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LETTERS TO THE EDITOR

Transcultural psychiatry and globalization: our experience as an international airport's referral hospital

Dear Editor,

Nowadays, in our globalized society, the daily number of passengers going through airports is ever-increasing. As an example, in 2006 more than 50 million passengers went through Madrid's international airport (AENA, 2017).[1] The effective hospital assistance of those psychiatric emergencies that affect patients (of different nationalities and cultures) transferred from airports, is a seldom studied issue despite the many troubles involved in their clinical control.

Stressful conditions related to air travel (e.g. diminished sleep hours, time zone changes, language barriers, non-direct flights) may act as trigger factors for psychopathology, especially among people with previous history of mental illness (Shapiro, 1977).[2] In other cases, the trip may be related to the disorder's symptoms (e.g. looking for new adventures in a manic phase) or be a consequence of such (e.g., paranoid ideas may lead to travelling as part of a fleeing strategy).

It is extremely complicated to perform a proper psychopathological evaluation and gather information about patients' baseline situations and backgrounds, due to the absence of previous medical records. Furthermore, most of them are of foreign origin and both cultural and idiomatic differences may act as barriers that are terribly difficult to overcome. These factors may generate great doubt when having to emit a clinical judgement or at hospital discharge.

Despite being a prevalent phenomenon that greatly impacts our daily clinical practice, very little information is available about the assistance of these ''airport patients''. To help fill the gaps in this area, we conducted a retrospective and observational study. We analysed the details contained in the admission history of 58 patients, aged between 22 and 66 years ($M \pm DT = 36.4 \pm 10.22$), transferred from ''Barajas-Adolfo Suárez'' International Airport in Madrid, all of whom required admission to the acute inpatient unit of the ''Hospital Universitario Ramón y Cajal''. Not only were clinical variables (e.g. diagnosis) registered, but also information about sociodemographic and other variables, such as those related to the trip (e.g. reason for travelling). The goal of this study is to identify key elements that may allow us to improve our knowledge and the quality of assistance in this particular area.

Table 1 shows descriptive results in more detail. Chi-square tests revealed an association between fleeing due to persecutory delusions and the existence of previous psychiatric history ($p < 0.01$). Regarding cultural issues, being diagnosed of non-otherwise specified psychotic disorders at hospital discharge was highly associated with patients originated from developing countries ($p = 0.01$). What is more, the existence of a language barrier was related to a higher number of therapeutic immobilizations ($p = 0.049$), and when the patient was foreigner more time was needed to contact with an informant ($p = 0.020$). Furthermore, there were statistically significant differences concerning the average stay in the inpatient unit (Table 1) depending on the possibility to access previous medical records ($0 = 0.029$) or on who managed the required and/or available aids at the time of hospital discharge ($p = 0.047$).

The data correlations we found suggest the existence of particular issues regarding the clinical and non-clinical management of airport-found patients. Forced transfers may also explain the difficulties experienced at the Emergency Room, as the existence of a language barrier would explain the difficulties with verbal containment. Moreover, another additional difficulty faced is lack of access to previous clinical histories, which frequently requires direct contact with foreign countries or their appointed embassies.

Culture has a great impact on the manifestation of mental ill-health. For example, in non-western cultures, panic reactions with paranoid ideas and brief psychotic episodes are way more common (Harris, 2004).[3] Additionally, major dissociative disorders as social manifestations of unpleasant emotions are a much less common phenomenon in western cultural communities (Matsumoto, 1996).[4] We should take into consideration this information since we may be over-diagnosing psychotic disorders in patients who have not been raised in western cultures. Therefore, mental health care provided to foreign patients requires some basic knowledge about transcultural psychiatry.

The present study has obvious limitations, such as the fact that our sample is exclusively composed of those patients that were hospitalised and does not include information on those patients that were directly discharged from the Emergency Room.

In conclusion, these findings show the need to implement translation teams (such as ''cultural translators'') (Pérez

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Table 1 Descriptive data and average stay comparisons.

Variable		N (%)	Average stay in days (M ± DT)	P
Sociodemographic data				
Gender	Female	44 (75.9)	12.57 ± 9.59	0.474
	Male	14 (24.1)	13.79 ± 11.7	
Marital status	Single	43 (71)	12.05 ± 9.64	0.373
	Married/civil partner	8 (13.8)	11.63 ± 8.45	
	Widowed	3 (5.2)	16.33 ± 4.9	
	Divorced/separated	4 (6.9)	21.50 ± 17.48	
Country of Origin	Spain	12 (20.7)	13.00 ± 10.74	0.462
	Other developed countries	18 (31)	13.49 ± 7.96	
	Developing countries	28 (48.3)	12.46 ± 11.17	
Travel-related variables				
Reason for travelling	Leisure trip/tourism	14 (30.1)	11.54 ± 6.61	0.745
	Bussiness	4 (8.5)	17.25 ± 16.24	
	Studies	2 (4.3)	24.50 ± 24.75	
	Social/family matters	12 (25.5)	16.75 ± 12.61	
	Escape	15 (31.9)	10.60 ± 6.30	
Airport-found patients' conditions prior to hospital referral	Homelessness/ marauding	13 (22.4)	13.92 ± 10.48	0.367
	Madrid, national origin	2 (3.4)	22.50 ± 10.85	
	Madrid, national destination	4 (6.9)	12.00 ± 7.12	
	Madrid, international origin	18 (31)	10.28 ± 9.38	
	Madrid, international destination	2 (3.4)	12.00 ± 9.89	
	Madrid, connection flights	19 (32.8)	13.84 ± 10.84	
Escort availability	Yes	6 (10.3)	12.50 ± 10.75	0.852
	No	52 (89.7)	12.90 ± 10.07	
Language Barrier	Yes	24 (41.4)	11.04 ± 6.26	0.204
	No	34 (58.6)	14.15 ± 11.95	
Clinical variables				
Previous diagnosis	None	11 (26.8)	11.64 ± 7.79	0.134
	Schizophrenia	13 (31.7)	16.15 ± 12.63	
	Bipolar disorder	8 (19.5)	7.13 ± 5.46	
	Unknown/unavailable	9 (21.9)	11.64 ± 7.79	
Previous Psychiatric Unit intakes	Yes	32 (55.2)	13.24 ± 11.20	0.483
	No	26 (44.8)	12.38 ± 8.60	
Diagnosis at discharge	Schizophrenia	14 (24.6)	13.71 ± 10.83	0.602
	Manic phase (Bipolar disorder or Schizoaffective disorder)	16 (28.1)	12.88 ± 6.67	
	Psychotic Disorder not Otherwise Specified	21 (36.8)	13.05 ± 12.62	
	Others	6 (10.5)	8.67 ± 5.82	
Access to previous medical records	Yes	15 (31.3)	10.67 ± 5-34	0.029**
	No	33 (68.7)	14.52 ± 11.87	
Discharge aids were managed by	Psychiatrist	15 (25.9)	9.87 ± 2.04	0.047**
	Family	22 (37.9)	10.5 ± 1.72	
	Consulate/Embassy	8 (13.8)	10.86 ± 1.65	
	Social Service's personnel	13 (22.4)	18.85 ± 3.13	

** $p < 0.05$.

Sales, 2004)[5] in hospitals and to improve the coordination between healthcare services and consulates in order to optimize the assistance to airport-found patients, with the aid of the appropriate diplomatic legations. This highlights the need for continued research to find better ways to improve mental health care by taking into account the universality of mental ill-health.

Statement contributorship

R. Paricio-del-Castillo conceived the work, wrote the protocole, assisted in the study design, selected articles for inclusion, extracted the data and wrote the paper. A. Pascual-Sánchez assisted in the study design and helped extracting the data and writing the paper. JM. Montes-

Rodríguez assisted in the study design and supervised the project. All the authors have revised and all have participated actively in the elaboration and approved the final draft.

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