Psychiatria Danubina, 2023; Vol. 35, Suppl. 2, pp 419-420
Conference paper
Case report

DENIAL AND DELUSIONS OF AN AIRCRAFT PILOT WITH ALCOHOL DEPENDENCE: A CASE REPORT

Ibrahim Khayar[1], Ana Sofia Ramos Dos Santos Serafim[2], Noémie Piccirelli[3], Gaspard Henri[2], Jacqueline Petit[2], Philippe de Timary[1], Peter Stärkel[2] & Nausica Germeau[1]

[1]Department of Adult Psychiatry, Université Catholique de Louvain, Cliniques Universitaires Saint-Luc, Brussels, Belgium

[2]Department of Hepato-gastro-enterology, Université Catholique de Louvain, Cliniques Universitaires Saint-Luc, Brussels, Belgium

[3]Faculty of Psychological Sciences, Université Libre de Bruxelles, Brussels, Belgium

* * * * *

INTRODUCTION

This case report describes the care of an aircraft pilot suffering from Alcohol-use-disorder and the difficulties encountered by our team whilst caring for him, both on a legal and a psychiatric level.

We used a multidisciplinary approach to process our interactions with the patient, which the writing of this article reflects.

CASE REPORT

Our patient, a 40-year-old male, made an appointment to our unit, specialized in the treatment of Alcohol-use-disorder. It was his first attempt to seek regarding his own alcohol abuse. As an aircraft pilot, he was experiencing problems at work with one colleague refusing to fly with him. The patient was asked to confirm whether he wanted to be admitted or not, with the aim of reinforcing own agency. The patient confirmed a week later.

Upon arrival on admission day, his blood alcohol concentration was measured at 2.4 g/L although he claimed that he took his last drink the day before. He experienced moderate withdrawal syndrome, with a Cushman score at 12, 48 hours after his admission, despite receiving proper medication. Both symptoms and alcohol level were not compatible with the patient's perception of a consumption of 3 to 4 units per day. However, when confronted, the patient denied consuming more alcohol than previously stated. The patient relapsed twice during that first week, the fourth day unbeknownst to us and then massively on the seventh day, the eve of his return home for his "intermediary week" (de Timary 2016).

We decided to terminate his hospitalization. We thought that our "open-door" policy did not meet the patient's needs and that a more closed psychiatric environment would be more fit to provide him appropriate care. Our three-week long program seemed too short considering the patient's denial. We also asked him to take a step back from work. The patient intended to fly for several thousand kilometers the next day against our advice to stay home. The patient was adamant about flying and none of the symptoms he experienced was sufficient to convince him to accept our sick leaf certificate.

He left with the certificate but stating clearly that he would not send it to his employer. However, he insisted on continuing the program despite our statement of termination. We informed him that we would reach out later that week to discuss and facilitate further care. The patient's denial rendered him completely inaccessible to reasoning regarding his sick leaf. We also informed him that we would have to act accordingly.

After the patient left, we decided to reach out to our ethics committee. It issued the opinion that a partial lifting of professional secrecy was allowed to protect the greater good that was the saving of human lives put in danger by our patient's decision to fly. The patient's employer being unreachable, we reached out to the deputy public prosecutor who dispatched a police patrol to the patient's home. With the forced assistance of the police, the patient sent his certificate.

The patient called the unit several times that night. He was calm and expressed that the police was "well-behaved". Furthermore, he did not demonstrate any anger towards the unit regarding our decision. During the whole week, he repeatedly asked to be readmitted. We stood firm on our decision to reach out to him after our team's meeting. The patient continued nonetheless to state his wish to come back as if what we were saying was not hearable. We decided that two doctors would evaluate him to determine whether he could be readmitted. He was readmitted for a full three-week program on the condition that he would get treatment in a long-term facility afterwards, a wish he expressed several times.

However, the patient rescinded that wish during his hospitalization. He became hostile and convinced that we were actively working against him, to the point of being delusional. The patient's denial made him refuse acknowledging any kind of psychological weakness on his part, even when he was asked about the shaking of

his arms. That symptom persisted long after the withdrawal period and a full neurological exam made it unattributable to any somatic cause. His delusions manifested themselves when the patient accused his psychiatry doctor of making up the wish he had expressed to be hospitalized in a long-term facility, despite another doctor being present then. The patient then proceeded to chase said intern in the corridor, repeatedly asking for results about his physical health given to him several times before. As his gastro-enterology doctor stated, words spoken to the patient about his physical health were not void of meaning to him (who understood them perfectly well) but void of personal or subjective signification.

DISCUSSION

This constant inquiry about his health makes more sense to us if we see it as a Freudian "displacement": "the fact that an idea's emphasis, interest or intensity is liable to be detached from it and to pass on to other ideas, which were originally of little intensity, but which are related to the first idea by a chain of associations." (Laplanche & Pontalis 1973). We underestimated the vital nature of his denial. It protected a fragile ego, which was threatened by our words (and actions), of worry about him (unbearable to him was the word "fragile" when used to describe him). A displacement was taking place from the real problems his alcohol consumption caused, to a delusional interest regarding his physical health that was inaccessible to reason. The paranoid character of his delusions should also be, in our opinion, understood not as the manifestation of an undiagnosed psychotic disorder but instead as a defense mechanism (Freud 1968). The trauma inflicted by our confronting decision to involve the law might have triggered said defenses.

CONCLUSIONS

At no point did the patient express the wish to go home. He left the unit at the end of the program for his home. We informed his GP, whom he trusted, of the developments of the case, and he agreed to follow up the treatment with him.

Acknowledgements: *None.*

Conflict of interest: *None to declare.*

Contribution of individual authors:

Khayar I: manuscript writing, case interpretation and literature searches.

Ramos Dos Santos Serafim AS, Piccirelli N, Henri G, Petit J, de Timary Ph, Starkel P and Germeau N: manuscript revising, case interpretation, literature searches.

References

1. *de Timary P: L'alcoolisme est-il une fatalité: Comprendre et inverser une spirale infernale. Mardaga, Bruxelles, 2016*
2. *Freud S: The neuro-psychoses of defence. In Strachey J (Ed.): The Standard Edition of the Complete Psychological Works of Sigmund Freud, volume III, 45-61. Hogarth Press, London, 1968*
3. *Laplanche J & Pontalis JB: The language of psychoanalysis, Karnac Books, London, 1988*

Correspondence:
Khayar Ibrahim, MD
Department of Adult Psychiatry, Université Catholique de Louvain, Cliniques Universitaires Saint-Luc
Avenue Hippocrate 10, 1200 Woluwée-St-Lambert, Brussels, Belgium
E-mail: ibrahim.khayar@student.uclouvain.be