INTRODUCTION

Several medical terms encompass the notion of pathological journey. Impulsive journey, compulsive travel, fugue states, ambulatory delirium, paranoid flight and wandering have all been used to describe patients who travel in unprepared or precarious ways in relationship with a psychiatric condition [1]. The more pejorative expression “psychiatric tourism” is also mentioned by some authors [2]. However, despite quite abundant clinical descriptions and vocabulary, very few studies deal expressly with this type of behavior.

One of the main reasons for this scarcity of data in this particular field is that pathological journey does not exist as a single diagnostic category amongst the main psychiatric classifications. In DSM IV [3], the topic is discussed in the diagnostic category of fugues, which occur during dissociation states. These fugues are sudden occurrences, accompanied by amnesia and confusion affecting personal identity. The differential diagnosis section mentions the fact that fugues or wandering may occur in general medical conditions, as well as during epileptic seizures or substance abuse disorders. Two other important mental disorders should be considered: purposeful travel can occur during manic episodes and peripatetic behavior is sometimes observed in cases of schizophrenia or delusional disorders. The categorization of fugues is similar in ICD-10 [4]. Pathological journey is originally a French concept which refers to episodes of mental illness in which travel plays a key part [5].

According to available data, pathological journeys are not exceptional, especially in large cities. Tannock and Turner, discussing the overloading of London psychiatric beds, took the following example: “Over the past two weeks one 17-bed ward in Hackney has admitted three non-Londoners: a psychotic patient from Sierra Leone, a Barbadian with learning difficulties, and a maniac Australian. On a similar ward last month there were five non-Londoners: two manic patients (from New York and Argentina), a mute man from Guadeloupe, a Nigerian with persecutory delusions, and a Kurdish patient seeking asylum who had been in Britain for two months. Currently, on one ward five patients are of no fixed abode” [2].

Controversy exists regarding pathological journeys to specific places. Authors in Israel have argued that there is a genuine “Jerusalem syndrome”, afflicting ardent religious believers who go to Jerusalem and develop psychotic symptoms during their stay [6]. It is not clear however if this syndrome should be regarded as a unique cultural phenomenon due to its overwhelming theatrical characteristics [7], or as the aggravation of an underlying psychotic disorder [8, 9]. To a lesser degree, a similar debate took place regarding possible specificities of psychotic episodes occurring among travelers to India [10]. Anecdotic reports of Paris and New York syndromes (affecting Japanese tourists disappointed by the city or confronted with situations of violence) and of Stendhal’s syndrome (affecting travelers to cities of art and culture, such as that described by Stendhal in 1817 after a visit to Florence, Italy) may be found in the media.

Our clinical practice indicates that psychiatric hospitalizations for pathological travels represent a significant phenomenon in Geneva, Switzerland. Some of these travelers appear not to have chosen this city randomly, but precisely because of its international reputation. They are usually admitted to the hospital following inappropriate visits to one of the many International Organizations with headquarters in Geneva, such as the United Nations (UN) and its different...
agencies. Our study was designed to assess this clinical phenomenon.

METHODS

Patients

We conducted a retrospective, case register study covering a 4-year period (November 2000 to November 2004). It included patients hospitalized at the only psychiatric hospital in Geneva, Switzerland (providing for a catchment area of approximately 430’000 inhabitants). The list of all hospital admissions was examined. When medical admission certificates bore the mention of pathological journey, the medical record was obtained and analyzed. Variables of interest concerned usual socio-demographic factors, diagnosis (our hospital diagnoses at discharge are ICD-10 diagnoses), psychiatric antecedents, country of origin, variables related to travel (alone or not, possible connections in Geneva) and characteristics of hospitalization (manner and motives of admission, duration of stay, psychotropic treatment, destination at discharge). The study protocol was approved by the ethics committee of the Psychiatry Department, Geneva University Hospitals.

Statistics

Group comparisons were performed with the Fisher’s exact test for categorical variables and the Student’s t-test for continuous variables. Significance level was set at 0.05 (two-sided tests). Statistical analysis was performed with SPSS version 11, with the exact tests option installed (SPSS Inc., Chicago, IL).

RESULTS

A total number of 11’950 hospitalizations were recorded during the 4-year period. Among those hospital admissions, less than 1% (N=104) were associated with a pathological journey mention on admission records. Twenty-eight cases were excluded as they concerned Swiss patients repatriated from abroad.

The present study thus included 76 admissions, corresponding to a sample of 76 different patients. Socio-demographic and medical characteristics are presented in Table 1. A majority of patients were male (58%), aged less than 50 (75%) and single (66%). In 62% of cases, they came from a European country (mainly France, Italy, Germany and Russia). Prior psychiatric history was documented for 84% of patients, and discontinued treatment for 63%. Most of patients traveled alone (92%), came directly from their home country to Geneva (62%), had no prior connection in Geneva because of its international organizations, while 60 came for other reasons. The two sub-samples are compared in Table 2. Patients attracted by international organizations differed from the other travelers as follows. They more often came from abroad (88% versus 63%, P=0.063). They less often had prior connections in Geneva (6% versus 32%, P=0.054). Police intervention was less frequent (19% versus 63%, P=0.002) but admissions more often occurred through emergency facilities (81% versus 42%, P=0.010). Conditions of discharge from the hospital also significantly differed (P=0.015), with a lower proportion of patients voluntarily repatriated (0% versus 25%) or transferred to hospital in residence place (25% versus 35%). Prevalence of persecutory delusions was significantly higher among travelers attracted by the “international Geneva” (88% versus 43%, P=0.002).

Different organizations were the target of unwanted visits: the UN (United Nations), HCR (High Commissioner for Refugees), ICRC (International Committee of the Red Cross) and WHO (World Health Organization) being the most frequently visited. A few representative clinical vignettes are presented below.

1. Mr. A., aged 30, born in Liberia, was an asylum seeker living in Germany. At age 29, he was hospitalized in Germany because he felt threatened and persecuted. After discharge, he spent several weeks wandering around in England and Ireland. He came to Geneva to seek help at the High Commissioner for Refugees (HCR). A few days after his arrival in Geneva and several phone calls to the HCR, he went to the local general hospital emergency department, complaining of itching that he attributed to intentional poisoning. Hospitalized in psychiatry with a diagnosis of delusional disorder, he refused repatriation to Germany. He improved with antipsychotic medication and was discharged 6 days later.

2. Mr. B., aged 25, born in Algeria was French and lived in Paris. He was single and unemployed. He came to Geneva in order to meet several representatives at various international organizations, claiming that the French authorities wanted to eliminate him. After unsuccessfully trying to obtain appointments, he went to the local general hospital emergency department asking for political asylum. His psychiatric history revealed several previous psychiatric hospitalizations and antipsychotic treatments in France, where he had been diagnosed with schizophrenia. Transferred to psychiatry, he refused treatment and repatriation. In the absence of imminent danger, he was discharged 48 hours later.
Mrs. C., aged 45, was a British subject living in Scotland. Divorced, she had a teenaged daughter who had left home during the previous year. Convinced that her daughter was manipulated by the Irish Republican Army (IRA), she asked for help at Amnesty International in England. Unsatisfied with their response, she came to Geneva, feeling that the International Committee of the Red Cross (ICRC) might have relevant information. As she refused to leave ICRC offices, the psychiatrist on duty was called and had her admitted in psychiatry. Repatriation was quickly organized and the patient was transferred to her country of residence 24 hours later. Despite possible suspicion of delusional disorder, she was discharged.
with a temporary diagnosis of acute transient disorder in the absence of additional information.

4. Mrs. D., aged 50, was Italian. Treated in her country for a bipolar disorder, she had been taking lithium since the age of 30. After treatment interruption, the patient became euphoric and left her place of residence for Venice, where she stayed for a few weeks. Eventually, she flew from Venice to Geneva. Upon arrival, Mrs. D went to the UN headquarters, asking for a subsidy to support the creation of a new sales company. Later on the same day, she went to the general hospital, asking for the removal of her psychiatric diagnosis. A manic episode was diagnosed and the patient was transferred to psychiatry, where she was successfully treated with olanzapine and lithium. Bipolar I disorder was confirmed and she voluntarily went back to her country.

DISCUSSION AND CONCLUSIONS

Despite its marginal importance (less than 1% of admissions), pathological journey represents an identifiable cause of psychiatric hospitalizations in Geneva. Among these patients, 21% do specifically travel to Geneva in order to contact or visit international organizations headquarters.

As similar studies are lacking, it is difficult to compare our figures with data from the literature. In 1981, French authors reported having retrospectively analyzed 214 medical records of pathological travelers, but presented qualitative data only [11]. Based on their clinical descriptions, these authors proposed a new typology of pathological travel. They distinguished between the simple, secondary and pure pathological travel. In the “simple pathological travel” travel obeys to delusional ideation without being integrated into a delusional system. In these cases, destination is of secondary importance (e.g., traveling to escape surveillance by secret services). By contrast, in the “secondary pathological travel” travel is integrated into a delusional system and destination plays a central role (e.g., in response to a delusional order to commit suicide in a specific location). In “pure pathological travel” delusional ideation or hallucinations are focused on the necessity to travel (e.g., hearing voices ordering the patient to take the subway several times a day). According to this typology, most of our cases of pathological journeys to the international Geneva would fit into the category of “secondary pathological travel”. Other French authors published a retrospective study of 29 pathological journeys to the Bordeaux area, in the south west region of France [12]. Their methodology was fairly similar to ours, since medical records were identified on the basis of admission certificates to a 20-bed inpatient unit. Their results were also comparable with the present study: patients were in majority male (20/29), with a mean age of 33 years. Most patients (22/29) presented with delusional symptoms, usually of the persecutory type. In their discussion, authors note that the travel destination is usually a non-random choice, since journeys retain some degree of organization.

From a psychopathological perspective, it is important to note that no single mental disorder can account for all pathological journeys. The clinical examples presented above illustrate this point. However, acute transient psychotic disorders, schizophrenia and delusional disorders are the most frequent diagnostic categories among this sample. Persecutory delusions seem to be the underlying cause of travel in most cases, while delusions of grandiosity account for the cases encountered during manic episodes. The four patients who had a main diagnosis of psychoactive substance use had traveled in a state of street drugs intoxication.

This retrospective study has several limitations. Firstly, patients’ medical records were selected on the basis of the content of hospital admission certificates. This method might possibly have underestimated the true number of pathological travelers. Indeed, the admission certificate is a brief document, written prior to admission, usually in emergency conditions. Some patients might have gone undetected since pathological travel is not systematically investigated or mentioned at initial assessment. However, because of strict legal rules regarding compulsory hospitalizations in psychiatry in our geographic area, the context and motives of emergency interventions is usually mentioned on certificates. Secondly, as most hospital stays were short, detailed data regarding psychopathology were often missing. The reason for the pathological journey may not have been scrupulously recorded in all case files. Thirdly, 60 of 76 subjects traveled for nonspecific reasons such as accessibility or random choice. As there was no control group comprising patients identified in another city using similar methods, the importance of the nonspecific determinants of travel can’t be fully assessed. Fourthly, it is probable that most individuals visiting international organizations with inadequate demands were not referred to psychiatry. Therefore, our study addresses only a subgroup of pathological travelers to Geneva. Fifthly, the association between pathological journeys and specific psychotic disorders should be investigated in prospective studies. Indeed, our results indicate that active delusional ideation (mainly of the persecution type) put patients at risk for pathological journeys but does not allow for reliable comparison between diagnostic categories (schizophrenia, acute delusional psychoses and delusional disorders).

In the context of globalization, international travel is on the increase. Of course, this may lead to a rise in pathological journeys as explained above, but traveling to an international city such as Geneva may also express help seeking behavior, for example because of human rights abuse in the subject’s country of origin [13]. One should be careful not to stigmatize such behaviors, no matter whether this is done in an appropriate manner or not.

In order to improve the scientific quality of future prospective studies and to limit the risk of stigmatizing people crossing borders to seek help, such as refugees or asylum seekers, we believe that a more precise definition of pathological journeys should be used. On the basis of available data, we suggest restricting this framework to conditions in which psychotic symptoms precede displacement and govern it (for example as a response to persecutory delusions). This definition excludes syndromes where mental disturbance is the consequence of displacement (such as the Paris or New York syndromes described among Japanese tourists, or culture shock, mainly described among expatriates [14]). This definition would also exclude the case of persecuted or desperate individuals traveling without preparation to ask for help in ways judged as inadequate.
Using this operational definition of pathological travels, it would be interesting to compare data involving various cities notable for their international organizations, such as Strasbourg, Brussels, La Haye, New York and Geneva. Whether these situations are a source of concern for international organizations medical services should also be investigated. In our study, none of the analyzed cases truly jeopardized the people working in the international organizations.

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REFERENCES