by increasing speed and strength. While this suggestion may be effective in a different setting, this researcher maintains that given the confines of an airplane it would be more effective for the attendant to lower their stress responses rather than speeding up their response patterns. Such speediness may only serve to further agitate the passenger who is presenting in a state of distress. Instead, the proposed manual teaches flight attendants to check-in with themselves. The manual accomplishes this by listing different indicators of an anxious or stressed response. Additionally, attendants are taught methods to help manage their own stress responses such as breathing techniques, balancing or challenging negative thought processes, and using positive imagery.

Within the literature there is a discussion of the effect that a responder's behaviors and attitudes may have on the individual who is in distress (CPI, 1995; Foxman, 1990). Specifically, CPI examine the effect that the responder's non-verbal communication, body language and body stance can have on the stress levels of an individual presenting

in a state of psychiatric crisis. CPI teaches responders to avoid a face-to-face position during an interaction as this stance may be received by the distressed individual as a challenging position. Instead CPI recommends standing at a 90 degree angle while giving the individual at least three feet of personal space. The proposed manual alerts flight attendants to the effect that their approach may have on the stress levels of a passenger who is in the midst of psychological distress. Additionally, the manual offers attendants suggestions with regard to appropriate intervention approaches.

Summary and Preview

While flight attendants are first-hand responders to passengers who present with a psychiatric emergency in-flight, it seems the training they receive is too minimal and does not adequately prepare them to handle such situations as they occur. Moreover, the vagueness of international standards, as put forth by the Federal Aviation Administration (FAA) allows each individual airline to use their discretion when determining the type and extent of training with regard to disruptive passenger behavior.

This section reviewed other training models which stress the importance of working in a client-centered manner by giving the client back control whenever possible, treating the client's reports with care and respect, and expressing validation and empathy with regard to their emotional discomfort. Additionally, the techniques discussed advocate the use of verbal de-escalation techniques as opposed to the use of physical restraints whenever possible. Moreover, this section surveyed recommendations offered by researchers and clinicians with regard to the management of specific crisis situations. Lastly, many of the sources explored in this section discuss the importance of the

responders learning to check-in and control their own behavior when managing a psychiatric emergency.

The next chapter will feature the proposed manual which attempts to account for the current deficiencies within the training protocols while also employing many of the techniques and methodology which have been reviewed within this section.

Chapter Six: Results

This section will present a manual that can be used to train flight attendants to manage psychiatric emergencies when they occur in-flight on a commercial aircraft. The manual synthesizes the research presented regarding elements of air travel that are stressful for travelers. Additionally, the manual attempts to incorporate suggestions within the literature on clinically preferable interventions and approaches. The manual responds to critiques regarding the current training system by offering a more in-depth approach to recognizing and managing psychiatric emergencies in-flight.

Training Flight Attendants to Manage In-flight Psychiatric Emergencies: A Training Manual

Introduction:

What is mental health?

Mental health refers to our cognitive and emotional well-being. As humans, we each navigate through our daily lives with different sets of interpretations, thoughts, and beliefs. Interpretations are the meanings that we ascribe to an event. For example, imagine seeing a stranger glance in your direction on the bus. While you might interpret the stranger's glance to be a demonstration of interest, another person could interpret the same glance as a judgmental stare or even a threat. The same act can have many different interpretations based on the point of view and disposition of the person who is observing the event. Our interpretations, thoughts, and beliefs ultimately impact the way that we feel and act. Our systems, or ways of being in the world, are partly born with us and also develop as we age.

Different elements play a role in shaping these systems. Some key elements include: genetic make-up, experience with caregivers during childhood, degree of violence that an individual encounters, social experiences, cultural and/or religious identities, presence of activities that nurture personal and academic development, and the way that an individual is viewed and treated by society. Additionally, the types of stresses, losses, and traumas to which an individual has been exposed and the degree to which they resulted in learning effective coping skills determines the individual's mental health. These elements are not necessarily static, as an individual's experience will often vary across their lifespan.

What is a psychiatric emergency?

A psychiatric or psychological emergency is any incident in which an individual's decreased mental health can result in harm to that individual or to others. The individual will often experience a sense that they are not in control of their own thoughts and/or bodies. All of us have experienced feelings of anxiety or stress at some point in our lives. However, an incident becomes an emergency when an individual is in an especially triggering situation in which they do not feel prepared or have not learned the tools to help them adequately cope (deal with the situation).

In the airline industry labels that are often used to describe psychiatric emergencies include: passenger misconduct, passenger behavior problems, unruly passenger behaviors, air rage, disruptive passenger behavior, travel syndrome, and travel fatigue. Some psychiatric emergencies even get categorized as medical emergencies.

How do I know if someone is having a psychiatric emergency? What kinds of things should I look out for?

Depending on the cause for the psychiatric emergency, each type will look different. In general, you are looking for: actions, speech quality, appearance and coherence of ideas that seem odd or eccentric, excessive, anxious, hostile or aggressive. There are specific behaviors listed with regard to the different types of psychiatric emergencies; consult individual sections within this manual for a list. Remember, even two individuals who have been diagnosed as having the same mental health disorder could have a different combination of symptoms.

How often does it occur on a plane?

Due to a lack of standardized reporting systems and no mandate to report such incidences, it is believed that incidences of psychiatric emergency are under-reported. While exact rates are unknown, we are aware that when such incidences occur they can cause major harm to passengers and flight attendants when they are not managed correctly.

Who can have one?

Anyone! Research has demonstrated that a psychiatric emergency may happen to anyone on a plane regardless of gender, ethnicity, socioeconomic status, or age. While a history of mental illness would seem to increase an individual's likelihood of having a psychiatric emergency in-flight, a passenger with no history of such illness may also have such an incident.

Why would this happen on a plane?

There are many elements involved in commercial air travel that can be stressful for a passenger. You can think of flying as a process that begins way before an individual enters the air-craft. The process of navigating through the airport, getting luggage checked, clearing security, and finding the gate can be quite stressful! Additionally, many passengers must say goodbye to their homes, belongings, pets, friends, and loved ones when they embark on a journey.

Once on a plane, a passenger must deal with a multitude of stressors (elements that cause feelings of stress or agitation). For example, during air travel, a passenger must adjust to the confined conditions in a cabin which forces individuals to sit in close proximity with strangers. Many passengers may feel trapped, as they sit for an extended period of time, in the confined space without an easily accessible exit. Moreover, as the plane travels the passenger must adjust to changes in altitude, temperature, noise level, and air pressure. This rapid change in environment can be anxiety provoking for some, producing physical and/or psychological discomfort.

The reason for a passenger's trip may also have an impact on their levels of stress while

traveling. Passengers travel for an array of reasons including: moving, business functions, meetings, reuniting with family, honeymoons, vacations, returning home, traveling to school, attending a funeral or to be with an ill loved one. All of the aforementioned reasons for travel can produce a range of emotions for passengers such as; anxiety, stress, anger, and sadness. Moreover, certain destinations can be quite emotionally triggering for some passengers. Research has demonstrated that some individuals who travel to Jerusalem (Israel) and Florence (Italy) may have a psychiatric emergency while en route. Furthermore, air travel can have a negative impact on psychiatric medications by changing the way that the medication affects the passenger or by disrupting the way the passenger usually takes their medications. It is not uncommon for a passenger to forget to pack their medications or to accidentally check it in along with their baggage.

Lastly, air travel offers passengers the ability to travel between time zones quite rapidly which, for some, may produce a condition known as Jet Lag. While Jet Lag commonly impacts a passenger's sleep patterns it can also have negative medical and psychological effects.

Why is this training necessary?

When a psychiatric emergency is not handled correctly on a plane, the incident may:

1. Threaten other passenger's emotional and/or physical well-being.
2. Be physically and/or emotionally dangerous for flight attendants.
3. Pose potential risk to the physical and emotional well-being of the passenger who presents in the state of disturbance.
4. Cause the plane to make an unscheduled landing

What is my role as a Flight Attendant during an in-flight psychiatric emergency?

As a flight attendant one of your main roles is to ensure the safety of passengers on an air-craft. During a psychiatric emergency you should avoid being overly directive or authoritative. Instead, imagine yourself as a guide leading a passenger from feeling stressed, overwhelmed and scared to a state of low stress and safety.

How should I use this guide?

Read through this guide to become acquainted with the general intervention strategies that are suggested. Once the guide has been read thoroughly, individual sections may be referenced during times of psychiatric crisis. Some readers may find it helpful to create a set of index cards with suggestions that they have found particularly important or difficult to remember. These cards may be carried with you onto the plane and kept with your other personal belongings. You may reference these cards during an emergency.

Checking In:

1. What are some of your fears with regard to working with a passenger who may have mental illness or a psychiatric emergency?

2. What do you hope to learn from this training?

The Non-Threatening Approach:

Learning appropriate ways to interact with a passenger who is in the midst of a psychiatric emergency will help you to avoid harm to both yourself and other passengers. This section will review some intervention basics which can be used when approaching any passenger who presents in distress.

Why should I be extra careful in the way I approach a distressed passenger?

When in a state psychological distress an individual may be extra sensitive to the ways that others interact with them. Think of a time when you have felt scared, did you notice that every little noise or movement felt alarming? Did you begin to pay extra close attention to your surroundings? Our bodies are made to respond in this way so that we can keep ourselves safe from potential harm.

Often, when an individual is in a state of psychiatric emergency they feel unsafe or threatened and rely on their hyper awareness to keep them safe. Even the slightest movement may be seen and interpreted as a warning of danger.

This section will teach you to pay close attention to the ways in which you stand, hold your body, speak, listen, and interact. Additionally, you will learn some key tips on ways to show the distressed passenger that you are not there to harm them but that you are someone who genuinely wishes to help.

(Source: Dorfman & Walker, 2007)

The Introduction: When you first begin interacting with a psychologically distressed passenger it is important that you introduce yourself to them. During your introduction you should state your name, job, and purpose. Try to come across as confident and assertive when making the initial introduction.

- Examples:
  - "Hi, my name is Rebecca and I am a flight attendant on this plane, I was called over because.."
  - " I am speaking with you because I am concerned for your safety, can you help me by telling me …"

(Source: Foxman, 1990)

Space: It is important to give a passenger at least three feet of personal space when approaching or interacting with them. Remember, each passenger's needs are different and depend on their culture, gender, and size. If you are in doubt you may ask the passenger directly if they feel as though they would like some more space. Additionally, we know that the space of a plane can be tight, but be extra mindful not to trap the

passenger into an area. Make sure that both you and the passenger can get out of the situation if either one of you feels unsafe.

- Look for signs that the passenger may need more space. Take notice of their behaviors:
    - Are they backing away from you?
    - Are they looking frantically around?
    - Are they backed against a wall?
    - Avoiding eye contact?
    - Blushing?
    - Laughing nervously?

(Source: Crisis Prevention Institute, 1995)

Stance: Avoid standing face to face with the distressed passenger. When an individual of authority stands facing someone who is feeling scared, it can feel really threatening. Instead stand in front of the individual on a diagonal, not facing them head on but rather standing alongside them (see illustration A.1 and A.2).

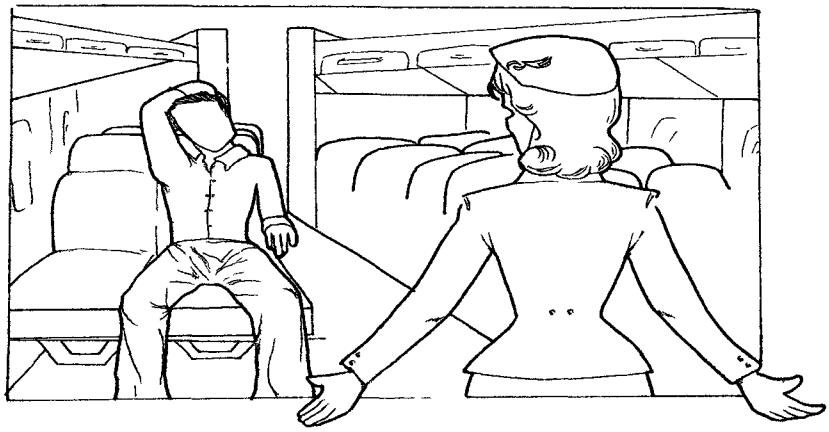

Illustration A.1

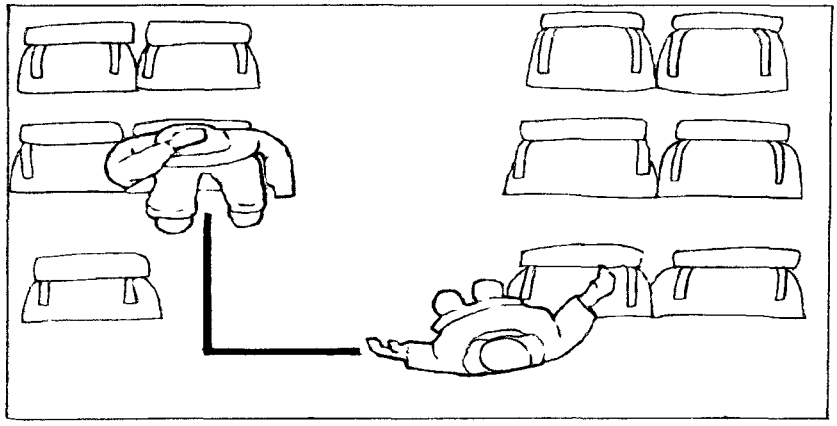

Illustration A.2

(Source: Crisis Prevention Institute, 1995)

Body Posture and Movement: Your body posture, facial expressions and gestures can have an effect on the distressed passenger's anxiety levels.

- Keep both hands where they can be visible to the passenger at all times. Avoid placing your hands behind your back or in your pockets. This may convey to the passenger that you have something to hide.
- Do not make any sudden or drastic movements with your body or your hands. If you need to reach for something make sure to announce your movements to the passenger and check with them to make sure they feel comfortable with the movement
    - Example: "Would it be o.k. if I reached over to my right to get a cup of water?"
- Stand in an open and interested manner: do not cross your arms in front of you. Stand tall and confident. Be careful not to appear threatening or challenging.
- Do not stare the passenger in their eyes; offer them breaks from direct eye contact by shifting your gaze away from their eyes every so often. If a passenger is avoiding eye contact with you, they are letting you know that direct eye contact feels uncomfortable, unsafe, or threatening. Look for these cues and respond by moving your gaze away from their eyes. You may be able to look in their direction without making direct eye contact.

Voice, Tone, and Speech: The manner in which we say something is often just as important as what we are saying. The following tips will help ensure that you communicate to the passenger in a respectful manner which lets them know that you are there to help.

- Talk in a calm manner.
- Use clear and concise sentences. An overwhelmed passenger may be become easily confused, sticking to short sentences may help to avoid confusion.
- Keep the volume of your voice normal for the distance and situation. If you need to be assertive, be careful not to scream but rather use a firm voice.
- Speak with an even rate. Be mindful not to speak to quickly; when in doubt, error on the side of speaking slowly.

- Be careful that your tone does not communicate impatience, frustration, or condescension.
- Avoid making any false promises.
- Try not to use any jargon. For example, when speaking about the airlines policies, speak in plain language to avoid confusion.

(Source: Crisis Prevention Institute, 1995)

Exercise: Say each of these phrases using different tones, volumes, rhythm etc. Notice how these elements change the way the statement comes across:

- Please take your seat.
- Prepare your seat for landing.
- I am sorry drink service is no longer available.
- Is there anything that I can do to help you to feel better or more comfortable?

How to Listen: A guide to empathic listening

- Try to be non-judgmental. A passenger who is in a state of psychological distress is doing the best that they can, given what they have to work with. Sometimes, we may wonder why someone cannot just 'snap out of it' or 'pull themselves together'. Remember, if they could just control their feelings of anxiety, they would! Most people do not like to be in pain or discomfort.
- Give the passenger your undivided attention; show them that you are really interested in what they have to say.
- Allow breaks for silence, the passenger may use these breaks to process what you are saying.
- When you listen to the passenger, try to listen out for feelings and not just the facts. What is the individual really trying to tell you?
- Sometimes when we speak we believe that our message is clear, however it is not uncommon for another individual to have trouble understanding what it is we are really trying to say. Remember, the passenger wants you to understand them, so if you are having a difficult time understanding what it is that they are trying to communicate, check-in with them to confirm that you understand. You may do this by repeating back to them what you have understood them to say and asking

them whether you got it right. This shows them that you are listening and interested in understanding what they have to say.

(Source: Crisis Prevention Institue, 1995)

Assessment Phase:

This section will teach you how to assess a crisis situation by guiding you to examine the passenger's behaviors and to gather relevant data. All interventions should begin with an assessment phase. It is during this time that you will become a conscious observer so that you may gain a better sense of what is going on for the passenger in distress. This phase is critical as it will determine the course of actions that you will take when trying to assist the passenger and deescalate the situation at hand.

Examine the passenger's behaviors:

Body Language:

- Does the passenger appear to be in physical discomfort?
    - For example: Are they clutching their stomach or head, hand clenching their chest?
- What is the passenger's level of activity?
    - For example: Are they pacing? Sitting motionless? Listless?
- Is the passenger showing signs of anxiety?
    - For example: Is the passenger pacing, laughing nervously, picking their hands or nails, wringing their hands together, sweating profusely, breathing heavily or with shortened breath, shuffling their feet, pacing?
- Eye Contact: Is the passenger avoiding eye contact, staring towards an area that appears empty to you?
- Breath: Do they seem to be breathing rapidly or gasping for breath?
- Appearance: Are they dressed appropriately?
    - For example: Is their clothing appropriate for the weather, if it is summer are they dressed in multiple layers and wearing a winter coat?

Speech:

- Pace: is the passenger speaking very quickly, rapidly? Or do they seem quiet, and unresponsive?

- Coherence: Is the passenger communicating in a way in which you can understand them? Are they using real words? Is there a logical flow to their sentences?

Responsiveness:

- Is the passenger responding cooperatively to your questions?
    - Assess for possible language barrier. Confirm that the passenger understands the language which you are speaking.
    - If the passenger speaks a different language than the ones which you are fluent in, ask them if they are traveling along with an individual who may be able to provide translation for the passenger.

Assess for Safety:

- Assess whether the passenger is at risk to harm themselves or others. Ask passenger directly:
    - Example: "I can see you're in distress and I know when people are in distress they can hurt themselves or others. Do you feel as though you want to hurt yourself or another individual on this plane?"
- Ask passenger if they have any objects that could be used as weapons
    - Examples: pen, utensils (fork, knife), prescription drugs.

Assess passenger's connection with reality:

- Do they know their name? Where they are? Where they are traveling to? Do they know what the time of day it is?

Assess for collaborators who can offer support:

- Ask the passenger if they are traveling along with someone who they trust, who may be able to offer help in this situation (help includes providing history and information that could be helpful in order to help this individual find safety)

Assess for history for a similar experience of discomfort:

- Ask the passenger if they have ever experienced this feeling before.
    - If so, do they have medications on board to help with this condition?
    - What did they do in the past that helped them to relieve their discomfort?

Sample Assessment questions:

1. What is your name?
2. Are you traveling alone?
3. How long have you been feeling this way?
4. Have you ever felt this way before?
5. Follow up question: what did you do then that was helpful for you?
6. Do you have any medical conditions which I should be aware of?
7. Are you currently taking/ prescribed any medications?
8. Have you drunken any alcohol or used a substance today?

General Intervention Tips and Strategies:

A passenger's agitated behavior may be an attempt to secure safety and self-protection from an actual or imagined threat. The goal of these strategies is to increase the passenger's sense of safety while decreasing their sense of vulnerability. This section lists key interventions that will apply to most crisis situations. Later sections will discuss specific recommendations which will vary depending on the type of situation.

Take the Passenger Seriously: A psychologically distressed passenger is experiencing feelings and thoughts that are very real to them. Sometimes, their complaints may sound exaggerated or funny to us, but it is important to remember that what they are sharing feels very real for them. It is not your job to doubt them or show them the truth. It is your job to take them seriously, to show them that you take their distress really seriously. You need to first understand that their pain is very real before you can try to help them deal with it. By doubting the validity of their complaints, you are showing them that you think they are lying or overreacting. Even if the passenger's complaints do not seem to be grounded in reality, you should make sure to give the person space to share their story. The process of sharing ones story or personal experiences can help an individual to feel less alone, less scared, and calmer.

(Source: Foxman, 1990; Practice Guidelines: Core elements for responding to mental health crisis, 2009)

Give Back Control: A passenger in a state of psychological distress often feels ashamed and out of control. In order to help the passenger to feel more in control, treat the passenger with respect. Be careful not to take the individual's rights away just because they are in a state of distress. Interventions that are done *to* the individual can exacerbate their sense of being out of control and increase their sense of helplessness (thereby worsening symptoms).

- Ask the passenger if you may be of any service to them.
- Ask passenger what they need, or what might help them to feel more comfortable.
- Work collaboratively along with the passenger whenever possible.
- Whenever possible, offer the passenger choices.

(Source: Foxman, 1990)

Preparation: When an individual feels scared or out of control, it feels as though things are happening to them without any sort of preparation. To help the passenger feel more in control, you should always prepare them for any procedures or events which may follow. By letting them know what they can expect to happen, it may decrease some of their fear and anxiety. The passenger should always have an understanding of what is going to happen next. For example:

- If you need to ask for help from another attendant or a doctor on-board, give the

passenger a heads up: tell them that you will be getting another individual to come and help and explain to the passenger why another person is becoming involved. Once the individual has arrived, have them stand back while you make introductions. Get the passenger's permission for the individual to come and help.

- If the passenger needs to be removed from the plane, explain to them how this will happen. Give details about the order in which the events will take place, so that they have a sense of what will happen next.
    - Example: "For right now, you are going to remain seated here in the back of the plane. The plane is beginning to return to the gate. Once we get to the gate, the plane will stop. A man or a woman who works as an Emergency Technician will board the plane. They are coming on board to help get you off this plane to a safer place. You will walk with the technician through the plane. Their job is to help take you to a safer place so that you can start to feel better. I am going to stay with you the whole time until the technician arrives. Once they are here, I will find out their name and introduce you to them. Does this sound ok to you?"

(Source: Foxman, 1990)

Act Carefully: When working with a distressed passenger, be sensitive and careful not to let them feel rejected or criticized in any way. Often an individual who has psychological distress will have a history of feeling inadequate and of losing relationships or connections that are important to them. Sometimes when a passenger is acting psychologically distressed it may seem to others that they do not really know what is going on around them. Often this is not the case, many individuals will remember the event and how it was handled in great detail. So handle each situation with great care, always err on the side of being compassionate and caring.

(Source: Foxman, 1990)

Asking for help: Speaking with a psychologically distressed passenger can bring up many different feelings in attendants. If at any point you feel anxious or confused do not hesitate to ask for help. Other flight attendants are there to help you. Additionally, it is within the protocol to ask over the intercom for the assistance of a passenger who is a professional psychologist, psychiatrist, or physician.

Team Approach: Remember: When a team of individuals is intervening, it is important that all participants remain somewhat active, by making minor supportive comments or by having their intentions made clear. When an individual stands by silently it may further aggravate the distressed passenger. The passenger may interpret the individual's silence as being an indicator of a number of things, including: "she is silent because she thinks I am crazy"; "she doesn't like me"; "he thinks that I am a hopeless case" etc.).

(Source: Foxman, 1990)

Setting Limits:
If a passenger's behavior has escalated to the point at which may harm themselves or others, it is critical that you learn ways to set appropriate limits for their behavior.

When you set a limit your task is not to *force* the individual to act in the way you want them to (this would not be possible!) but rather, to *show* the person that they have choices to make and to explain to them what the consequences of each choice will be.

- Start by stating positive choices and consequences first. If you start with the negative, you may make the passenger feel more defensive.
    - Examples of a positive choice stated first:
        - " If you hand me that sharp object then I can call the pilot and ask him/her to land the plane early"
        - "If you can sit down in this chair I can get you a cup of water"
- Limits are most effective when they are:
    1. Simple and Clear.
    2. Reasonable: do not ask the passenger to do something that seems unreasonable for their current state.
    3. Enforceable: Avoid threatening or promising something that you cannot provide.

(Source: Crisis Prevention Institute, 1995)

Flight Attendant Self Care:

Working with a passenger who is feeling psychologically distressed and overwhelmed can bring up a number of feelings in flight attendants. Feelings may include: fear, frustration, anxiety, overwhelm, sadness, and anger. These feelings are natural and are a common response to a crisis situation.

Emotions such as anxiety and fear can occur at different levels. Think of a time when you had to get something done and you felt moderately anxious about it. That moderate feeling of anxiety probably motivated you to get the task done faster. Now think back to a time when you felt so much anxiety that you had a difficult time getting anything done! Research demonstrates that extreme levels of anxiety can make it difficult for an individual to think, plan, and organize.

This section will teach you how to check-in with yourself during a crisis situation and recognize feelings of anxiety and fear. Additionally, you will learn techniques that can be used to manage the intensity of your feelings so that you can remain effective during a crisis situation.

What does it mean to "check-in"?
Every person will experience feelings of anxiety and fear in different ways. During a crisis situation, pause and listen to your body.

- Do you notice any of the following?
    - Pounding heart, perspiration on brow, shaky legs, light headiness, quickened or stifled breathing

(Source: Foxman, 1990)

Tools to help manage feelings of anxiety and fear: There are many different tools that can be used to lower anxiety levels. Some individuals may find that certain tools are easier to use than others. I encourage you to try each of the tools listed below and to practice them.

Like with any newly learned skill, these techniques work best when they have been rehearsed. Try not to dismiss a tool if it does not immediately work for you. These techniques may take some time to get used to. Be patient with yourself.

1. Breathing: Often when we become stressed, anxious, and fearful, we tend to breathe very quick, shortened breaths. This quickened breath actually signals to our brain and bodies that we are feeling anxious or scared. In response, the body may begin to prepare you for a crisis response, known as 'Fight, Flight, or Freeze'.

This is your mind and body's natural response which is meant to keep you safe. However, at times the mind and body can over-react and treat a crisis situation as more threatening than it actually is. This is where learning to slow your breath down will come in handy. By slowing your breath you are telling your body and mind that you are in control and that there is no need for a crisis response.

- **Fight**: you stay around and defend yourself
- **Flight:** you flee the scene
- **Freeze:** you stand still-unable to act.

Steps to slow your breath:

Take a deep, purposeful breath in through your nose. You should feel as though you are inflating your lungs to their fullest capacity. Hold the breath for 4 seconds (you may count in your mind). Release the breath, pushing it all the way out of your nose. Imagine as you push out that you are using your exhaled breath to push away a wall that is in front of you.

Repeat this process 5 times. Countdown at the end of each exhale. The pattern should follow like this:

- inhale, hold, exhale-5;
- inhale, hold, exhale-4;
- inhale, hold, exhale-3;
- inhale, hold, exhale-2;
- inhale, hold, exhale-1;

There may be situations in which you do not have time to take 5 deep breaths, in such cases take 3 deep and purposeful breaths. After completing the breath sets, try to continue breathing at a slowed rate. Be mindful to take nice deep breathes even while talking with the passenger.

This breathing sequence should be practiced. Like any skill, the more you can practice this type of breathing the more effective it will be when used in a crisis situation.

2. Thoughts: When we become scared or anxious we begin to have thoughts that feed these feelings. Our thoughts may predict that things will only get worse, or that there is no hope. Additionally, our thoughts can convey how horribly difficult a situation is and how difficult it will be to get out of it.

Steps to work with your thoughts:

1. Pause and notice your thoughts. Do you notice a theme? Do they seem overly negative or pessimistic? Are your thoughts predicting something bad or a possible failure?

2. Tell yourself more positive messages or statements. At first you may not believe these positive messages, but it is important that you offer alternative thoughts to the negative one.

Sample Positive Statements:

"I am safe. I learned how to deal with situations like this one"

"I am not alone, there are other people here who can help me manage this situation"

"This passenger is just scared and frustrated. They are human like everyone else"

"I can get through this. I have managed more difficult situations in the past"

"I am a strong and caring person. I am here because I want to help"

"I don't need to know all the answers, I just need to be patient and try to figure out the best way to help"

What are some other positive statements that you can think of?

1.

2.

3.

4.

3. Safe Scene: Sometimes when we feel anxious or scared we see images in our minds of things falling apart.

Try to think of a positive place: a place where you feel comfortable and safe. Imagine that you will be going to that place when you are done with the intervention. The idea is not to escape to this place during the intervention, but rather to use the safe scene in the moment when you feel most overwhelmed.

Sample Safe Scenes: The beach, in my partners arms, in my bed at home, my comfy chair in the living room, my parent's kitchen, on my back porch.

Exercise:

The following questions will help you to develop a safe scene. By answering the questions you will begin to develop a scene that feels safe, calm, and comfortable for you.

1. Can you think of a time, in the recent past, when you felt comfortable, safe, or relaxed? Where were you? Who were you with? Were you alone?

2. What is a place that you consider safe?

3. Is there one person or a group of people who you like to be around? A person or group of people who make you feel calm and safe?

Preview: These next sections will focus on specific types of psychiatric emergencies. You will learn how to recognize these events as well as helpful strategies and tips which you may use to help comfort a distressed passenger during such events.

Panic Attack:

What is a Panic Attack?

A Panic Attack is an episode which is marked by feelings of anxiety and often includes intense feelings of fear or discomfort. The "attack" can develop suddenly and tends to reach a peak within 10 minutes.

Typically the first time an individual experiences a panic attack they mistake it for a heart attack. A Panic Attack can feel really scary for the person who is having it. All of a sudden, they feel overwhelmed with anxiety and they might feel as though their bodies are out of control. Moreover, some individuals may feel as though they are on the verge of death.

Who can have a Panic Attack?

Each year approximately 6 million American adults aged 18 and older have a Panic Attack.

(Source: National Institute for Mental Health)

What does a Panic Attack look like?

The passenger experiencing the Panic Attack will often complain or experience some or all of the following:

- Heart palpitations, pounding heart, accelerated heart rate
- Sweating
- The passenger may be appear to trembling or shaking
- Difficulty breathing or shortness of breath
- Feeling as though they are choking
- Pain or discomfort in the chest, such as chest pressure- or a heaviness in the chest region
- Stomach or intestinal discomfort marked by upset stomach or nausea
- Feeling dizzy, lightheaded, unsteady on their feet (difficulty steadying themselves, or achieving balance); passenger may note that they feel as though they might faint
- The passenger may feel detached from reality, having difficulty feeling connected to who they are, might have an outer body experience in the sense that they lose

connection to the parts of themselves that they are usually connected to, such as who they are, why they are traveling, where they are traveling to .. etc.? Being in the present or feeling detached from themselves (i.e. having difficulty knowing who they are etc.)

- The passenger may express a fear of losing control or going crazy
- Passenger may express a fear that their illness may result in death
- The passenger may feel as though they feel numbness or tingling sensations in regions of their body such as feelings of pins and needles in limbs
- Passenger may complain of body chills or hot flashes

(Source: American Psychiatric Association, 2000)

How can I help a passenger who is having a panic attack?

Introduction:

Introduce yourself to the passenger by telling them your name and position on the aircraft. Tell them that it is your job to help them. Ask them what you can do to help them feel better.

Assessment:

- Look at passenger's behaviors and complaints, do they fit with the list of panic symptoms?
- Ask the passenger if they had ever had a Panic Attack before
    - If they have had one, ask them to tell you what they did in the past that helped them to get through it.
- Ask the passenger if they are traveling along with a companion?
    - Ask the companion if this has ever happened to the passenger before.
    - Ask the companion if the passenger has any medical issues.
- Confirm that they are not having a heart attack. A panic attack can look quite similar to a heart attack. If the person notes that they have never had a panic attack in the past and that they believe this is a heart attack, take steps in first aid. Ask if there is a physician on-board.
    - If you or a medical professional have determined that the passenger is not having a heart attack, you can briefly explain to the passenger that it seems

as though they are having a panic attack. Remember, the passenger will probably feel scared and confused. Sometimes, people can feel some relief when they are able to understand what is happening to them. Take a few moments to explain to them what a panic attack is. Explain that during a panic attack it is normal for an individual to feel the way that they are feeling.

Help the individual move to a safe space: if the passenger seems to be feeling uneasy on their feet, offer them to take a seat in the back of the air-craft, be careful not to block them in with your body, always leave space so the passenger can move freely if they need to.

What Should I tell the passenger? How can I comfort them?

- Take the persons complaints very seriously, do not belittle their experience.
- Reassure the passenger that they are safe. Acknowledge that while a panic attack can feel very frightening it is not dangerous.
- Remind them that although panic attacks feel really serious and life threatening, you know that they will be o.k. People do not die as a result of a panic attack.
- Reassure the passenger that the symptoms will pass.
    - You can share with a passenger that while everything may feel really intense right now, we know that the intensity of a Panic Attack usually lowers after 10 minutes.
    - You can use an analogy: a panic attack is similar to a wave in the ocean; it comes up slowly, gets really big and tall and then slowly begins to disappear.
- Remind the passenger to slow their breath down. Breathing quickly only makes the feelings of panic worse.
    - Guide them to slow their breath. Ask the passenger to inhaling and exhale through their nose. to the following instructions:
        - "Breath in, count in your mind to one and as you exhale count to 2."
        - "Breath in again and count to 3, as you exhales count to 4."
        - "Breath in again while counting up to 5 and exhale counting to 6."

- You can offer the passenger some water as they begin to calm down.

(Source: Many of the suggestions featured conform to guidelines set forth by: Kelly, Jorm & Kitchener, 2009)

How should I act?

- Check-in with yourself: When an individual is feeling panicked it can make others feel anxious. It is important that during the process of talking with the passenger that you take great care to remain calm (consult the section regarding flight attendant self-care to learn ways to keep yourself calm during a crisis situation).
- Keep your voice steady, try to avoid sounding impatient, condescending, or frustrated.
- Keep the volume of your voice at a moderate level.
- Do not crowd the passenger; make sure to give them at least three feet of personal space. Instead of standing face to face stand in 90 degree formation (see section on General Tips for an illustration A.1)
- Pay attention to <u>your</u> body language, facial expressions, and movements:
    - Do not cross your arms.
    - Keep your hands visible at all times.
    - Avoid sudden or exaggerated body or hand movements.
    - Show the passenger with your facial expression that you are concerned and caring. Avoid appearing frustrated or anxious.

Manic Episodes:

What is a Manic Episode?

Mania is a term used to describe a period of extremely elevated mood which may cause an individual to feel irritable or expansive. Mania is a criteria used in the diagnosis of Bi-polar disorder

What does mania look like?

- The individual may have an inflated sense of self-importance and a sense that they are invincible.
- The individual may act in an impulsive manner, spending large amounts of money at one time or engaging in risky pleasurable behaviors, without any thought of possible risk factors.
- The individual may appear as though they are revving at high speeds; acting more talkative than usual, becoming easily distracted, feeling as though their thoughts are racing, and experiencing a decreased need for sleep.
- Because of the extreme nature of many of the symptoms of mania, a manic episode often causes disruption to an individual's ability to function at work, in relationships, and other social contexts.
- For some individuals, manic episodes also include psychotic features (symptoms). See section on Psychosis for a full description of possible symptoms and tips to manage them.

(Source: American Psychiatric Association, 2000)

How can I help someone who is having a manic episode?

Introduction: Introduce yourself to the passenger, tell them your name and position on the air-craft. Tell them that it is your job to help them. Ask them what you can do to help them feel better.

Assessment:

- Examine the passenger's behaviors and complaints, does their behavior fit with the list of manic symptoms?

- Ask the passenger if they had ever felt this way before.

    - If they have experienced a manic episode before, ask them to tell you what they did in the past that helped them to get through it?

- Assess for Safety: Assess whether the passenger is at risk to harm themselves or others. Ask passenger directly:

- Example: "I can see you're in distress and I know when people are in distress they can hurt themselves or others. Do you feel as though you want to hurt yourself or another individual on this plane?"

- Ask passenger if they have any objects that could be used as weapons
  - Examples: pen, utensils (fork, knife), prescription drugs.
- Ask the passenger if they are traveling along with a companion.
  - Ask the companion if this has ever happened to the passenger before.
  - Ask the companion if the passenger has any medical issues.

Help individual move to a safe space: if the passenger seems to be feeling uneasy on their feet, offer them to take a seat in the back, be careful not to block them in with your body, always leave space so the passenger can move freely if they need to.

What should I tell the passenger? How can I comfort them?

- Let the passenger know that you are taking their complaints very seriously.
- Reassure the passenger that they are safe.
- Remind the passenger that they are not alone and that you are there to help them get through this experience.
- Let the passenger know that other help is available.
- Inform them that although they may feel stuck or trapped the plane will eventually be landing at which time they will have the opportunity to exit the air-craft.
- Remind the passenger to slow their breath down. Breathing slowly will help them to begin to slow their thoughts and body down.
- If the passenger displays inappropriate behaviors, give them choices with regard to other more appropriate behaviors which they may choose.
  - Example: "Sir, standing in the isles during landing is not permitted, you may choose to take your seat or to come and sit with me in the back of the plane"

How should I act?

- Be assertive: this is not about challenging the individual, it is a matter of showing the individual that you are a person of authority who will be enforcing certain

limits (see section titles "General Intervention Tips and Strategies" for guidelines on how to set effective limits).

- Check-in with yourself: You may notice that being around a manic passenger makes you feel agitated, frustrated, or anxious. It is important that during the process of talking with the passenger that you take great care to remain calm and to feel in control (consult the section regarding flight attendant self-care to learn ways to keep yourself calm during a crisis situation)
- Take the person's complaints very seriously, do not belittle their experiences.
- Keep your voice steady, try to avoid sounding impatient, condescending, or frustrated
- Keep the volume on your voice at a moderate level.
- Do not crowd the individual make sure to give them at least three feet of personal space. Instead of standing face to face stand in 90 degree formation (see section titles "A Non-threatening Approach" for an illustration, A.1).
- Pay attention to <u>your</u> body language, facial expressions, and movements:
    - Do not cross your arms.
    - Keep your hands visible at all times.
    - Avoid sudden or exaggerated body or hand movements.
    - Show the passenger with your facial expressions that you are concerned and caring. Avoid appearing frustrated or anxious.

Anxiety:

What is anxiety?

Anxiety is the mind and body's response to situations which feel threatening or stressful. Anxiety can be experienced in four domains: the body, thoughts, motor activity (body movement), and emotions.

What does anxiety look like?

- Sweating, weak in the knees, flushing, dizziness, heart palpitations, hyperventilation
- Headache, dry mouth, feelings of weakness, hot flashes or gastronomical issues
- Motor impairments: ticks, shaking, tremors, acting jumpy, hypersensitivity/over-reactivate to minor stimuli, vigilance (individual may be on edge and easily activated by minor noises or movements)
- General tenseness, tightness in the chest or stomach, sense of panic, irritability,
- Fear that one is going crazy or experiencing a medical emergency which may become fatal.

(Source: American Psychiatric Association, 2000)

What are some forms of anxiety that I may see on a plane?

Passengers may experience anxiety for a number of reasons. As stated in the introduction, the process of flying can be quite stressful for many passengers. However, there are certain mental health disorders which increase the likelihood that a passenger may have an anxious response when flying on a plane.

Below is a list of some anxiety disorders along with a very basic explanation of each disorder.

- Phobic response: A phobia involves feelings of fear and anxiety which are triggered by certain situations.
    - **Agoraphobia:** Anxiety in response to being in a situation in which escape might be difficult or embarrassing. As a result, the individual may feel quite anxious and may feel as though they may have a panic attack if their anxiety levels escalate.
    - **Acrophobia:** Fear of heights.

    - **Claustrophobia:** Fear of enclosed spaces.
    - **Fear of flying**.

- Panic Disorder*:* see section on Panic Attacks
- Social Anxiety: An individual may feel anxious when they are in the presence of strangers and fear that they may be humiliated or embarrassed. The individual often expects that others are constantly judging them.
- Obsessive-Compulsive Disorder: Individual experiences repetitive thoughts, impulses, or images (obsessions) that cause the individual to feel anxious. In an effort get rid of the anxiety, the individual engages in repetitive behaviors or mental processes (compulsions).
    - Examples of compulsive behaviors: hand-washing, checking and re-checking
    - Examples of compulsive mental processes: praying, counting, repeating words silently
- Post-Traumatic Stress Disorder (PTSD): This disorder describes a set of responses which an individual may have after they have been exposed to an event in which their own life was threatened or another individual's life was threatened or actually taken. The individual may experience thoughts, images, and/or dreams in which they relive the traumatic experience. Additionally, the individual may feel stressed in response to places, objects, symbols, and people that remind them of the original traumatic event.

(Source: American Psychiatric Association, 2000)

How can I help a passenger who is dealing with anxiety?

- *Introduction:* Introduce yourself to the passenger; tell them your name and position on the air-craft. Tell them that it is your job to help them. Ask them what you can do to help them feel better.
- *Assessment:*
    - Check to see if the passenger feels as though they might harm themselves or another individual on the plane (see general tips section for more specific assessment guideline).
    - Ask the passenger if they had ever had a panic attack or experienced anxiety before.

        - If they have had one, see section on Panic Attack for further instruction.

    - Ask the passenger if they are traveling along with a companion?

        - Ask the companion if this has ever happened to the passenger before.

        - Ask the companion if the passenger has any medical issues.

- *Help individual move to a safe space:* if the passenger seems to be feeling uneasy on their feet, offer them to take a seat in the back, be careful not to block them in with your body, always leave space so the passenger can move freely if they need to.

- You can offer the passenger some water as they begin to calm down.

What should I tell the passenger? How can I comfort them?

- Let the passenger know that you are taking their complaints very seriously.

    - You may acknowledge how scary anxiety can feel.

- Reassure the passenger that they are safe.

- Remind the passenger that they are not alone and that you are there to help them get through this experience.

- Let the passenger know that other help is available.

- Inform them that although they may feel stuck or trapped the plane will eventually be landing at which time they will have the opportunity to exit the air-craft.

- Remind the passenger to slow their breath down. Breathing quickly only makes the feelings of anxiety worse.

- You may ask the passenger some questions to help them to focus away from their feelings of anxiety. Questions should be aimed at getting to know other parts of the individual which are separate from their feelings of anxiety. Please note, if the individual's anxieties revolve around flying, you may want to avoid questions on the topic of flying.

    - Sample questions:

- How often do you travel?
- What is the most interesting place you have ever traveled to?
- What are some hobbies that you enjoy? (You may have to list some options to help prompt the individual, "do you collect anything? Do enjoy watching films or certain television programs? etc.)
- Have you watched any of the in-flight entertainment?
    - Did you enjoy the program?
- What are some things you like to do for fun?

How should I act?

- *Check-in with yourself:* When an individual is feeling panicked it can make others feel anxious. It is important that during the process of talking with the passenger that you take great care to remain calm (consult the section titled "Flight Attendant Self-Care" to learn ways to keep yourself calm during a crisis situation).
- Take the passenger's complaints very seriously, do not belittle their experience.
- Keep your voice steady. Try to avoid sounding impatient, condescending, or frustrated
- Keep the volume of your voice at a moderate level.
- Do not crowd the individual make sure to give them at least three feet of personal space. Instead of standing face to face stand in a 90 degree formation (see section titled "A Non Threatening Approach" for an illustration)
- Pay attention to <u>your</u> body language, facial expressions, and movements:
    - Do not cross your arms.
    - Keep your hands visible at all times.
    - Avoid sudden or exaggerated body or hand movements.
    - Show the passenger with your facial expression that you are concerned and caring. Avoid appearing frustrated or anxious.

Psychosis: Responding to a psychotic episode

Who is likely to become psychotic?

Individuals who have the following mental health diagnosis may have had a psychotic episode occur at least once in their lives: Schizophrenia, Schizoaffective disorder, Delusional disorder, Major Depression, Bi-polar Disorder, and Brief Psychotic disorder. Often, individuals who have psychotic episodes are not psychotic all of the time. The psychotic features (symptoms) tend to be triggered by stress. However, for some the episode may occur at seemingly random times.

Additionally, symptoms of psychosis, such as hallucinations and delusions can also be the result of medical conditions or a reaction to substances use and are not always related to mental health issues.

When assessing for psychosis, it is important to take into account the cultural, spiritual, and religious contexts of the individual's behavior. Some behaviors may seem unfamiliar or odd to us, but they may be perfectly normal for the individual's culture or religious background.

What are symptoms of psychosis?

A psychotic episode occurs when an individual presents with a specific set of symptoms (signs or indicators). Symptoms include:

- Odd, eccentric, or irrational beliefs regarding things that do not actually exist in reality (delusions)
- Imagined sensory experiences (hallucinations).
- The individual may find it difficult to figure out what is actually real from what feels real.
- An individual in the midst of a psychotic episode may experience difficulty communicating in a coherent manner or convey ideas which sound confusing and nonsensical to others.
- The individual may also display bizarre behaviors and appearance.
    - For instance, the individual may dress in multiple layers of clothing which are inappropriate for the season or weather
- The passenger may demonstrate a disconnect between content of what they are talking about and their emotional expression.
    - Example: laughing while sharing a tragic story.
- Some individuals experiencing a psychotic episode may feel very suspicious of others (paranoia).
- An individual in the midst of a psychotic episode may express an interest in either harming themselves or another person.

(Source: American Psychiatric Association, 2000)

Below are more detailed descriptions of some of the symptoms of psychosis along with instructions regarding the ways that you may approach and manage each set of symptoms when they occur. Additionally, at the end of this section some general tips will be reviewed and a vignette will be offered to demonstrate how all of these interventions may look during an interaction.

What is a delusion?

A delusion is a *belief* about the world that is not based in reality. A delusion may have a theme. Some common themes include: religious, alien-related, involving germs or insects, conspiracy theories regarding governmental agencies, being watched through the implantation of an internal device etc.

Examples of delusional beliefs include:

- A passenger believes that his intestines are turning to concrete due to elevated altitude.
- A passenger believes that space aliens are taking over the plane and are planning to kill everyone on board.
- A passenger believes that they are a space alien who is on a mission to take over the world.
- A passenger believes that there is an electrode implanted within her brain which will explode if the plane takes off.
- A passenger believes that devious dwarfs have access to his apartment and move things around while he is asleep; they also are capable of reading his mind and stealing his thoughts.
- A passenger believes that he/she is being watched by the CIA or FBI.

An individual diagnosed with delusional disorder may present with a delusion which could possibly be true, but is not true. These delusions often do not sound as bizarre as a delusion which someone with schizophrenia may have. Themes may include grandiosity, jealousy, and bodily experiences.

A sample of delusional beliefs which may sound less bizarre:

- A passenger believes that a flight attendant is a member of a terrorist group.

- A passenger may tell a flight attendant that they work for the FBI and were directed to monitor the behavior of all passengers who may have dark colored skin.
- A passenger believes that the man seated across the aisle from him is in love with him.
- Passenger believes they are dying from a diagnosable disease or defect or undying love.

What is a hallucination?

A hallucination is a *sensory experience* (involving any of the five senses) which is not based in reality and not experienced by others who are in the same environment.

There are different types of hallucinations:

- *Auditory:* hearing voices; may be one or many, could be arguing or commanding the individual to do things.
    - Command hallucinations can be dangerous especially if the individual believed that the voice is god or the devil telling them to harm themselves or others.
- *Olfactory*: smelling something which does not actually exists.
    - Example: smelling burnt flesh on the plane.
- *Visual*: seeing images of people or objects that are not actually present.
- *Tactile*: feeling something on body that is not actually present.
    - Example: sensation of bugs crawling all over body.

How should I respond to a passenger who is experiencing Delusions and/or Hallucinations?

- *Introduction:* Introduce yourself to the passenger; tell them your name and position on the air-craft. Tell them that it is your job to help them. Ask them what you can do to help them feel better.
- *Assessment:*

  - Check to see if the passenger feels as though they might harm themselves or another individual on the plane (see general tips section for more specific assessment guideline).
    - Do they have any objects which could be used as weapons (utensils, pens, pencils, keys)?
  - Ask the passenger if they have any medical conditions.

- The individual experiencing delusions or hallucinations may already be overwhelmed; you should attempt to minimize external stimulation. You may do so by speaking softly, removing unnecessary personnel or equipment, giving the passenger a safe space that is quiet and shielded from other passengers or staff. (Source: Dorfman & Walker, 2007)
  - Do not overwhelm the individual with too many staff members and do your best to keep other passengers away.

- Watch <u>your</u> own responses;
  - Approach the passenger in a non-threatening manner and restrain from using unnecessary force on the passenger.
  - Avoid any comments, facial or body gestures that may convey to the passenger that you feel alarmed, horrified, or embarrassed by their hallucinations or delusions.
    - This may include laughter or the use of sarcasm.
  - Be aware of your body posture, avoid sudden movements, stand in an open and non- threatening stance, and have your hands visible at all times (avoid tucking hands into pockets or crossing your arms).
  - Use a moderate, non-threatening tone of voice. Speak quietly at a moderate pace, answering any questions in a calm manner.

- The content of many delusions can be extremely terrifying. For some individuals, even talking about the experience feels quite scary and traumatic. If the passenger is sharing with you the details of their experience you should realize how much the individual is trusting you and looking to you for help. Some passengers may not feel comfortable sharing the content of their experience with a stranger. Be extra careful to respect the passenger. If they do not seem comfortable sharing, do not force or insist that they do so.

- Recognize that these feelings and/or experiences are very real for the person who is experiencing them. While these beliefs may seem irrational to many of us, we must remember that for the individual experiencing the belief, this is a truth.
- When responding to the passenger's account of their experience, be careful not to argue with the individual regarding the validity of their statements. Avoid dismissing or minimizing their experience. Instead, you can offer expressions of empathy and concern with regard to how these experiences are making them feel.
- Be aware that the individual might act upon a hallucination or delusion. Because these beliefs and experiences feel so real, an individual may feel the need to take action in order to comply or fight against the belief.
- An individual's delusions may cause them to be very suspicious of the intentions and behaviors of others (paranoia). If the passenger demonstrates paranoia, be careful not to encourage or inflame their symptoms by doubting their experience or trying to make light of their concerns using humor or sarcasm.

(Sources: Dorfman & Walker, 2007; Langlands, Anthony, Kelly, & Kitchener, 2008)

Exercise:

- Imagine if you believed that someone from one of your flights was following you around, waiting outside your home and stalking you in the airport on your way to work. How would this make you feel?
    - For most, this experience would feel scary.
- Now, imagine reaching out for help, perhaps first telling a friend and maybe a co-worker. Eventually you might even contact the police.
    - How would it feel if those who you reached out to for help looked at you like you did not know what you were talking about?
    - How would you feel if they doubted your experience and accused you of making it all up?

This exercise is meant to give you some insight into the experience that many individuals have when they share the content of their delusions with others.

What do communication difficulties look like?

When an individual is experiencing symptoms of psychosis, their thought processes (the way they think and process their world) and reasoning abilities are often irrational and

disorganized. The individual may feel as though it is difficult for them to think clearly. As a result, the individual's expression of ideas may seem like it is all over the place or hard to follow. This can often make it difficult for others to understand them and get information from them.

Styles of passenger speech that may make it difficult for you to follow:

- Individual may jump from topic from topic without an obvious/logical connection between topics.
- May provide irrelevant and random information that is off topic, rarely returning to the topic at hand.
- Passenger may suddenly stop mid thought and present with a mental block, losing track of their thoughts.
- Statements may sound very philosophical in nature but lack content which is understandable. No actual meaning seems to be being communicated (or it is difficult to discern the meaning).
- Individual may use words that they have invented; words that do not actually exist in commonly used speech (neologisms).
- Individual may refuse to speak at all (mutism).
- Examples of abnormal speech patterns:
    - **Flight Attendant:** "sir, can I help you?"
      Passenger: "well.... I was walking here and then I saw the windows and they were all peering out at me like they wanted to fly. I could fly, but they had cut my wings... they told me I was too wingoded. Uh, what was the question?"

How do I deal with communication difficulties?

- Respond to speech that seems unclear or incoherent by talking in an uncomplicated, clear, and concise manner.
- Repeat statements when necessary.
- Be patient! After you speak allow some time for the individual to process and digest what you have just said before responding.
- Remember: while it may seem as though the individual is showing a limited range of emotions, this does not mean that they are not feeling a range of strong

feelings. Just because they are not showing or telling you how they feel does not mean that they are not feeling.

- The individual may not respond directly to your questions- this should not be interpreted as though they do not understand you- they just may be responding in a limited manner.
    - Confirm that the passenger understands English.

(Sources: Dorfman & Walker, 2007; Langlands, Anthony, Kelly, & Kitchener, 2008)

How do I know when someone is aggressive or may pose as a potential threat to themselves or others?

- Has the individual expressed any statements regarding wanting to hurt or punish themselves?
    - Some delusions or hallucinations may be persecutory in nature, such as the passenger may hear a voice informing them that they are bad and deserve to be punished.

How should I deal with someone who seems aggressive?

Individuals in the midst of a psychotic episode may respond violently in order to defend themselves against feelings of distrust and paranoia with regard to the intentions of others.

Remember: Not all individuals who have been diagnosed with schizophrenia are dangerous and will behave violently towards others. Often individuals with schizophrenia are not more dangerous or violent than the general population at large unless they are not properly medicated or are abusing drugs and/or alcohol.

(Source: Dorfman & Walker, 2007)

- If you feel frightened always ask for help, do not place yourself at risk.
- Be aware that individuals who have psychosis do not tend to act aggressively to others; they are actually more likely to harm themselves than others.
- Do not respond in a hostile or challenging manner when working with the individual who acts in an aggressive fashion.
- Do not threaten the individual as this may result in fear or prompt aggressive behavior.

- Avoid raising your voice or talking too quickly.
- Avoid exhibiting nervous behavior like shuffling your feet, fidgeting, or making abrupt movements.
- Be sure to have your hands visible at all times (do not keep your hands in your pocket or behind your back).
- Do not try to restrict the passenger's movements, for example if the person seems like they need to pace, give them some space to do so.
- Understand that for someone acting aggressively a step like involving the police might actually escalate their aggression, be prepared for this possibility when involving the help of law enforcement.
- Take all threats or warnings seriously particularly when the individual believes that they are being persecuted by imagined threats.
- If you feel like their behavior is escalating out of control get help immediately!

(Source: Langlands, Anthony, Kelly, & Kitchener, 2008)

What are some general tips that can be used when working with a psychotic passenger?

- Always assess whether the individual may act in a way which could harm themselves or another.
    - If the person is a danger to themselves or others you need to try to get them more help as soon as possible, get them to a treatment facility.
    - Assess whether it is safe for the individual to be left alone. If not, make sure someone remains with them at all times.
- Assess whether the passenger is traveling along with someone who they trust who might be able to offer some assistance.
- Remain calm; check-in with yourself regularly throughout the interaction. Utilize techniques described in section regarding Flight Attendant self-care in order to keep your emotional response at levels which are manageable and allow you to remain effective.
- Offer assistance initially by asking the passenger what may be most helpful to him or her. Ask the passenger directly what will help them to feel safe and in control.

    - You can offer the individual choices of ways that they can be helped. By allowing the passenger to choose amongst certain options you are giving them back some control in the situation.

- Be sensitive to the passenger's needs. For example:
    - If the individual is avoiding eye contact this should be respected by not staring them directly in the eyes or forcing eye contact
    - Give the individual the space that they need. Do not crowd the passenger into a space where there is no exit.
    - If it appears as though the passenger needs space to pace or fidget allow them to do so. You may clear some of the isle space towards the back of the plane by having any other passengers seated in that space reseated in a different area of the plane.
- Respect the passenger and their boundaries; avoid touching them, even if your intention is to be caring.
    - If you do need to touch the individual make sure to only do so with permission from the passenger.
- Convey a sense of hope: assure the passenger that help is available and that there is hope that they can feel better. Make it clear that your goal is to help them to feel better and to keep them safe.
- Sometimes when trying to come across as caring, we may speak as though we are interacting with a child. Be careful not to speak in a way which undermines the individual's intelligence and comes across as patronizing.
- Do not make any false promises; always be honest during an interaction.
- Allow the person to feel somewhat in control:
    - Try to comply with requests that seem reasonable and will not place anyone at danger.
    - Whenever possible allow the passenger to set the pace and style of the interaction.
- The primary goal is to deescalate the situation, do not do anything which may agitate the person further.

- Make sure to have access to an exit; do not trap you or the individual into a confined space.
- When involving the assistance of others:
    - Provide any officials who may be called in to intervene with a really clear description regarding the severity of the passenger's behaviors and symptoms.
        - For example, inform the official if the individual has expressed anything to you which has led you to believe that they are risk for harming themselves or others.
    - Make sure to prepare the passenger when other staff members or professionals arrive to help. Clearly introduce the individual, making their title and intentions clear. Additionally, whenever possible, tell the passenger what the individual will do to help.
        - Example: "This is Dr. Rhonda Helpstein; she is a psychologist who would like to talk to you for a few minutes to see if she can help to make you feel safer. She does not have any medications with her and will not be forcing you to do anything that is unsafe.")

Vignette: The following is a sample of a fictional interaction between a flight attendant and a distressed passenger who presents on a commercial airline with symptoms or psychosis. Following the vignette there will be a section which highlights key elements in the interaction.

While reading this vignette, try to take notice of your own response to this interaction. Do you notice any physiological changes in response to this scenario, any signs of stress, fear, and sadness? Try not to focus on changing these responses, just try to notice them for now.

Passenger: *looks agitated, paces in the back of the plane by the restrooms*

Attendant: Ma'am, can I help you?

Passenger: *looks apprehensive...* Listen, I am scared for my life, I need to get off of this plane immediately!

Attendant: (flight attendant stands next the woman in 90 degree formation) Ma'am it sounds to me like you are very frightened and it is my job to keep you safe. Are you traveling with a companion today?

Passenger: No, I am by myself

Attendant: OK. Ma'am. Could you tell me a little bit more about what is going on for you so that I can try to help you feel more comfortable?

Passenger: An electrode was implanted in my brain which will explode if the plane takes off

Attendant: I understand. I am really concerned for your safety and I am sorry that hear that you are experiencing that situation. It sounds really serious to me. It is my job to make sure that I keep you safe. What can I do to help?

Passenger: Get me off of this plane!!

Attendant: Would you be willing to wait with me in the back of the plane while I instruct the captain to return to the gate?

Passenger:...ok

Attendant: then you and I can walk off the plane together and get you to a place where you can feel safe?

What Strategies did you notice the Flight Attendant using in this scenario?

_____

_____

_____

Some strategies used by the Flight Attendant include:

1. The flight attendant did not challenge the delusion but instead took the passengers concerns very seriously.
2. The attendant asks the passenger whether they are traveling with a companion, this is crucial as the attendant may benefit from gaining collaborative information from a companion (e.g. ask them about history, medications get them on board to help etc.).
3. The attendant asks passenger what they can do to help.
4. By suggesting that they stay in the back of the plane, the flight attendant helped to isolate the passenger from external stimuli that may have overwhelmed or aggravated her.
5. By standing alongside the passenger, the attendant is assuming a non-threatening position.

6. By noting how serious and scary the situation is the attendant is offering empathy towards the passenger, which again relays how seriously the attendant is taking the passenger's concerns.

7. The attendant creates an action plan in order to get the passenger into a safer situation (last two lines); the action plan is then revealed to the passenger. The attendant asks for buy-in from the passenger. This strategy will allow the passenger to feel a sense of control. Remember that the passenger is presenting in a state of agitation because they feel they are being threatened by an outside force that they cannot control. By getting the passenger on board with a plan of action, they are being included in the strategy which will likely decrease their sense that others are out to get them. It will also increase their sense of trust in you as someone who sincerely wants to help (you are showing them that you are on the same team).

8. The flight attendant stresses that keeping the passenger safe is their job, again an attempt to be transparent and gain the trust of the passenger.

Are there other things the Flight Attendant could have done?

_____
_____
_____
_____
_____
_____

(Source: Many of the suggestions offered within this section reflect the guidelines proposed by Langlands, Anthony, Kelly, & Kitchener, 2008)

Suicide & Self-harm Behavior:

Research has demonstrated that acts of suicide and self-harm do not occur very frequently on a commercial air-craft. While a terrorist inflicts harm upon themselves while attempting suicide, the author of this manual does not see this event as a psychiatric emergency. In most cases, the terrorist's behavior comes from a culturally based desire to harm others and does not seem to be related to the passenger's mental health.

What are self-harm behaviors?

- Cutting, scratching, or pinching of the skin to the point where the passenger begins to bleed or leaves a mark which remains on the skin.
- Banging or punching an object or the person's own body to the point that they inflict harm (bruising or bleeding).
- Picking at wounds that are in the process of healing, not allowing them to scab-over.
- Burning the skin with matches, cigarettes, or hot water.
- Feeling the pressing need to pull out large portions of hair in order to relieve anxiety (compulsion).
- Over-dosing on medications in a deliberate way which is not intended to take one's own life but rather done as a means to inflict harm.
- Attempting to end their lives by means of suicide.

Why might an individual harm themselves?

- To deal with emotions which feel unbearable such as anxiety, sadness, guilt, and anger.
- To get other people to change their behaviors.
- To demonstrate to others how much pain they are really in.
- To get revenge on others who may have caused them to feel pain.
- To let others know that they need help.

How can I know if a passenger is suicidal?

- Ask the passenger if they feel they are at risk to harm themselves.

    - Example: "I can see you're in distress and I know when people are in distress they can hurt themselves or others. Do you feel as though you want to hurt yourself or another individual on this plane?"

- Ask passenger if they have any objects that could be used as weapons
    - Examples: pen, utensils (fork, knife), prescription drugs.
- The passenger is speaking to you or others about death and the possibility of taking their own life.
- The passenger sounds especially hopeless about their life; they express to you that their life has no meaning or there is no reason for them to consider living.
- The passenger is behaving in ways that seem risky, as if they have no regard for their personal well-being. Their behaviors may seem extreme, excessive, and reckless.

How should I respond to self-harm or suicidal behaviors?

If you witness a passenger engaging in activities or behaviors in which they are attempting to harm themselves, it is best to respond in the following manner:

- Address the passenger in a nonjudgmental and supportive manner.
- Remain calm and avoid expressing shock or anger through your comments, body posture, or tone of voice.
- Tell the passenger that you are concerned for their well-being.
- Remember while you may be able to recognize and even relate to how much pain the passenger is in, no one but the passenger themselves is able to truly comprehend all of the feelings of hurt which they are experiencing.
    - Avoid making statements in which you state that you *know* how the passenger is feeling. Instead, you can notice that it seems as though they are in a lot of pain.
        - " It sounds to me like you are experiencing a tremendous amount of pain"
- Let the passenger know who you are and that you are there to help. Ask them directly what you may do for them to help them to alleviate or lesson their feelings of distress.

- Ask the passenger if they require any medical attention.
- Tell the passenger in very clear terms what the consequences of his behaviors will be. Give the passenger the opportunity to make a choice as what behavior they will choose to act out. When a passenger is able to feel as though the results and consequences of his/her own behavior is under their own control and responsibility, he/she will likely feel less threatened, maintain a greater sense of dignity and be more likely to comply with your request.
    - Example: "If you choose not to give me that sharp instrument then you will be turned over to the authorities once we have reached the gate, if you give me the object you can take a seat in the back of the airplane and get a cup of water or magazine"
- Always inform the captain and ground personnel if you are speaking with a passenger who is threatening to take their own life.

(Source: Foxman, 1990)

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Chapter Seven: Discussion & Conclusion

Limitations of Study

Due to the proprietary nature of training materials, the current research was limited as this researcher lacked access to training materials and as a result relied heavily on the critiques offered within the aviation field. Additionally, the lack of training standards in the field of aviation has made it difficult to assess the variance in training protocol across the field. Lastly, there was a dearth of research available with regard to an examination of the best mode of treatment for psychiatric emergencies by non-mental health care professionals. As a result, this research relied heavily on suggestions made by experts within the field and would benefit from increased empirical support.

Suggestion for Further Research

Further research would be beneficial in measuring the effectiveness of the proposed manual as a training instrument for flight attendants and the effectiveness of such intervention techniques with passengers from various cultural and ethnic backgrounds.

The research could include a questionnaire given to Flight Attendants who have completed the training to assess whether they feel more prepared to handle such emergencies when they occur in-flight. Additionally, the effectiveness of the manual's ability to help Flight Attendants more accurately recognize psychiatric emergencies in-flight may be measured by examining whether there was a change in reporting behavior (level of detail in reports, frequency of reports etc.) and outcome of emergency situations

(as measured by decrease need for emergency landing, decrease in harm or injury caused to the distressed passenger, attendants and other passengers aboard). This data may also be obtained through focus groups in which individuals who have completed the training may share how the training has affected their attitude towards mental health and confidence levels regarding managing psychiatric emergencies.

Application of Research

The manual can be integrated into the training materials which are currently used in the field of commercial aviation training for Flight Attendants. It is this researcher's recommendation that the manual be taught to attendants by a trained mental health care professional. A professional can appropriately lead group exercises and discussions while also being available to help answer any questions that may arise regarding the materials in the manual.

Summary and Conclusion

The current research examined the stressors involved in commercial air travel and the relationship between psychiatric emergencies and commercial air travel. This research found that the current systems used to train commercial flight attendants in the United States are too basic and minimal. Additionally, critiques of the current training system have noted that attendants are not well versed in the use of verbal de-escalation techniques. As a result, flight attendants often rely solely on the use of physical interventions, such as the use of restraints.

In contrast with the current model of training, this manual offers a thorough presentation of various mental health emergencies and includes clear behavioral

indicators to help the attendant recognize the type of emergency which is occurring. Furthermore, the manual integrates an understanding of the most effective treatments for common mental health emergencies and provides attendants with clear step by step instructions and tips which can be employed when managing a psychiatric emergency. Additionally, the manual offers attendants a clear understanding of the role which they play during an emergency situation, by focusing on ways in which the attendant may monitor and moderate their own behaviors in an effort to promote de-escalation of the situation at hand. The attendant is also instructed regarding ways in which they may monitor and manage their own stress reactions to a psychiatric emergency.

This manual, when used appropriately, may better prepare flight attendants for in-flight psychiatric emergencies thereby allowing the attendants to be more effective in their interventions while decreasing the need for physical means of restraint (which have been found to be dangerous). By managing psychiatric emergencies more effectively, the attendant will make air travel safer for all, especially those individuals within our culture who suffer from mental illness.

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