AMP Short Course
Neurological, Psychiatric and Psychological Aspects
of Aerospace Medicine
(Aspects Neurologiques, Psychiatriques et Psychologiques de la Médecine Aérospatiale)
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The material in this AGARDograph has been prepared under the sponsorship of the Aerospace Medical Panel of AGARD and was presented as a Short Course at Pensacola, United States from 18th to 20th October 1989, at Brussels, Belgium from 18th to 20th October 1989 and at Ankara, Turkey from 30th October to 1st November 1989.
The Mission of AGARD

According to its Charter, the mission of AGARD is to bring together the leading personalities of the NATO nations in the fields of science and technology relating to aerospace for the following purposes:

- Recommending effective ways for the member nations to use their research and development capabilities for the common benefit of the NATO community;
- Providing scientific and technical advice and assistance to the Military Committee in the field of aerospace research and development (with particular regard to its military application);
- Continuously stimulating advances in the aerospace sciences relevant to strengthening the common defence posture;
- Improving the co-operation among member nations in aerospace research and development;
- Exchange of scientific and technical information;
- Providing assistance to member nations for the purpose of increasing their scientific and technical potential;
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Preface

This Short Course was offered as part of the North Atlantic Treaty Organization's (NATO) Advisory Group for Aerospace Research and Development (AGARD) program of education. It was offered at the Naval Air Station, Pensacola, Florida, United States (18th to 20th October 1989), Centre of Aerospace Medicine, Brussels, Belgium (25th to 27th October 1989) and Air Force Hospital, Ankara, Turkey (30th October to 1st November 1989) The Course was originally conceived during discussions by the Aerospace Medical Panel of AGARD. In particular, Colonel James R Hickman, Jr, Chief, Clinical Sciences Division, USAF School of Aerospace Medicine, was a primary advocate and supporter of our effort.

The faculty was selected from among international experts in aeromedical neuropsychiatry. Each faculty member brings a unique experience and background. Similarly, however, the faculty adheres to common principles derived through operational experience and consultation with aviators. Each faculty member supports the idea of performance enhancement, health promotion, and prevention as the primary contribution of neuropsychiatry to aerospace medicine. Further, each faculty member advocates the need for careful clinical assessment with specific attention to the unique aspects of the aviation occupation requirement for the central nervous system performance. Finally, the faculty members recognize the strengths and weaknesses shared by individuals drawn to aerospace operations and recognize that while failure can occur, it is rare and often can be prevented or overcome.

In retrospect, the course was very well attended, beautifully supported by each host’s institution, and exceptionally well received by the participants. Thus, this monograph is the result of presentations by the faculty with additional information added from the participants. Clearly, the aeromedical world is advanced by the efforts and support of the Aerospace Medical Panel of AGARD, these faculty members, and the participants who so richly added to the course.

Aerospace operations and aerospace medicine have had a long, but at times confusing, relationship. There is much ahead for this relationship between aerospace operations, aerospace medicine, and neuropsychiatry. We all have much to learn and a continuing responsibility to “keep ‘em flyin’.”

I appreciate our neuropsychiatric pioneers and ancestors who fought the early battles and had the courage to go beyond their traditional training and venture into this frontier. The foundation they have provided is solid and their heritage of enthusiasm, coupled with hard work, has been infectious and is perhaps their best gift to us for the future. To the Aerospace Medical Panel, I offer my gratitude, particularly for their foresight in advocating this course. Finally, to the faculty members whose hard work in aerospace medicine has brought them well-deserved recognition, I offer my sincere gratitude for their willingness to share their knowledge and make the course the success that it was. To all the participants and readers of this document, I wish you continued success with the hope that this course may make a contribution to your work.

John C. Patterson, Ph D.
Course Director
Préface


L'idée du cours trouve son origine dans des discussions qui ont eu lieu entre les membres du Panel AGARD de Médecine Aérospatiale. En particulier, le Colonel James R. Hickman, Jr, Chef, Clinical Sciences Division, USAF School of Aerospace Medicine, a été l'un des instigateurs du projet et un partisan convaincu de nos efforts.

Le corps enseignant a été choisi parmi les experts mondiaux de la neuropsychiatrie. Chaque membre de l'équipe a apporté une compétence et une expérience uniques. De la même façon, chaque membre a souverain à des principes communs, dérivés de l'expérience opérationnelle et de conversations tenues avec les aviateurs. Chaque membre a reconnu que l'amélioration des performances, la promotion de la santé et la médecine préventive étaient la principale contribution de la neuropsychiatrie à la médecine aérospatiale.

En outre, chaque membre du corps enseignant a préconisé la nécessité d'un contrôle clinique metteux ou une attention particulière serait accordée aux aspects uniques du métier d'aviateur, en ce qui concerne les performances exigées au niveau du système nerveux central. Enfin, le groupe s'est déclaré conscient des points forts et des points faibles des personnes impliquées dans les opérations aérospatiales et a reconnu que, bien que l'échec soit toujours possible, il est rare et peut être évité ou surmonté dans bien des cas.

Le cours a été caractérisé par une assistance nombreuse, un soutien logistique remarquable dans chacun des pays hôtes et un accueil très favorable de la part des participants.

La monographie de ce cours comprend les présentations données par les membres du corps enseignant, ainsi que certaines informations fournies par les participants. Il est clair que la communauté aéro-médicale internationale a fait un pas en avant grâce aux efforts et au soutien du Panel AGARD de Médecine Aérospatiale (AMP), des membres du corps enseignant et des participants qui, chacun pour ce qui le concerne, a beaucoup contribué au succès du cours.

Les opérations aérospatiales et la médecine aérospatiale sont liés depuis longtemps, malgré la confusion qui a pu caractériser leurs rapports de temps à autre. Il reste beaucoup à faire pour le trio opérations aérospatiales, médecine aérospatiale, neuropsychiatrie. Nous avons beaucoup à apprendre et nous aurons surtout une responsabilité permanente en ce qui concerne l'aptitude au vol des équipages.

Il y a beaucoup d'estime pour nos anciens pionniers de la neuropsychiatrie qui ont mené les premiers combats et qui ont eu le courage d'outrepasser les limites de la formation classique et d'explorer ces terres nouvelles. Ils nous ont fourni des bases solides, leur enthousiasme et leur audace, qui sont très communicatifs, ont peut-être été les éléments les plus importants de l'héritage qu'ils nous laissent.

Je tiens à remercier le Panel AGARD de Médecine Aérospatiale, en particulier pour avoir eu la présomption de proposer ce cours. Je tiens enfin à exprimer mes sincères remerciements aux membres du corps enseignant dont le travail conséquent dans le domaine de la médecine aérospatiale leur a valu une reconnaissance bien méritée.

Ils ont bien voulu partager leurs idées avec les participants, assurant ainsi le succès indiscutable du cours. Je souhaite à tous les participants et à tous les lecteurs de ce document la réussite dans leur entreprise, en espérant que ce cours pourra y contribuer.

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Introduction and History

by

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This course was developed with the support and help of many prominent aerospace medicine experts. This course is the specific result of efforts made by my colleagues and friends, Dr. Dick Hockman, who has long been a partner in the development of aerospace medicine, and Dr. Michael Centers, who is well respected in the field. Thus, my fellow faculty members and I are deeply indebted to them for their encouragement and leadership in making this course a reality.

In this introduction, I will briefly review the history and relevant concepts of neuropsychiatric evaluation, and consultation in aerospace medicine. I will discuss the practical and unique contributions of this specialty area to aerospace operations and this introduction will provide an overview and perspective for the rest of the presentations.

One of the most difficult questions that face aerospace medicine is the relationship of man to the atmosphere and to the aerospace environment. Specifically, neuropsychiatrists and flight surgeons alike are concerned with man's brain and the central nervous system as it acts on and responds to the atmosphere. It is at this crossroad where neuropsychiatry, flight surgeons, and aviators meet and share common goals and problems. The faculty will discuss these common goals and problems and ways flight medicine can better use neuropsychiatric consultants and will offer ways flight surgeons can improve neuropsychiatric services and outcomes for aviators, but first we should briefly review the original work in this area.

The history of neuropsychiatry involvement in aviation goes back to the very early days of selection for flying training. Psychologists and psychiatrists, in particular, were called in to improve the selection process over the "in situ" selection procedures first used in early aviation. Indeed, interviews and psychological tests were developed and showed some promise, but countries continued this research and non-use highly sophisticated neuropsychiatric selection procedures. Notably, the United States did not complete its research program and currently does not use neuropsychiatric information in selection. Since those days, psychiatry, psychology, and neuropsychiatry have remained important areas of aerospace medicine due to the importance of the brain and central nervous system to flying.

While selection was emphasized in some countries, others developed consultation related to issues of the actual flying physical return to fly, or injury or death, administrative recommendations such as which airframe to fly, and most recently, enhancement programs that deal with improved performance in an already healthy population. Notwithstanding this, these aeronautical interests are significantly different from the traditional neuropsychiatric areas such as mental disorder, personality, seizure, and severe head trauma. It is important to recall that as with other medical specialties, the aviation environment brings up many issues not seen in standard clinical neuropsychiatric practice and the reverse is true, there are many conditions seen in standard clinical neuropsychiatric practice which occur only rarely if at all, among aviators. Thus, errors can occur when neuropsychiatric consultants overdiagnose a healthy aviator or undiagnose an aviator who is clinically within normal limits but who presents an aeronautical risk. Thus, as with other medical specialties, it is advantageous for flight surgeons to consult aero-medically trained and experienced neuropsychiatric consultants. Further, flight medicine specialists must be well-trained in aero-medical aspects of neuropsychiatry to produce occupationally relevant and efficient consultations.

Neuropsychiatry shares common aeronautical concerns with flight surgeons and operational managers. These common concerns include safety, mission completion, human performance, and the desires of the individual and the aviator for the highest standards of safety. Flight safety is the priority concern among all areas of aviation medicine. Flight safety can be jeopardized through a variety of organic and functional difficulties found in various human systems. The neuropsychiatric issues of sudden or insidious incapacitation, performance decrement, and loss of motivation will be covered in this course. Mission completion and mission completion also have neuropsychiatric implications for military aviation. In some civilian aerospace operations, readiness and mission completion may be of equal importance to flight safety factors. High performance flying most often found in military aviation presents neuropsychiatric implications in areas such as G-fs, of consciousness, fatigue, hypoxia, and others. Finally, neuropsychiatry can provide information about the individual needs and desires of the aviator which involves evaluation of initial motivation sufficient to complete training and then the evaluation of flying motivation as it may change across the life span. Thus, neuropsychiatry can provide information about the individual and the aviator's needs and desires and the cognitive and intellectual performance of these areas apply to flying.

These areas of the central nervous system require specific care and careful evaluation and will be discussed in the program. Neupysiologist also seeks to protect the flying organization as well as the individual aviator against diseases and dysfunctions of the nervous systems, that is, to say, neuropsychiatric consultants can identify disorders at the time of selection or, in many instances, to provide early warning about those disorders most relevant to aviators. Operations that might cause sudden incapacitation (e.g., anxiety, seizures) and insidious performance decrement and motivational problems. Finally, neuropsychiatry as applied to aerospace medicine should help prevent disabling
disorders through education and early consultation before disorders require grounding.

Thus, this course will cover the important and relevant features of psychiatry, psychology, and neurology as these disciplines relate to the aerospace environment. The course is designed for flight surgeons, as well as consultants in neurology, psychology, and psychiatry. It is our hope that flight surgeons completing this course will improve their utilization and supervision of neuropsychiatric referrals and will improve their neuropsychiatric case management skills.

Secondly, we hope that consultants in psychiatry, psychology, and neurology will improve their understanding of the aviation environment, the requirements of aviators and flight surgeons for neuropsychiatric evaluation and consultation and will improve the relevancy of their knowledge as it applies to aviation.

I am delighted to introduce the rest of the faculty to you. Each has been a professional resource for me in my work in the aviation community and thus, because I know their work, I have selected them as excellent examples of neuropsychiatric consultants in aviation. Each brings a wealth of unique knowledge and experience. Dr J R Galles-Tessonneau, psychiatrist and flight surgeon, is the Chief of Medicine at the Medical Centre, Psychology Clinic at the Aeromedical Center in Paris, France. Dr Galles-Tessonneau's topics are “The Pilot-Flight Surgeon Bond” and “Fear of Flying.” Dr David R Jones, psychiatrist and flight surgeon, is the former Chief of the Neuropsychiatry Branch, USAF School of Aerospace Medicine, a long time colleague and friend and now editor of Aviation, Space, and Environmental Medicine. Dr Jones will discuss “Psychiatric Diagnoses and Disorders”. Psychiatric Reactions to Medications”, “Mishap After Care” and “Personality Disorders”. Dr Marc Ketchen, neurologist, flight surgeon and research colleague is the former chief of aerospace neurology at the USAF School of Medicine and now is in private neurological practice. He will discuss “General and Introductory Issues in Aeromedical Neurology”, “Unexplained Loss of Consciousness”, “Head Trauma” and “Selected Concerns in Neurological Disease in Aviation”. Dr Grete Myre, psychologist, and frequent consultant for me, is Chief Psychologist at the Institute of Aviation Medicine in Oslo, Norway. She will be discussing “Aviation Psychology in the Operational Setting”, “Finally and Domestic Problems in the Aviator”, and “Mishap Aftercare”. Dr Jim Pacino, psychologist, is former chief of aviation psychology for the United States Army at Ft Rucker, AL, and a research/clinical colleague. He will discuss “Stress as it Relates to Human Performance, Health, and Mishaps in Aviation”, “Interview and Psychometric Approaches to Adaptability in Aviation”, and “Cognition as it Relates to Pilot Judgment”. Finally, I am Dr John Patterson, psychologist and the course director and, as such, I selected the panel members and topics. I am the Chief of Aerospace Clinical Psychology at the USAF School of Aerospace Medicine. I will be discussing “Psychometric Evaluation of the Aviator”, “The Failing Aviator”, “Mishap Aftercare” and “Personality Disorders”. That completes the course introduction. I hope you will find the papers that follow stimulating and useful.
The Pilot Flight Surgeon Bond

by

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To become a physician it is necessary to learn medicine and to know diseases. But it is also necessary to have some notions about medicine psychology.

To become a flight surgeon, it is necessary to know medicine, it's necessary to know aeronautic medicine but it's also necessary to have some notions about pilot psychology and pilot-flight surgeon relationships.

Pilots are not ordinary patients; pilots present some particularities about health and diseases, about medicine and physicians.

There are few examples of human activities which, like aeronautics, have required such extensive medicalisation, and aeronautic medicine may legitimately seem like one of the most sophisticated and most performing models of occupational medicine. The reasons for this development may be summarized in two major characteristics:

The first is associated with the significance of the risks involved. For a long time, these risks have made it impossible to fly. Even today, news periodically reminds us of the risk we are exposed to when moving in the air and now in space.

The other characteristic is represented by the force of attraction of the conquest of air and space on men and this is despite (or precisely because of) the magnitude of the risk they are faced with.

If aeronautic medicine finds its foundation in the biological and physiological sciences, the role of psychopathology was found there at a very early date. In the preface of the first work devoted to aeronautic medicine in 1912, Charles Richet wrote, "The main danger is the psychology itself of the pilot."

This role is still current, whether it be the role it plays in causes of the medical inaptitude of the airplane or in the predominance of the human factor in air accidents.

However, psychology and aeronautic medicine should not be considered as the only affair of specialists. Actually, real specialists are not those researchers or clinicians working in a narrow and restricted space in their necessarily limited field of experience, but those who in contact with concrete realities are faced with multiple and complex facets of daily problems they will have to provide a pluridisciplinary synthesis and assume the responsibility for the flight surgeons.

In the psychological cause, our contribution will consist of initiating flight surgeons in theoretical notions and practical attitudes likely to clarify and make understandable phenomena which would otherwise risk appearing unintelligible.

Actually, owing to the rigorous medical and professional selection they are subject to, we will find in the airplane only very few cases of mental diseases that are real in the nosographic sense of the term. In contrast, we will very often be confronted with the magnitude and psychopathological dimension in adaptation disorders.

As an introduction, I will stress three specific and important aspects in the psychology of a pilot: his body, his motivation, and his environment.

THE PILOT'S BODY

The body, the object of medical care, is the physiological body, the network of organs and functions whose good functioning is checked by the doctor measuring its patterns during control examinations and aptitude tests. Good health is sometimes defined as "the organ silence", which means that, except for disease, seen as a fault in the organ functioning, the body has nothing to say that could be of interest to the doctor. This is often what happens when the pilot, alarmed by a functional disturbance, a new sensation, or an unusual perception, is told that there is no reason for concern and that it does not exist because his complaint cannot be related to any organic lesion needing medical attention.

However, the body is not only the centre for disease, suffering and death, it is also the place for life manifestations, activities, and pleasant or unpleasant sensations, since the pilot's body is certainly engaged in dynamic actions.

Let us imagine being coiled in the tightness of a fighter's cockpit, wrapped in an insulated flying suit, squeezed in straps as fastened to the ejector seat, the head enclosed in a helmet, the nose and mouth covered with a mask, headphones on. "The cockpit is the maternal womb, the pilot is a fetus in its egg. Above your head, beyond the plexiglass envelope of this closed-in world, the sky. They feel like supermen, and also like uncouncerned children above the world". This excessively lyrical statement from a pilot puts the emphasis on his bodily sensations. The contrast between inside and outside the cockpit provides some pleasure Saint-Exupéry, pilot and writer, wrote: "The airplane makes my well-being. It's the plane that feeds me. Nursed by the plane, I feel for it some kind of filial tenderness, some kind of nurse-child tenderness". The fighter pilot is literally at one with the machine which appears as an extension of himself, which is a great pleasure to him. But at what price! You all know the physiological consequences of hypoxia, the changes in atmospheric pressure and the importance of accelerations modifying gravity, the distribution of blood mass and sensory perceptions. The wealth and abundance of the body feelings are far removed from the "organ silence" mentioned earlier.
We see, therefore, why the pilot's body is the object of value and an important investment. It is mandatory for the skyman to feel in good shape; for his health is of great concern to the aeronautic and medical services which check him periodically.

To the pilot, physical health is one of the basic components of his professional personality. He needs to be able to control his physical activity, to rely on his perceptions, because it is a matter of his professional identity and, at times, of his very life. To the pilot, good health is what fingers are to the pianist, ears are to the musician, and eyes to the painter, the photographer or the movie maker.

It explains some pilots' attitudes toward the medical doctor and excessive and dramatized worries regarding symptoms of ailments that will appear to us as meaningless when compared to the rules of medicine and his tendency to conceal affections in an effort to maintain his feeling of good health. We will understand his apprehension before an aptitude examination, his reluctance to show up, and his feeling of triumphant relief, usually hidden behind a cool attitude or a battered manner, upon his return from the Investigation Center of Aerospace Medicine.

THE PILOT'S SPIRIT

After his observation of the pilot's body, let us now look at his spirit. Long before flight became a human concrete activity, developed nowadays to a great extent, it existed in human desire and aspirations in the form of myths and legends. In prehistoric times and in antiquity, the sky was seen as the dwelling place for gods and heroes.

In myths, flight appears as a means to escape from terrestrial dangers and constraints, and to get closer to celestial power. A well-known example is Phaeton who, demand of his father permission to drive the celestial chariot, but his youth makes him unable to control the team, and Jupiter struck him down in order to avoid a greater catastrophe. One can imagine that the discarding intervention of a mythological flight surgeon could have prevented such tragic results.

Beyond the anecdote, Levi-Strauss tells us that 'mythical and scientific thought use the same logic.' Such legends, featuring children firing dangers that challenge the limits of their abilities, show that, when the heroes ignore the elders' rule and advice as they are carried away by their desire, they receive capital punishment, downfall and death.

Symptoms called heroic identifications are often found in children and adolescents; they identify with characters which possess superhuman abilities, and are able to overcome dangers. Although the process usually remains limited to familiarity with novels, comic strips or movie heroes, it can enter reality in some cases. In that light, pilots, and now space men, seem to play the role of knights and conquerors of our modern time.

So the aeronautic motivation takes its energy from mental representations based on body enjoyment, a feeling of power and invulnerability, the pleasure to dominate and to destroy, to give and receive death. Numerous guilt feelings are sufficient to such fantasies.

If a few pilots easily recognize such ancient origins, most of them only see, in the choice of their profession, some effects of a rational dimension due to existential circumstances. But we know that "he who strongly wants something is always well served by circumstances" (Balzac).

At any rate, the aeronautic motivation to become a fighter pilot is not a simple and unique tendency, or a quality that one has or does not have. We must consider it as a result of an equilibrium and a compromise between different or even opposed tendencies. He should explain why the pilot's motivation is likely to undergo variations, hazards and turmoil.

What constitutes a good motivation and a healthy psychological adjustment? We will distinguish three aspects:

- the first one is libidinal: the well-adjusted and motivated pilot feels pleasure in flying, in spite of the dangers and physiological disturbances.

- the second is narcotic self-image: the pilot is proud of his activity.

- the third is defensive: On the psychological level, the pilot must be well-equipped with a defense mechanism that will protect him against his own anguishing representations, his inner feelings of weakness and inadequacy. He specifically needs to feel protected against the fear of death because his profession is a daily challenge with it.

THE PILOT'S ENVIRONMENT

Such a psychological organization does not occur at once. It has to be built up in a time. It is not only based on individual capacities, but also relies on a collective organization and on specific factors characterizing the environment. The pilot's motivation cannot be solely his own pleasure. As an Air Force member, he wishes to be totally accepted by his institution, which is his way to find a socially recognized professional identity. In recognizing the pilot's desires, the institution will contribute to settle and reinforce the necessary protective means and defense mechanism.

After undergoing highly selective recruiting procedures, the pilots-to-be feel aptly chosen, therefore better than average. During his school training, different apprenticeship stages will signify many rituals of initiation; these challenge the motivations and abnegations of students who are confronted with the numerous air demands and realities. Because of physiological and sensory stimuli, modifications will take place in the pilot's mental image of his body. He will learn to know his plane, the rules governing his machine, the ground and air discipline. His psyche will undergo a great deal of work as he learns to control himself and his machine. Trainers, and especially flight surgeons, know well the mishaps arising in such a process.

In diverse somatic manifestations—fatigue, arrhythmia, hyperactivity, in flight, and behavior modifications an experienced physician will recognize underlying anxiety, and will offer solutions by providing adequate individual counseling or conferences with trained personnel. He may also suggest, eventually, honorable ways to end the flying career; the physician response is the most efficient solution to both the individual psychological well-being (a medical reason is usually more acceptable than a professional incompetence). An early decision being far better than a latter failure.

In an operational wing command, the physician must know the aerial environment, its organization and functioning system. The first thing the physician will notice is the contrast between the great number of employees who provide support services at the air base, the small group of pilots who seem to live among themselves and evolve somewhat separately, in a relatively closed world. He will
have to become familiar with a specific technical language
He will learn to know the characteristics of the air mission,
the necessity of a long preparation at ground level, and the
detailed report during the debriefing of everything that
happened in flight. He will get acquainted with a very
structured and thorough organization where each one has a
specifically defined role and place. In group cohesiveness,
team spirit and solidarity are essential elements, but
emulation can take the forms of competition and rivalry.
Promotion possibilities and career development are related
to the type of recruitment, but even more to professional
capacity, operational abilities and good health, all of
these being checked regularly. The air group's state of mind
is, therefore, close to the statement that Joseph Kessel puts
in the words of Dider Daurat, the father of arnimal: "Give us
a collective goal, put it almost beyond reach, in an ideal
realm, direct all the effort into competition, into endless
emulation, and you will transform formless human matter
into a quality substance.'

And so, within the group, individual characteristics will
shape themselves into the demands of a thorough collective
organization capable of creating and maintaining an
operational efficiency for the whole, and safety for each
individual. We will easily understand that such a process
will not develop without difficulties, any short coming will be
perceived in the group as interfering with the common ideal
and with the aerial mission's safety.

THE PILOT'S ADAPTATION DIFFICULTIES
It is the physician's responsibility to prevent such difficulties,
since they are not easily recognized by the pilot. The most
obvious and frequent of these is fatigue, the sign of good
health in one who just challenged all his abilities for the
highest level of efficiency, who feels "worn out but great!"
There is a deceptive kind of fatigue, which could follow the
preceding, which does not go away with rest, which will stay
with the pilot, as a shooting pain, without any apparent
reason; this fatigue means that the pilot can no longer
tolerate the stresses of his profession. Do not expect much
here from objective methods of measurement, they are
decreasing, individual variations and subjectivity are of
utmost importance.

In these states of fatigue, you will soon recognize the
underlying anxiety. The latter is visible either through
behaviour disturbances, somatic complaints, or in some
type of preoccupations.

Behaviour modifications are obvious: awkwardness in flight,
frequent piloting errors, impulsive reactions or too passive
ones. On the ground, fatigue is followed by an attitude of
withdrawal, irritability, and often muttering.

We will recognize anxiety in somatic complaints and sensory
dysfunctions which show through painful functional
manifestations.

In some cases, the psychic expressions of the problem will
lead you to preoccupations which reflect a real fear of flight.
The latter can be summarized as a feeling of insecurity,
expectation or foreboding of a forthcoming danger, and a
very careful or exaggerated attitude towards external or
internal perceptions.

Such disturbances can remain transitory and limited to
specific situations. They can spread progressively and take
on a more obsessive dimension, invading the whole
nocturnal and day time psyche. Some manifestations are
more obvious and brutal. For instance, the eruption of an
indisposition during flight. Whatever the cause of such
discomfort and etiology, the psychopathological aspect must
always be considered, because it affects, usually, the pilot's
professional future

In the consequence of an air accident, it is not sufficient to
evaluate the immediate emotional reactions. We must also
be concerned with the latter reactions exhibited in the
injured pilot and his peers.

On the physiological as well as psychological levels, we can
see that the man characteristic and uniqueness of aeronautic
medicines is the strong and peculiar relation existing between the mental and physical health, on one
hand, and the professional activity on the other hand. Not
only diseases are disruptive of the professional activity, but
professional activity also influences the pilot's health. As a
matter of fact, lack of adjustment manifests itself as a disease
with autopoietic symptoms directly related to the job
performance.

One must also remember that minor health disorders which
would have no effect in any ordinary profession might result
in a physical or psychological inability for the pilot to fly,
because of the high risks involved.

One must also remember that minor health disorders which
would have no effect in any ordinary profession might result
in a physical inability for the pilot to fly, because of the high
risks involved.

LIFE EVENTS
Certain existential events can take on a particular colour and
will sometimes brutally reveal the role played by the
emotional life in the professional adjustment and
motivation. Modifications within the group (professional
transfer, mission change, an engine type change, a
promotion) will bring into light an underlying anxiety which
will supersede the usual defence mechanisms. A death, an
incident, a trivial somatic affection, will damage the
necessary feeling of invulnerability which allows the pilot to
face challenges and risks. Marriage, paternity and ejection
in emotional and sexual life can modify and displace the
personal investment that was placed in the air profession.

The loss of motivation is often blamed for the
psychopathological dimension of some disorders. In fact,
the simple loss of motivation does not represent an
overwhelming psychological problem. It is always possible
to change one's job without too much pain and trauma. The
problem lies in the conflict of desires, an insatiable desire
to fly as opposed to a lowered capacity or to it, creating
suffering and symptoms.

We usually say that such patients do not know what they
want. They need our help because they no longer find the
energy to deal with their contradictory desires. The
problems cannot be limited to a process of elimination. It is
more a matter of helping to resolve the conflict, or at least of
brining it to a level which maintains the patient's health, yet
allows him to meet the demands of his profession.

THE FLIGHT SURGEON'S DIFFICULTIES
But a knowledge of pilots, of their specific pathology and life
environment will not be enough for us to be good flight
surgeons. We will also need to come to a level of knowledge
of our own motivations, and of our medical personality. As a
Chinese proverb says: "Science is knowledge of others,
intelligence is knowledge of one's self."
We have built our identity as physicians and checked out our therapeutic motivation in a particular and accept environment: the hospital and the university, a world organized around doctors and patients. Hence the patient needs to receive care, the physicians need to give medical attention can be satisfied and does not have to be questioned. In the air environment, our therapeutic duties will be confronted to other desires that we will not be allowed to ignore. In that sense, it is probably easier to be a hospital physician than an air base physician.

We will soon perceive, sometimes with frustration, that our good will and our professional consciousness will encounter difficulties. First, we will have to deal with people who will inflict on us the insouciance of their good health, we will be asked to do numerous exams and teaching them to guard against abuses, and maintaining our medical image. We will not easily resolve our secret antipathies to ask for their wounds and diseases, which would finally allow us to demonstrate our medical abilities. We will feel frustrated in front of an apparently symptomatic, our jubilant interest in a well-formulated diagnosis will be received with reserve and distrust. We will probably not receive much recognition for the prospect of a more thorough examination that could result in a statement of inaptitude. The pilot will see in our performance may be disrupted by the bitterness of a patient who is reluctant and anxious at the prospect of being declared unfit.

In such an environment, the flight surgeon may be disappointed, displeased and angry. Perhaps he becomes suspicious and thinks that the pilot conceals something and does not say all the truth about his health.

So he may increase the examinations in a perceptive manner.

As a feedback, the pilot will feel threatened by the physician's attitude. So the relationship becomes aggressive and threatened for the professional identity of both protagonists.

In that case it is frequent that each one thinks the other was first to aggress him. Each one says, "It is the other who first began" and he develops a defensive attitude and a manifestation of power.

So he accepts the situation.

By making such presumptive suggestions, I should wish, to bring your attention to the necessity, for us physicians, to question our own attitudes, in the hope that we will accomplish the means to reach a more satisfying and efficient performance.

As the saying goes, "The most important and the most neglected conversation is the dialogue with oneself." If our good will and our science are not enough, we must turn back the uncontrolled misuse of our therapeutic desires, and hold a suspicious look on the flames of a blazing professional ideal. In manifesting an exclusive interest for the weaknesses and diseases and the pilots, we give them an image of themselves with which they cannot easily identify.

A physician animated with an excessive therapeutic desire can be perceived as a threat against the necessary feeling of immanence, and may inflict a natesensive wound against which the pilot must legitimately defend himself in order to preserve his identity.

We first must control our imaginary wish to turn pilots into patients, if we want to give them the real medical care needed in reality. If we want to have access to their weaknesses and difficulties, we first have to show interest in what makes their strength in what gives them their worth and the rules and values ordering their professional axis. Our medical universe is taken for granted in hospitals, we must conquer it in the air base, we have to be adopted by the air environment.

The flight surgeon must adapt his therapeutic desire and his professional personality to the air environment and to pilot psychology.

To prepare your young flight surgeons in France we organize small group sessions about pilot case stories. Here, for instance, we are listening to one of the group.

During a flight training course, he was performing a stunt flight exercise with an old confirmed pilot. They were exchanging feelings about the flight, and the pilot wondered about the way the young physician endured the flight. After a while the pilot confided himself: he suffered from a hernia, and sometimes was disturbed, but he had never talked about it to any doctor before because he was afraid of a flight amputation. At these words, the young doctor, became anxious and asked the pilot to fly safer and more quickly.

Back in the base, they talked together about the hernia and the pilot accepted the idea of consulting a surgeon. What this old pilot felt unable to confess to confirmed doctors during many medical checks, he felt able to confess to a young one with whom he'd been flying.

In that case, what appears to be efficient for the pilot's health was not the doctor's science and experience, but his youth and the sharing of an activity.

Some years earlier, during a similar flight training course, a confirmed pilot and a young doctor took off together. It was the doctor's first flight. They never came back. They crashed.

The official conclusion of the enquiry commission mentioned: "pilot having carried out operations that were not forecast on flight orders, perhaps with a didactic aim for the doctor.

What might have been hidden behind this official statement made us impulsive, and we asked ourselves the following questions:

- what sort of didactic aim?
- was the pilot showing off to impress the young doctor who was flying with him?
- did he have a bone to pick with doctors and with medicine?
- what was the atmosphere like in the cockpit?

From a confidence from a fellow pilot, a very close friend of the one who crashed, we managed to figure out the circumstances and to formulate assumptions that, if they are only assumptions, are not far from the truth.

This pilot, aged thirty, became a father a few months earlier. The child had health problems, which doctors did not agree with each other. This pilot was particularly irritated with doctors regarding his child. This worry had consequences on his professional adaptation that had worried the flight surgeon.

On the very day of the flight, the flight surgeon had seen the pilot and the next day, the pilot was to go through medical checking at the investigation center of aeronautic medicine.
About the young doctor, we know from his friends that he was a brave and easily provocative young man. They went to fly together, and never came back.

What really happened? Nobody will ever know. One can imagine a relationship based on mental challenge and demonstration of power. One can also imagine that it was not to be wished that, under these circumstances, that pilot flew on that day with that doctor.

THE MEDICAL MOTIVATION
But what are the physician’s expectations? What are the physician’s motivations?

Like the pilot profession, the profession of the physician requires a strong motivation. This motivation is often very obscure and relies on powerful impulses as in aeronautics. It is the thing to challenge natural rules, to transgress them by mastering a complex technique and to have a kind of omnipotence upon life disease and death.

In medicine, like in aeronautics, more is often not too much self-confidence is dangerous. Doubt and humility must always look down the doctors, hurts to consider themselves omnipotent. Despair of omnipotence may sometimes lead a doctor to impose his authority and his power upon the patient, sometimes in a sadistic way.

A doctor may and must look at and palpate naked bodies, puncture and move the skin, flow blood, explore outside and inside the body as well as its apertures.

A doctor may and must collect confidences, secrets and weaknesses of suffering persons.

The power is enormous! It’s a source of pleasure and sometimes a source of anguish as well. It also gives an important narcissistic value. The doctor’s power upon his patient is often compared to the mother’s one upon her child.

But the pilot who needs to feel strong and powerful is reluctant to position himself as depending on the doctor.

PILOT AND FLIGHT SURGEON = CONVERGENT POSSIBILITIES
As a matter of fact, he is not ill, he is in good health and this good health deprives the doctor from his power.

What makes the profession of flight surgeon interesting is not the pilot’s disease, his body being in good health. What makes the profession interesting are the risks of the profession of the pilot.

Similarly it’s the risk of crash that gives aeronautics its prestige. But if it is not ill, it is necessary for the pilot to feel protected and secured in order to practice his profession.

If the flight surgeon is able to answer this demand of protection and security without competing with the pilot on the grounds of power, he will be a good flight surgeon.

To achieve that a certain knowledge and some identification to the pilot are certainly necessary. This is the reason why in most armed forces all over the world, special flight surgeon courses have been created.

But if the flight surgeon has to be close to the pilot, to know well his environment, and his psychology, he will have to ensure that this doctor’s attraction would not lead him into such a strong identification with certain military and aeronautic aspects, that he would lose his medical identity, being well integrated into the air environment should not make him oblivious to preserving what inspired him to become a physician in the first place (“Officer, give back to Ceasar what belongs to Ceasar”). But as physicians, we must keep to ourselves what does not belong to Ceasar, if we are to respect the deontological rules of our profession. We must remember that we are a depository for a suffering person’s intimate secrets. There will be ethical problems, for instance, how far should a medical action go if it addresses only the pilot’s therapeutic needs, or also the necessity for this man to perform aerial operations better? By the way, one may wonder about this strange alliance and cooperation between physicians and warriors, between those who are to inflict death and those who are to prevent it, between those whose function is to destroy and those who must preserve and repair. Some would quickly attribute themselves in the dignity of their professional ego’s ideal.

Looking into this closer, we will notice that the medical vocation and the aeronautic vocation tend to realize in the adult stage, very ancient intimate fascinations, we will notice that both take roots in desires of almighty power and immortality, such desires lead them to face death. And, as physicians and soldiers confront it from different viewpoints, finally is not death their common enemy?
The bottom line in aerospace neurology is the evaluation for the appropriate medical and behavioral standards that are required for both the vehicle and the mission. These factors are no less important than the physiognomy or physical standards and a great deal more complicated. We are still learning these lessons day by day when we read of aircraft accidents because of the lack of management skills by the aircrew members or the inability to tolerate the necessary G-forces because the pilot was not appropriately trained. A more subtle issue is the ability for the aircrew member to have quick and accurate information processing in a multi-modality environment.

In the area of retention standards, the problems are just as complex. We are faced with a rated pilot who has had an initial neurologic event, which may or may not be the forerunner of aeromedically significant disease. Although many aeromedically significant illnesses are considered clinically benign conditions, they have to be considered in the flying environment. It is the role of the aeromedical community to identify areas of aeromedically significant illness and to base decisions upon experience, knowledge of the illness and the known literature. The risk of continuing to fly this resource versus the risk of an impairment to flight safety, mission completion or personal safety is an ongoing problem.

In the field of aerospace neurology, the question can then be raised whether there is historical evidence that specific illnesses that are considered clinically benign have caused Class A, B or C accidents in the past or affected mission completion. This question was reviewed by Colonel Russell Raymond in 1973 in the August, 1973 issue of Aerospace Medicine on causes of sudden incapacitation in the United States Air Force between 1966 and 1971. He found 8 out of 36 cases of loss of consciousness were secondary to seizures and that seizures were the most common cause for loss of consciousness. In reviewing these cases, Col Raymond found 7 out of 8 of the seizure cases had normal screening EEGs on file. Since these were all witnessed seizures, one can only speculate on the number of unexplained Class A mishaps during that time or since that may be due to seizures of unknown etiology. Col Raymond again reviewed the literature between 1970 and 1980 and found 4 out of 146 cases of loss of consciousness identified as seizures in flight. In 1989, I participated in a review of the causes of sudden incapacitation from 1978–1987, which has not yet been published. Maj Tom McCormick was the main investigator along with Lt Col Terry Lyons. This study looked at total flying hours by multi-placed crews and single-seat aircraft separately. When looking at medical causes of in-flight loss of consciousness in Class C accidents, disorders of the nervous system were the most numerous with 7 seizures and 2 neoplasms. Only two cardiovascular causes were identified, one myocardial infarction and one case of atrial fibrillation.

When in-flight incapacitation, without loss of consciousness was reviewed during that same period, there was only one case of CNS disease, three cardiovascular and four gastrointestinal cases. Therefore, in cases where aircrew members
could be observed. Neurological causes were the major medical cause of incapacitation. Again one might be tempted to extrapolate the potential for neurological causes of illness in the flying crew to this study. This certainly needs to be done.

The concept of "aeromedically significant disease" needs to be explained. It is sometimes a point of contention between civilian "medical authorities", the active member and the aeromedical community. Many times the civilian authorities, which are often in a university center, do not understand the aeromedical consequences of what is to them a minor problem. Let me present two case histories. First is a 27 year old pilot who experienced three episodes of unexplained loss of consciousness. One was witnessed clonic movements on one side of his body, followed by confusion and tremors. The aeromedical opinion was that these were seizures and inaplicable with further flying duties. The pilot was evaluated at two prestigious epilepsy centers with testing performed including prolonged EEGs. He was told he did not have seizures but "spells." In his final report they wrote that our pilot could not be given the diagnosis of seizure disorder and he might be able to fly multicopter but not a jet. When speaking with the physicians at the epilepsy center, they said that the pilot was such a likeable person and he had asked them specifically not to write the word seizure on his chart. They acquiesced thinking we would ground him anyway. As you might guess this side stepping of the hard question created new problems. Next is a 30 year old pilot who experienced the sudden loss of vision in his right homonymous field followed by a throbbing headache. The total event lasted less than one hour and the headache was not incapacitating. This pilot presented letters from two neurologists stating that he did not have migraines because by definition migraines is a recurrent disease. They ignored the question of flight safety, especially formation flying, in a subject who loses an entire field of view. But the point I would like to bring out is the dilemma of predicting future developments when faced with the first unexplained event. The difficulty in predicting from one event comes from the shortcomings found in civilian studies which will be discussed later on.

THE SCOPE OF AEROSPACE NEUROLOGY

Aeromedical neurology should be considered a part of a multidisciplinary approach in aerospace evaluations. It addresses many of the standard neurological problems including headaches, vemoceps, chronic pain, vertigo, sleep disorders and head trauma among others. In addition it searches for forme frustes of aeromedically significant diseases. It is also involved in many fringe areas such as subjective effects of head trauma, information processing, laterality, cognitive evoked responses, spatial disorientation and neuroepidemiology. These "fringe areas" are really the areas of research, which will help us greatly in the area of active selection discussed above.

Now that I have stated the case of aerospace neurology based on historical precedent and modern need, the next step is to suggest how to go about evaluating and researching this problem before us. The focus then is on research. There are two ways to gain information from research. One is to perform your own and the other is to interpret the work of others and apply it to your own Clinical trials under in-flight or "face" conditions. Large controlled studies using pilot or other crew controls are even less available. That leaves us to review the non-aerospace literature and try and apply it to the flying environment. This then raises the differences one finds in adapting clinical studies found in the field to aeromedical decision. These include:

- Populations studied
- Age of the populations studied
- Sex
- Controls
- End Points
- Severity of Illness

In general the populations studied in a clinical research are beyond the usual pilot crew member ages. In addition they rarely include individuals that have been prescribed physically and tested as the flying population. Therefore extrapolating results from civilian trials is not always applicable. The increasing number of female crew members has increased our need to understand all the unique circumstances that must be anticipated in this relatively new part of the aerospace population. Controls for studies are meant to any well controlled study. Because of the above problems it becomes essential that controls be drawn from within the aerospace community matching the test subject as closely as possible for job range, flying hours, and even command in addition to the usual variables. The end points of most civilian literature are usually morbidity or mortality.

In the aeromedical research we are always searching for "subclinical" disease or predictive factors and do not have the luxury of following the natural history of an illness once it proves itself aeromedically significant and the crew member grounded. This also goes for the severity of illness. We search for the forme frustes of disease and the severity is judged with respect to the aerospace environment. Because of these reasons "in house" research is required. The researchers must be familiar with the weapon flavors, missions and the human factors involved if they are to identify problems and provide appropriate support. Long term prospective studies are essential to distinguish aeromedically significant disease.

The future of aerospace neurology lies in applying these principles in our research. In addition, the "fringe areas" represent the avenues for research into the 21st century.
Standard Neurological Problems:
- Headaches
- Syncope
- Chronic pain syndromes
- Vertigo
- Sleep disorders
- Head trauma

"Fringe Areas:"
- Circadian rhythm disturbances
- Neuro-behavioral effects of head trauma
- Information processing
- Laterality and decision making
- Cognitive-evoked potentials
- Cognitive enhancement
- Spatial disorientation
- Neuroepidemiology

Points of Contention in Civilian vs. Military Research
- Population studied
- Ages studied
- Sex
- Controls
- End points
- Severity of disease
Aviation Psychology in the Operational Setting

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Being an aviation psychologist in a small airforce has its advantages, since one has to cover a wide spectrum of tasks compared to the aviation psychologist in a large airforce who has to specialize in one or two fields.

The main tasks of an aviation psychologist are:
(a) Teaching flying personnel aviation psychology
(b) Act as a consultant to the aviators on personal matters
(c) Perform surveys on the flying personnel's social and working conditions
(d) Assist the flight surgeons on medical boards
(e) Act as a member on aviation accident boards where human factors are involved
(f) Act as a consultant in an operational setting

In large airforces these tasks have to be performed by different psychologists. This has its advantages since one then only gets acquainted with part of the aviator group in a special setting or under special circumstances, instead of getting to know the pilots in many different conditions.

It is imperative that the flying personnel have confidence in the psychologist. That was one gets information about problems while there are still possibilities to correct them.

That part of the job is imperative in a flight safety connection

(a) Teaching flying personnel psychology.

Statistics from aviation accident investigation boards all over the world imply that human factor limitations cause close to 75% of all aviation accidents and incidents. I feel that by lecturing the aviators on perception and perceptual systems and what affects them the aviator becomes aware of how his/her systems work and what precautions to take.

Thus the aviator also gets to know how his attitudes influence his perception. The effects of learning, overlearning and oversimulation in critical situations have to be demonstrated from the subject of oversimulation there is a logical path to stress and stress reactions. It is extremely important for the aviator to be familiar with his own stress reactions and the situations that cause them.

Fatigue is another important subject in aviation psychology. From studies on the effects of fatigue in a cockpit setting one has learned that fatigue leads to delayed motoric responses and more automatic reactions, instead of carefully considered actions. Further, tired subjects are more willing to accept lower standards of performance, in addition they are more forgetful when it comes to checking instruments out of the immediate visual range.

The aviators have a thorough knowledge of their aircraft, its construction, modes of functioning, and strategic operations, to mention some of the subjects they are briefed on through their education and everyday work, while knowledge about their own stress reactions are scarce.

The key to effective stress management lies within the person's own ability to identify the problem and thus be able to control the effects of stress.

After lectures which include information about usual signs and symptoms of stress that may vary from depression, anxiety and fatigue, followed by physical symptoms of nausea, headaches and gastrointestinal upset, pilots have reported that they have been able to identify their own stress reactions at an earlier stage. They feel that they have developed coping mechanisms that did not exist before.

Much of the aviators working environment consists of team work, cramped quarters and being short of time. It is imperative that people working under such conditions are also able to recognize stress symptoms in their colleagues. This may prevent development of inter-human related problems. One is usually more overbearing with other people's poor performance if one knows it is caused by stress. One may also be more alert that the other guy may fail and thus be more prepared to take over. Signs to look for in this situation are rapid thinking, decreased problem solving abilities, reduced stimulus processing and angry outbursts. Normal sleep pattern, what disturb it and how it is affected are also given much attention in the lectures.

Knowledge of this aspect has also influenced the programming of daily hours in the airforce.

The feedback one gets after these lectures is that the aviators really realize that the care to stress lie within themselves and that the first step on the road to accident prevention and recovery is that each pilot has to be responsible for his own well being. One also experienced an upsurge of willingness that did not exist prior to this program.

It is the psychologist's responsibility to know these people as persons. Therefore one should visit the different squadrons, take part in missions, survival courses and dry fly drills whenever it is convenient. This will prepare the ground for an open dialogue between the aviator and the psychologist.
As a consultant to the aviators on personal matters

Military pilots represent a rigorously selected group both physically and psychologically. This selection procedure is based on the recognition of the fact that some individuals are better suited for some tasks than others, and that there are more people who want to do these tasks than required. To some pilots this selection procedure and the fact that they are accepted for undergraduate pilot training make them believe they are invulnerable for ever.

Once selected as a superman makes them believe they are better than the others. The realization that military pilots also are vulnerable and have limitations in critical situations comes as a shock to some of them.

It is important to be at hand for questions which the pilots do not like to ask the flight surgeon for fear that they may lose their licence. It is doubtful whether the problems may influence the pilot's performance one should inform the pilot about the doubts before informing anybody else about the matter.

Problems that most likely occur during consultations are related to jealousy, marital problems, financial obligations, and sleep problems.

Up to today less than 10% of such questions have been reported to the aviator's superior. The rest of the problems the aviators and the psychologist should be able to sort out together. The confidence is of great value and it saves the airplane several sick leaves every other year and in addition simplifies the flight safety work.

Ten years ago it was not considered appropriate for an aviator to approach a psychologist with personal problems. Today this fear of being seen consulting the psychologist has completely disappeared. It has even become popular for pilots to graduate from war college as a major in psychology. This would have been unheard of just some years ago.

Perform surveys on the flying personnel's social and working conditions.

Working as a personal counsellor to the aviators one should also be interested in mapping several aspects of both the social and the working conditions of a squadron. Several surveys have been performed in collaboration with physiologists and nutrition advisers.

The purpose of these surveys is manifold, and the results make it possible to reveal hidden problems and do something about them. Secondly, the aviators get information about their conditions, instructions for their personal physical training program and diet, information about the psychological aspects of their working conditions, and how they are doing in the system.

This may act as a gateway to mutual understanding and trust between the aviators and the medical and psychological professions. The more information is furnished to the aviators, the better service they are able to offer.

Assist the flight surgeons on medical appeal boards.

Whenever a military pilot loses his licence, temporarily or permanently, he has to meet a medical appeal board. If the reasons for altering the licence are due to psychological matters there is always a psychologist on the board. The psychologist is a good judge of the pilot's mental development from the time of selection and up to the day of the board's evaluation. In Norway all pilots have been psychologically tested before entering undergraduate pilot training. The psychologist who has had close contact with the pilot and the squadron in question, should therefore be able to make a fair evaluation of the pilot's total life conditions.

The psychologist has attended some of these boards.

The psychologist's performance in connection with aviation accidents

The psychologists have at least four tasks in connection with military accidents:

1) Immediate, on the scene psychological consultations to reduce or eliminate long term psychological and physical symptoms.

2) Analyse human factor accident data.

3) Research on human factor aspects of flight safety.

4) Contribute to the accident investigation.

Usually the pilots and the squadrons in question want the presence of the aviator psychologist after an accident, as does the flight surgeon. So at that time he is occupied on the accident investigation board and who is usually happy to leave the aftercare of the persons involved to somebody else.

When arriving at a squadron right after an accident has taken place, one is usually briefed by the squadron leader about the accident. If the accident was non-fatal the psychologist generally starts the session by talking to the pilot and the crew involved. It is important that they put words to their immediate feelings and thoughts related to the accident. It is undesirable that information given under these circumstances will not be revealed to the accident investigation board.

After the initial conversation in which thoughts and feelings originated in the accident have been revealed, the pilot and the crew are subjected to a short stress management and burnout prevention program.

It has proved very useful to brief on common feelings and reactions to disasters. What immediate reactions and delayed reactions to expect. In order to get flying personnel back to flying status it is important that they be familiarized with emotions they most likely will experience in the aftermath period. They are encouraged to talk openly about these reactions and share them with others instead of keeping them to themselves in fear of losing their licence. This openmindedness also simplifies inter-human relations on the squadron. After the mishap previous experience has shown that pilots who have been involved in accidents need it long time to build up natural relationships with fellow aviators again.

I have received feedback from pilots and crews informing me that stress reactions have more easily
been accepted after they have been prepared for them.

Pilots should also be informed that in the immediate future after an accident they ought to stick to a conservative flight program. Even if they have no identifiable serious emotional reactions to the accident, it takes time to build up the old confidence and self-esteem again. These pilots are also likely to experience a narrowed attention span and thus more prone to making mistakes. They are also likely to experience gloom and depression which may reduce their alertness and responsiveness in a critical situation.

The rest of the squadron should also be addressed after an accident since stress reactions also are common in people closely related via work or geography to the accident. They may have the same reactions as the afflicted pilot, and if not prepared this response may come as a surprise to many people. It is also important for everybody at the squadron to be mentally prepared for emotional traumas that may evolve so they can be on guard both for themselves or other afflicted persons.

Administrators and officers in command in Norway are aware of this stress reduction program, and most of them leave emotional accident reactions to be handled by qualified people instead of not caring and ascribe the problems as signs of cowardice in the pilot. This alleviates much of the acute and long-term stress in their personnel which one had to cope with earlier and which often resulted in the feeling of burn out that is a painful state of fatigue and physical exhaustion.

**f) Act as a consultant in an operational setting**

The above-mentioned points are all parts of the aviation psychologist's work in the operational setting, a close contact with the aviators and their wives under informal conditions, and as lecturer in more formal surroundings.

The aviation psychologist may also act as an advisor to the flight safety inspector and his board. This includes briefings on human factor aspects on actual accidents, teaching management stress reduction and interpersonal relationship problems to the squadron leaders on the bases and on their premises.

In my situation the flight safety inspector and I have come to the conclusion that addressing the leaders on their home base makes it easier to get to the heart of the matter, than when they are called to a meeting at Headquarters. This is simple psychology in practice everybody feels more secure in his own territory. If you are serious about getting in contact with someone, do it at his terms.

Last spring the flight safety inspector and I carried out a program with the following heading: The leader, leadership and flight safety. The background for this heading was:

- The recent flight accident statistics, are the leaders to blame?
- Is management style dependent upon the level of experience of subordinates?

It turned out that the actual situation differed so much on the various bases, that the subjects for discussion were different for each place.

After this trip the flight safety inspector and I made a report to the Airforce Inspector General informing about our impressions and made proposals on how to work out the different problems.

Tasks like this make one feel a part of the operational setting even when a civilian in a military system.

The conditions and advantages for this work arrangement are a possibility of multi-way communication. Probably the psychologist and the officers see problems from different viewpoints and are therefore able to have fruitful discussions on the human factor aspects and arrive at new conclusions.

Looking at the increasing number of problems and subjects passing my desk I do have the feeling that the aviation psychologist belongs in an operational setting and should not be considered an intruder in a closed circle.

**Case 1**

As stressed earlier in my talk I always tell the pilot who has just been exposed to an accident that he should not try to reach new goals or try to prove anything to himself the first six months after a mishap. Even if he has no serious or grave emotional reactions he is not able to perform his job the way he used to do prior to the crash.

One of the reasons is that the pilot needs time to process the incidence and the overstimulation he has been exposed to, and that his vigilance therefore will be reduced for some time. These six months of reasonable caution are also important for building up the self-confidence that he needs for feeling safe in the cockpit once more.

The first time I got a confirmation that this was the right procedure was after a fighter accident where the pilot ejected and landed safely in the sea.

We had a critical incident stress briefing right after the accident where I also reminded him that it would take some time making him a champion of the skies again. I also told him to stick to old, well-established procedures and to overtrained performance in case of a new emergency. If he wanted to test some new procedures in another, critical situation, most likely his mind would not function as well as prior to the ejection.

Two months after this talk the pilot phoned me and told me about his latest flight. He had been out on a training mission, air-to-air combat which had worked out well. After concluding the training the pilots were expected to land on a nearby airport. Suddenly the weather changed and the only way to land was by instruments1 procedures. The pilot could suddenly not remember how to perform an instrument landing, and started to leaf through the handbook, realizing he was short of time and afraid he would have to eject a second time. Then he suddenly remembered the a twice one should not be inventive in a situation of crises, but to retreat to well-established routines. He called ATC and asked for permission to go back to home base. Permission was granted. He went home and landed under exactly the same bad weather conditions, using an instrumental approach1. How was he able to do this? Because he had performed landings on his home base innumerable number of times. He knew this procedure like reflex actions and did not have to be aware of them.

This explains also why it is so important to train certain aspects of an flight to the extent that you can do it without...
putting your attention to it. In critical phases this attention may be useful in performing other tasks.

I have had several confirmations of similar experience.

**Case 2**

A fighter pilot who had ejected five months earlier came to my office. He wanted to talk about some personal problems. He had just been to a thorough medical examination because of several physical complaints, upset stomach, a heart condition and severe headaches. He was afraid he would lose his pilot licence because of these physical conditions, and would get information about alternative occupations.

This was our first meeting. The ejection had taken place before there was any psychologist employed in the airforce. The pilot told me he was sent home after he had been through a medical examination after the ejection and that the medical doctor had slapped his back and told him that he had been lucky since he did not have a scratch on his body.

After some time he did not feel so lucky, he did not enjoy flying and he felt he had lost contact with his mates after the incident. He was also convinced they blamed him for the accident. In addition he felt aggressive and had problems with sleeping through the nights.

It turned out that all his physical complaints were in his head; it was pure imagination. He had the classical reactions of a human being who has been through critical incident stress without an emotional debriefing.

This incidence gave rise to the post accident stress debriefing program that I have told you about.

The actual pilot had to be made aware that all the strange torment he was undergoing were due to crises reactions, and that they were all normal reactions that would vanish after some time if he would accept being guided through a debriefing in order to control the effects of overloading the system.

Today this pilot is a well adapted pilot in a civilian airline.
Psychiatric Disorders in Aerospace Medicine: Signs, Symptoms and Disposition

by

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INTRODUCTION
This presentation will consider the major categories of psychiatric diagnoses and how a few that are more commonly seen in aviators may affect flying duties. Major psychotic disorders are always disqualifying, as are major affective disorders, manic or depressive. Lesser depressive disorders may not be so, depending on the depth of symptoms, the reaction of the flier, and his/her insight into the condition. Neurotic disorders may or may not require grounding, again depending on the degree of symptoms. Organic mental disorders are generally cause for permanent grounding, unless the cause is reversible and not likely to occur again (e.g., acute toxic reactions). Personality disorders are always troublesome and are likely to be handled through administrative rather than medical channels. The general symptoms involved in these disorders will be discussed in a later presentation.

Psychiatric disorders are frequently undiagnosed, both because operational personnel may not recognize these ailments for what they are and because a tendency of some non-flying psychiatrists and psychologists to avoid the flier from grounding by not accurately diagnosing what they see, by avoiding their proper name. This dangerous practice may allow possibly dysfunctional flyers to fly, and deny them adequate treatment, specifically, medications.

PSYCHOTIC DISORDERS
Psychotic disorders are those which present with a gross impairment of the ability of the flier to perceive reality, creating a personal interpretation of the surrounding world even in the face of evidence which would convince a non-psychotic person. Functional psychoses include such disorders as schizophrenia, manic-depressive psychoses (now known also as bipolar mood disorder), major depression, delusional (paranoid) disorder and others. Organic psychotic disorders are also known as dementia and delirium, and are due to some known physio-causal cause such as metabolic disorders, psychoactive substances, infections, or degenerative disorders. Classic symptoms include hallucinations (false perceptions), illusions (misinterpretation of real sensory stimuli), loose associations (illogically connected ideas), delusions (false beliefs about real situations), bizarre behavior and thought disorder, poor judgment, and counterproductive reactions to recognized external stressors, occurring within six months after the onset of the stressors. By definition, they persist no longer than six months. Any longer than twelve months, and the physician must be seriously considered permanently disqualifying unless the cause is unequivocally identified as one which is temporary, has ceased, and is expected never to recur. Such judgments may be difficult at times, and one should err on the side of caution, regardless how sympathetic one is to the desire of the flier to fly.

ANXIETY-BASED DISORDERS (NEUROSES)
The current American Psychiatric Association nomenclature has renamed the next traditional category of mental illness, the neuroses, and has substituted a number of diagnoses, some of which are relatively unfamiliar (Ref. 1). These are now classed as anxiety disorders, somatoform disorders, and dissociative disorders. Classically, neuroses were considered to be based upon underlying unconscious anxiety, which was expressed through symptoms which allowed that anxiety to be dealt with indirectly and symbolically. The debate goes on, but the rise of biologically-based psychiatry, and the use of the scientific method to test etiological hypotheses, allow for some alternate explanations. Genetic studies are particularly informative in this regard, and the fact that medications help many of these disorders reinforces the idea that biochemical or metabolic alterations play a part in their etiology.

These disorders include the various forms of clinical depression (except those with psychotic features such as delusions). Anxiety disorders include phobias, panic attacks, obsessions, compulsions, post-traumatic stress disorder, and generalized anxiety disorder. Somatoform disorders include hysteric or conversion disorders, hypochondrism, and some pain disorders. Dissociative disorders include multiple personality, fugue. amnesia, and similar entities.

PERSONALITY DISORDERS
The next level of psychiatric diagnoses are the personality disorders, which will be discussed in more detail in a later presentation. Briefly, these diagnoses imply enduring and deeply engrained behavioral patterns, inflexible and severe enough either to impair social functioning or to cause symptomatic and subjective distress. In some cases, these manifestations are referred to as personality traits, these may exist for years and not cause much problem unless exacerbated by external events or stressors.

ADJUSTMENT DISORDERS
These disorders represent maladaptive or counterproductive reactions to recognized external stressors, occurring within six months after the onset of the stressors. By definition, they persist no longer than six months. If they do, the diagnosis must be reclassified (as a minor depression, for example). These disorders affect functioning in occupational, scholastic, social, or relationship settings, and exceed the usual or expected reactions to the specific stressors. One assumes that the reaction will subside once the stressor disappears, or that a new and less symptomatic level of adaptation will be attained in time.
The stressors may be single or multiple, may be a "one time" bad deal or recurrent may be intermittent or continuous. They may be associated with the marital or the parental family, with flying, with social relationships, with job relationships, with physical illnesses, or with religious, legal, financial or other such matters. Late events both shown and unforeseen, may precipitate them. The severity of the stressor does not necessarily relate to the severity of the disorder since (a) some people are more vulnerable to one stressor than another, and (b) the amount of stress already present in people's lives may also vary. A number of such disorders have been described, and there is not time or space to describe them all. Their names, however, give clues to their description adjustment disorder with anxiety mood, with depressed mood, with disturbance of conduct, with physical complaints, with withdrawal, with work inhibition, and with mixed features. Each is characterized by a reaction to an identifiable stressor within three months, by impairment of some aspect of function in excess of the normal or expected reaction, by being unique (not just another instance of a pattern, that would indicate a personality disorder), and by persistence of less than six months.

SOME SPECIFIC PROBLEMS COMMON TO FLIERS
Psychiatric problems are encountered in all branches of the medical sciences, even among the practitioners. Thus, the aeronautical physician must be particularly keen to detect them in fliers at a lower level of symptomatology presentation because of the ever-present dangers that exist in flight. As with most somatic disorders, we want to detect psychiatric disorders earlier because of safety implications. The old saying has it that "flying is hours of boredom interspersed with a few moments of pure terror." Plainly put, although the flier may be able to get along perfectly well, at say, 75% efficiency during the hours of boredom, there is no way to predict at which terror-filled second he or she will suddenly need 100% efficiency to live -- and 92% will not do. All aeronautical practitioners have had some psychiatric training, and I am sure that none would have any particular difficulty recognizing a floridly psychotic patient, or one with a deeply pervasive depression. The problems one is likely to encounter among fliers will seldom be so dramatic, however, and so let us consider a few of the more common ways in which fliers may present with psychiatric difficulties.

DEPRESSION
Depressed fliers are likely not to recognize their emotional status clearly enough to define it as the cause of their difficulty. Since they tend by nature to pay less attention to their internal emotional climate and more to their physical symptoms, they are more likely to complain about the way they feel physically. Thus, depressed fliers may complain of symptoms relating to insomnia, chronic headache, or trouble with memory or concentration. The more common symptoms of depression are listed below in two groups, the somatic and the emotional, to emphasize the difference:

Somatic symptoms:
- Depression or decrease in appetite, perhaps with weight change
- Constipation
- Change in sleep pattern
- Difficulty falling asleep, insomnia
- Difficulty staying asleep, early awakening
- Sleep that is not restful, early morning fatigue
- Too much sleeping
- Fatigue or lack of energy and drive
- Loss of usual concentration and memory, distraction
- Headaches or other minor but annoying aches and pains

Psychological symptoms:
- Loss of interest in usual activities, apathy
- Loss of "joie," anhedonia
- Variable slowing, or jumpeyness, psychomotor agitation, or retardation
- Depressed mood most of the time
- Fearfulness
- Feelings of worthlessness or guilt, undeserved, self-reproach
- Desire to "get away"
- Death-related ideas, which may represent or may be suicidal

Seen in a clear list like this, few flight surgeons would miss the diagnosis. Seen in a flier who is a friend, in whom these signs and symptoms have slowly developed over several weeks, the picture is not so clear. Some aeronautical physicians identify so closely with their fliers that they do not wish to label what they are seeing. Some fear that they will lose favor with the flier and his or her friends if they attach a psychiatric label. Some profess not to believe in psychiatry, and actively avoid the entire issue. Whatever the reasons, we see at times what amounts to an unspoken collusion between flight surgeon and flier. Worse, some mental health professionals allow themselves to be drawn into this state of affairs, even in formal consultation. Symptoms are minimized or explained away. Incorrect "lesser" diagnoses are given, at times with the stated intention of "not hurting him (her) career." While this is unfortunate from the ethical point of view, to see the least, it may have other and more serious consequences. If the disorder is under-diagnosed, it may also be under-treated. If a major depression is labeled an adjustment disorder, the proper medications may be withheld, or under-used.

It is not proposed to discuss treatment in any detail, but all flight surgeons have at least a passing acquaintance with antidepressant medications, the tricycles such as amitriptyline (Elavil) or nortriptyline (Norpramin). The monoamine oxidase inhibitors are somewhat less known, but may be extremely effective. Newer agents are now available, bupropion (Wellbutrin), fluoxetine HCl (Prozac) and others. Such medications must be used properly, with a clear eye to target symptoms, adequate doses, side effects and so on. In my experience this is not done nearly as well in patients labeled "adjustment reaction", "situational reaction", and the like.

The plain fact is that depressive disorders are disabling for flight duties. They are also very treatable disorders, and once the flier is free of symptoms and off medications for one or two months, flight duties may be resumed with proper documentation. Only in rare instances, and then only with authoritative and knowledgeable consultation, should a civilian flier who has been stable on antidepressant medication for years and who relapses when the medication is discontinued be considered for return to flying duties while taking an antidepressant medication. Flight surgeons who are sure of themselves will avoid the traps of overidentification with their fliers, and of sympathetic but misguided under-diagnoses and under-treatment.
ADJUSTMENT (STRESS-RELATED) DISORDERS
In my experience this is the category most likely to apply to aviators. Although all successful fliers must be able to deal with the stresses of flight, ability to do so does not necessarily mean the flier can also deal with family stresses, or job stresses or interpersonal stresses from other sources. Although I have never kept statistics on the matter, my impression is that marital or other close relational stresses are the most common source of difficulty, followed by interpersonal job-related stresses and career stresses. Some fliers may be aware of the connection between stressor and symptoms, and others may not.

Marital stresses may include basic control issues, often disguised as repetitive arguments about the same matters (sometimes fairly trivial on the surface) without resolution. The flier may retreat into “logic” and “rational thinking,” and the spouse may feel demeaned and ignored.

Job or career stresses may include failure to be promoted, or to get a cherished assignment. Occasionally the flier is trapped in an administrative web that will not allow an otherwise logical career progression to occur, or block access to a desired aircraft. Sometimes such events mark the first time the flier has ever failed to achieve a goal, and this failure may coincide with feelings of getting older, being at a dead end, or even the dreaded “midlife crisis.” All of these events share a feeling of loss of control, a lack of power, and some fliers find this intolerably anxiety-provoking.

Some common symptoms are listed below. Please note that these may combine elements of depression, anxiety, and behavioral “acting out” of distress. Some may be exaggerations of a specific flier’s normal personality, while others may represent a considerable change from his or her norm.

- Repetitive non-productive thinking about the problem
- Sleep disturbance, may be linked to the repetitive thoughts
- Feelings of being trapped by the problem
- Preoccupation with otherwise minor physical complaints
- Barely disguised or overt fear of flying, not related to a mishap

I have written elsewhere about some manifestations of fear of flying (Refs 2, 3), and will not repeat any comments here. Most of the other factors noted will be familiar to flight surgeons or other aero medical practitioners who work closely with their fliers. In fact, there is some evidence that the more experience a flight surgeon has, the more value he or she places on psychiatric knowledge. I recommend that interested aero medical practitioners become more familiar with the disorders covered in this presentation, and especially with ways in which stress-related somatic symptoms may be diagnosed positively, rather than by elimination. If flight surgeons overlook psychiatric considerations until all possible somatic causes have been eliminated, the time, effort, and sheer number of tests involved serve to reinforce the symptoms to the flier. If psychiatric causes are included in the differential diagnosis from the first, both the flight surgeon and the flier will find it easier to deal with them later.

REFERENCES
Psychological Factors Influencing Performance and Aviation Safety: I

by

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In this presentation, I will discuss two major psychological factors which can adversely affect health, flight performance and decision making in aviation personnel: stress and hazardous thought patterns.

PRINCIPLES OF STRESS

In recent years, the topic of stress has received considerable attention in the biomedical literature. I do not intend to systematically review these studies, rather my intent is to organize and summarize major findings around a model of stress which has been adopted from several sources in the behavioral sciences. This model is pictured in Figure 1.

Most simply, this stress model is a stimulus-organism-response model. That is, there is some event in the environment, it is processed by the organism, and an appropriate response is made. Ultimately, there are consequences which result, and we will focus on performance-related consequences of stress later in the discussion. This conceptualization of stress is clearly transactional and involves the individual interacting with, and operating upon the environment.

THE STRESS RESPONSE

Let us first turn our attention to stress as conceptualized as a physiological response by the body. The stress response was most thoroughly articulated by Dr Hans Selye and was considered to be a non-specific physiologic response to any event, which forces the individual to adjust or adapt to this threat. According to Selye, this response occurs in three stages: alarm, resistance and exhaustion.

The alarm stage represents an initial "call to arms" of the body's defensive forces. It is very brief, lasting usually a matter of minutes to hours and is mediated by the endocrine system. It is characterized by an increase in adrenal cortical secretions. Physiologically, resistance to stress is decreased, and psychologically, the organism is "aroused" with accompanying tension, anxiety and fear.

If the stress persists, the organism then enters the resistance stage. In this more prolonged phase, resistance to stress is greatly increased as the body continues its endocrinological effort to adapt to the threat. However, it is also in the resistance stage that we begin to see physiological changes manifested as a result of stress - shrinkage of the thymus gland and gastrointestinal ulcerations.

If the threat is extremely prolonged or intense, the body begins to wear down and "exhaust" its resources. During the exhausted stage the body's resistance drops below its normal level and over time we begin to see the "diseases of adaptation" manifested such as cardiovascular disorders, hypertension, peptic ulcer disease and psychological disorders.

Although this description of the body's response to stress has been revised slightly over the years with research, it continues to provide a good outline of the physiological response of the organism under stress.

STRESS STIMULI

A critical component of the stress model is that something must trigger this response. Some stimulus must be present. The stimuli are called "stressors." Stress is an event or stimulus which forces the individual to adjust or adapt in some way. Stressors can be physiological, environmental or psychosocial.

Early in stress research, Holmes and Rahe attempted to catalog major life stressors and quantify levels of stress. Using expert ratings, these researchers developed the Social Readjustment Rating Scale (SRRS) which listed 43 major life events weighted from a value of 1 (minor violation of the law) to 100 (death of a spouse). To "quantify" levels of life stress, one simply added up the value of the life events experienced over a six-month to one-year period. Later research by Holmes and Masuda found that life change totals over 200 were associated with the development of significant illnesses in over 50% of the general population they studied within one year. For values over 300, the percentage increased to 79. Such findings provide the first empirical evidence that excessive stress could lead to physical and psychological illness in a sense, this research was also to promulgate a false notion that stress was undesirable and always resulted in illness.

Several points need to be made here about stressors. First, both positive and negative life changes are considered sources of stress. Any event which forces a change in stressful. Second, stressors include psychosocial or life events as well as aspects of the environment and the organism's physiological state. In its response to stress, the body does not distinguish life events stressors from environmental sources of physiological stressors. In short, a stressor is a stressor. It is virtually impossible to quantify the magnitude of environmental sources of stress, for example, noise, heat, cold, acceleration and so on. Nor is it possible to apprise individual physiological sources of stress, namely fatigue, caffeine, nicotine, alcohol, etc. But there is little doubt that the effects of stressors are cumulative.

Recently, McCarron and Haakanson attempted to catalog sources of stress (stressors) in the aviation environment. Although their categories were slightly different than the three used here (i.e., personal, environmental, and
organismic factors mediating the stimulus-response relationship

Organic factors are based on one-to-one relationships. It is statistically much more modest but it is consistent, and it is replicated repeatedly in stress research. Not everyone under a great deal stress will become sick as a result. Certain organismic characteristics mediate this relationship.

An important, but rather immutable, mediator in this relationship is the genetic-constitutional makeup of the individual. This factor determines the individual's overall physical health and baseline physiological reactivity to stress. Rigorous physical and psychological selection standards help to ensure that only individuals who have the best chance of remaining their health under very adverse circumstances are selected for certain professional aviators.

From a psychological perspective, the individual's response to stress is mediated by both the appraisal of that stressor as well as the individual's "vulnerability" or susceptibility to the stressor. Appraisal is the process by which the person evaluates the significance of a particular stressor. Vulnerability is the extent to which the individual is threatened by the stressor. Both processes are influenced by several factors including underlying personality and psychological needs, and coping resources, etc.

Generally speaking, personality can be described as a constellation of enduring characteristics or patterns of perceiving, relating to, and construing the environment and oneself. Research into the pilot personality construct has been dominated by the idea that pilots tend to be active, dominant and extraverted, to have high needs for achievement and mastery, and to be less inclined toward introversion. Such personality characteristics are quite similar to those that have been identified by psychologists called "hardness" a personality construct which has been associated with increased resilience to stress. Thus, the personality traits of typical pilots suggest that pilots typically have effective psychological resources for managing life stress.

One of the primary ways in which personality influences resilience to stress is through the development of effective stress coping strategies. Stress coping strategies are the processes individuals use to manage internal and external demands placed upon them by problem-situations. These processes are thought to reflect personality predispositions such that individuals bring preferred ways or "styles" of coping with stress to each coping situation.

There have been several empirical efforts to describe the typical stress coping styles of pilots. In one of the first, Fike and Hartman found that pilots predominantly coped with stress using emotional and life style by seeking constructive solutions. Somewhat less common, but nevertheless utilized processes were rational, joking, and ignoring the situation. Only rarely did pilots use cognitive coping processes. In fact, one of the problems with the research presented by Sloan and Cooper is that coping resources (supportive wife) are confounded with coping processes (talking to understanding friends).

More recently, I studied coping processes of United States Marine pilots using a new measurement of dispositional coping styles. Compared to a reference sample from the general population, the pilots were more inclined to active, problem-solving coping strategies and reported a greater tendency to seek information from others in times of stress. More significantly they tended to rely less upon emotional support-seeking, denial and withdrawing from the stressor. Coping tendencies when compared to other aircrew members and military personnel, the pilots still reported a significantly greater tendency to seek information during times of stress and a significantly lower tendency to disengage from the stressor. Thus, these coping tendencies appear to reflect differences in psychological predisposition independent from adaptation to the military or aviation environment.

In general, the typical stress coping styles of pilots emphasizes mastery of problem situations through direct action. Such processes can be very effective ways of coping with stressors, and can greatly reduce adverse effects of highly stressful lifestyles.

SUMMARY

The model of stress presented here is clearly transactional. The individual interacts with the environmental stress to mediate the physiological response. Thus, the stress response is a function of the stressor and the individual's ability to mediate the stress. Let us now direct our attention to the effects of stress on performance and the role of stress in aviation safety.
The Effects of Stress on Performance and Aviation Safety

In order to appreciate the role that stress plays in aviation safety, it is first necessary to understand how stress affects human performance. Studies from cognitive and physiological psychology show that performance and stress are related in the form of an inverted-U shaped function, such that performance is best at some intermediate (optimal) level of stress. Moreover, this optimal level can vary depending upon task difficulty and task novelty. Thus, new learning tasks as well as more complex tasks can be disrupted by much lower levels of stress than overlearned or simple tasks.

I have used the term performance in the general sense but let me illustrate this relationship by an aviation-relevant example using the construct of attention. Inattention is frequently cited as a cause of human-error related accidents. Attention is affected by level of arousal. Thinking back to the stress model, the physiological stress response can be understood as impacting the individual's level of arousal such that too little stress is associated with underarousal whereas too much stress is associated with overarousal. Thus, attention is best at some optimal level of arousal. Attention anomalies can be evident on either side of the arousal-performance gradient. Inattentiveness as a result of underarousal on the individual's part can be seen with two examples in aviation: boredom resulting from repetitive, mundane tasks and complacency in which overconfidence in one's ability leads to undermotivation.

On the other side of the gradient, attention anomalies also occur as a result of overarousal. Two such anomalies related to aviation performance problems are internal distraction and fascination. Internal distraction refers to inattention due to non-task related mental processes or emotion, and is similar to the inattention that we experience when we are 'preoccupied' with something. Fascination is an attention anomaly in which the individual observes cues but does not respond to them. Fascination occurs in high stress or crisis situations.

Inadequate Stress-Coping and Pilot-Error Accidents

A review of United States Army accidents between FY 1982–89 indicated that approximately 75% (+ or - 5%) of aviation rotary wing accidents (Class A-C) involved pilot error. About half of these were due to causes which were felt to be self-generated, and included stress related physiological and psychological changes such as fatigue, motivation and attitude problems, and drug use.

More direct evidence of the role stress plays in aviation safety was provided by the United States Navy in an investigation of Class A aircraft accidents over a four year period (1978–1982). A 26-item questionnaire designed to assess observable facets of stress and personality was completed on each crew member involved in a mishap by the flight surgeon assigned to the accident investigation board. A number of the crew members involved in pilot-error accidents from those who were not involved in pilot error accidents I have organized the results according to the stress model presented earlier.

In terms of stress stimuli, stressors, pilots involved in pilot-error mishaps were significantly more likely to have been experiencing financial problems, to have made a recent decision to marry, and to have been contemplating a major career decision. Interestingly, both social and occupational spheres of life were in a state of change.

With respect to personalities, pilots who were judged to be at fault in their mishaps were seen as lacking in maturity, as having had a poor sense of their own limitations, and as being unable to quickly assess potentially troublesome situations. It is conceivable that the latter two descriptions represent an artifact of the method, in that these evaluations were retrospective, and the cause of the accident may have been known. Nevertheless, the implication of immaturity is important as it may suggest a potential vulnerability to poor stress-coping.

More importantly, pilots who were at fault in their mishaps evidenced observable behaviors which can be understood as representing maladaptive consequences of poor stress-coping. These included difficulties in interpersonal relationships including marital as well as with superiors and peers; excessive use of alcohol, unprofessional flying, and a significant "change in personality.

The results of this study provide empirical evidence of the relationship between poor stress-coping and adverse pilot performance. The study also provides some clues to the observable early manifestations of poor stress-coping in pilots (i.e., "acting-out") and suggests the potential for identifying pilots at increased risk for human-error mishaps on the basis of predisposed susceptibility (personality factors) to stress or inadequate coping ability.

Summary

This section has presented a model for understanding stress and appraising its effects on human performance in aviation. Understanding the effects of stress on health and performance is essential to designing and implementing proactive preventative programs aimed at promoting and preserving the health and welfare of our pilots and enhancing aviation safety.
Unexplained Loss of Consciousness

by

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The differential diagnosis of unexplained loss of consciousness can be divided into two categories, primary cardiovascular disorder or primarily a central nervous system disorder. This section describes the cardiovascular causes of unexplained loss of consciousness, such as, massive cerebral vascular accident, heart attack with ventricular failure, known cardiac arrhythmias (such as, ventricular tachycardia), insulin dependent diabetes or known seizure disorders are obviously aerodynamically significant disease and do not usually come into play in unexplained loss disorders are obviously aerodynamically significant disease and do not usually come into play in unexplained loss of consciousness. The aeromedical question is usually deciding after a single witnessed or unwitnessed loss of consciousness. Whether a cause can be identified and if so, does it pose danger to safe and efficient flying.

By far the most common cause of loss of consciousness is vasodepressor syncope, also called vasovagal syncope. The classic presentation is triggered by a real or perceived threat of threatening circumstances, such as, blood drawing, emotional upset or pain, followed by the symptoms of lightheadedness, nausea, diaphoresis with gradual going out or tunneling of vision. The patient usually slumps to the ground and experiences a brief loss of consciousness lasting seconds. Brief tonic/clonic or myoclonic jerks may occur with vasodepressor syncope. This is usually associated with syncope in the upright position where the patient cannot fall or is held up in the sitting position. A retrospective study by Zigler et al, using blood donors under a controlled setting, reported a rate of syncope of 0.31 percent during 262,935 donations and 0.04 percent of cases developing convulsive syncope. Of the total number of syncopal events, the number of convulsive syncopal episodes calculated to be 10 percent. A repeat study performed prospectively with trained observers increased the percentage of convulsive syncope slightly.

The evaluation of an episode of unexplained loss of consciousness begins with a detailed history, including the events in the preceding several days, events occurring within minutes of the syncope and any prodromal symptoms they may have experienced. In addition, the position of the crew member at the time of syncope and approximate time of unexplained loss of consciousness and time of coherency along with any atypical findings, such as, head injury, tonic/clonic movements, urinary incontinence or tongue biting, the patient's vital signs, such as blood pressure, heart rate as close to the event, is important information in distinguishing syncope from seizures. The suggested worksheet is seen in Table 1. In a retrospective study of crew members evaluated for unexplained loss of consciousness, from 1974 to 1988, performed at USAF SAM, 60 percent were diagnosed as vasovagal syncope and an additional 9.8 percent as supravagal syncope. A complete distribution of cases is seen in Table 2. This list in Table 2 reflects the referral pattern seen at USAF SAM. Explainable causes of loss of consciousness, such as, a seizure secondary to a mass lesion, a witnessed seizure or cardiac dysrhythmia would not have been referred. These cases would have been handled at the local hospital. The workup after the detailed history has been obtained from both the subject and any eye witnesses should include routine metabolic evaluation, including hematological, biochemical and electrolyte blood work. Cardiovascular evaluations include routine exercise testing for cardiac muscle damage, EKGs, 24 Hour Holter Monitors of at least 48 hours duration and an echocardiogram. Neurological evaluation, in addition to the neurological examination, include awake and sleep deprived electroencephalograms and a neuro-imaging study, either a CT scan or MRI 24 Hour ambulatory electroencephalograms are being performed with increased frequency for the evaluation of unexplained loss of consciousness when a seizure is strongly considered. In some centers, the performance of ambulatory EEGs and EPGs can be performed simultaneously, when there is doubt whether the unconsciousness is primarily cardiovascular on CNS in origin. Although not a usual consideration in the aeromedical community, the electrophysiological studies of the heart are performed when there is recurrent unexplained loss of consciousness associated with cardiac tachyarrhythmias.

The distinction between convulsive syncope and primary CNS seizures is sometimes quite difficult. Although there are no firm rules to apply, the extent occurrence of multiple seizures, the persistence of postictal confusion and the presence of any focality during the seizure activity are useful in distinguishing the two entities. The most useful information, once again, is the history of the event just prior to the syncopal episode. Reviewing Table 1 and looking specifically for atypical features, such as, urinary or bowel incontinence, tongue biting or head trauma, may point to a primary seizure disorder, although this is not 100 percent diagnostic. Historical features, including a rapid loss of consciousness with little prodrome or an event occurring during sleep or in the horizontal position, along with signs or symptoms of brain stem dysfunction, such as, tachycardia and hypertension in the postictal period, point toward a seizure event.

The differential diagnosis of unexplained loss of consciousness is explained in both neurologic and cardiovascular textbooks. Benign causes are those which stimulate the vagal reflex resulting in both a drop in heart rate and blood pressure. These can occur in crew members who are dehydrated after sleep deprivation or dehydration or healthy members, such as, micturition syncope or under extreme real or perceived threat. Transient ischemic attacks are a rare cause of syncope. Transient ischemic attacks to the vertebral basilar system can cause a loss of consciousness, but is usually accompanied by other brain stem signs, such as, nausea, vertigo, diplopia or cerebellar signs. The same is true of basilar migraines. Anterior circulation transient ischemia should show focal neurological deficits along with
any decreased level of consciousness, as would a cerebral vascular accident. Although sleep disorders, such as, narcolepsy or idiopathic hypersomnia can sometimes present as an unexplained loss of consciousness, there is always more history such as, excessive daytime sleepiness, cataplexy, sleep paralysis or other distinguishing features, which would separate it from an unexplained loss of consciousness.

In summary, the evaluation of unexplained loss of consciousness requires detailed history from subject and eyewitnesses, vital signs and physical and neurological examination, along with both detailed cardiovascular and neurological workups. The cost effectiveness of detailed workups is questioned in the civilian occupation in the Aerospace community, the further cost of this detailed workup is justified.

Table 1
Suggested Worksheet for Syncope in Aviators

<table>
<thead>
<tr>
<th>History from witnesses</th>
<th>Position at time of syncope</th>
<th>Horizontal</th>
<th>Vertical</th>
<th>Inclined</th>
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<td>Time unconscious</td>
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<th>Within one week</th>
<th>Within minutes of event</th>
<th>Prodrome</th>
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<td>Flu symptoms</td>
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<td>Party with alcohol</td>
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<td>Depression</td>
<td>Recent travel</td>
<td>GI symptoms</td>
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<td>Excessive alcohol intake</td>
<td>Insomnia</td>
<td>Emotional event (death/divorce)</td>
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<td>Dieting with weight loss</td>
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<td>Hot flashes</td>
<td>Feeling ill</td>
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<td>Vital Statistics</td>
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<td>Tussive syncope</td>
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<td>Venipuncture syncope</td>
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Assessing Adaptability for Military Aeronautics

by

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The assessment of adaptability for military aeronautics is an important aspect of selection in aviation provided by the flight surgeon as part of the aeromedical evaluation. Adaptability for military aeronautics is a complex issue which involves motivation to fly, ability to fly, and psychological/emotional suitability for a career in military aviation. Each of these addresses a slightly different facet of adaptability. For example, motivation to fly focuses on the underlying question of who is willing to fly, whereas ability to fly deals with the question of who can fly. Psychological suitability for flying requires the evaluation of who should fly.

Cognitive and psychomotor testing performed elsewhere in the selection process typically ensures that only those individuals with the requisite abilities to master flying will be selected in the United States Army and Air Force. The determination of a candidate's potential for successful adaptation to military aeronautics is made by the flight surgeon following a thorough physical examination and a brief interview with the candidate. During the interview, the primary task of the flight surgeon is to determine the nature of the motivation driving the individual to pursue military aeronautics, and the psychological/emotional stability of the individual for a career in military aviation.

In this presentation, I would like to review psychometric and interview findings from studies of pilot personality in an effort to identify common characteristics of typical or successful military aviators. In addition, I would like to discuss important issues in the assessment of psychological adaptability which can be addressed in a brief interview of a pilot candidate. The issue of motivation to fly will not be addressed here, but those interested in this topic should refer to two excellent articles on the subject by Dr. David Jones (Adams & Jones, 1986; Jones, 1986) which found that "typical pilots tended to be domineering, outgoing and active individuals with high needs to achieve. Such individuals were identified as having strong needs to master their environment and as having a strong desire for novelty and change. These individuals were also described as lacking in introspection and as controlled in the expression of emotion. Similar personality characteristics were also reported in a sample of United States Navy pilots (Renhardt, 1970) who were nominated as "outstanding" in their flying squadrons (top 10%). More recently, Ashman and Telfer (1983) found similar characteristics in their samples of experienced Royal Australian Air Force pilots. Collectively, these studies suggest that a distinct constellation of personality characteristics distinguish well-adapted, or "successful" military pilots. Interestingly, comparable findings have been reported in civilian general aviation pilots for both males and females (Novello & Youssef, 1974 a & b) providing additional evidence for a core "pilot personality".

STUDIES OF PILOT PERSONALITY

First, I would like to review findings from psychometric studies of pilot personality which bear on the assessment of aeronautical adaptability. Presumably, the focus of early research in this area was on developing a composite personality profile of an individual who was likely to be successful in military aeronautics. Thus, I will present findings from studies which have identified personality characteristics of typical or successful, well-adapted pilots.

Note that there are numerous studies which have used personality measures in order to predict success in flight training. Those interested in this line of research should consult a recent review of the literature by Dolgan and Gibb (1988).

In a new classic study of pilot personality and adaptation in a sample of experienced USAF pilots, Fine and Hartman (1986) found that "typical pilots tended to be domineering, outgoing and active individuals with high needs to achieve. Such individuals were identified as having strong needs to master their environment and as having a strong desire for novelty and change. These individuals were also described as lacking in introspection and as controlled in the expression of emotion. Similar personality characteristics were also reported in a sample of United States Navy pilots (Renhardt, 1970) who were nominated as "outstanding" in their flying squadrons (top 10%). More recently, Ashman and Telfer (1983) found similar characteristics in their samples of experienced Royal Australian Air Force pilots. Collectively, these studies suggest that a distinct constellation of personality characteristics distinguish well-adapted, or "successful" military pilots. Interestingly, comparable findings have been reported in civilian general aviation pilots for both males and females (Novello & Youssef, 1974 a & b) providing additional evidence for a core "pilot personality".

The identification of homogeneous personality traits among successful pilots might, at first glance, provide a convenient and useful way for flight surgeons to evaluate the psychological suitability of an individual for military aeronautics. Upon closer inspection, however, it is relatively easy to see the difficulties with this approach. First, psychometric studies of pilot personality have relied on "mean" comparisons among the groups using scale averages for the sample. Such an approach empirically emphasizes homogeneity and obscures variability, or heterogeneity, within the sample. Secondly, such studies imply that the nature and degree of the characteristics identified constitute the "right stuff" for military aeronautics and anything less is not adaptive.

However, it is well known in the aviation community that there are at least several different "types" of individuals who successfully adapt to military aeronautics. Recently, Retzlaff and Gibertini (1987) empirically identified three distinct personality subtypes among USAF aviation trainees. The type which characterized the largest percentage (58%) of the sample was described as achievement-oriented, dominant and affiliative, with a structured approach to problem-solving. A second type, which characterized 21% of the sample, was similar in many ways to the one previously described. They were also more aggressive, exhibitionistic, and self-aggrandizing. The third type, which also comprised 21% of the sample, was described as cautious, comparative, and socially retiring. Later research by Retzlaff and Gibertini (1987) showed that none of the three personality types was proportionately more likely than the others to complete flight training.

Although these findings suggest that no one type of
personality is likely to be more successful in completing flight training. It is important to discover whether or not such personality types are equally viable in aviation over a longer period of time. Thus, I collected personality data on a sample of pilots (United States Army) using new measures of personality specifically developed for use in occupational settings (Pavcoo, in press). All of the pilots had at least completed their initial aviation career milestones or gates, and in this respect were considered to have made a successful initial adaptation to military aeronautics. Using cluster analysis, three distinct personality types emerged from the data. These types closely resemble those described by Retzlaff and Gihertiu. The most prominent type, comprising 48% of the sample, is characterized by traits frequently ascribed to the "pilot personality." These pilots appear to be the most affable and outgoing in the sample, and have a structured approach to problem solving which emphasizes planning, logical analysis, and attention to detail. A second type characterized 36% of the sample. Individuals of this type appear to be the most emotionally controlled, inhibited, and conscientious. A third type, which included 16% of the sample, appear to be similar in many ways to the first group, but are more highly independent, competitive, and decisive. These individuals appear to be the least concerned with making a good impression, and are the least emotionally sensitive.

The results of this study, along with those of Retzlaff and Gihertiu, suggest that the "right stuff" is certainly not the "only stuff" when it comes to personality types likely to be successful in military aeronautics. Likewise, the research to date does not provide clear data on a personality type which it embodies the "wrong stuff." Such findings warn against relying on stereotypes of pilot personality for determining suitability for military aeronautics. Further indicate that personality inventories do not yet fulfill the promise of providing an economical means for accurately selecting certain personality types for military aeronautics. Clearly, more research is warranted with more differentiated criteria of successful aeronautical adaptation. With the above discussion in mind, I would now like to review some of the life history findings associated with successful aeronautical adaptation among pilots, and to provide some guidelines for evaluating adaptability within the context of a brief interview. 

LIFE HISTORY CRITERIA OF SUCCESSFUL ADAPTATION

In general, behavior over time should provide a more reliable assessment of adaptability than a one-time psychometric evaluation. Yet surprisingly few studies have investigated the life history characteristics of successful military pilots. Remhardt (1977) found that anordinate amount were born or only sons. Of course, this is not surprising given the fairly consistent empirical findings between birth order and occupational achievement and success. It has also been noted that the relationship between father and son in childhood is typically described as "close." The developmental and social histories of well-adapted pilots include significant achievements in academics and athletics and such individuals are typically seen as "team players." Thus, it is reasonable to expect that candidates who have been successful in chalenging exploits, and who have been active in team sports or other competitive endeavors are more likely to be successful in aviation than those who have not. Interestingly, Remhardt noted that despite the active and competitive lifestyle of the men he had studied, their medical histories were significant for few injuries and illnesses. Thus, one marker of suitability for military aeronautics may be a history of excellent health and vitality. As with personality traits, these characteristics represent the ideal. Certainly, there is wide variability.

GUIDELINES FOR ASSESSING AERONAUTICAL ADAPTABILITY

For the flight surgeon unfamiliar with the techniques of psychiatric interviewing, some guidelines for assessing aeronautical adaptability within the context of a brief interview might be helpful. The assessment of a candidate's psychological suitability for military aeronautics can usually be assessed fairly thoroughly in a brief (usually 30 minutes) interview. This interview should be somewhat loosely structured to allow for the development of rapport and to permit an assessment of the candidate's poise and adequacy in dealing with the flight surgeon and the stress created by the situation. Thus, in addition to the candidate's remarks, the flight surgeon should attend to any nonverbal cues, as well as the flight surgeon's own feelings about the candidate which may arise during the course of the interview. The flight surgeon should carefully review the candidate's academic and occupational patterns of achievement. It is especially important to assess the individual's capacity to persevere with challenges and accomplish goals which have been set. Especially significant is the poise of set goals which are inconsistent with the candidate's realistic abilities to accomplish them. This is usually evident in transfers from more competitive to less competitive colleges, college majors, or career interests and jobs. Helpful data toward this end include number of years required to obtain a college degree and number (and type) of college majors. I once interviewed a candidate who was transferring to a flight surgeon who had four different college majors, indicating electrical engineering and ending with a degree in social sciences. This same student enrolled for 21 credits in his first semester of college. Needless to say, he ended up withdrawing from several classes that semester. Related to the issue of goals and accomplishments, I usually ask a candidate to describe their most significant achievement to me. A life history without significant accomplishments or one with a spotty academic and occupational record might portend difficulty adapting to the rigors of military aviation.

In addition to achievement, the capacity to relate well with others is important in military aviation, especially with multiview aircraft. The flight surgeon should be alert to interpersonal difficulties manifested as difficulty making friends, excessive solitude, or on the contrary, excessive egocentricity and self-aggrandizement. Such individuals might be prime candidates for performance problems related to poor cockpit resource management, a topic currently receiving a great deal of attention in the human factors literature. Another important area of life history to review is the individual's response to structure and authority. Flying is a rule-bound activity and the candidate's past history with respect to conforming his or her behavior to societal expectations and norms can provide an important means to assess whether or not the individual is likely to fly in accordance with the rules and regulations guiding safe flight. A history of conduct problems in school, multiple traffic convictions, or other evidence of excessive risk-taking and bravado should alert the flight surgeon to potential problems in this area.
Finally, as a result of my experience with candidates referred for evaluation because of stress or performance related problems in flight training, I have learned to ask very specifically about past history of psychiatric or psychological consultations. In this way, we have identified several candidates with histories of learning disabilities or other childhood difficulties whom we would have not otherwise discovered.

SUMMARY

It is said that one of the most important sources of information regarding the potential adaptability of a pilot candidate is the flight surgeon's own response and impression regarding the individual. While this is a valid and important source of information, the flight surgeon must be careful not to rely on stereotyped or idiosyncratic ideas of what constitutes acceptable adaptability. As of yet, there is no convenient or accurate way of assessing adaptability for military aeronautics other than psychometrically or by life history criteria. The information presented here serves as a guideline for the aeromedical examiner. If there is any doubt about the psychological suitability of an individual for military aeronautics, a consultation with a psychiatrist or psychologist familiar with aviation is recommended.

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Domestic Problems and Aviator Family Support

by

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In Norway the flight surgeon has no obligation to take care of the family of an aviator. Actually his only task is to see that flying personnel are fit for flying. This limitation of the flight surgeon's task leaves the family members out of the system, and they have to address the local general practitioner for their medical problems. Usually this arrangement functions adequately, however, there are special situations when the aviator family needs additional support.

The spouses of an aviator face special responsibilities that spouses of husbands in other professions never get to face. She is well aware that her husband's professional performance is very much dependent upon his mood and well being. The pilot's wife therefore often feels that she is responsible for her husband being fit for the day's performance, and therefore she has to be very considerate. This responsibility is probably more difficult to handle today than ten to twenty years ago. This is partly due to changes in society which among other things are that close to 75% of the pilot's wives have their own professions outside the home and thus have become more distant to the problems of the flight squadron. In addition the technical progress of the aircraft require more alertness of the pilots today than the old aircraft did.

In other career flying personnel have to attend a short course in aviation medicine and psychology every third year. During this course the participants are taught general medicine, how their body reacts to certain strains during flight operations and how to prevent or reduce this strain. Further they are taught aviation psychology and reactions to stressful events. The idea behind this choice of subjects is that the aviator will be better prepared to cope with reactions to mishaps and other critical incidents.

Being concerned with flight safety one also realizes that the wives need some psychological education and consequently should be included in a special teaching program. Consequently it was decided that the psychologist should meet the wives of one squadron at a time. The introduction to this group would be the concern about their situation, and how to administer social support after an accident. Then they would get a short, intensive course in psychology emphasizing emotional reactions in crisis situations and after an accident. One should also stress the importance of belonging to and identifying with a group which can be approached in days of depression and grief. In other words giving the wives a breather very much the same as their husbands.

In the beginning of this program one usually faces a quiet group. The wives find it difficult to talk about problems they are used to handle themselves, and which they are not used to mentioning to anybody. After a few minutes of reflection one may direct a question straight to the wife of the squadron leader like "Have you always felt on top of the situation?" or "How you always wanted to talk to other wives about worries you have in connection with your husband's work?"

If you can get the squadron leader's wife to answer such questions honestly the rest of the session is simple.

There is such a relief to the wives to know that others are in a similar situation and have the same worries and problems as they have themselves. It makes them feel relieved to share problems they have not dared to share with their husbands, partly because they have been afraid to upset them, and partly because they have been afraid the problem was irrelevant, and that they were the only ones with problems like that! After years as aviators' wives they believe they should be able to cope with every day problems themselves, and not bother the husbands with trivialities since these might interfere with their flight performance.

Many Norwegian airline is in remote places and therefore the wives feel often isolated from their ordinary social safety net which usually consists of family and close friends. This is an important aspect to consider when working with these wives. They need some sort of substitute for this missing social safety net. This substitute may be a group of spouses from the same squadron, which should not be confused with the ordinary officer's wives committee.

The wives' squadron group have a common basis in that their husbands have the same working surroundings, and often the same worries which they bring home to their spouses. My experience with these groups, which usually meet once a month, is that they function as a safety valve. The wives feel they have a place to take their problems, they do not have to burden their husbands and thus give them unnecessary problems to cope with.

"Domestic Problems and Aviator Family Support" by Grette Myhre, Ph.D, Institute of Aviation Medicine, PO Box 14, N-0313 Oslo 3, Norway. This text discusses the special responsibilities and support needs of the spouses of aviators, highlighting the importance of providing psychological education and support to these families. The text emphasizes the need for additional teaching programs to help wives cope with the stress and emotions associated with aviator careers, offering a structured approach to addressing these issues.
Do not jump to conclusions believing that pilot husband and wife should not work through their own problems. The suggested groups only work as a place where one may test worries or thoughts in an order to see how realistic they are, and further act as a place to get ideas on how certain problems may be solved. Quite often the aviator's wife feels that she should keep all her worries to herself in order to shield her husband. Such feelings may lead to an experience of unfamiliarity that she has to cope with all the problems and keep things to herself in order not to be the cause of an aviation accident.

This is the way the squadron wives' group works in everyday life. But unfortunately there is also another side of life on a squadron: the accidents and mishaps.

After accidents and mishaps we have evolved one program for the aviators and one program for the spouses. If the accident is a fatal one the spouse is the first to be informed either by a friend from the squadron or the local minister. She is offered help in order to manage the psychological impact of the accident. She may also take part in the debriefing of the accident together with the rest of the wives' group if she wishes.

This debriefing of the wives is imperative. The wives also experience critical incident stress reactions after an accident, not only the aviators. The wives' stress reactions stem from the uncertainty from not getting all the information available, from sitting at home alone, waiting for the husband to come home and till her in on details concerning the accident.

Often the husband does not want to talk about the accident when he gets home. He wants to relax and put the stressful event behind him. Imagine what it must be like knowing a little, wanting to know more, and not being able to ask because you have to show consideration for your husband and his mood.

After an accident the wives are gathered in a room at the officers' mess. Firstly they are briefed about the accident or mishap and what is known at the actual time. Then they will get a debriefing on the psychological reactions to disasters and what reactions to be expected during the next period of time. It is important to repeat this lecture in disaster psychology whether there has been a fatal accident or not. The reactions may be the same, just differing in intensity. By giving the wives such debriefings one also obtains a supporting individual for the aviator at home, instead of two persons in need of support.

This gathering of the wives after an accident has been a success. They feel that they can cope better with realities, both because they are together with other people experiencing the same situation and because they have the extra knowledge that enables them to face the problems in a more relaxed way, because they know what to expect in the times to come, and what are the natural emotions of these situations.

During such debriefings I have also received reports from the wives which imply that the children may have after reactions even if it is not their father who has been involved in the accident. The parents should be aware of this phenomenon and keep an eye on their children during the aftermath of an accident.

Children may often be observed to have bad dreams or sleep problems during this period. I encourage the parents to talk to the children about the accident in simple language, but be sure not to answer more than what the child asks. Many parents are overdoing the explanation instead of just answering the actual questions. Some parents also force the child to listen to explanations they have not even asked for.

The only result these parents may gain is that the child withdraws and will be difficult to communicate with in another crisis situation. One should be careful, because we still know very little what such experiences may do to a child's mind later on.

In this connection a word of warning. I have sometimes experienced after fatal accidents that children of other pilots have been persecuted in school and been told that their fathers were killers and a danger to other people! Parents should be on guard for incidents like this. As therapists you should prepare parents that this might happen to their child, and that the child might try to hide these incidents from their attention. Tell the parents to be on the lookout for signs like nightmares, disrupted sleep patterns or social withdrawal symptoms in periods after an accident.

**GENERAL PSYCHOLOGY IN RELATION TO CRISIS SITUATIONS**

It is important to present a number of key concepts considered fundamental to the understanding of disaster or accident reactions to the wives' group.

Stress reaction of the total organism to a situation or to a condition and may be related to the person's psychophysiological makeup. The strength of these reactions may vary within the individual depending on the context, the stimuli, the state of the individual's health, the types of support in the community, the family network of safety, and last, but not least, on the individual's habitual patterns of human interaction.

Crises develop at a point where the intensity of the impressions on an organism exceeds the system's capacity to adjust and adapt.

An accident may in other words be experienced as a situation of understimulation, when the senses are not able to process the incoming stimuli the same way as in the same rate as usual. Stress and crises are associated with loss and mourning, social and emotional supports, and coping and adaptation. The levels of stress and the psychological dimensions are of importance in attempting to understand accident victims and to intervene in offering them psychological support.

The most common feelings after an accident are grieving, loss and mourning. The processes of grieving and mourning involve cognitive elements and may thus be expressed by physical and psychological symptoms. The individual may suffer physical discomfort or increased susceptibility to illness.

It is important to explain to the group of wives that the social and emotional resources after an accident or mishap are related to earlier experience of stress and coping. Stable, social groups tend to promote strong bonds between the members and help them against post crisis pathological outcomes. In times of stress, individuals may use both formal and informal support systems to help them mitigate their problems. As professional health practitioners our task is to underline the importance of an open climate and trust among the wife group members to the victim or victims. A variety of support systems will aid the victims a coping with accident stress and in retaining personal adaptation to the new situation.
Coping is the behaviour that helps the individual manage stress. It depends on the victim’s psychological tools. These include a person’s ability to communicate, his sense of self-esteem and his capacity for bearing discomfort without disorganization. Communication skills facilitate expression of the problem and the means to work help to resolve it.

The first overt emotional reaction occurs at the beginning of the post-impact phase, this is why it is important to have a social network at hand right away which may take action. At this time the wife or close relatives have an imperative need to be with others and to relate their experiences. When such immediate expression is delayed the result may be helpless, undirected activity and depressed behaviour.

The post-traumatic phase is usually associated with fluctuating anxiety, fatigue, insomnia, nightmares and depressive reactions. So many victims information about normal reaction patterns is enough to help them adapt and cope with the new reality. A confirmation that their reaction patterns are according to the book is very reassuring and makes the adaptation to the new situation less traumatic.

In addition to this general information about reactions to traumatic events some victims may need coaching into the new reality. There is a danger of passivity after a psychological impact. It is extremely important to be attentive to such tendencies and encourage the social support network to help the wife back to a normal situation with meaningful duties. It is also important to remember that victims after accidents will need support in the days to come, after the news has left the media.

CASE STORIES

Case 1
After a fighter accident where the aircraft went into the ground on an island in the northern part of Norway it was my responsibility to visit the family of the unmarried pilot and fill her in on the accident. At the time I got to the house the only thing we knew for sure was that the aircraft had crashed. There was no knowing if the pilot had managed to eject.

This family lived far away from the base, approximately 1000 miles, but the mother had talked to her son on the phone the night before the accident when he had asked her to send his cross country skis and some sportsgear because he was going on a holiday at the end of the week. The boy had been in high spirits. When the mother was on her way from the airport the next day after sending the goods to her son, she got a phone call on her mobile telephone in the car telling her that her son’s aircraft was missing. She went straight home and summoned her daughter, sister and parents. Her husband was on a business trip to Switzerland and was difficult to get in touch with.

That was the situation when I arrived at the scene. Even if the pilot was still missing the grieving process had already started. They were of course clinging to the hope that the boy had had time to eject and that he was soon to be picked up from the sea.

I had to be realistic since I knew that the other pilots on the flight had not observed an ejection, and prepare the family for the boy being dead. It was not until one hour after my arrival the telephone from Headquarters confirmed the worst assumptions. His family easily expressed their grief, they cried and talked incoherently. After a while the crying stopped and they started to talk about the boy and what he had felt any pain and how he had experienced the last minutes before the impact. These worries is quite common in pilot relatives. Fortunately I knew that the aircraft had gone straight to the ground after an interception where the pilot probably had been subjected to high G-forces and most likely had lost consciousness.

It is important to look for positive elements in a situation like this. That is one way to pull people under extreme emotional strain back to reality. In this case it was easy to point out how this boy had been able to realize his dreams, how happy he had been when he talked to his mother. It also turned out that he had been a coach for a basketball team, and was highly appreciated as such. That way I got the family to talk about the deceased instead of sitting quietly and not being able to phrase their thoughts. Of course they cried a lot during this session and also when they got the final message that he was dead. But during this period I was also able to tell them what emotional reactions they could do to expect in the future, and advise them how to cope. When I left I told them to call me whenever they had a problem or if there was something I could do to help.

I talked to the mother on the phone several times. Most of these calls were related to emotions and thoughts she had had — if they were strange or if they were normal.

Fourteen days after the accident the mother phoned me and told me proudly she had been able to comfort neighbours who had just lost their daughter. She felt that this was a kind of work that helped her in her grief.

After this experience she has started a support group consisting of other mothers of wives who have lost their sons or husbands in aircraft accidents in the airforce.

Case 2
The scene was a mid-air collision where one pilot survived and the other pilot followed the aircraft into the ocean and was killed.

After the wife was informed about the accident she wanted to be present when the wives’ squadron group met. The other wives were very quiet when the meeting started. They had a hard time putting words to their thoughts until the widow started talking. She told the group that even if she had only been married one year, she was so grateful to have experienced a relationship like the one she and her husband had had. She revealed she had an unhappy childhood and that her husband had taught her to believe in people and relationships again, and she felt sure that this strength he had given her would help her through her grief. She is an open, positive person. Her way of getting through her grief was to support the squadron wives’ club. She told me that the group made her feel like she still belonged to the airforce community, and that she was not being left out in the cold.
Fear of Flying

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DEFINITIONS

Some confusion is caused from the use of the term fear of flying to describe problems arising from anxiety disorders, phobic reactions, traumatic stress, exhaustion, psychoses and motivational changes. So first it is necessary to give some definitive terms to bring more understanding.

The term fear generally refers to a set of acute emotional manifestations experienced by people facing a dangerous situation. This danger is a real and specific danger existing in outside reality. The emotion experienced is associated with such various somatic motor-sensory and neuro-vegetative manifestations as palpitations, sweat, tachycardia, polypnea, etc. Fear can have some adaptive function when it remains limited and controlled because it forewarns the organism of a danger and raises its alertness.

Worry, manifesting itself in anxiety, is a subjective feeling of apprehension to flying. It is characterized by an unpleasant emotional experience, physical symptoms, and an irrational desire to avoid flying. As with so many other areas of science, World War II was an opportunity for many studies and progress for understanding the fear of flight. We must mention Davis, Grinker and Spiegel and especially Douglas Bond. During the Korean conflict, fear of flying was studied by Schulze, Lifton, Gatto and Tempea.

Douglas Bond's work, "The Love and Fear of Flying", was the most important contribution for the understanding of the fear of flight based on the psychoanalytic theories.

These psychodynamic studies were continued by Eggersten who offered an existential formulation of the motivation to fly and suggested a pervasive (but usually controlled) suicidal dynamic in fliers and especially Morgenstern who described the counterphobic motivation to fly. Among recent contemporary authors we must cite Gourney and O'Connor in Great Britain; Perry, Remhardt, Maguire and Jones in the United States; Morvanard and Gelly in France.

HABITUATION AND PSYCHODYNAMIC DATE

In phobia, anxiety appears in a concrete and external situation generally always the same, but that situation does not have an objectively dangerous nature. Most people are not afraid of it (crowd, empty space, high place, etc.). What happens for phobic people? We understand phobic reactions as the result of a stress conditioning, a sort of bad training. We also understand it as the effect of the symbolic meaning which this specific situation represents for this person.

At that point the question is: is flying an objectively dangerous situation?

For someone who has never flown, it is conceivable that flying can be a dangerous situation. Air crashes are realities. But when one asks a flier: "What do you think about the dangers of flying?", the most likely answers are: "It's not more dangerous than any other situations". It means that combi...
flying is certainly a dangerous situation for many people but not for a pilot.

So another question is: “Why then are not afraid to fly?”

When they fly, they do not only feel safe, but they also enjoy it. We have known for a long time, that flying is not only a dangerous behaviour, but also a symbolic situation of power. In myths and legends, the sky is the place where heroes and gods live. In imaginary, the flyer challenges the human condition and terrestrial limitation. Higher, faster, further. But generous guilt feelings are inherent in such fantasies.

Remember that flying is dangerous in reality and also in imaginary. So what motivates people to do something as dangerous as flying? Generally many people avoid the dangerous situations and the risks. But some choose to challenge the risks and not to avoid them. This behaviour is a typically counter phobic attitude.

In phobia, one escapes from anxiety by avoiding the phobic object, the phobic situation or by using a contra phobic object (an object or an accompanying person whose presence makes one feel safe).

On the other hand, in a counter phobic attitude, the situation that might generate anxiety is actively sought in a kind of forward running. The danger is faced on the outside and the anxiety is overcome on the inside.

This counter phobic attitude motivates people to many other professions. The psychodynamic organization allows an overcoming of the inside anxiety and a facing of the risks with intellectual and physical means, getting pleasure in facing the danger. In that kind of situation people are not afraid of the idea of death. They enjoy an intense feeling of life instead of the brittleness of the existence.

But sometimes this organization of personality may be shaken or broken down and then, fear and anxiety may reappear. The adaptive mechanisms are unavailing and the idea of possible death becomes conscious. Fear of flying is transformed into fear to be killed in an aircraft, feelings that can be sometimes as heavy as the idea of suicide.

CLINICAL ASPECTS

Overview

A difference should be made between manifestations of reactionary fear which occur in unusual or difficult situations involving unusual flying and mission conditions or a weakness state (operational fatigue, physiological weakness). These manifestations are temporary and easily disappear with rest.

- Many mental disorders such as depression, neurasthenia or psychosomatic whose symptoms and manifestations may be disturbing for a flyer and bring a non-specific anxiety in flight.
- Lasting anxious manifestations which occur under normal and usual flying conditions, which are recurrent and form actual fear of flying.
- The clinical expression of the fear of flying may be
  - manifest at first, it is then felt and described as such by the flyer. These are the most uncommon cases.
  - manifest, but its expression is only gradual, the subject trying to hide it and minimize its problems. He (she) will express his (her) disorders only after it recurs over a certain period of time, after really fighting against the uncomfortable feelings he (she) is experiencing.
- most often, the fear of flying will be latent. It is not expressed as such, but through symptomatic manifestations, taking on the form of somatic disorders, or in professional behaviour and personal relations.

The most of onset is variable:

- either sudden, for example in the form of discomfort while flying often occur by suddenly in a pilot without previous disorder.
- gradually and insidiously by disorders that are small and insidious at first and which gradually become more intensive and permanent after lasting a fairly long time.

Triggering or promoting factors of these disorders are often discovered by examination. These are events associated with the professional or personal life and affective life. The significance and role of an event is not so much due to objective reality as to its subjective value whose psychopathological meaning may be assessed only after several psychological discussions.

The circumstances surrounding its onset may be diverse: but the disorders may sometimes occur during certain missions or during certain special flight configurations high or low altitude, formation flying, without visibility, etc. Limited initially to specific circumstances, the disorders gradually spread to any type of air activity, even transport or displacement means (car, train) or other situations (social phobia).

CLINICAL FORMS

(1) Forms with predominantly somatic expression

- The most typical and spectacular picture is discomfort in flight with its suffocating intense acute functional manifestations to disturb or suspend a mission. It is most often associated with neurosensory disorders, a change in alertness, if not obtundation or temporary loss of consciousness, painful, respiratory, cardiovascular or digestive manifestations, with a later very intense feeling of anguish. They are primarily observed in fighter aviation where physiological stresses prevail, but they are also found in other types of piloting.

The psychological approach of the discomfort in flight is always necessary regardless of the etiopathogeneous factors involved. In fact, either the discomfort is an expression of a phobic manifestation of flying or it may be the starting point of subsequent anxious manifestations, in which the subject is afraid of seeing the discomfort recur in future flights.

- Without reaching the intensity of discomfort in flight, other somatic type disorders may be observed in flight. These are primarily sensorial manifestations (visual, hearing or dizziness) or function disorders such as incapacitation with painful sensations (cramping, muscular pain, pseudoparalysis, etc.). The temporary nature of these disorders, their recurrence, the absence of
(2) **Anxiety expressions**

- They include a psychic syndrome in the form of an unpleasant and painful state of tension with a feeling of insecurity, anticipation and presentiment of future danger (fear of losing one's self-control, losing consciousness, dying, becoming crazy), an attitude of hypervigilance, of exaggerated attention to perceptions from the environment or from oneself, with difficulties in concentrating or reacting.

Some effects of anguish may associate with:
- dyspnea, palpitations, pain or thoracic annoyance,
- perception, trembling, muscular shakings,
- nausea, abdominal pain,
- sensations of heat or cold,
- giddiness, dizziness, psychomotor instability.

These anxious effects may remain limited to certain situations or may gradually spread and take on an increasingly obsessive form which haunt the pilot in other situations: fear of causing an accident or causing the death of others, for example.

(3) **Neurotic disorders after an air accident**

A distinction should be made between:
- immediate emotional reactions after the accident, anxious manifestations at thinking in retrospective about perishing with death, but most often a state of excitement and euphoria at the idea of having escaped a fatal outcome,
- delayed reactions which combine anxiety with feelings of aggressiveness and guilt, particularly when the accident, the victim is responsible for, had victims.

The accident may affect the pilot's feeling of professional integrity and invulnerability. It may cause doubt and a feeling of uncertainty about his aptitudes and capacities. Some subjects often clearly express the impression of "having betrayed" themselves, by the aircraft or by the air institution and lose all or part of their feeling of professional confidence.

Finally, in a few cases, after a period of latency, an actual traumatic neurosis may develop with its typical repetition syndrome of the traumatic event which invades the psychic life in the daytime or at night.

(4) **Behavioural disorders**

- Some pilots do not express their disorders in a somatic or psychic mode, but draw attention by changes in their behaviour.
- Disorders in professional behaviour: reluctance to fly, refusal to undertake certain missions, under various pretexts, excessive inspections before and during the flight, missions cut short, flight incidents, frequent mechanical failures whose origin cannot be demonstrated on the ground, attitude of withdrawal toward other members of the air force group.
- General behavioural disorders: the most common and benign of these is anxiety. It is a lasting fatigue, which may disappear with rest, but reappears as soon as the pilot resumes flying. Fatigue is associated with somatic, unpleasant dreams, nightmares, irritability, excessive and unusual tobacco, alcohol or drug consumption.

**ETIOPATHOGENIC FACTORS**

**Predisposing factors:**

- Inadequate adjustments should be briefly mentioned. There are cases of subjects who never fully adapted to aeronautics, had undergone a long and painful training and whose professional history was always tainted with problems. The disorders here are in continuity with previous disorders and are due to inadequate training and insufficient adaptation.

In the case of pilots who had been a professionally well adjusted until then and without a history of disorders, we may seek the predisposing role of motivation supported by a neurotic pattern of the personality that had been well compensated until then. On the occasion of a promoting or triggering factor, a breakdown may occur in the pattern of the personality and of the professional motivation leading to a neurotic conflict involving professional activity. Flying is the object of ambivalent feelings that are both positive and negative. The fear of flying then stems directly from this neurotic conflict. These psychopathological mechanisms are quite distinct in paranoiac patterns which cause the subjects to actively seek the situations they unconsciously dread rather than trying to avoid them.

**Motivation conflicts** may be found in other pressure patterns. We may also make the assumption that there are always conflicts in aeronautic motivation at the beginning. Accordingly, it is the magnitude of the psychic conflict or its reactivation on the occasion of risks in the affective and professional life that is a determinant in the onset of fear of flying.

**Promoting factors:**

- These factors that may be called "overloads" are capable of causing excessive stresses on the ability of the subject to adapt and break down his defensive mechanisms: intensive operational activities leading to overwork and fatigue, poor
collective environment, difficulties in relating and in communicating within the air group, and of course all personal, affective and somatic problems

Triggering factors:
During the psychological examination of subjects suffering from the fear of flying, it is common to expose special events that the subject is highly sensitive to, from the affective standpoint, and what seems to be the actual factors that trigger the disorders.

These are:
- events of a personal nature, i.e. illness, promotion, taking on new responsibilities, change in aircraft or in type of mission, an incident or accident.

It is the symbolic and subjective meaning of the event that is important and the alteration it causes in the psychic pattern of the flyer. Thus a somatic disorder affecting the physical integrity and the usual perception of good health alters the feeling of invulnerability. Marriages, pregnancy, can watch the affective, investments from one's professional life to one's family life. One day, an accident may reactivate a latent anguish of death.

The pathogenic value of the event is often difficult to establish and assess. However, most often, everything happens as if, because of this event, the balance of psyche forces upon which a professional adjustment is based, is altered.

PROGNOSIS
Very similarly, in contrast to practice and to the progress, we may describe two forms of fear of flying among confirmed aviators.

Phobi reactions which are temporal and limited manifestations, which are followed by an event that is experienced as a trauma at the moment but that does not seriously affect the personality and professional adjustment pattern of the subjects, and plays a simple role of temporary deconditioning.

Fear of flying that form an organized pattern, often over a period of several months, considerably alters the pattern of conflict in aeronautic motivation, the prognosis of which becomes much less favorable.

TREATMENT ASPECTS
Preventive treatment:
Recruiting, selection. As with all disorders in aeronautic adaptation, the prevention of disorders begins with the initial recruiting and selection conditions of candidate pilots. Subjects exhibiting psychopathological disorders in their medical history and those with fragile psyches should be excluded. However, the methods of selection have their limits.

These limits are associated with the age of the subjects whose motivations and personality are not yet well defined and also to the static and limited nature of the initial selection process because of the number of subjects to be examined. It is therefore necessary that the selection process continues during the training and air instruction in flying schools.

Prevention and mental health within the navigating units:
Good cohesion of the air group, high morale, interpersonal quality relations play an obvious and essential role in collective mental health. The preparation of missions, a sustained flying rate, while providing for adequate and necessary rest, relaxation and leisure activities organized jointly ("redistributed"), proper knowledge of the personal traits of each, of his capabilities and his limits are well known principles of the command that assumes responsibility.

The flight surgeon can play an essential role in this regard. Although integrated within the group, personally knowing each one, he may encourage members to confide personal stories, give advice and play an informal role as a middleman, detached from the normal formalities of hierarchical relationships.

Curative treatment:
When addressing a pilot having problems, the flight surgeon should often understand implicit meanings of the manifested disorders. He may, allow the problems to be expressed verbally, provide moral, and often drug support, prescribe rest as needed. Minor disorders, detected early, will often fund their solution within the unit itself.

When addressing characterized disorders, specialized examiners will make it possible to form a careful analysis that will examine the mode of onset the circumstances surrounding its manifestation, the duration and the forms of progression, the characteristics of the previous adaptation and of the personality of the subjects and the quality of their motivations.

On the treatment level, we will recommend:
- rest and isolation from stressing situations,
- an amnestic drug treatment,
- discussions for psychotherapeutic purposes which will allow the expression and verbalization of potential conflicts,
- relaxation and specific deconditioning techniques which may often be effective.

Keeping the subject within his flying unit will be desirable. If this is desirable in the case of minor disorders that can be quickly solved, a transfer will often be preferred to avoid rejection from others and potential loss of self-esteem. Air groups can readily be intolerant to ineffective members who do not carry on the same activities and responsibilities and who give the impression of not sharing the same common ideal of flying. Middle-of-the-road solutions may be found with the help of the flight surgeon and with the authorities.

Medico-aeronautical decisions will make it possible to restrict the missions and to limit the medical aptitude for a reconversion into another aeronautical activity.

If in some cases the onset of fear of flying quickly leads to impotence, sometimes, a long psychotherapy is required for a subject to be able to accept his ambivalence of flying and to accept the changes occurring in his motivations to exercise his professional activity.

TAT. AERO
A projective test derived from the Murray thematic apperception test based on aeronautic topics is able to give some interesting indications about pilots' troubles of adaptation and to focus the medico-psychotherapeutic examination.

This test was realized by Doctor Hadn in 1970 (he was my professor — my master but he was also affected with a good gift for drawing).
This test was named AERO T A T

This test is not used in selection, but only for the understanding of cases of pilots presenting some psychological difficulties in flight or a loss of professional motivation.

Just like in the classical technique of Murray's T A T, the pilot is given instructions to create a story of his own from each plate he is shown.

When the last plate, the blank plate is shown to him, he is asked not only to create a story of his own but also to describe the picture that would be its support.

In the theory of the T A T, there is a relation between the story that is told and the everyday-life attitude of the patient.

For each plate, we note ordinary stories which are produced by most pilots and more original topics related to personal experience.

In Plate I, a young boy is constructing a model aircraft, some tools being displayed on the table. Usual stories are about ability to build, aeronautic motivation, the possibility for the model aircraft to fly and what the young boy will become.

His plate is the introductory plate and we frequently notice aggressive reactions expressed as criticism.

Plate II: Here's a young boy with his mother watching some real planes.

What are the boy's feelings? His motivation to become a pilot? And his mother, how does she feel about it? She is certainly proud of her son, but also a little anxious. But what about the father? And where is he? Perhaps in the plane?

And is this a departure or a return? And the boy, is he glad to see his father come back or go away? It's very nice to be alone with one's mother. Sometimes there is not even a father.

Plate III: The great farewell scene.

"Don't you ever forget me" or perhaps a great comeback scene. This picture illustrates the conflict between the love of flying and the love of a woman. This conflict is sometimes very hard. It may either be expressed with guilt or remain, completely avoided (for example a story about a man and a woman who go away together).

Plate IV: Here some men are working on an aircraft.

Many stories describe checking, preparations for a mission. Other stories deal with crash, rescue and wounded.

Plate V: About this plate, stories concern authority, military orders and also mistakes, scolding and guilt. And sometimes congratulations.

Some pilots talk about a medical investigation, strange, isn't it? But disclosed of the pilot's feeling about physicians.

Plate VI: This plate suggests stories about a crash or fight. It's important to note where is the hero. Has he crashed? Is he safe? Is he winner? Or loser?

Plate VII: Anguish — anxiety — fright — pain at the instant which just precedes a crash — what happened? What is the issue? Some pilots don't identify with the hero and are very critical about his behaviour. "He isn't a good pilot", or he is afraid of another drama other than an aeronautic situation or he is simply angry. The attitudes are typical of denial.
Plate VIII: The usual story suggests that two officers are announcing a pilot's crash to his wife. Questions are: What happened? Is the pilot safe or was he wounded or killed? But many patients choose sadless stories as the pilot's comeback, a friends' meeting and also a story with an erotic signification.

Plate IX: This plate suggests solitude and sadness — some perceive a figure lying in a bed, which suggests disease, suffering and death. But some pilots avoid such bad ideas and talk about a non-aeronautical scenario, for example a father who says good night to his child, or an intimate scene of a man, thinking.

Plate X: The blank plate offers all liberty for choice. It's a possibility of discharge in freedom. The stories are various, but generally optimistic feelings which contrasted with the precedent stories.

We analyse protocols in two aspects:

1. A vertical analysis: Who is the hero? What are his relationships with the environment? What are the most frequent issues? What is the general feeling? Optimistic or pessimistic? What are the original scenarios?

2. A horizontal analysis:
   - Aeronautical motivation (plate one-two-three)
   - Conflict type with father-mother-wife
   - The importance of aeronautical anxiety and defence mechanisms
   - What sort of reactions about the idea of death — The authority relations

This text is not very precise and doesn't give absolute and sure results. It's an empiric test which brings out more features concerning a pilot than his behaviour and his speech. With these pictures, a pilot can speak about a hero who is not himself, but who is very close to himself.

Some attitudes are different between pilots without difficulties and pilots in difficulties. Pilots in good adaptation have an attitude of de-nial and avoid all family conflict. There is no problem with wife, parents or children about their job's danger. There is no problem. Never!

Ideas of death are expressed without anxiety and a dangerous situation (flight or crash) is described with positive issue. The hero is a heroic man. He is able to overcome dangers without difficulty and to come back safe. This attitude is in accordance with the invulnerability feeling which is a characteristic mechanism against the anxiety of death.

At last the adapted pilot is at ease with his hierarchy and he talks about it without guilt or difficulty.

On the other hand, a pilot in professional difficulties is uneasy with hierarchy. He expresses some conflict relationships. He lost trust in the aircraft and feels it is a dangerous and unsafe object, capable of involving him in a crash. He perceives the aircraft as an ambivalent object with a good and also a bad aspect.

The ideas of death are avoided or refused. He cannot easily face the anxiety of death.

The aeronautical thematic is generally pessimistic and sad and he cannot rid himself of the desphoric feeling of the plate.

These data are only subjective indications and they have no absolute value, but these indications are sometimes useful when pilot difficulties approach.
Psychometric Evaluation Techniques in Aerospace Medicine

by

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As noted in the course introduction, neuropsychiatry specialists have been involved in aviation since the beginning. Originally, psychologists in particular were asked to improve selection of aviator candidates with psychological tests. Unfortunately, research programs in the selection of aviators have waxed and waned over the years, but for the most part, have not received adequate attention or funding. However, in some civil and military aviation programs, psychological evaluation has become a major component of the selection process. Further, psychological tests and evaluation are important and commonly used in the retention and return to fly decision processes used by many aviation organizations. This paper will focus on general issues in psychological testing of aviators, with particular emphasis on retention and return to fly questions. Before I turn to the testing used in occupational retention, I’ll say a bit about selection. Psychological evaluation for selection can be divided into two areas: select-in and select-out. Select-in research is not as well developed as select-out research. Select-out refers to identifying undesirable and even pathological characteristics of an individual that may be incompatible with flying. In this area, psychological evaluation is used much the same way as it is used for retention and return to fly questions. Here, we are looking for pathognomonic signs, psychiatric diagnoses, or even subtle cognitive and personality factors which may result in an individual’s failure to learn to fly or may result in failure to be productive in a flying career. Select-in psychological tests identify highly desirable cognitive, personality, and emotional factors that predict highly successful applicants for flying training and flying careers. Though this research is not highly developed, we can propose broad areas of the question. Select-in tests can be broadly classified as ability, stability, and motivation. All three of these characteristics may be necessary for flying status but may not be sufficient. That is, in an individual possesses positive and strong characteristics in each of these categories, it is highly likely that he or she will be successful in flying training and in a flying career as long as these characteristics remain stable throughout the individual’s career. It may also be true, however, that high levels of all three are not absolutely required for flying training or a successful career. For instance, an individual with less ability, but strong motivation and adequate psychological stability may be fully successful. Thus, some variability among the three characteristics is likely to be acceptable, though there would be a point at which no amount of motivation or stability could overcome inadequate ability and so forth.

We often see individuals who have inadequacies in stability, ability, and/or motivation which have likely accounted for the individual’s failure. And indeed, ability and stability may be broken down into “who can fly”, while motivation may characterize “who will fly.” The USAF has limited experience in using psychological assessment for selection so I must defer any further discussion on this topic to experts in the literature, as well as my colleagues in other military and commercial organizations who have, for many years, routinely used psychological assessment in selection (e.g., JAL, Lufthansa Northwest Airlines, Norwegian Air Force, German Air Force, Israeli Air Force).

I will now discuss the use of psychological evaluation in an area with which I am more familiar, that of retention and return to fly. Aeromedical consultants in the area of retention are characterized by such questions as “is this anything new since the last evaluation, and can we return this aviator to fly after a medical problem?” The first question involves the routine annual flying physical. The aviator is usually asymptomatic and is only coming in for a routine checkup. Return to fly questions, however, involve returning an aviator to flying status after there has been a medical problem such as head injury, anxiety, or suicide attempt.

The psychological evaluation process, in general, involves two components: the clinical interview and psychological testing. The clinical interview involves history, current functioning, motivation and adaptability to fly and the mental status examination which results in an impressionistic description of the aviator’s status. History should include information about parents and siblings, with particular emphasis on education, health, mental health, and work history of parents and siblings. Further, the history should include the educational, social, health, and marital history of the aviator, and any history of legal conflict or entanglement. Current functioning refers to the aviator’s current situation to include sleep, diet, exercise, and other health habits as well as marital, interpersonal, and leisure time information.

A review of the pilot’s motivation to fly can be very important as this may change across the lifespan. Motivation to fly can be viewed as how one gets interested in flying. In the first place, how one deals with the dangers of flying, what one has been told about flying, and any experiences, or other interests. Motivation to fly also involves “who’s” perceptions such as those of parents or spouse. A good understanding of why the individual chooses to fly is an important part of the assessment. Motivation to fly can be healthy and strong, or overtaken by other motivations which may be less positive. A further detail of motivation refers to appropriate motivation for the type of flying (private, commercial, schedule airline, military, combat). Each of these types of flying requires variations in motivation and often as aviators age, the strength of the components of motivation to fly changes.
Finally, the clinical interview should include an assessment of mental status which is reflected in the acronym AMSIT: Appearance (behavior and speech), Mood (and affect), Sensorium, Intellectual function, and Thought. There are other methods for assessing the mental status but AMSIT is sufficient. The traditional mental status exam requires some modification when evaluating an aviator because of the need to be sensitive to relevant aero-medical concerns. That is to say, rarely is the area of sensorium ill an aviator need to be evaluated on orientation to time, place, and person. However, mood and affect which is usually readily apparent in the psychiatric patient may be highly relevant to assess in an aviator but also difficult to assess. Due to the usual aviator psychological defenses of denial, rationalization, etc., mood and affect may be very difficult to assess. Thus, the clinical interview is an important part of psychological assessment and indeed is something all aero-medical specialists, neuropsychiatrists, and flight surgeon, as well, should use in routine assessment.

Psychological testing is the second component of psychological evaluation. Psychological tests can be categorized into two broad areas: neuropsychological tests and personality/psychological adjustment tests. Neuropsychological tests are those tests which evaluate brain functioning. The areas of evaluation include memory, attention/concentration, information processing, and language. Neuropsychological tests involve visual, auditory, tactile, and kinesthetic stimuli, they are based on right or wrong answers and actual performance, and they are often timed. These tests have clinical norms which have been developed mostly from hospital data bases though some aero-medical centers have developed norms for aviators. The neuropsychological testing evaluates aero-medical referrals such as closed-head injury, memory change, aging, training and upgrade issues, and flying deficiency. Examples of tests in this category are the Intelligence tests (e.g., WAIS-R) and the Halstead-Reitan Neuropsychological Test Battery.

Personality/psychological adjustment tests comprise the second category of tests used for psychological evaluation of aviators. These tests measure both the long standing personality structure of an individual, as well as the aviator's current psychological adjustment. These tests measure anxiety, depression, and energy level, as well as self-concept, personality style and traits, and psychological defenses. In general, these tests are opinion questionnaires, with no right or wrong answers, and these tests are usually not timed and are self-administered. The aero-medical referral questions appropriate for personality tests include alcohol abuse/use and misuse, somatization, stress reactions, and malingering. Examples of these tests include the MMPI, NEO-PI, and projective tests such as sentence completion forms and the Thematic Apperception Test.

As noted above, psychological tests are best used when combined with the clinical interview. Both tests and interview have strengths and weaknesses. Interview can be highly efficient, and relatively short especially for self-reported and apparent problems. However, most interviews are not standardized or normed and do not develop specific numerical profiles that can be compared with the responses of other aviators. Thus, psychological subtleties may be missed. Psychological tests on the other hand are normed and standardized. Therefore, psychological tests provide objectivity, standardized questions to all evaluators, and testing provides detailed coverage of all important areas of psychological function. However, testing can be quite time consuming and psychological test results can be misinterpreted if the results are not compared with aviator norms.

Both interview and testing are vulnerable to examiners without aero-medical experience. Lack of experience in the evaluation of aviators can result in missed critical, subtle, or aero-medically relevant interpretations or may result in overinterpretation of aero-medically insignificant findings. Thus, psychological evaluation is best used in the context of the full medical evaluation and should include both clinical interview and psychological testing as the important components to the full psychological evaluation of the aviator.

Psychological evaluation should result in relevant recommendations about flying status based on the examiner's experience and the specific evaluation of the aviator. These evaluations take time and are highly dependent on the experience and training of the examiner. Thus, the psychologically-aware flight surgeon working with well-informed and trained neuropsychiatrists can produce excellent products which result in highly complex neuropsychiatric and aero-medical questions being resolved with clear and concise diagnoses, recommendations, and dispositions.
PILOT JUDGMENT AND HAZARDOUS THOUGHT PATTERNS

The next topic I would like to address again involves the psychological status of the pilot as it relates to performance. However, I would like to discuss two additional constructs related to these issues: pilot judgment and "hazardous thought patterns.""'

PILOT JUDGMENT

Pilot judgment involves a complex series of psychological processes by which the pilot analyzes and evaluates information about himself, the aircraft, and the environment. The outcome of this process is a decision regarding the safe operation of the aircraft.

In an early study, Jensen and Betel reviewed four years of general aviation accident data and concluded that faulty pilot judgment was implicated in 35% of non-fatal, and 52% of all fatal, human-factor accidents. These researchers speculated that faulty pilot judgment might be related to the pilot's susceptibility to situational factors affecting their psychological status and mental operations.

Shortly after this study was completed, the FAA contracted with Embry-Riddle Aeronautical University (ERAU) to develop educational materials for pilot judgment training. In addressing this issue, the ERAU researchers isolated five specific thought patterns from the literature that might serve as precursors to faulty judgment and labeled them "hazardous thought patterns." These hazardous thought patterns represent mediating constructs between information processing (analyzing, evaluating situations) and judgment or decision-making. They are, in function of the psychological status of the individual.

THE FIVE HAZARDOUS THOUGHT PATTERNS

The five basic hazardous thought patterns affecting decision-making are 

- An submissive
- Impulsiveness
- Invulnerability
- Macho
- and Recognition

An submissive is the hazardous thought pattern found in people who cannot tolerate being told what to do. Such individuals may not regard rules, regulations, or procedures as necessary, or may not see them as relevant to themselves.

Impulsiveness is the thought pattern of people who feel a need to respond immediately. Such a thought pattern is reactive and is not typically well thought through. Impulsiveness implies doing the first thing that comes to mind.

Invulnerability is the thought pattern embodied in the belief that "it won't happen to me." It represents a form of denial of the real danger or risk of a situation, and may be prominent in individuals who engage in an excessive amount of risk-taking.

Macho involves the thought pattern that one must constantly prove oneself. This thought pattern can also be associated with increased risk-taking.

Recognition is the thought pattern of individuals who do not regard rules, regulations, or procedures as relevant to themselves, but rather as "victims of circumstances." Typically this thought pattern reflects the attitude that one's actions do not determine what happens to oneself.

In addition to identifying and defining the five basic thought patterns, the researchers at ERAU also developed a ten-scenario self-assessment inventory to measure them. The inventory yields scores that reflect the relative strength of the five hazardous thought patterns in an individual. This tool also provides an independent measure of the strength of each thought pattern.

Subsequent empirical research with hazardous thought patterns did show modest relationships with some measures of personality suggesting that these patterns might represent stable, response dispositions. This same study also found that three of the five hazardous thought patterns (Invulnerability, Impulsiveness, Macho) subsumed 77% of all subjects, and nearly half the subjects studied displayed a predominantly invulnerable hazardous thought pattern.

SUMMARY

The role of the pilot's psychological status in human factor analyses has begun to receive increasing attention in the aeronautical literature. I have focused on two factors which can impact flight performance and decision making in aircraft. Ultimately, our understanding of these psychological processes might help to guide future selection and training procedures, and serve to enhance both the performance and well-being of our flight personnel.
Stressors
- Psycho-social
- Environmental
- Physiological
- Situational

Organisms
- Genetic/Constitutional
- Psychological
- Personality
- Psychological Needs
- Appraisal
- Coping and Defense Mechanisms
- Past Experience

Response
- Physiological
- Alarm
- Resistance
- Exhaustion
- Psychological
- Arousal

Fig 1 The Stress Model
Psychiatric Reactions to Common Medications

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While flight surgeons are responsible for the health care of their fliers, a wide variety of non-prescription medications is available to fliers through drugstores and other sources, and non-flight surgeons may also prescribe medications without realizing the need to suspend flying duties. The somatic effects of these sorts of medications are usually well known to the flight surgeons, but some of their effects on mental euphoria, effects of these sorts of medications are usually well known to the flight surgeons, but some of their effects on mental euphoria, are not equally well known to non-flight surgeons may also prescribe medications without realizing the need to suspend flying duties. We will consider a case study involving an idiosyncratic reaction to sympathomimetic amines, the use of a sedative medication for an unusual purpose, and review a few hypnotic medications commonly used for sedation.

PHENYLPROPANOLAMINE HYDROCHLORIDE

Phenylpropanolamine hydrochloride (PPA) is a sympathomimetic amine found in most common remedies for colds and allergies. In the individual sensitive to it, PPA may precipitate a full-blown manic psychosis which may not be recognized for what it is without a careful history.

Case history

Capt A's history centered about two events. In 1981 this 34 year old flier was on temporary non-flying duty, and decided to lose some weight. He took Dexatrim, an over-the-counter medication containing 50 mg of PPA in sustained release form. He also took Vit A 5000 IU and Vitamin D, 400 IU per day, and ate low calorie food which he prepared himself. He maintained this regimen for about six weeks, during which time he noted an elated mood, a feeling of pressured speech and thought, and a sort of inner conviction that his decisions must reflect God's will because they made him feel so good. Apparently this did not affect his ability to function in any way detectable to other people, and the symptoms disappeared a few days after he went home, discontinued the Dexatrim, and resumed his normal life habits.

About five days later, he joined a team investigating a fatal aircraft accident. He found this particularly distressing, because he knew all the dead fliers. During this time he experienced no depressive symptoms, in spite of the grievous circumstances. Shortly after, his excellent performance resulted in a significant job promotion. He continued to function well, even though his mother died the next year. Obviously, he was not in psychiatric difficulty.

Two years after the initial episode, he was grounded for a minor upper respiratory infection, and was given Ornade (a combination of chlorpheniramine maleate, an antihistamine, and PPA) and Afrin (oxymetazoline HCl), a long-acting sympathomimetic nasal spray prescribed for use twice a day. He was sent on temporary duty again, and took these medications while living alone in a hotel. He used the Afrin about every three hours. He noted a decreased need for sleep, and again felt that all his decisions were being ratified by a higher power. Upon his return to his home base, he was returned to flying status but continued to use the Afrin as well as taking Sudafed tablets (pseudoephedrine HCl, a non-prescription sympathomimetic amine). He noted continuing insomnia, hypersexuality, and a feeling of divine mission in his life. His wife noted symptoms of elation, euphoria, pressured speech, and progressively inappropriate behavior at home, although apparently his work and his flying were going well. Matters came to a cross when he awoke one night with a strong conviction that Armageddon was coming, and that he and his family had to go naked in order to demonstrate their faith. His wife took him to the Emergency Room the next morning, where the physician on duty gave him Valium (diazepam), a benzodiazepine. His condition worsened over the next few hours to the point that he felt as if he were dying, and that his children would die also. Returning to the Emergency Room, he was admitted and given Navane (thiothixene HCl), an antipsychotic agent. He slept well that night, and the next morning was coherent, logical and cooperative, showing no evidence of the pressured speech, thought disorder or abnormal thought content present on admission.

Review of family history revealed that his father had had two episodes of significant depression, seven years apart, which responded well to antidepressant medications, and had not recurred. No family history of manic disorders was elicited.

He continued to do well from the second hospital day. He received a brief course of Lithium, but all psychotropic medications were discontinued by the sixth hospital day, and he has required none since. After an extensive medical and psychiatric workup he was diagnosed as having had two episodes of an organic manic syndrome. He was thoroughly counselled on his vulnerability to sympathomimetic amines, and educated in their names and presence in prescription and non-prescription formulations. He was observed in a non-flying status for one year, and continuing to do well, was returned to full flying duties. He has had no recurrences.

As of our last contact, Capt A was psychiatrically normal. He was relaxed, pleasant, balanced and serene. He understood his condition well, and knew that any sympathomimetic drug, and possible parasympathomimetic drugs as well might trigger manic episodes. He understood that he must never take any medications on his own, and that any physician treating him in the future must be given this history. He was instructed to trust his wife's assessment of his personality, should she detect any manic tendencies. His functioning was worthy of our trust, and he has continued to fly safely.

We were concerned if these toxic manic episodes indicated any tendency toward spontaneous manic disorders. After an extensive review of the literature and conversations with several authorities in the field, we could find no data either...
way. We concluded that there was ample history of people becoming maniac on clinical levels of PPA, and that discontinuing the PPA would quickly reverse the symptoms. There were no follow up data over one year, and some of the cases reported were multiple drug abusers, and had other psychiatric history. Review articles noted that PPA could be

\[ \text{PPA} \times \text{cafeine} \] with caffeine, and implied that other sympathetics amine, such as Sudafed or Afrin

TRIFLUOPERAZINE (Stelazine)

In addition to being a report of a rather unusual case, the previous example underscores the need to educate flyers on the dangers of flying on any medication, whether prescribed, borrowed, or bought on the open market. We are all familiar with the slowed mentation and drowsiness resulting from many antihistamines. I have recently encountered a case in which a flier was taking trifluoperazine (Stelazine), a high-potency piperazine phenothiazine which is related to chlorpromazine (Thorazine), 2 mg each night for bruxism. This medication had been refilled for some ten years by flight surgeons who did not have any record of why he was taking it, and who did not use the drug in their ordinary practice. None appeared to know that this family of medications, ordinarily used to treat psychotic patients, has a slow rate of biological clearance, and may be found in the body up to six months after the last dose is taken. None appeared to know that there is absolutely no literature (at least, I could find none) that supports the use of Stelazine nor treatment of bruxism. And none would recall telling the flier not to fly while on the medication. Indirect evidence indicated that he did not take the medication on night before he was scheduled to fly, but this was clearly not sufficient time to clear the medication.

I mention this case also to remind you that procainophenazone (Compazine), widely used to suppress motion sickness without, is another member of the phenothiazide family. Although such drugs require a prescription, family members tend to share medications which they regard as used for everyday symptoms such as nausea. Flyers may easily acquire such medications in this manner.

BENZODIAZEPINES

Diazepam (Valium) and Chlordiazepoxide (Librium)

I wish now to consider a few facts about the benzodiazepines. This family of drugs is so commonly used that one year during my tour as a hospital commander, physicians in my hospital prescribed more tablets of Valium than of aspirin! Sharing another person's Valium is not at all uncommon, because this medication is regarded as so safe in everyday life, and my perception is that flyers tend to believe that 24 hours is enough for any drug to clear their bodies. Actually, the biological half life of Valium and its metabolites may be as long as 48 hours, this is also true of the similar medication chlordiazepoxide (Librium). Please recall that it takes about seven half-lives for a medication to achieve a biological steady state in the body, and about seven half-lives for a medication to clear once it is discontinued. This assumes that the measurements in serum or urine reflect the general presence in the body, and one must recall that some medications are more firmly bound to tissues which are not so easily assayed. Thus, once a patient has been taking Valium or Librium steadily for a week, it may take two weeks (7 times the 2-day half life) for these medications to clear.

Flurazepam (Dalmane)

Dalmane, another benzodiazepine used for nocturnal sedation, is widely regarded as of no concern 24 hours after use, since its mean apparent half life is about 2.5 hours. However, the half life of one of its metabolites, N1-desethyl-flurazepam, which accounts for about 1% of the dose, ranges from 4 to 100 hours. Recalling that Dalmane reaches a steady state in the body after taking it for 7 to 10 days, and that, once in this steady state, it can be detected in the body for two weeks after discontinuation, one begins to get a little uneasy about flyers using the medication at all.

Triazolam (Halcion)

Another benzodiazepine commonly used for brief sedation is Halcion. This drug reaches its maximum effect in about two hours, and it appears to have no long-acting metabolites. One distressing effect has been reported in a few individuals, however, which in my opinion would disqualify its use in flyers. Rare cases of transient global amnesia have occurred on the day following the use of Halcion for sedation, amnesia of up to several hours in which the individuals functioned in apparently normal ways, but which they could not remember the next day. The neuromedical implications of this need no emphasis to this audience.

Temazepam (Restoril)

Restoril has been used by the RAF as a hypnotic for its flyers. It, too, has a rapid onset, with peak levels at 2-3 hours. It has a very clean metabolic path, with no active metabolites formed. Although it should be used with caution, and only after adequate pre-testing, it appears to be the medication of choice for sedating flyers. As always, the flight surgeon must be responsible for an informed choice as to which forms the greater hazard to safety for the flier to fly without adequate sleep, or to fly after adequate sleep obtained through use of a medication with known risks. Clearly, this set of choices obligates the flight surgeon to understand the consequences of use of the hypnotic medication, its metabolism, the bioactivity of its metabolites, its biological elimination pathways and schedules, and the reactions of each individual flier to the drug.
Sequelae of Head Injury

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The risk of permanent neurological deficit is extremely high and is usually not considered for return to flying status. Reviews in the literature by Dr. Caveness and colleagues in their post-war studies, including Korea and Vietnam, have documented open head injury sequelae quite well. The Aeromedical Panel, after closed head injury, can be divided into three categories:

1. The risk of permanent neurological deficit
2. The risk of sudden incapacitation
3. Transient neurologic and neuro-psychological deficits

The first category represents deficits, such as, loss of motor function, decreased cognitive ability or dementia, the loss of language, such as an aphasia or the development of a speech problem, etc. These deficits, usually significant and remove the crew member from the flight position. Their evolution usually reveals the deficits without any difficulty, although mild aphasia may require full neuro-psychological testing in order to document the problem. In the past four years at USAF SAM, there has only been one evaluation for possible aphasia related to head injury. The second category, the risk of sudden incapacitation, includes those individuals who are at risk for post-traumatic seizures. This category causes great concern in the aeromedical community, since, as mentioned in my introductions, seizures account for a significant number of aircraft accidents. The problem of predicting who will have a seizure following head injury and what are the safe limits for followup after head injury remains a problem. The risk of post-traumatic seizures is related to the degree of head injury received. The difficulty with predicting how long an aircrew member should be followed for before returning them to their flying duties is complicated for the lack of good information from the literature on which to make a prognosis. In 1979, there was a panel discussion and a publication in the Archives of Neurology on "Neurological Conditions Associated with Aviation Safety." This panel addressed the problem of post-traumatic seizures and produced the statement "new seizure cases level off after one year, and beyond two to three years, new cases are rare but do occur." They also address the role of the electroencephalogram and stated "the EEG is firm diagnostic confirmation when it shows a paroxysmal abnormality and correlates with the attack pattern." The obvious message from this conference was that closed head injury is a risk for post-traumatic seizures, but the time for safe return to the cockpit is somewhere after one year. They did not breakdown the risk by degree of head trauma. In 1985, Dummer and Lott reported an assessment of epidemiologic literature in post-traumatic seizures in the journal Central Nervous System, Volume 2. In that article, they reviewed the post-traumatic seizure literature and found only two articles that included a controlled matched population in predicting the post-traumatic onset of seizures. One article was in the pediatric population and the other was by Antunes reported in Neurology, 1980 Volume 30. From my review of the literature, this remains the only controlled study and is the one most often referred to in books and articles on post-traumatic seizures. In their article, they broke down the risk of post-traumatic seizures by the degree of head trauma. Fortunately, their definitions of severe, moderate and mild head trauma are the same as used in the United States Air Force regulations. Severe head trauma is defined as loss of consciousness or post-traumatic amnesia lasting greater than 24 hours. Other causes of severe head trauma, such as, brain CSF leaks greater than 7 days or depressed skull fractures, and intracranial or intraorbital bleeds all are included as severe head trauma. Moderate head trauma is defined as loss of consciousness or post-traumatic amnesia less than 30 minutes. It is important to note that the definition of post-traumatic amnesia is defined as the return to continuous memory function after head trauma. This requires a continuous fading down of memory traces by the injured person. One should be careful when trying to determine the extent of post-traumatic amnesia not to include times when the patient was intermittently remembering events or had events told to them by family members, which they have now incorporated into their memory. This will give a false early reading of their post-traumatic amnesia. The Antunes study calculated the relative risk for post-traumatic seizures at one and five years. The severe group had a risk of 7.1 percent and 13.3 percent for those years respective. This shows a significant risk at both cut off dates. The moderate head trauma group showed a 0.6 percent risk at one year and a 1.6 percent over 5 years. This group represents the most difficult in the decision making process. Since this is the best data available, there appears to be minimal risk at one year with a slight increase in risk over the next four years. Unfortunately, there was no cutoff at 2 and 3 years to define the extent of this risk. The mild head trauma group did not show any increased risk at one year. An important point, which cannot be found in the data, is that this study is in a civilian population who return to their usual work following head trauma. Their work did not include the stresses which accompany the aerospace environment. This environment is one of high stress, including chronic fatigue, circadian rhythm changes, intermittent hypoxia or hypobaric conditions, sleep cycle alterations and sleep deprivation. A similar study to that of Antunes, using military subjects, would be much more applicable. Until such a study can be done, the return to flying status is best made on a conservative bias.

The third category consists of transient neurologic or neuro-psychological deficits. This, for the most part, is the post-traumatic syndrome. This syndrome is a complex of
signs and symptoms, including poor concentration, increased irritability, headaches, vertigo and behavioral changes which can be a sequelae to mild head injury or injuries with no loss of consciousness, such as, in ships. This type of sequelae is the most difficult for the flight surgeon to evaluate. The airmen member will probably not complain and complaint of the difficulties they are having. If the flight surgeon is not thinking about this possibility, it may be missed. It is unknown how this sequelae of head trauma has affected flight safety because there were no studies that could be found. It is well documented in the literature that neuro-cognitive processing is affected by mild head trauma. There have been many reports of neuro-psychological testing following mild head trauma showing processing deficits. In addition, there is an abundance of literature on the symptoms of the post-traumatic syndrome which have caused people to miss weeks to months of work. Most of the studies are not as demanding as the aerospace environment. At USAF/SAM, we have seen several cases where neuro-psychological testing has been abnormal following head injury, but this is usually after at least moderate type. Recently, there has been one case with well documented decrements in the neuro-cognitive functioning, followed mild head trauma, which improved with time. It is important that the flight surgeons make the post-traumatic syndrome known to their airmen members as part of their safety briefings. This will raise the airmen members' awareness and allow them to understand that symptoms after mild head injury can prevent a danger in the flying environment, but yet do not pose a threat to their career. It can be emphasized that with time, these symptoms will subside and they will return to the flying environment.

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This might be one of the most difficult topics in aerospace medicine. Many of us spend our professional time supporting the aviator. Our practice is prevention of problems, and we deal with a highly personable, bright, and enjoyable group of people who are aviators and, in time, some become friends. Thus, to discuss the process of failure somehow seems disloyal and a betrayal of the “bond.”

Dr. Galée-Tessonaneu discusses some enjoyable group of people who are aviators and, in time, problems, supporting this combination of denial, rationalization, administration, and homology, may make it difficult for us to consider or accept the idea that even healthy bright, friendly aviators have problems so significant that they are incapable of effectively maintaining their flying status. Thus, there is an area that has not been discussed in the open literature very often. The papers that are available are anecdotal, leading us to believe that aviator failure is an isolated, and insignificant, low incidence occurrence. Further, it’s difficult, partly due to our own reluctance to ask the question, and partly due to the aviator’s resistance to scrutiny, to know the true prevalence of psychological and emotional failure among aviators and whether those who are identified only represent the “tip of the iceberg.” It is likely that most signs and symptoms of failure in aviators are not directly detected, but rather show up subtly in performance, satisfaction, safety, and retention problems.

Perhaps, the biggest problem with the failing aviator is the individual’s failure to recognize early signs of failure. Often no one else in the flying organization including peers, flight surgeons, or supervisors will notice or say anything about these feelings. As described above, aviators are an unusually intelligent, often well educated, and generally healthy group of people who, however, may also be uninformed about or actually avoidant of the psychological part of their lives. Thus, when faced with emotionally laden issues such as marital problems, family illness, etc., they often ignore (deny) their emotional reaction and when denial fails, they become frightened or depressed in reaction to feelings of loss of control, helplessness and hopelessness. Usually, these feelings develop after long periods of emotional stress lasting from months to years but finally, if there is no resolution of the problem, though the aviator has been able to “keep up a good facade” the profound process that has been working for so long may become an acute event demanding immediate attention and intervention.

The early warning signs of failure begin in the family, and then progress to the social and work environment, and finally, but most importantly, to the cockpit. Escalating or new signs of family conflict are often associated with the failure process. Most of us, but in particular aviators, view family as a safe haven or sanctuary from other stresses in the world. Indeed, this may be the only phase of respite. If this also becomes a source of stress instead of a source of support, the failure process is accelerated. In fact, this formerly dependable source of safety and comfort may be the original beginning of the failure process.

The Failing Aviator

by

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However, such stereotypes greatly underestimate the rich diversity of style, expression, and ability found among those who fly.

Many such stereotypical aviator descriptions are nothing more than caricatures which may be humorous and actually contain grains of truth but tend to oversimplify, overgeneralize, and lead us to inaccurate assessments and conclusions about individuals. However, several studies have found common personality themes among groups of aviators. Aviators as a group tend to be achievement oriented, adventurous, self-reliant, healthy, and disciplined. They also tend to be emotionally controlled and cautious and they often use a variety of defense mechanisms such as denial and rationalization. They tend to be socially gregarious but superficial and actually are interpersonally distant especially in intimate relationships. It is here in the generally healthy aviator personality that we begin to see the potential for failure. That is, while aviators are selected for their general health, there are areas of psychological vulnerability, which when combined with environmental stress, lead to psychological distress and can then develop into emotional dysfunction.

One author (Ursano, 1980) notes that the aviator is “likely to fail when unavoidably confronted with his emotional life having few mechanisms available to deal with the long- dened part of his personality.” Indeed, Ursano’s description is a common theme in numerous neuropsychiatric consultations. As described above, aviators are an unusually intelligent, often well educated, and generally healthy group of people who, however, may also be uninformed about or actually avoidant of the psychological part of their lives.

This stigma is a significant part of the aviation culture which precludes the idea that loss of self-control is cause for personal humiliation and shame. Whatever the source, the stigma associated with psychological failure is well understood among aviators that one would much rather have a cardiovascular defect rather than be found to have a psychiatric diagnosis or emotional disorder. This stigma is a significant part of the aviation culture which precludes the idea that loss of self-control is cause for personal humiliation and shame. Whatever the source, the stigma associated with psychological issues and problems among aviators promotes avoidance and ignorance of the early signs of failure. This difficulty in recognizing failure as a process rather than an acute event, often leads us to wait for an acute event such as a mishap or suicide gesture before help is offered or before formal evaluation is requested.

To understand the process of failure in the aviator, one must first understand the aviator. Simple stereotypes of daring, carefree men and their machines have romantic appeal.
studies which describe personality attributes of emotional control and interpersonal cautiousness help us understand how family life may be difficult for an aviator. Thus, it may be that other family members demand change in the aviator and the aviator may agree that change is required but does not know how to change and may not even know what needs to be changed.

In the social setting, or workplace, early signs of failure include alcohol abuse, somatization, cynicism, procrastination, distraction, signs of fatigue, and a change in level of friendliness or social participation. Again, these changes are often slow but one can begin to perceive these changes and notice the difference over a matter of months. Failure signs in the cockpit are often the last to appear but may include distraction, incomplete or late briefings, poor cockpit resource management, and other things best described by professional pilots. If the failure process reaches the cockpit, the end of the failure process (an acute event) may not be far off. We find that conflict is most often seen first in the family environment, then if not resolved, it extends to the social and work environments but the last place problems will arise is in the cockpit.

These subtle signs of withdrawal, loss of humor, fatigue, and procrastination can lead to a collection of signs and symptoms associated with mild, moderate, or severe psychiatric diagnoses. The common diagnoses seen among aviators include anxiety, depression, somatization, marital discord, alcohol abuse/misuse, and obsessive personality disorder or acute situational adjustment reactions. At this level, the failure process is essentially complete and depending on the judgment of the consultants involved, temporary removal from flying is often wise. The aviator will feel an initial sense of betrayal and extreme failure but in some ways, he may also feel a sense of relief that long months of struggling against uncertain problems with few skills are over and help and improvement are available.

The purpose of this paper has been to increase the awareness and alertness in those of us who work with aviators about the early signs and symptoms of failure. The solutions, prevention, and treatment of aviator failure are beyond the scope of this paper. However, solutions can start by addressing the failure process early, by providing training in areas of psychological functioning such as parenting and marriage communication, by changing the selection process to include not only competitiveness and achievement, but also openness to emotional experience and finally by improving the relationship between mental health providers, flight surgeons, and aviators. Our problems remain stigma, denial, lack of understanding of the emotional problems of aviators and how these problems may lead to failure even as far as failure in the cockpit.
Selected Concerns/Excessive Daytime Sleepiness

by

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The evaluation of an individual with excessive daytime sleepiness requires an extremely careful history and a systematic approach that we will review in this lecture. Much of this information was published in an article in "Aviation Space and Environmental Medicine" authored by Dr. Gary Grunstein and myself in 1987.

We performed a retrospective study involving all patients referred to USAF SAM for the diagnosis of excessive daytime sleepiness between 1958 and 1987. We then performed a review of the literature and compared our findings with those reported from United States Sleep Laboratories. It should be noted that the evaluation of sleep disorders and the growth of sleep medicine has undergone tremendous changes in the past 10-15 years. It was only in the mid-1950s when the phase of sleep, including rapid eye movement sleep, were described on the electroencephalogram. Since that time, there have been great strides and changes in the technology for evaluating sleep disorders. The establishment of sleep centers utilizing polysomnography has increased the precision of diagnoses, especially in the areas of sleep apnea and parasomnias. I mention this brief review of our results, since our retrospective study included years when this type of sophisticated evaluation was not available. In our evaluation of 15,000 patients, we found 33 percent with narcolepsy, 7 percent with primary hypersomnia, 13 percent with insufficient sleep, 7 percent with no disease and 40 percent with an unknown diagnosis. When compared to the United States Sleep Lab Experience, sleep apnea accounted for 25 percent, narcolepsy — 30 percent, primary hypersomnia — 10 percent, insufficient sleep — 5 percent, and other — 20 percent. There was only a 10 percent unknown diagnosis category. When comparing these two results, there is an obvious lack of the diagnosis of sleep apnea in the USAF experience. This may have been from the different time periods and lack of polysomnography in the period reviewed by our paper. In addition, it may be that many patients with sleep apnea have a psychosocial, which is incompatible with military selection. The obese patients known to have sleep apnea would be excluded from military service. This certainly does not make up the entire category of sleep apnea patients, but may be a contributing factor. The percent of narcolepsy cases were almost equal, as were the primary hypersomnia diagnoses. The other major difference is that the current United States Lab Experience reported less than 10 percent with an unknown diagnosis, whereas our study showed 40 percent unknown. Again, this may be from the difference in times when the information was collected and the current use of sleep centers and polysomnography. By way of review, it should be remembered that the diagnosis of narcolepsy requires a history of irresistible daytime sleepiness, cataplexy, sleep paralysis, and hypnagogic hallucinations during the episodes of sleep attacks. In addition, the finding of early onset rapid eye movements with the onset of sleep on the EEG is characteristic of narcolepsy. Recently, there have been reported HLA types which are characteristic of narcoleptics. The HLA type DR-2 has been found in 98 percent of caucasians in the United States with narcolepsy. This finding is not found with such high incidence in the black population, but there may be a separate marker in this population. This means that a patient who is a narcolepsy suspect who does not have a HLA DR-2 marker is unlikely to be a true narcoleptic. In the past several years, there have been reported cases of "monosymptomatic" narcolepsy. These are reported cases of narcolepsy, which do not fit the classic tetrad of signs and symptoms, but have characteristic EEG findings along with excessive daytime sleepiness. It is unknown at this time whether these patients will evolve the full narcolepsy syndrome or are a sub-population within narcolepsy patients.

What is needed by the flight surgeon is a paradigm with which to evaluate cases that are referred for excessive daytime sleepiness. Such a paradigm is copied on the last page of the article attached (Fig. 1).

The first part of this evaluation includes a thorough physical examination, some routine blood work such as a CBC, thyroid profile, liver function tests, etc., looking for the more obvious causes of daytime sleepiness. The most important part of this initial contact is the history. A careful review of the patient's past medical history, looking for signs of excessive sleepiness which preceded their military career is very important. If there is no obvious cause to the excessive daytime sleepiness and it is a persistent problem, the obtaining of a 21-day sleep diary is essential to get objective measures of the patient's nocturnal sleep, daytime napping and overall sleep hygiene. It is not enough for the patient to self-report that he sleeps well or sleeps poorly, since many of these patients do not have insight into their sleep habits. Once the sleep diary is obtained and you are satisfied that there is no evidence of a neurologic or psychiatric disorder which can be contributing, one can move to the left of the paradigm. In reviewing the sleep history, you can determine if there is an inadequate quantity of sleep or an adequate quantity of sleep. If there is an inadequate quantity of sleep then one breaks this down into either voluntary or involuntary. The voluntary poor sleep quantity is usually related to poor sleep hygiene. These are the people who are burning the candle at both ends and do not realize it. These may be very high performing individuals who are over extending their work days or allowing extracurricular activities to interfere with their sleep. In these cases are best managed with the help of some type of counseling or psychosocial evaluation. The involuntary causes of inadequate quantity of sleep lead to the many problems that cause insomnia. In more specific terminology, this is considered a disorder of the initiation and maintenance of sleep. The causes for insomnia are many and will not be reviewed at this time. It is important to distinguish an acute...
The last part of the paradigm reviews those patients who have had an adequate quantity of sleep. According to their sleep history. These patients will require referral for sleep studies. The initial sleep study, which is called a "mean sleep latency study," will distinguish those patients with early onset rapid eye movements from non-rapid eye movement sleep. The obvious diagnosis with early rapid eye movement, along with early onset sleep, is narcolepsy. This has already been discussed. The patients who have early sleep on their EEG without early rapid eye movement will require a nocturnal polysomnogram to distinguish the diagnoses of sleep apnea vs primary hypersomnia or parasomnias. The parasomnias include restless leg syndromes and nocturnal myoclonus. The former diagnosis will most likely be told to you by the patient, since it is a consciously annoying problem, where the patient develops recurrent urges to move their feet at night and this keeps them from initiating sleep. The latter diagnosis, nocturnal myoclonus may not be reported by the patient, but by their bed partner. The recurrent jerking movements during sleep do not arouse the patient to conscious awareness, but do cause intrusions in their sleep. The bed partner is usually the recipient of these jerks and many times keep them awake. This is important to note, because interviewing the bed partner may give you a hint to the cause of the excessive daytime sleepiness early on and avoid an excessive workup. Using this paradigm should allow the flight surgeons to establish a diagnosis in over 90 percent of his cases. I would like to mention that flight crew members, like residents, interns, and many physicians, often experience daytime fatigue. As residents and interns, many have witnessed their associates falling asleep during morning report and conferences after a 36-hour shift. Physicians, in general, are very leery when it comes to other members being sleepy during the day. Aircrew members, many times, are the same way because of the hectic schedules and extra work that is many times placed upon them. It is usually not until the aircrew member is considered unsafe or unable to perform their job on a recurrent basis, that they are referred to the flight surgeon. Therefore, a red flag should go up from the beginning when an aircrew member is referred for an evaluation of excessive daytime sleepiness.

The first case is a 27-year-old KC-135 pilot who fell asleep during one mission. His physical examination and neurological evaluation were within normal limits. There was no hint of psychiatric illness. Review of his past sleep history, especially in the previous work, revealed obvious sleep deprivation, which was reported in the initial evaluations. This pilot was thought to have poor sleep hygiene and he was allowed to return to flying status. This case illustrated how important it is to take a careful sleep history.

The second case is a 29-year-old B-52 pilot who was brought in for recurrent episodes of falling asleep during missions. This pilot gave definite history of sleep paralysis and hypnagogic hallucinations upon falling asleep. It became evident that this pilot did not have narcolepsy and was disqualified.

In summary, it is important to emphasize the need for a careful history during the initial evaluation, obtaining a good 21-day sleep history, if necessary, before embarking on an extensive evaluation. Speaking with the bed partner will help understand if the patient has any parasomnias. Talking with his crew members to establish if this has been a chronic problem or if they are under any underlying difficulties which could be contributing is also essential.

Fig 1 Suggested algorithm for evaluating excessive daytime sleepiness. "A normal sleep-latency study suggests that the patient's complaint is related to fatigue or malaise and not to a formal sleep disorder."
Multiple Sclerosis and Optic Neuritis

by

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The following paper entitled Selected Aeromedical Concerns: The relationship of optic neuritis to multiple sclerosis was the review paper from which this lecture was derived. It contains greater details and a bibliography, which was not part of the original lecture, therefore, I have submitted this in lieu of the lecture itself. This paper was prepared by myself and Colonel Wade Baldwin, D O M PH FS, United States Army.

Optic neuritis (ON) occurs relatively infrequently (Ref 14). It may be a complication of mumps, measles, chickenpox, pertussis, follow a wide variety of other infectious diseases, or immunization procedures (Ref 14). It has also been reported following exposure to toxic agents and a number of drugs (Ref 14). An isolated attack of ON may also be the first sign of multiple sclerosis (MS); followed by other symptoms years later. Finally, ON may occur as an isolated episode having a self-limited course and carrying no prognostic implications with respect to central nervous system disease. Reports of an interval of 20 or more years between an initial attack of ON and later disseminated involvement have caused authors to consider an episode of ON as the first sign of MS. (Ref 14)

Most studies over the years have used several schemes for the diagnosis and clinical classification of MS. The best known and most widely used had been the criteria published by Schumacher et al. (Ref 1). These criteria were established in order to select patients for participation in therapeutic trials and pertain only to what might be called definite MS. As no one laboratory test is diagnostic of MS, the diagnosis remains a clinical one. However, several laboratory and clinical procedures contribute to establishing the diagnosis. Besides a detailed history and clinical evaluation in MS, immunological observations, cerebrospinal fluid (CSF) tests, neuroophthalmological procedures (including visual, brain stem auditory, trigeminal, and somatosensory-evoked potential measurements), evoked blink reflexes, a variety of physiological and psychophysiological procedures, neuropsychological assessments, tissue-imaging procedures such as computer-assisted tomography (CT scanning) and magnetic resonance imaging (MRI), and urological studies of bladder, bowel and sexual dysfunction have been used. The MS suspect may undergo any number of the above tests, although not all are performed in every case.

The aeromedical significance of the relationship of ON to MS applies to both the selection and retention of aircrew. The potential for loss of a special vane as a result of symptomatic MS makes a rated aircrew member a threat to flight safety and mission completion. The potential for long-term disability and loss of strained crewmembers makes the cost of selecting an MS suspect as an aircrew member prohibitive.

It is our goal to review the world’s literature to
(1) see what subpopulation of ON has been identified to be at high risk for MS,
(2) present a standard for working up and diagnosing MS, and
(3) suggest a policy or establish research guidelines for handling ON in the aircrew population.

In addition, we reviewed the cases of ON and MS evaluated at USAF/AM over the past 15 years to look for patterns and effects on retention and flight safety. We present two recent cases to illustrate the difficulties evaluating the above diagnoses.

Approximately 35% to 50% of MS patients have a clinical episode of ON at some time during the course of their disease. The risk of developing MS later in patients with isolated ON is less certain. The published incidence varies between 13% and 85% (Ref 1, 6, 13, 17). Most studies indicate that 25% to 35% of patients with ON will develop MS. The length of follow-up is an important variable in assessing the risk of developing MS, since many years may intervene between ON and symptoms of MS. Intervals of 24, 29 and 37 years have been recorded. Kurtzke (Ref 17) showed that the proportion of patients developing MS increased to rise with prolonged follow-up, which agreed with the work of McAlpine (Ref 1). However, serial studies reviewed in Kurtzke’s article demonstrated that MS developed in 25% of patients who developed MS do so within 5 years (Ref 1, 14, 24).

Despite many studies on the rate of conversion of ON to MS, the subject remains controversial. There are hardly two studies that have treated the problem in quite the same manner. This reflects the fact that many variables affect the described outcome. Most investigators accept a close relationship; since many patients with clinically definite MS have had ON at some point in the course of their disease. The longest follow-ups have been in some of the studies with the lowest conversion rates. This has led to isolated ON being considered a diagnostic status appropriate that of a specific disease despite the fact that ON is not a clinical pathologic entity (Ref 13). Variables used and the period of follow-up obscure the relationship of the criteria for both the diagnosis of ON and of MS. Kurtzke (Ref 17) showed this in his tables comparing the rate of MS in studies grouped by like variables such as criteria for MS (see Table 1).

How can we identify those people with ON who will go on to MS and what tools are available to make this differentiation? Most patients with one episode of ON do not have any workup outside of ophthalmological care and follow-up. Little attention has gone to the etiology because of its status as a benign, self-limited disease. When studies are performed where idiopathic ON patients are worked up as MS, the predictive value of the standard MS workup battery shows a
<table>
<thead>
<tr>
<th>Source, year</th>
<th>Total MS %</th>
<th>Confidence interval</th>
<th>Possible MS %</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Series Reporting Percentages in excess of 40%</td>
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<td></td>
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<td>85</td>
<td>74—93</td>
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<td>Rechschneid, 1968</td>
<td>83</td>
<td>74—89</td>
<td>—</td>
<td>Part of MS prevalence survey</td>
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<td>Haller et al., 1980</td>
<td>80</td>
<td>61—92</td>
<td>—</td>
<td>Abstract only</td>
</tr>
<tr>
<td>Nikoskelainen et al., 1980</td>
<td>75</td>
<td>63—86</td>
<td>19</td>
<td>1 eye clinic, prior symptoms 19%</td>
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<tr>
<td>Landy, 1983</td>
<td>62</td>
<td>51—72</td>
<td>—</td>
<td>1 N, traced cases</td>
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<tr>
<td>Perkin &amp; Rose, 1979</td>
<td>58</td>
<td>46—69</td>
<td>71</td>
<td>1 HR(O), traced cases, not all ON onset bouts</td>
</tr>
<tr>
<td>Nikoskelainen &amp; Rekkmene, 1974</td>
<td>56</td>
<td>45—66</td>
<td>13</td>
<td>1 eye clinic, traced cases</td>
</tr>
<tr>
<td>Rose, 1970</td>
<td>55</td>
<td>44—65</td>
<td>—</td>
<td>Abstract only</td>
</tr>
<tr>
<td>Landy, 1983</td>
<td>54</td>
<td>44—64</td>
<td>—</td>
<td>1 N; all ON cases</td>
</tr>
<tr>
<td>Hutchison, 1976</td>
<td>53</td>
<td>44—62</td>
<td>22</td>
<td>Input bias</td>
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<tr>
<td>Bradley &amp; Whitty, 1968</td>
<td>52</td>
<td>39—64</td>
<td>32</td>
<td>1 HR(N), traced cases</td>
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<td>Lyn, 1959</td>
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<td>39—59</td>
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<td>Taub, 1954</td>
<td>46</td>
<td>33—60</td>
<td>—</td>
<td>Mayo Clinic, ages 20—44, traced cases</td>
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<tr>
<td>Stendahl-Brodin et al., 1978</td>
<td>44</td>
<td>32—56</td>
<td>—</td>
<td>1 HR(O), traced cases</td>
</tr>
<tr>
<td>Hyllested, 1950</td>
<td>44</td>
<td>31—58</td>
<td>some</td>
<td>1 HR, traced cases</td>
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<tr>
<td>Bradley &amp; Whitty, 1968</td>
<td>41</td>
<td>31—52</td>
<td>26</td>
<td>HR(N); all ON cases</td>
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<tr>
<td>B. Series Reporting Percentages of 30%–40% inclusive</td>
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<td>Collins, 1965</td>
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<td>Cleveland Clinic, ages 20—44, traced cases</td>
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<td>Hyllested &amp; Moller, 1961</td>
<td>39</td>
<td>24—56</td>
<td>32</td>
<td>1 HR(NO), traced cases</td>
</tr>
<tr>
<td>Hyllested, 1950</td>
<td>38</td>
<td>27—51</td>
<td>some</td>
<td>1 HR, all ON cases</td>
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<tr>
<td>Compton et al., 1978</td>
<td>36</td>
<td>28—44</td>
<td>11</td>
<td>1 physician clinic eye hospital, traced cases</td>
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<tr>
<td>Taub, 1954</td>
<td>34</td>
<td>24—46</td>
<td>—</td>
<td>Mayo Clinic, ages 20—44, all ON cases</td>
</tr>
<tr>
<td>Cohen et al., 1979</td>
<td>32</td>
<td>21—45</td>
<td>3</td>
<td>1 HR(NO); traced cases</td>
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<tr>
<td>Stendahl-Brodin et al., 1978</td>
<td>32</td>
<td>23—42</td>
<td>—</td>
<td>1 HR(O); all ON cases</td>
</tr>
<tr>
<td>Collins, 1965</td>
<td>32</td>
<td>22—44</td>
<td>—</td>
<td>Cleveland Clinic, traced cases</td>
</tr>
<tr>
<td>Kahana et al., 1976</td>
<td>32</td>
<td>22—43</td>
<td>—</td>
<td>Population survey, includes RON, traced cases</td>
</tr>
<tr>
<td>Tatlow, 1948</td>
<td>32</td>
<td>15—53</td>
<td>12</td>
<td>1 eye clinic, traced cases</td>
</tr>
<tr>
<td>Taub, 1954</td>
<td>32</td>
<td>22—43</td>
<td>—</td>
<td>Mayo Clinic, traced cases</td>
</tr>
</tbody>
</table>

Abbreviations:
- MS = multiple sclerosis
- ON = optic neuritis
- RON = recurrent optic neuritis
- HR = hospital records
- HR(N) = all inpatient hospital records limited to neurology
- HR(O) = all inpatient hospital records limited to ophthalmology
- HR(NO) = all inpatient hospital records limited to neuro-ophthalmology

Confidence intervals (95%) from binomial distribution
Percent possible MS included in total MS
hierarchy of findings with the MRI being the most predictive (Ref 9, 10, 11, 12, 15, 21, 22, 23, 26, 28). The MRI is now the standard for discovering both the symptomatic and asymptomatic lesions, especially in the area of the brain stem and spinal cord (Ref 1). In addition, MS plaques do not fade as do in CT scans (Ref 10). It is also reported that the MRI can differentiate between active and inactive plaques (Ref 19). It is for this reason that researchers have begun to apply the MRI in cases of idiopathic ON after an initial episode in an attempt to differentiate cases of idiopathic ON from ON as an initial symptom of MS. By doing this, they can distinguish two groups of patients:

1. those with ON, a normal MRI and normal neurological findings;
2. those with MRI consistent with a diagnosis of MS and normal neurological findings.

Recently, Posner et al. established research guidelines (see Table 2) using clinical and laboratory data in diagnosing MS (Ref 26). These criteria provide several levels of diagnostic certainty and are currently used as guidelines for research protocols.

Before continuing a review of the literature and discussion, two case studies are presented to illustrate the aeronautical problem.

**CASE 1 – MULTIPLE SCLEROSIS**

Major G was a 35-year-old right-handed navigator with a history of 3,000 total flying hours. His first complaint was diplopia on left lateral gaze which persisted for one month. At that point, he was seen by an optometrist who diagnosed a left VIth nerve palsy and a right upper quadrantanopia. The only significant preceding history was that his entire family had come down with the flu just before he had become symptomatic. Major G admitted to a tingling sensation in his left arm when he moved his neck anteriorposteriorly, but denied any other symptoms. On his USAFSAM evaluation, his neurologist and ophthalmologist examinations were normal, but he had a subjective complaint of difficulty in “keeping track of where cars are” while driving. This was worse during the evening.

**Comments**

Major G had two hard neurological findings, both within the same time frame. There were VIth nerve palsies on the left and a right upper quadrantanopia on the right. These would place possible lesions in the left brain stem and the left optic radiations. The most likely diagnosis would be dysmyelinating disease. He had an abnormal MRI consistent with dysmyelinating disease, and a lumbar puncture with a mildly increased protein and IgG synthesis rate. Other testing included visual evoked potentials and brain stem auditory-evoked potentials. These were normal. The categories established by Posner et al. (Ref 26) allows the combination of the history and supportive lab material to give a degree of certainty in diagnosing MS. In Major G’s case there were two positive laboratory findings and a positive history. This combination allowed us to make the diagnosis of definite laboratory-supported MS. It is also possible that Major G’s inability to track cars while driving was a subtle deficit as a result of a plaque in the tracking integration area which could not be tested directly. No waiver was granted.

**CASE 2 – OPTIC NEURITIS**

Capt J was a 35-year-old left-handed pilot who was healthy until June 1983, when he complained that he could not clear the vision in his right eye. The following day, he noticed that...
his central vision was decreasing. An ophthalmologic examination revealed vision in the right eye to be 20/200 and the diagnosis of retrobulbar optic neuritis was made. He was treated with oral steroids. Two days later, his vision was 20/400 and he was referred to an academic neuro-ophthalmologic center. Their examination revealed finger counting only in the right eye and no other abnormalities. He had a CT scan which was reported as normal. He was treated with pulse high-dose steroids for three days. Six to eight weeks later, he had improved although his vision was still not 20/20. He was first seen at the neuro-ophthalmologic center in October 1983. At that time, his visual acuity was reported as 20/20 and he had a positive color vision deficiency. He remained disqualified from flying duties until January 1985, when he received a waiver. His USAF SAM evaluation in 1987 revealed a normal neurologic examination except for a positive Marcus Gunn pupil on the right. An MRI, performed prior to the USAF SAM evaluation, revealed multiple lesions in the periventricular and deep white matter, consistent with MS plaques. The rest of Capt. J's workup was normal including a lumbar puncture and evoked potentials.

Comments

The question was then raised whether an episode of ON, followed by an abnormal MRI, was substantial enough evidence for the diagnosis of MS. There is great controversy in the literature over this, and the decision was to wait 4-6 months and repeat the MRI to look for evidence of ongoing ulcerative which at that time, the decision was to recommend a review, looking at the specific question of optic neuritis and MS, is ongoing at the present time in a multi-center study in the United States. In addition, all cases of ON are currently being entered into a study group at USAF SAM.

REVIEW OF LITERATURE

From our review of ophthalmologic features of ON and MS, we decided to focus on the MRI as a tool in predicting MS in ON patients.

In answering the question "Does the MRI predict MS in ON patients?", we selected the following articles to be presented in depth. This can be done under the special case, since the literature using the MRI to specifically diagnose MS in cases of new onset ON is limited.

MRI in the Diagnosis - A Prospective Study with Comparison of Clinical Evaluation, Evoked Potentials, Oligoclonal Banding, and CT

Authors: D W Paty et al. (Ref 22)

Multiple sclerosis is diagnosed clinically by the demonstration of white matter dysfunction disseminated in time and space. Clinically defined MS (CDMS) (Ref 26) in recent years, paraclinical evidence for dissemination in space has been accepted for research protocols. The presence of oligoclonal banding (OB) or evidence for increased rates of immunoglobulin in CSF is required to meet criteria for laboratory-supported definite multiple sclerosis (LMMS). MRI of the brain is more sensitive than CT for demonstrating MS lesions. Lukas et al. studied ten patients with CDMS and found MRI lesions in all of them. Gebarski et al. found that 26 of 30 (87%) CDMS patients had MRI lesions. Paty's experience shows that 124/137 (92%) of CDMS patients have abnormal MRI scans. Of these 135, 117 (88%) had "MRI strongly suggestive of MS." The frequency of abnormal studies in "suspected MS" patients is lower than in CDMS. The ability of MRI and the category of LSMS to predict the clinical diagnosis of MS (CDMS) has not been determined.

Paty et al. examined 261 patients referred to our MS clinic, and to other university neurologists for the diagnosis of suspected MS. When possible, within a period of six weeks, they performed the following on each patient:

1. Neurologic examination,
2. High-volume delayed CT (HVDDCT),
3. Visual-evoked potentials (VEP),
4. Somatosensory-evoked potentials (SEPs),
5. CSF analysis for OB, and
6. MRI

They did not use brain stem auditory-evoked potentials because they had not been of major utility in their experience.

Two hundred of these patients form the basis of this report. They analyzed the data on these 200 patients to answer the following questions:

1. What is the value of MRI studies in comparison with other paraclinical tests in demonstrating dissemination in space?
2. Can a logical, systematic approach be developed to determine which paraclinical test would most useful in certain clinical situations?
3. What percentage of patients suspected of having MS can be moved into the category of LSMS by using these paraclinical tests?

They herein report their initial findings. Only long-term clinical follow-up will allow comparison of the results of this study with the diagnosis of CDMS.

Results

Two hundred patients have completed all studies. Table 3 gives the clinical characteristics of these patients. They separated them into clinical subcategories of optic neuritis (ON), CPM (chronic progressive myelopathy), patients with a completely normal neurologic examination (NNE), and patients with brain stem and cerebellar presentations. Table 4 gives a summary of the positive results of the various tests, broken down by clinical categories. MRI, evoked potentials, and CSF all had an approximately 50% abnormality rate of 25%. The frequency of VEP abnormality in ON was 37%, and the frequency of SEPs abnormality in ON was 75%.

The MRI was 'strongly suggestive of MS' in 25/38 (66%) of ON and 33/52 (65%) of CPM patients. The frequency of MRI abnormality was low in the NNE group. Table 5 gives the other paraclinical results for all categories of MRI abnormalities. For the 9 patients with only a single lesion on MRI, 7 (78%) were OB-positive. These findings support a proposition that a single, appropriate, and asymptomatic lesion on MRI can be useful as evidence, for dissemination in space when used in conjunction with independent clinical and CSF findings appropriate to MS. The other studies (except for C 11) were abnormal in 16% to 26% of patients with normal MRI. The other MRI diagnoses were two cortical infarctions, one cerebral and one cerebellar atrophy, one brain stem and one cerebral tumor, and one brain stem arteriovenous fistula malformation.

Discussion

Paty et al. have previously found pathologic correlation of
### TABLE 3
Clinical Characteristics in 200 Suspected MS Patients

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Number</td>
<td>134</td>
<td>66</td>
<td>200</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>42 yrs</td>
<td>46 yrs</td>
<td>43 yrs</td>
</tr>
<tr>
<td>Age (range)</td>
<td>12–79 yrs</td>
<td>22–74 yrs</td>
<td>12–79 yrs</td>
</tr>
<tr>
<td>Duration of disease (mean)</td>
<td>7.4 yrs</td>
<td>7.4 yrs</td>
<td>7.4 yrs</td>
</tr>
<tr>
<td>Duration of disease (range)</td>
<td>0–48 yrs</td>
<td>0–48 yrs</td>
<td>0–48 yrs</td>
</tr>
</tbody>
</table>

### TABLE 4
Frequency of Paraclinical Abnormalities in 200 Patients with Suspected MS and Clinical Subcategories

<table>
<thead>
<tr>
<th>MRI Diagnosis</th>
<th>VEP (%)</th>
<th>SEP (%)</th>
<th>CT (%)</th>
<th>MRI SS (%)</th>
<th>MRI AA (%)</th>
<th>OB (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (N = 200)</td>
<td>92 (46%)</td>
<td>98 (49%)</td>
<td>50 (25%)</td>
<td>98 (49%)</td>
<td>124 (62%)</td>
<td>93 (47%)</td>
</tr>
<tr>
<td>ON (N = 38)</td>
<td>32 (87%)</td>
<td>13 (34%)</td>
<td>8 (21%)</td>
<td>25 (66%)</td>
<td>29 (76%)</td>
<td>23 (61%)</td>
</tr>
<tr>
<td>CPN (N = 52)</td>
<td>28 (54%)</td>
<td>39 (75%)</td>
<td>11 (21%)</td>
<td>31 (60%)</td>
<td>36 (69%)</td>
<td>32 (62%)</td>
</tr>
<tr>
<td>NNE (N = 34)</td>
<td>7 (21%)</td>
<td>10 (29%)</td>
<td>4 (12%)</td>
<td>6 (18%)</td>
<td>11 (38%)</td>
<td>9 (27%)</td>
</tr>
<tr>
<td>Brain stem (N = 54)</td>
<td>22 (41%)</td>
<td>28 (52%)</td>
<td>11 (22%)</td>
<td>26 (48%)</td>
<td>32 (59%)</td>
<td>26 (48%)</td>
</tr>
<tr>
<td>Cerebellar (N = 22)</td>
<td>13 (59%)</td>
<td>13 (59%)</td>
<td>6 (29%)</td>
<td>13 (59%)</td>
<td>18 (82%)</td>
<td>10 (46%)</td>
</tr>
</tbody>
</table>

**Abbreviations**
- CPM = chronic progressive myelopathy
- MRI SS = strongly suggestive of multiple sclerosis (MS)
- MRI AA = any MS-like abnormality (one or more MS-like lesions)
- NNE = normal neurologic evaluation
- OB = oligodendroglial banding
- ON = optic neuritis
- SEP = somatosensory-evoked potentials
- VEP = visual-evoked potentials

### TABLE 5
Frequency of Other Paraclinical Abnormalities in Various Categories of MRI Diagnosis

<table>
<thead>
<tr>
<th>MRI Diagnosis</th>
<th>VEP (%)</th>
<th>SEP (%)</th>
<th>CT (%)</th>
<th>MRI SS (%)</th>
<th>MRI AA (%)</th>
<th>OB (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly suggestive of MS (N = 98)</td>
<td>65 (66%)</td>
<td>64 (65%)</td>
<td>56 (37%)</td>
<td>66 (67%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestive of MS (N = 9)</td>
<td>4 (44%)</td>
<td>2 (22%)</td>
<td>1 (11%)</td>
<td>4 (44%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible MS (N = 8)</td>
<td>3 (37%)</td>
<td>3 (37%)</td>
<td>1 (13%)</td>
<td>5 (63%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One lesion (N = 6)</td>
<td>3 (50%)</td>
<td>6 (67%)</td>
<td>4 (50%)</td>
<td>7 (71%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal (N = 69)</td>
<td>16 (23%)</td>
<td>18 (26%)</td>
<td>6 (9%)</td>
<td>11 (16%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-MS finding (N = 7)</td>
<td>1 (14%)</td>
<td>5 (71%)</td>
<td>2 (29%)</td>
<td>0</td>
<td></td>
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</table>

**Abbreviations**
- OB = oligodendroglial banding
- SEP = somatosensory-evoked potentials
- VEP = visual-evoked potentials
dysmyelinated areas in the majority of MRI abnormalities in MS patients. In systematic serial studies (Ref 8), new lesions that are entirely asymptomatic may appear and disappear. The occasional lesion that disappears indicates that it has resolved to a state below the detection threshold of the technique or the particular machine used. Nevertheless, they are impressed by the lack of specificity of MRI for MS. The present study used patients in whom MS was clinically suspected by MS-knowledgeable neurologists. They found that a "MRI strongly suggestive" pattern can be produced by other disease states. One particular problem will always be that of acute disseminated encephalomyelitis (ADEM), which can produce both disseminated clinical CT- and MRI-detected lesions and OB.

This prospective study of paraclinical tests in diagnosis of MS has shown that the MRI is the most sensitive way of demonstrating dissemination in space. MRI not only had the most frequent overall abnormality rate (62%), but, in analyses of ON and CPM patients, it identified all patients that could be diagnosed as having LSDMS in 18-19 (95%) who later developed diagnostically significant clinical events. OB was the nest most sensitive predictor of CDMS, at 75% 1-20 years of age idiopathic plaques because the pattern. Most important in the evolution of the disease process.

MRI: Sensitive and Safe in Diagnosing MS

Author: D.H. Miller (Ref 18)

Brain MRI Sensitivity

Magnetic Resonance Imaging (MRI) is very sensitive in detecting the brain lesions of MS. They are best seen on moderately T2-weighted sequences. Miller analyzed 200 consecutive patients who had clinically definite MS according to the Poser criteria.

The characteristic MRI pattern, based on this study, is one of multifocal white-matter lesions, particularly appearing in the periventricular location and most often involving the body of the lateral ventricle. Postmortem studies have confirmed that such MRI lesions correspond to MS plaques.

Multifocal white-matter lesions, indistinguishable from those of MS, are also seen in patients with cerebrovascular (CV) disease. Furthermore, 5%-30% of normal individuals 50 years of age or older have white-matter lesions, which are seen more frequently in those with risk factors for CV disease (including hypertension), and with increasing age. It seems most likely that the lesions are due to asymptomatic CV disease.

In idiopathic MS, a highly suggestive in detecting the characteristic brain lesions of MS, but the MRI pattern is not specific for these lesions.

Brain MRI Age and Activity of MS Plaques

Simple inspection of the MRI scan does not differentiate new, active lesions from old, inactive ones. Relaxation-time measurements are also ineffective in distinguishing the age of lesions. However, recent experience with serial MRI, using the contrast marker gadopentetate dimethylurea, has shown that it is a useful marker of new and biologically active lesions. Enhancement is a consistent feature of new MS plaque while it appears only infrequently in older ones. These observations also suggest that blood-brain barrier (BBB) impairment may be of importance in the pathogenesis of MS lesions.

Sclerotic Brain Lesions in Patients with Isolated Optic Neuritis — A Clinical and MRI Study

Authors: L. Jacobs et al.

Lawrence Jacobs, et al. stated that MRI has proved to be much more sensitive than CSF and evoked potentials studies for making the initial diagnosis of MS. In this study, Jacobs et al. used the MRI to image the brains of 10 patients with isolated ON. All had normal findings on CT examination. All patients had definite isolated idiopathic ON by accepted clinical diagnostic criteria. There were 7 female and 3 male patients, aged 12 to 62 years. The ON was unilateral in 15 patients and bilateral in one patient.

Results

CT findings were normal in all patients, but the MRI scan was abnormal in 8 patients. The MRI identified multiple lesions (2 to 7 lesions) in 6 patients, in 2 patients, only one lesion was identified.

The only CSF abnormality in any of the patients was the presence of oligoclonal bands (identified in 5 patients). There was no consistent relationship between the MRI and CSF findings.

Three patients with abnormal MRI examinations had normal CSF; study results. One patient, with a normal MRI refused lumbar puncture.

The follow-up of these patients since the time of their MRI examinations had been 20 to 144 months for a total follow-up since onset of idiopathic ON symptoms of 3 months to 7 years. None of the patients had a new episode of ON or developed symptoms or signs of disseminated lesions of the CNS. All of the patients have remained neurologically normal except for symptoms and signs related to their previous episode of idiopathic ON.

Comment

Their findings demonstrated that half of the patients who experience an episode of idiopathic ON may harbor one or more lesions of the brain that are clinically silent. It is likely that these lesions are MS plaques because the pattern, location, and extent of the MRI abnormality observed is similar to that seen in patients with proved MS. However, published criteria (Ref 26), the four patients with abnormalities of both MRI and CSF have definite MS, the other four with abnormalities by MRI but normal CSF have probable MS.

In the majority of their patients, the idiopathic ON seemed to be the only clinical manifestation of a disease process that was already disseminated in the CNS. However, none of the patients has gone on to develop overt MS during the period of follow-up. While our mean follow-up period for the entire group is relatively short, one patient with an abnormal MRI scan has been followed up for over seven years and another for over four years without developing clinical signs of dissemination. It has been stated that, if a patient with idiopathic ON is going to develop MS, he/she will usually do so within four to five years (Refs. 1, 12, 16, 17). However, there have been many recorded exceptions, and MS has evolved.
from a background of ON occurring as long as 33 years to 56 years previously.

**MRI of the Brain in Isolated Optic Neuritis**

**Authors** K. Johns et al (Ref 12)

Karen Johns et al. (Ref 12), in their article used the MRI of the brain in isolated ON to look for evidence of subclinical disseminated intracranial demyelination.

**Patients and Methods**

They selected 10 patients (age range 15 to 45 years) with isolated ON for the study. Each had a rapid onset of decreased vision, achieving a maximum deficit within 7 days. None had retinal, vascular, or neoplastic lesions to account for the symptoms. Results of a neurological examination by a neurologist were otherwise normal.

From all patients, they obtained a complete blood count (CBC), anti-nuclear antibody test results, an ESR, a chest roentgenogram, and a complete physical examination results to exclude collagen vascular disease, sarcoid, and other systemic diseases.

**Results**

Ten patients with isolated ON were studied; seven had abnormal intracranial lesions in the periventricular white matter similar to that previously described in MS. These lesions were asymptomatic. The follow-up time of these patients ranged from two months to two years, with a mean of 13.6 months. A summary of the findings and clinical courses in these ten patients is listed in Table 6.

**Comment**

In one clinical study of 42 patients with clinically definite MS, all had abnormal MRIs, but only 45% had abnormal CT scans. The sharp margins of these lesions and the periventricular and brain stem distribution are similar to the configuration and distribution of demyelinating plaques seen in autopsy studies of patients with MS. Using MRI, they found that 70% of patients with ON did, in fact, have asymptomatic disseminated lesions. Thus, with MRI, much more widespread involvement of the CNS is demonstrated than is clinically suspected. Two recent studies have demonstrated subclinical MRI findings in 50% and 61% of patients with ON (Ref 20). However, in this study, the interval between the onset of symptoms and MRI scanning was short (mean ±5 days), compared with means of 1.5 years and 6.3 days, respectively, in the above studies. In addition, Jacobs et al. criteria were more stringent. Thus, findings may represent the incidence of subclinical dissemination early in the course of isolated ON with greater accuracy.

**Impact of MRI on the Assessment of Multiple Sclerosis Patients**

**Authors** L. Jacobs et al. (Ref 11)

Lawrence Jacobs et al. noted that CT examinations of MS patients were usually normal. The last few years' experience with MRI in the clinical environment seems to demonstrate its superiority over CT for assessing the brain in MS.

They studied 147 patients with definite or probable MS. Each of the patients had simultaneous or near simultaneous CT and MRI examinations and the two examinations were compared.

**Clinical Correlation**

Patients' clinical profiles were categorized by functional groups and disability status according to a modified Kurtzke scale before or shortly after scanning. Patients were clinically reassessed and recored at time of repeat scanning. In 27 of the patients, the lesions identified by MRI were compared with the patient's clinical status and correlated as follows:

1. definite, lesion definitely caused clinical symptoms or signs,
2. possible, lesion may have caused symptoms or signs,
3. none, lesions definitely did not cause symptoms or signs (clinically silent).

**Results**

CT was abnormal in 56 (38%) and MRI in 98 (67%) of the patients. The most common CT abnormality was one or more areas of decreased density of white matter (42 patients), which were diffuse and ill-defined. Brain stem and cerebellar lesions were not identified by CT. MRI identified all of the lesions that had been demonstrated by CT. It also revealed one to several more lesions than were not demonstrated by CT.
shown by CT. Moreover, MRI revealed one to several more lesions in 42 patients whose CT examinations had been normal. In 14 patients, the MRI identified lesions of the posterior fossa that were missed by CT.

**Serial Studies**

Parenchymal enhancing lesions were observed to disappear in 4-6 patients who were studied with serial CTs. In 2 patients, one or more nonenhancing areas of decreased density were also observed to disappear. However, MRI lesions corresponding to the CT lesions (nonenhancing enhancing) persisted unchanged after they had disappeared on CT.

**Commons**

Their experience with 147 MS patients indicates that this technique has had a major impact on the assessment of these patients. MRI usually showed more lesions and extensive involvement than the CT. Even more striking was the observation that MRI revealed obvious lesions that were often extensive in 91 patients who had completely normal CT scans. MRI revealed posterior fossa lesions that were completely missed by CT in 14 patients. The explanation for this increased sensitivity of MRI for identifying posterior fossa lesions is that MRI images are not affected by artifact from adjacent bone, as are those of CT.

MRI identified all of the parenchymal abnormalities (nonenhancing, enhancing) shown by CT. It also continued to show the lesions (unchanged in appearance) after they had stopped enhancing. Thus, some lesions will be visualized only temporarily by CT (when they show contrast enhancement), but this is not the case with MRI. In their experience with 147 patients, once an MS lesion is seen by MRI, it does not disappear during serial examination.

Detailed clinical correlations of the lesions identified by MRI have been conducted on 27 of these patients to date and reported elsewhere. These correlations have shown that 75% of the lesions were clinically silent. A similar poor correlation between lesion size and clinical signs was found in another recent study. Some combination of physiologic activity and anatomic location probably determines whether or not an MS lesion will become symptomatic. Anatomic location may be most important, since the only lesions that had definite clinical correlations were located in the posterior fossa, whether the patient was in exacerbation or remission.

**Serial Gadolinium-Enhanced MRI in MS**

**Authors: D H Miller, et al (Ref 19)**

**Introduction**

D H Miller et al. stated that MRI is highly sensitive for demonstrating brain lesions in patients with MS. Abnormalities are reported in 85% to 100% of patients with clinically definite MS, and the MRI lesions have been correlated with plaques on postmortem. The characteristic pattern is one of multifocal white-matter lesions, many of which are adjacent to the lateral ventricles.

At present, it is not possible to determine the age of state of biological activity of a plaque seen at a single MRI examination. It would be of value to establish the lesion ages in two groups of patients with (1) single clinical episode of typical demyelinating disorder (e.g., acute optic neuritis) and (2) MRI evidence of asymptomatic multifocal brain lesions. Evidence of lesions of different ages in such patients would suggest a multiphasic disease (i.e., MS), if all lesions were the same age, the monophasic disease (i.e., acute disseminated encephalomyelitis) would be more likely (2). MS patients participating in therapeutic trials, where the appearance of new and active lesions would provide evidence of continuing disease progression while serial CT studies show that the blood brain barrier (BBB) abnormalities correlate with clinical disease activity; they do not establish the age of the lesions. Because unenhanced CT has a low sensitivity for detecting plaques, it is not possible to state whether a new enhancing lesion represents reactivation of an old plaque or the development of a new one.

MRI, with its high sensitivity in detecting plaques, is well suited to a serial study of BBB abnormalities in MS. Contrast agents are required to demonstrate BBB impairment with the MRI. The most useful to date is gadolinium DTPA (Gd-DTPA), a paramagnetic agent which strongly enhances the relaxation of water protons.

Miller et al. performed a serial study with Gd-DTPA-enhanced MRI in MS to establish (1) the duration of enhancement of MS plaques and (2) the relationship of enhancement to the age of the lesion.

In view of a previous report that acute lesions have longer relaxation time than chronic ones (Ref 20), they also recorded these times in enhancing and nonenhancing lesions.

**Methods**

Ten patients aged 28 to 47 years with clinically definite MS (Ref 21) were studied. Eight were in acute clinical relapse at the time of the first scan; 1 had a relapse 3 months before the first scan; another had had gradual deterioration over several months. Follow-up scans were performed approximately 1 month and 6 months after the first scan. Eight patients completed 3 scans.

**Results**

**First Scan**

In all 10 patients, enhanced MRI demonstrated multiple, mainly white-matter brain lesions typical of MS. In total, 56 of the lesions showed contrast enhancement. Enhancing lesions were seen in 8 patients, the 2 with no enhancing lesions were not in an acute relapse at the time of scanning. Enhancing lesions in a site compatible with the acute clinical relapse were seen in 6/8 patients. Most enhancing lesions were asymptomatic. Enhancement most often involved the whole lesion, but occasionally there was peripheral ring enhancement only.

**Second Scan**

This was performed in 9 patients 3 to 5 weeks after the first scan. Of the total of 54 enhancing lesions seen in these patients on the first scan, 42 were no longer enhancing, while 12 showed persisting but sometimes diminished enhancement.

Twelve new lesion areas (8 new lesions and 4 definite areas of extension of old lesions) were identified on the unenhanced scan, and all displayed enhancement. Enhancement was also seen in 2 older lesions which on the first scan were nonenhancing.

**Third Scan**

Light patients were rescanned 6 months after the first scan.
A total of 15 new lesion areas were seen in the unenhanced scan, of which 8 displayed enhancement. Enhancement was also seen in 2 older lesions which had been nonenhancing on earlier scans. No enhancement was seen in any of the lesions which had enhanced on earlier scans.

Lesions Seen Only with Gd-DTPA Enhancement

Over the course of the study, a total of 63 small enhancing lesions, which had enhanced on earlier scans individually or grouped are not good predictors of developing MS.

A longitudinal monitoring of new plaques should be useful for lesions that were otherwise normal. It is not surprising then that the enhanced MRI delineated of small cortical or subcortical white matter, and were no longer visible on follow-up scan.

Reference to Gd-DTPA

No side effects were noted in association with Gd-DTPA administration. The relapses which occurred in 1 patient within several weeks of the scan were probably coincidental.

A transient elevation of serum iron level was seen in 8-27 examinations 4 to 24 h after injection, and returned to normal in all cases within 48 h.

Comments

The study confirms that Gd-DTPA-enhanced MRI frequently demonstrates enhancing lesions in patients with clinically active MS. The majority of enhancing lesions are asymptomatic. Most lesions-enhanced for less than 1 month, and none longer than 6 months. Enhancement was seen in every new lesion which appeared in a period of approximately 1 month (between the first and second scan), and in many but not all lesions that appeared in a period of 5 months (between the second and third scan).

The study also showed that the BBB impairment develops in new plaques without evidence of increased size.

It is not surprising then that the enhanced MRI demarcated a number of small cortical or subcortical lesions that were otherwise invisible.

The main conclusion from this study is that Gd-DTPA is a sensitive marker of the BBB impairment which occurs in new plaques. It should prove useful in monitoring therapeutic trials in MS.

Comments

There is no doubt that a certain percentage of idiopathic ON patients will develop MS. In a civilian setting, it's not cost effective to evaluate each patient with ON as an MS suspect.

In the aeromedical community, where the diagnosis of MS can lead to a loss of a trained aircrew member and expose the service to costly long-term care, the evaluation for potential MS may become cost beneficial. To improve on the predictive value of the standard MS battery, our review of the literature gives us several suggestions. First, there may be a subgroup of patients with idiopathic ON who are at high risk for developing MS. Second, this subgroup may be identified by MRI scans, specifically, those patients who have MRI findings consistent with typical plaques by description and location for MS. The final stage of this research has to be the longitudinal follow-up of this subgroup. Preliminary data by the six articles used reveal that the MRI may be predictive in 37% to 50% of the patients. If this predictive rate is substantiated by other studies, this would lend the aeromedical community to a specific policy as regards ON patients.

Given the information gained so far, only the following conclusions can be made:

1. ON is a first symptom of MS in a significant percentage of patients.
2. The specific risk factors such as age, sex, age at the initial event of ON, recurrent or bilateral ON, either individually or grouped are not good predictors of developing MS.
3. The MRI divides the idiopathic ON patients into two groups, those with normal MRI and those with MRI consistent with MS.
4. Longitudinal studies thus far show a higher rate of MS among the abnormal MRI group.
5. If this finding holds true in large long-term studies, it suggests that the MRI may be a cost-effective tool to select out candidates for aircrew prior to the cost of training. It will also allow us to identify a rated aircrew member who has an increased risk for special service loss after recovery from idiopathic ON.
6. The United States Air Force has evaluated 63 aircrew members with ON at USAFSAM. Applying the MRI criteria, these cases can be divided into two groups and followed longitudinally. This would help answer these questions raised by the review. This effort could be furthered in a longitudinal study by serial MRIs.
7. D. H. Miller et al. suggest that the expense of gadolinium contrast with the MRI may allow dating of the different plaques, which would show ongoing disease and make the diagnosis of MS more secure.

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Headache

by

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Headaches of some type have been reported to occur in up to 70% of the population of the United States at some point in their lifetime. Vascular headaches are reported in up to 20% of this population. Our task is to properly classify the headache, discover any triggers or unique circumstances of the headache and decide if it is aeromedically significant.

The classification of headaches and facial pain has undergone its first revision since 1982 and was published in Cephalalgia 1988, 8 (1–72). The title of this special supplement was Classification and Diagnostic Criteria for Headache Disorders, Cranial Neuralgias and Facial Pain. This divides the many types of headaches by description and specific criteria much like the DSM III. This manual will help the flight surgeon understand the complexity of headache description and may save valuable time.

The main issue is when does a headache become aeromedically significant? The answer seems to differ from service to service and country to country. I prefer to use the rules of thumb which measure the headache and their accompanying symptoms against their effect on flight safety and effectiveness. Headaches, specifically vascular headaches, such as classic migraines are not innocuous problems. Loss of a visual field which can occur before a headache or an aphasia can be a serious safety hazard. There are documented losses of a loss of life or aircraft accidents directly related to this problem. Our rule has been that headaches that cause incapacitating pain or loss of a special sense constitutes an aeromedically significant disease. Making that distinction and making sure of your diagnosis is the crucial issue. We will review several examples that have been seen in the last 3 years. These cases raise the areas of controversy often accompanying a headache evaluation.

1. How can one make the diagnosis of a recurring illness as a migraine after just one episode?
2. How can incapacitating headaches be waivered?
3. How can we more effectively deal with these problems?

Case 1: 30 year old pilot with sudden right homonymous hemianopsia and headache.

This pilot realized he had a problem when he could not see his wingman. The headache was very mild. He was originally told that since his headache was not incapacitating he could continue to fly. The pilot felt this was unsafe and requested a full evaluation. Appropriately he needed a CT scan to rule out a mass lesion. This was normal. The pilot recognized that loss of this special sense which could occur unpredictably was incapacitating with flying safely and he remained grounded even though he had only one event.

Case 2: A student pilot with the worst headache of his life during intercourse. He had been a weapons officer in the F-4 for 5 years previously.

This student had clearly what he described as an incapacitating headache, but there was a specific and unique trigger. This was a classic costal migraine of the explosive type (see above references) which was not transferable to similar M-1 or L-1 anti-G-straining maneuvers proven by his past history in the F-4. Because of this he was able to continue his flying career.

Case 3: A 35 year old pilot complained of similar costal migraines but also developed paroxysmal incapacitating headaches on anti-G straining. His costal migraine overlapped into a type of exertional headache and he could only be allowed to fly in non-high performance aircraft. But he was retained as a valuable resource and kept his flying career. The point of these cases is that there are many shades of headaches and many causes. A careful history is the most important part of the evaluation including dietary history, sleep patterns, drinking etc. Certainly any patient with neurologic deficits or impaired consciousness requires neuro-imaging. Patients with the worst headache of their lives also deserve lumbar punctures.

To help guide your exam and history, I have enclosed a check-list of questions concerning the entire headache episode. This list is currently being used in a retrospective study of patients seen at USAF/AM and hopefully will begin being used for a prospective study in the near future. As you can see from this list of questions the headache is divided into signs, symptoms and on-set of symptoms. There is a section on testing but this does not imply every test listed needs to be performed on every patient. If there is any local deficit with the headache a type of neuro-imaging should be performed. You are welcome to use these sheets for your own purposes.

At present there are no anti-migraine medications waivered to allow for prophylactic or on an as-needed basis so the diagnosis is important to your flyer’s career and every effort should be expended to make the best diagnosis.

HEADACHE STUDY

Event (Circle Number)
A Occurred Prior to Event (Within Days)
1 Viral-Type Symptoms (malaise, muscle aches, nausea, GI distress)
2 Febrile Illness
3 Sleep Deprivation
4. Sleep Cycle Alteration
5 Altered Diet (introduction of new food or food source)
6 Atypical Alcohol Consumption
7 Photophobia
8 Neck Pain or Stiffness
9 Stressors (death/divorce/family relationship/work change)
<table>
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<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>10</td>
<td>New Diet or Weight Reduction Scheme -- describe</td>
</tr>
<tr>
<td>11</td>
<td>Over-the-Counter or Other Medications</td>
</tr>
<tr>
<td>12</td>
<td>Head Trauma</td>
</tr>
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<td>13</td>
<td>Travel</td>
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</tbody>
</table>

**B** Occurred Just Prior to Event (Seconds to Minutes)

1. Emotional Shock (describe)
2. Head Injury
3. Valsalva
4. Eversion (nerve or synovial)
5. Eversion (anterior, e.g., weight lifting)
6. Rapid Movement
7. Intercourse
8. Coughing
9. Sleeping
10. Just Awoke from Sleep
11. Eating (specify food - ice cream, etc)
12. Study
13. Hyperventilation
14. Facial Pain or Abnormal Sensation

**C** Symptoms Just prior to Event (Hours)

1. Uneasy Feeling
2. Nausea
3. Vomiting
4. Neck Pain/Tightness
5. Facial Pain/Dysesthesia
6. Scotoma (ventilating or other)
7. Field Cut
8. Paresis
9. Dysesthesia (face/arm/leg on one side)
10. Malaise
11. GI Distress (gas, diarrhea)
12. Chest Pain
13. Photophobia
14. Loss of Appetite
15. Increased Appetite
16. Chills
17. Decreased Level of Consciousness
18. Loss of Consciousness
19. Increased Irritability
20. Abdominal Pain
21. Other Visual Disturbance -- describe
22. Other -- describe

**D** Occurred Just Prior to Event (Seconds to Minutes)

1. Nausea
2. Vomiting
3. Neck Pain/Tightness
4. Facial Pain/Dysesthesia
5. Scotoma (ventilating or other)
6. Field Cut
7. Paresis
8. Dysesthesia (hemisensory)
9. GI Distress
10. Chest Pain
11. Abdominal Pain
12. Photophobia
13. Other Visual Disturbance -- describe
14. Chills
15. Decreased Level of Consciousness
16. Increased Irritability
17. Decreased Concentration Ability
18. Uneasy Feeling
19. Other -- describe
20. Headache Quality (Can be More Than One)
   1. Tightness around Head (hand-like)
   2. Aching
   3. Pulsating (pounding-throbbing)
21. Location of Headache(s) (Can be More Than One)
   1. Hemispherical
   2. Whole Head
   3. Migrating
   4. Facial Only
   5. No Headache Noted
   6. Occipital
   7. Neck
   8. Jaw
22. Headache Pain (At Its Worst)
   1. Incapacitating
   2. Not Incapacitating
   3. Able to Work through It
   4. Able to Work after Awhile
   5. Greater than 7 on a 1–10 scale
23. Duration of Headache (Total Headache)
   1. Less than 1 minute
   2. Less than 5 minutes
   3. Less than 15 minutes
   4. Less than 1 hour
   5. Less than 4 hours
   6. Less than 12 hours
   7. Less than 24 hours
   8. Greater than 24 hours
24. Accompanying Symptoms
   1. Neck Tightness
   2. Jaw Pain
   3. Nausea
   4. Vomiting
   5. Scotomas
   6. Field Cut
   7. Other Visual Disturbance -- describe
   8. GI Distress
   9. Photophobia
   10. Dysesthesia (hemi-touch)
   11. Confusion
   12. Irritability (increased)
   13. Decreased Level of Consciousness
   14. Chills
   15. Other -- describe
25. Accompanying Signs
   1. Rhinorrhea
   2. Conjunctival Injection
   3. Tearing
   4. Ptosis
   5. Dysarthria
   6. Aphasia
   7. Paresis
   8. Persistent Defect -- Stroke
   9. Cranial Nerve Deficit -- describe
   10. Other -- describe
I. **Family History**
   1. Positive for Migraines
   2. Positive for Headaches or Other Pain Conditions
   3. No History of Above

M. **Personal History**
   1. History of Motion Sickness
   2. History of Head Trauma
   3. History of Mitral Valve Prolapse
   4. History of Syncope
   5. History of Labile Hypertension

N. **Work-Up**
   1. Neurological Exam (If Abnormal, Describe)
   2. CT Scan (If Abnormal, Describe)

O. **Diagnosis**
   1. Vascular Headache — Common Migraine
   2. Vascular Headache — Classic Migraine
   3. Vascular Headache — Complicated Migraine
   4. Acephalic Migraine
   5. Cluster Headache
   6. Tension Headache

3. EEG (If Abnormal, Describe)
4. Echocardiogram (If Abnormal, Describe)
5. MRI Scan (If Abnormal, Describe)
6. Lumbar Puncture (If Abnormal, Describe)
7. Angiogram — Cerebral (If Abnormal, Describe)
8. Other Related Tests (If Abnormal, Describe)
Mishap Aftercare

by

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This paper is the result of a panel discussion which was held during the AGARD course on neuropsychiatry and aerospace medicine. Of primary concern after a mishap are physical and somatic matters which are covered well in other places. Secondly, however, evidence is mounting that emotional and psychological adjustments to a mishap can be very important to various categories of victims who may be involved in a mishap. Relatively simple and straightforward psychological mishap aftercare principles are available and have been tested in a variety of disaster scenarios. Victim identification and intervention strategies are key concepts in mishap psychological aftercare.

A first step in psychological aftercare is identification of victims affected by a mishap. There are the obvious victims who experience a mishap directly. For the purposes of this paper, these are the surviving aviators who were flying the mishap airplane. Naturally, there can be other passengers aboard airplanes and people on the ground who may be victims. Other less obvious victims, however, may be professional disaster workers such as body handlers, medical personnel, police and firemen whose jobs and occupational responsibilities bring them in contact with the mishap. Also, there are the family members of the aviators and victims and members of entire flying organizations such as squadrons and pilots based together who may become secondary victims as their friends die in or suffer through the mishap. Thus, victims can be categorized in the following ways: Primary victims are those who have received direct exposure and survived the mishap. Secondary victims are the family and friends of those involved in the mishap. Both supervisors and those who were killed. Tertiary victims are the rescue workers. The fourth level victim is the community from which the primary victims have come and also those supervisors, managers, and leaders who might be seen as responsible or might feel responsible for the mishap. The fifth level victim includes people who are emotionally unstable and may overdentify with the mishap and finally the sixth level victims are those who barely missed being primary victims.

Particular attention should be paid to the third level victim, the professional rescue worker, as they are often not considered victims and, no doubt, have many defenses against accepting help. Research suggests that 35% of rescue workers may be at high risk for any one particular mishap to stress the worker's ability to balance between the demands of their job and their ability to cope. Professional rescue workers are likely to have a great deal of experience with disaster and thus have built protection strategies against the negative impact of their work. However, they suffer a variety of unusual stresses to include body handling, exhaustive work schedules, and they often feel responsible for life and death decisions and outcomes even though there may be very little they can realistically do. A cumulative effect may partially explain why a rescue worker will go for years without a negative emotional reaction to a mishap and then on one particular mishap, have a stress reaction. Further, there may be something very specific about a trauma scene that is particularly gruesome or has a personal connection to the rescue worker that may bring about a reaction. Thus, as with other classes of victims, the aftercare plan should be offered using techniques of education and ventilation as noted below.

Providing services to these various classes of victims can be important to the future stability and productivity of the victim. Many victims will not experience significant emotional reactions in response to exposure to trauma or disaster scenes. Those victims who experience emotional reactions will present with fatigue, and sleep, appetite or gastrointestinal disturbances and increased alcohol use or abuse. Other signs of emotional reaction include social withdrawal, depression and emotional liability, memory and cognition difficulties, as well as intrusive thoughts. Thus, the goal of the evaluation and intervention associated with the stress of the mishap is to limit symptoms and return these individuals to normalcy as soon as possible by attending to these acute emotional reactions.

The specific interventions for victims after a mishap tend to be relatively simple but are also quite specific in terms of effectiveness. Individuals associated with a mishap are likely to need to express their feelings and observations. Many will fully respond to questions asked while others may deny problems or reject any form of help. On occasion, those who simply reject interest and concern or help are those who may later show significant emotional reactions. Much of the psychological intervention can be accomplished in a group setting so that one or two care providers can help a large number of victims simultaneously. It is best to keep different classes of victims separate, their needs will be different and, indeed, their training and experience with mishaps will be different.

The first level of intervention is education. It is important that victims understand that humans have natural emotional reactions to physically and emotionally traumatic experiences. Victims should know that the range of reactions includes the symptoms noted above of somatization, social withdrawal, mood depression, emotional liability, and disturbances of sleep, appetite, and digestion. They should further be warned about abusing drugs and alcohol use, memory and cognitive disturbance and the possibility of intrusive thoughts. In the second phase of intervention, victims are encouraged to ventilate or describe their experience. Depending on the reaction of a particular victim, some may actually relive the experience but most will describe what they saw, heard, and felt. This "telling the story" seems to be very important and only requires a listening ear and an occasional open-ended question that encourages the person to go on with their story. As noted
above, most victims will respond well to education and brief ventilation with no need for further care. Some, however, will obviously not be doing well and can be identified during the education and ventilation portions of the meeting. The third phase of intervention is applied to the few individuals who need further consultation. These individuals are approached separately and offered more specific care with scheduled follow-up. If these victims need individual care, specific referral can be made to a mental health care provider with phone follow-up at a set time to ensure that the person has been seen and that their needs are being cared for.

This model of intervention is relatively simple but it provides understanding to the victims that they may have a normal reaction which may be somatic, emotional, or both. Victims should be assured that if they experience this reaction, it will resolve with time and that specific help can be sought to help deal with these feelings. Further, ventilation seems to help relieve the emotional tension caused by the mishap and the idea of care and concern may be extremely efficacious in returning the victim to normal functioning rapidly.

Mishap aftercare for various levels of victims is relatively simple and cost effective. Where victims are given only physical examinations and treatment, some may experience long periods of dysfunction, distress, and low productivity may occur. Very few victims will experience crippling emotional reactions to mishaps but, as with other areas of aerospace medicine, preventing rare occurrences of severe problems with significant consequences is highly preferable to waiting for dysfunction to occur in an attempt to restore the individual to full capability. Mishap aftercare is an area where significant gains can be realized with a small expenditure of resources.
Medical or Administrative? Personality Disorders and Maladaptive Personality Traits in Aerospace Medical Practice

by

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Aeromedical/occupational decisions are hard enough to make when there is concrete evidence of disease, such as a malignancy or an abnormal coronary angiogram, and they are even more difficult when the evidence consists of abstract symptoms rather than physical signs, as in the case of most psychiatric disorders. Yet most aeromedical practitioners can diagnose severe depression, or a functional psychosis, of organic brain disease on the basis of the presentation of the patient in the examining room, recognizing the symptoms before they occur. But what do we do when confronted with a flyer whose off-duty interpersonal relationships are so strained that he (let us presume a male patient) is a constant source of irritation to those around him, one who is chronically involved in disputes or whose personality simply rubs other people the wrong way? What are the standards here? What degree of upsetting behavior should be tolerated before action is taken? How do we decide if this behavior represents a disease which requires treatment or if a willful activity which affects the need for some sort of administrative intervention? And, more directly to the point, can such people fly safely?

CASE REPORT

Mr. A, a 35-year-old flyer, was referred for outside psychiatric and psychological evaluation when his organization was unable to decide how to deal with his situation. Divorced because of his wife’s infidelity after a 5-year marriage, he established a 6-year live-in relationship with a young lady who worked with him. She had become depressed and hostile during the latter 3 years, and was smoking and drinking excessively. He suggested that they both enter counseling, and they did so for about 3 or more sessions. However, she then entered a romance with a man who worked in the same company with the two of them. This triangle led to a number of fights, some physical and the police arrested her for assault after one of them. Word of the situation got back to the company, and the other man and the young lady resigned after some uproar, including physical threats between all three parties involved.

Mr. A took a prolonged leave of absence from his flying job in order to settle the dispute, during which time he was seen by a local psychiatrist. His young lady joined him in this therapy, and they re-established their relationship. However, there were numerous arguments between the psychiatrist and the aeromedical examiner as to therapeutic goals and follow-up, and Mr. A was finally medically grounded with a diagnosis of an adult situational anxiety reaction with depressive and anxious features. The dispute between the local medical authorities led to a joint decision to seek outside aeromedical mediation.

At the time Mr. A was seen, he was free of psychiatric symptoms, was doing well in a non-flying career field, and was planning to marry his young lady. No overt psychopathology was noted during the psychiatric and psychological evaluations. The parallels between the circumstances involved in the breakup of his marriage and in his latter live-in relationship were noted. His personality style was described as one which might find irritating, from which one might assume that the psychiatric patient is irritated. He was bright and apparently functioned well under pressure, but his intense and dogmatic desire always to be in the right and in control, which served him well in an aviator, did little for his relationships with the women in his life. He also had personality conflicts within his organization. A clear indication that his behavior was not that of the usual aviator His attitude toward flying was that it was mostly boring, and he looked upon it mainly as a diversion from his usual activities. His on-the-job attitude of "supremacy" antagonized the other flyers, who were generally more enthusiastic and goal-oriented.

During his evaluation, he presented as direct and blunt, demonstrating some lack of social judgment by behaving antagonistically toward those who were evaluating him, even though he was seeking their approval to return to flying duties. His psychological testing showed him to be self-centered, manipulative, and one who demanded attention. He was over-sensitive to criticism and held rigidly to his ideas regardless of the other view. He was intelligent, compulsive, over-reactive and narcissistic. He enjoyed intricate abstract arguments and was hurl-spittingly irritatingly logical. He was quite aware of his petulance, and described it in rather prudish terms as a virtue. These traits had clearly not been serving him well, but had not yet been too severe. He was a flyer (often, however, these individuals are marginal performers in their work as well, but managers and supervisors may be reluctant to confront them directly unless their behavior deteriorates to a completely unacceptable level.)

The mental health consultants recommended that he be
medically cleared for flying duties, but they acknowledged that he would probably experience future interpersonal difficulties. Since these had never resulted in a compromise of aviation safety, nor placed him at aero-medical risk, he was returned to fly. The consultants specifically recommended to the company management that his supervisors judge his retention on the basis of his subsequent performance alone.

**DISCUSSION**

American psychiatrists and psychologists use the revised third edition of the diagnostic system published by the American Psychiatric Association, the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-III-R (Ref 1). In discussing the personality difficulties of aviators, let us presume no other category of psychopathology is present no organic disorders, schizophrenia, delusional or other psychotic disorders, disorders of mood or anxiety, somatoform or dissociative disorders. The behavior which will be described concerns personality problems, whether present in situ or as overt disorders.

**Personality** may be defined as the distinctive set of behavioral patterns and tendencies of a given individual, the characteristic way that the individual behaves in the environment. It results from genetic, biological and physiological constituents, along with the influence of the environment on the individual as registered, interpreted, stored and integrated by the central nervous system (Ref 2). Through this combination of nature and nurture, of heredity and environment, of experience and adaptation, an individual develops the enduring, consistent, and somewhat predictable attitudes, base beliefs, values, interpretations, and patterns of adaptation to life which, taken together, make each of us a unique human being. As we mature, we learn different ways to react to different situations. To some extent, these reactions are flexible and adaptive. If one response does not seem to satisfy our own and others' needs, we try another. If that response works, we remember it, and use it the next time a similar situation arises. We learn what is appropriate in various social contexts — with peers, subordinates or superiors, with men, women or children, with strangers, friends or rivals, in our own culture, other cultures or ambiguous situations, and so on.

One measure of the success of such a behavioral spectrum is pragmatic: does it work? Do or can we adapt to novel situations to our own satisfaction, and to the satisfaction of the others involved, by whatever standards we choose to judge such encounters? Obviously, the standards we choose derive from matters of opinion, moral judgement, ethics, politics, religion, and other abstract ideas which may be much debated. One key to a healthy personality, however, is *flexibility*, the ability of the individual to fit his behavior to various situations so that interpersonal relations run smoothly most of the time.

The failure of this behavioral spectrum is another matter altogether, and may be identified by the reaction of other people to the individual, who may see himself as having no problem at all, blaming the turmoil on everyone else and feeling persecuted by his involvement. Generally, the upsetting behavior fails into a pattern which can be identified, using a classification system such as the DSM-III-R. A major part of the problem is the lack of flexibility of the individual, who continues the upsetting behavior but fails to get his needs met. At least part of the problem is that this . . . the only way he knows how to behave. Such behavior is his nature. It is a natural part of him, so basic that he may never question its lack of effectiveness, regardless of how much he upsets others or gets into trouble because of it. Surprisingly, these difficulties seem to meet just enough of the individual's basic emotional needs that the process of change may be seen as more distressing than the repeated negative outcomes of such behavior. Thus, non-professional counseling on the need to change is either rejected outright, or is given just enough lip service to mollify the counselor for the time being.

Such problems usually arrive in the aeronautical examiner's office amid a flurry of telephone calls and paperwork. Everything seems unusually complicated. Stories are told of upsetting incidents sometimes precipitated with "Don't quote me," or "I don't want to get him in trouble, but." The aviator may lack judgment and insight into the situation, not seeing what the problem is, citing personality conflicts or other perceived failings of those around him: Lawsuits, formal complaints, union grievances, or other appeals to authority are mentioned, all aimed at getting other people to change. And above it all, two questions: First, is this flyer safe to fly? Second, is this flyer ill in some way, and therefore in need of treatment, or may he be regarded as a misfit, an eccentric, or some other, ruder lay word implying a variant of normal, deserving disciplinary action, reprisal, or other administrative retribution? In other words, is this problem medical or administrative? As with most aeronautical questions, there are also matters of degree to consider. The problem may be mild, or manifest only under certain occasional conditions of stress. These behaviors we define as *personality traits*, pervasive patterns of feeling, thinking and behaving which may be appropriate (i.e., not distorting to self or others) under most conditions. To quote DSM-III-R, "It is only when personality traits are inflexible and maladaptive, and cause either significant functional impairment or subjective distress that they constitute *personality disorders*." (Ref 1) These disorders thus interfere with normal social functioning, and certainly may interfere with the interpersonal aspects of normal cockpit functioning. They are lifelong, one can recognize them (usually in retrospect) in adolescence, and they continue to affect people's behavior, although this effect may tend to diminish somewhat in the fifth or sixth decades. Although their exact classification has been the subject of much debate among psychiatrists (Ref 3), and will undoubtedly change somewhat in future editions of DSM-III-R, the present nosology is useful in categorizing problems which may be seen in fliers, and we will consider four such disorders in detail. The description of some of these disorders will probably recall someone you have known, either professionally or socially. Some of these characteristics apply to many of us at times, but not to the exclusion of other ways of dealing with life, and not so strongly that they keep us in friction when we desire harmony. All of the descriptions below have been derived from the DSM-III-R diagnostic criteria, to which the reader is referred for a more complete definition of the condition in question (Ref 1).

**Paranoid personality disorder** The essence of this condition is "a pervasive and unwarranted tendency, beginning by early adulthood and present in a variety of contexts, to interpret the actions of people as deliberately demeaning or threatening." These people question the motives of others, are jealous, expect the worst, read hidden meanings into innocent remarks or situations, are easily insulted and quick.
to anger. They are unforgiving grudge-bearers, avoid blame even when deserved, and are seen as secretive, guarded, and humorless. Quick to criticize others, they react to criticism with angry counterattacks. They are rigid, hostile, stubborn, and usually friendless. They see no fault in themselves, and cannot "take a joke." They elicit anger from others with surprising speed. Every official office in the world has received inappropriately large mail from such individuals. Under extreme stress, these people may undergo brief psychotic episodes, not of sufficient duration to warrant a more serious diagnosis.

The diagnosis is indicated by at least four of the following:

1. Expect demands, without sufficient basis, to be explotted or harmed by others
2. Questions, without justification, the loyalty or trustworthiness of friends or associates
3. Read hidden demeaning or threatening meanings into benign remarks or events, e.g., suspect that a neighbor put out trash early to annoy him
4. Bear grudges or are unforgiving of insults or slight
5. Is reluctant to confide in others because of unwarranted fear that the information may be used against him
6. Is easily startled and quick to react with anger or to counterattack
7. Questions, without justification, fidelity of spouse or sexual partner

Here you may see the difficulties in medical judgement—how does one know whether the aviator'ssequel of an unfaithful spouse are justified? What degree of quickness to anger is pathological? How much can you attempt to investigate the situation before you, too, are seen as a threat and reacted to with anger? How much of this behavior can be tolerated in the cockpit of a commercial air transport?

The level of judgment required in such instances emphasizes the need for the mental health consultants involved to be familiar with the particular requirements of aviation, especially commercial aviation.

Antisocial personality disorder is characterized by irresponsible and antisocial behavior from late childhood on through adolescence and into adulthood. They can be charming figures at times, and have the classic "con man" personality. If they are intelligent, they may be very successful, though utterly amoral and without scruples or conscience. They have no remorse about the effects their behaviors have on others, and may even feel justified. After age thirty the more moral behavior may diminish, especially the promiscuity, fighting, and criminal behavior. One may see signs of personal distress sometimes to the point of diagnosable depression, but there still may be an inability to sustain close, warm, caring relationships with anyone. Those who do achieve some success usually do not have the full clinical picture. There is some familial predisposition to this disorder.

The diagnosis requires three or more of the following behaviors before age 15

1. Felt often truant
2. Ran away from home overnight at least twice
3. Often intemperate physical fights
4. Used a weapon in more than one fight
5. Forced someone into sexual activity

(6) was physically cruel to animals
(7) was physically cruel to other people
(8) deliberately destroyed others' property
(9) deliberately engaged in fire-setting
(10) often lied (other than to avoid physical or sexual abuse)
(11) has stolen without confrontation (fraud, forgery)
(12) has stolen with confrontation (mugging, purse-snatching)

The diagnosis further requires at least four of the following since age 15

1. Unable to sustain consistent work behavior
2. Fails to conform to social norms by repeated antisocial or illegal acts
3. Is irritable and aggressive (repeated physical fights or assaults on spouse, child, or others)
4. Repeatedly fails to honor financial obligations
5. Fails to plan ahead, or is impulsive; travels without a job or a clear goal or a clear date of termination, lacks a fixed address for over a month
6. Has no regard for the truth—lies, uses aliases, cheats
7. Is reckless regarding safety of self or others
8. Not a responsible parent—neglects or abuses child
9. Has never sustained a monogamous relationship more than one year
10. Lacks remorse (feels justified in having hurt, mistreated or stolen from another)

Passive-aggressive personality disorder represents a lack of adaptation to usual occupational and social roles. Anger and resentment are expressed indirectly in ways which they may then disavow or deny blaming others, or circumstance, or other matters "obviously" beyond their ability to control. They will be late for their appointment with you, and have a very poor excuse.

This diagnosis is indicated by at least five of the following:

1. Procrastinates, puts things off, misses deadlines
2. Becomes sulky, irritable or argumentative when asked to do something he or she does not wish to do
3. Seems to work deliberately slowly, or to do a bad job, on tasks that he or she does not wish to do
4. Protests, without justification, that others make unreasonable demands
5. Avoids obligations by claiming to have "forgotten"
6. Believes that he or she is doing a much better job than others think
7. Receives useful suggestions about improved productivity
8. Obstructs efforts of others by failing to do own share of the work
9. Unreasonably criticizes or scorns people in authority

Obsessive-compulsive personality disorder represents a pervasive pattern of perfectionism and inflexibility, beginning by early adulthood and present in a variety of contexts. Striving for perfection, they set strict and unattainable standards; defy common sense. Things are never good enough. They are preoccupied with trivial details to the exclusion of the big picture. They allocate time poorly, resist authority from superiors, and misuse it upon subordinates. Decisions are postponed because of the fear of mistakes, and there is never enough information anyway. Form is more important than substance. They are stiff, formal, hide feelings, are stingy, and rarely compliment, since things are never quite perfect enough. They have a strong need to control, and may be depressed.
This disorder is indicated by at least five of the following:

1. Preoccupation with details, rules, laws, or order; organization, or schedules to the extent that the major point of the activity is lost
2. Unreasonable insistence on others to submit to exactly his or her way of doing things, OR unreasonable reluctance to allow others to do things because of the consequence that they will not do them correctly (can't delegate)
3. Excessive devotion to work and productivity to the exclusion of leisure activity or friendship (not economically necessary)
4. Indecisive avoids, prolongs, or postpones decisions, e.g., does not do task because of rumination about priorities
5. Overly conscientious, scrupulous, or inflexible about matters of morality, ethics, or values, beyond usual cultural or religious identification
6. Restricted expression of affection
7. Lack of generosity in altruistic giving of time, money or gifts
8. Will not discard worn-out or worthless objects with no sentimental value
9. Empathy

These full-scale personality disorders represent some of the more common seen, but less full-blown, patterns of personality inferences among fliers. Other personality disorders include dependent, histrionic, narcissistic, paranoid, borderline, masochistic and avoidant.

Decisions about such disorders are difficult. The diagnoses themselves are not easily made, since the consultant may see only brief bits of the problem when the aviator is on his best behavior. Meaningful information may be available only from sources who may be unwilling to commit themselves because of possible legal, administrative, or personal repercussions. Such diagnostic evidence is only secondhand at best, and may be colored by other issues. When it is one person's word against another's, the issue is often uncertain, and mental health consultants are not judges or detectives. Still, the diagnoses may be made with accurate information and skillful appraisal of the individual in the office setting, especially if, in addition to psychiatric consultation, psychological tests of personality structure are obtained. Although not infallible, these may suggest or reinforce the diagnosis. Obtaining such testing allows two independent consultants, the psychiatrist and the clinical psychologist, to work within their own areas of expertise toward a diagnostic formulation in these difficult situations. The consultations are of especial value if aviation-oriented mental health consultants work directly with the aero-medical examiner to give realistic and practical recommendations to the necessary agency.

Once a diagnosis of personality disorder is made, the consultant(s) and the aero-medical examiner must then decide what to do. If the diagnosis is disqualifying for flying duties, the aviator will likely be unhappy, if not openly antagonistic. This is especially true if the grounding is administrative, and therefore not compensable. Treatment of these conditions is very difficult, since the problem involves the very essence of the aviator's personality, the way he reacts to those around him. There are no short-cuts here, no trendy books or three-week therapies. However,

- if the disorder is mild, and
- if he has access to a knowledgeable psychiatrist or psychologist who is willing and able to undertake a lengthy therapeutic endeavor aimed at helping the aviator understand how he came to be the way he is, and to make life-changing decisions about the way he perceives and reacts to the people around him,

then there is some chance for change.

Usually one or more of these conditions is not met, however, and it then remains for the consultant to articulate the problem clearly, and for the appropriate medical and administrative bodies concerned to decide whether the aviator can continue to fly, or, if not, whether the disorder should be compensable. Most flying organizations with which the authors are familiar have established these disorders as not medically disqualifying, and thus not compensable. These troublesome fliers then become the primary responsibility of their supervisors, and are subject to the organization's administrative regulations for job performance. Mental health consultants can be used to support management and supervisory handling of such cases, but often cannot provide the ultimate "fix" of medical grounding.

In the last analysis, the aero-medical disposition depends on the regulations under which you work, and the diagnostic categories which you use. In the United States, there are five sets of regulations which apply: Federal Aviation Agency (FAA), National Aeronautics and Space Agency (NASA), Army, Navy, and Air Force. In each of these, personality disorders may be considered disqualifying for initial selection. The armed forces thereafter consider the individual's behavior to be under his or her control, and therefore handle such problems administratively. Other agencies must decide on the criteria outlined above, usually on a case-by-case basis, and decide each on its merits. These cases are frequently disruptive and are never easy to deal with. Nevertheless, with informed consultants who understand the unique demands of aviation and informed aero-medical examiners who understand at least the general nature of personality disorders, fair and intelligent decisions may be made.

REFERENCES

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