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### Health issues in international tourism

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### 13 **Health Issues in International Tourism: The Role of Health Behavior, Stress and Adaptation**

Ad Vingerhoets, Nanda Sanders, Wendela Kuper

#### **Introduction**

In the last decades, people from western countries go increasingly and more often abroad, visit exotic places, and come into contact with different cultures (cf. Cossar & Reid, 1989). For example, according to recent figures from the Dutch Tourism Office and the Dutch Central Statistical Office, approximately 78% of the Dutch population spend their annual vacation away from home and 56% go abroad (NBT/CBS, 1996). The increase in the number of international tourists is paralleled by an increased number of contacts with emergency centers, which are encumbered by travellers with serious mental or physical health problems, who in some cases need to be repatriated. This number probably only reflects the top of the iceberg where tourists' health problems are concerned, since the more frequent but less dramatic forms of somatic and psychic health problems associated with travelling/ being abroad will not be reported and can only be investigated in specific studies (e.g., Cossar et al., 1990; Page, Clift, & Clark, 1994).

The aims of the present contribution are twofold. Firstly, we want to give a brief review of the minor and major health problems that typically face the international traveller. We will also identify and briefly discuss the health risks and the adverse health practices of international tourists. Secondly, we will argue that tourists may be at greater risk because their resistance may be lowered due to exposure to typical holiday stressors and because of the physiological challenge of adaptation to the new holiday environment. There is little doubt that many of the associated health problems can in principle be prevented, since most problems are caused by taking inadequate health precautions. We agree with authors like Cossar (1996) and Page et al. (1994) when they say that the time is ripe for more specific scientific investigation into the issue of international travelling and the related health aspects. The above mentioned increase in the numbers of international tourists and business travellers has not been paralleled by an equal interest on the part of investigators into the inherent health issues. Our aim is to provide a health psychological basis for health promotion campaigns for the international tourist aimed at reducing the number of incidents. Our discussion will focus mainly on the health psychological aspects instead of on merely medical or epidemiological points of view, like, for example, in the studies of Cossar and Reid (1989) and

Pasini (1989). For a more extensive discussion of the psychiatric aspects of travelling, the reader is referred to the chapter by Monden in this volume.

### **The health risks of international travellers**

The traveller seems to be vulnerable to health hazards on account of the very nature of the travel itself and because of being in a new environment (Cossar, 1996). Travelling implies being exposed to new cultures and new experiences. We assume that the traveller's ability to cope with such changes depends on his (pre-)existing mental and physical state of health, a factor which in turn is, at least partly, influenced by demographic variables, personality factors and health behavior.

The health risks of the international tourist are manifold and diverse. Travelling may be associated with sustaining possibly serious injuries due to traffic accidents, or with putting up with minor but rather annoying health problems like travel sickness and jet lag. Abundant use of alcoholic beverages and recreational drugs are not uncommon. Sun tanning may be excessive. Sleep patterns may be disturbed and practising unprotected sex has its inherent health risks. There might be further exposure to unfamiliar pathogens, which may form a serious threat to one's health status, because of the lack of natural resistance we have to such micro-organisms. We shall discuss below these problems in more detail devoting attention to the stressors associated with travelling and vacations. Finally, a discussion of some aspects of modern stress theories will be presented, which we feel are relevant to the holiday situation.

#### *The journey*

Whereas public transport and air travel may be generally thought of as safe modes of transport, travelling by car seems to carry more risks. Drivers often fail to rest sufficiently before and during the long journeys to their holiday destinations, which may sometimes result in a dangerous combination of sleepiness, inclement weather and hectic or unknown traffic situations. It has been established that the efficiency of car driving is affected by ambient temperature. Both cold ( $< 50^{\circ}$  F) and hot ( $> 90^{\circ}$  F) temperatures may negatively affect driving performance because grip strength is reduced and muscle dexterity impaired. In addition, there is diminished and less sensitive tactile discrimination and poorer vigilance and tracking performance. It is common practice for youngsters to buy themselves (very) cheap but unsafe 'holiday' cars. Unanticipated traffic jams, the behavior of impatient and bored fellow travellers or the aggression of fellow road users may turn the journey into a rather stressful experience. This is not to speak of the possible accidents, break downs, or travel-sickness among journey fellow travellers, all of which may make heavy demands on one's adaptational resources. Finally, there is some evidence that

carbon monoxide and oxidants in the blood of drivers may negatively affect mental responsiveness. For a review of these factors, the reader is referred to Bell, Fisher, Baum, and Greene (1996).

Although airtravel may be considered a safe way of transport, it does not preclude the occurrence of health problems. A common cold may turn a potentially pleasant flight into a very painful and stressful event. Unstable atmospheric conditions may facilitate the development of travel-sickness, characterized by nausea and vomiting. These health problems are generally not too serious and as far as is known hardly any research has so far focussed on these aspects of travelling (see for further information on motion sickness Bick, 1983; Dobie & May, 1995; and Reason & Brand, 1975). By contrast, more is known about jet lag, which results from the rapid crossing of time zones. The recent (relevant) literature is summarized below.

#### *Crossing time zones*

In former times one used to travel by boat or by train and the transition to another time zone went gradually. Nowadays, aeroplanes travel fast and cross time zones forcing travellers to adapt to new times. Jet lag or 'time zone fatigue' can be regarded as an entirely self-inflicted condition resulting from transmeridian air travel. It is often accompanied by several subjective symptoms, including difficulties with concentration, fatigue, disorientation, loss of appetite, gastrointestinal disturbances, and lightheadedness.

Air travellers also frequently report experiencing delayed sleep phase syndrome after flying eastwards and transient advanced sleep phase syndrome after flying westwards (Lewy, Ahmed, & Sack, 1996). There are important individual differences in the type and severity of the symptoms that one experiences. It is not yet clear whether repeated time zone transitions always induce the same symptoms within an individual. On the other hand, it has been established that the severity of the symptoms increases with the number of time zones crossed. When crossing more than six time zones it will take four to eight days to adapt to the new time zone situation. Flying eastwards demands longer periods of readjustment and is more tiresome than flying westwards. These eastward bound travellers have great difficulty falling asleep before 1.00 a.m.. Data gathered from experiments with shift-work schedules further suggest that extroverts adapt faster than introverts. The so-called 'evening types' may also be expected to cope better with time shifts than the 'morning types.' Finally, older travellers suffer more from these symptoms.

In the adaptation phase many biological rhythms have to be readjusted some of which will adapt at a slower rate than others. Body temperature, for example, takes more time to adjust to a new time zone than do some hormonal rhythms. During this adaptation phase the human body is more vulnerable to infectious agents. Reviews on this subject have been written by McFarland (1975), Redfern (1989), and Redfern, Minors and Waterhouse (1994).

*Alcohol consumption*

The adverse effects of alcohol abuse are well-known and include impairment of cognitive, perceptual and motor functions for several hours. Long-term heavy drinking is associated with serious health problems like cirrhosis, some forms of cancer, hypertension and heart and brain damage. During their holidays many people consume more alcohol than they normally would, which can lead to recklessness and all kinds of careless behavior, which considerably increases the risk of becoming involved in accidents or conflicts (Sanders, Kuper & Vingerhoets, 1996). In addition, alcohol can have adverse effects on several travel-related complications, including motion sickness, heat exhaustion, and jet lag (cf. Lange & McCune, 1989). Even relatively small increases can contribute to acute ventricular fibrillation, also known as the 'holiday heart syndrome' (Baars & Tjia, 1990). The symptoms of the holiday heart syndrome-patient include palpitation of the heart, shortness of breath, atypical pain on the chest, dizziness and fainting.

*Excessive exposure to the sun*

Excessive exposure to sunlight predisposes people to premature skin ageing, skin cancer and to cataract development (Cossar, 1996). The power of the sunlight can be amplified by the effects of water, snow, sand, altitude and latitude. Tanning is considered an enjoyable pastime related to leisure time activity; it is often associated with increased feelings of health and well-being, as well as with high self-esteem, fashion and sexuality (Weston, 1996). From 11 a.m. till 3 p.m. direct exposure to the sun should be avoided. During this period the sun is nearest to the earth and ultra violet light is at its most damaging state. Protective clothing, gradual exposure to sunlight and using appropriate sunscreens are all good protective measures against sunburn and skin cancer.

*Exposure to unfamiliar pathogens*

Animals (humans included) living in a stable environment are able to react relatively rapidly to the continuously changing threat of parasites. However, travelling involves being exposed to new and unfamiliar micro-organisms, which can seriously threaten one's health. How dramatic these effects may be is best illustrated by reports on the effects of native Americans' exposure to viruses from the Old World, such as smallpox, measles, and influenza. It has been found that native American civilizations were primarily struck down by newly introduced diseases of this kind. It is estimated that no less than 90 to 95% of the total indigenous American population was killed as a consequence of lack of immunological protection against these pathogens. In addition, statistics on British military personnel show a mortality rate of 11.5 per 1,000 among males living in England between 1817 and 1936, whereas the corresponding figure for the English troops stationed in the African Gold Coast was 668 per 1,000. More recent data collected from a retrospective study carried out among 1427 Scottish

missionaries who worked abroad between 1873 and 1929 showed that 25% had to return prematurely because of personal or family ill health and a further 11% died in service. Significant differences were found in the numbers affected by adverse health, depending on the period of time, the specific area, and the personal level of medical knowledge (Cossar, 1987).

Nowadays, we do not simply depend on our inherited immunological resources. We are able to artificially decrease susceptibility to disease by having vaccinations and taking other medication. It is thus desirable to prepare oneself adequately when one travels to regions with specific pathogens.

### **Hygiene and protection against pathogens**

Most complaints of international tourists are related to alimentary issues (diarrhoea and/or vomiting). Cartwright (1992) analysed data on self-reported health problems gathered from as many as 2,756,321 questionnaires, completed during summer seasons from 1984 to 1991. The symptoms of diarrhoea often commence during the first few days after arrival in a high risk area. During the first week the traveller seems to be at highest risk of developing diarrhoea. Similar variations between countries were observed over the years. Low incidence rates of such alimentary problems were experienced from Italy and Florida (< 5%), whereas Turkey, Tunisia, and the Dominican Republic had rates of respectively 23%, 34% and 40%. What was also remarkable was the decrease in the peak incidence between the years 1984 and 1986 (15%) dropping to 6% in 1989. It is not entirely clear what mechanisms accounted for this remarkable reduction.

Traveller's diarrhoea is essentially a condition that can be prevented, for instance by keeping high standards of health behavior, in particular, those aspects which are concerned with the safe provision of water supplies, food and sewage disposal systems (Cartwright, 1996). The traveller is exposed to more risks when he travels to less developed countries, but many safety measures can be taken to prevent diarrhoea by, for example washing one's hands after going to the toilet and before handling any food. Food that might possibly be contaminated has to be avoided. One can conclude that the traveller has a great personal responsibility to maintain high levels of hygiene. The highest frequencies of such health problems were reported by the younger age group (20 - 29 years, 48%) in a study by Cossar et al. (1990) with the lowest rates being among those aged 60 and older (20%). Smokers reported more symptoms episodes than non-smokers, but no sex differences were reported.

Other examples of preventable disease conditions associated with travelling are malaria and hepatitis. Malarial parasites are injected into the human bloodstream when a person is bitten by an infected mosquito. The infection produces subsequent attacks of fever varying in severity and frequency. The

number of people suffering from malaria is increasing. The solutions proposed in the last century have included using pesticides like DDT, and providing medical treatment with anti-malaria drugs (Rudkin & Hall, 1996). The malarial parasites have not been destroyed by the widespread use of chemical pesticides. Instead they have now developed high genetic resistance to these insecticides. The use of such insecticides has also had negative side effects on other insects. Malarial parasites have also become resistant to anti-malarial prophylaxis. The traveller should take precautions to minimize mosquito bites, because no current antimalarial measures can guarantee absolute protection (Cossar, 1996). Possible preventive measures include taking preventive medication, covering skin with clothing and using mosquito nets over the bed. A final remark concerns the recent observation that antimalaria medication may increase the risk of mental health problems in tourists.

Hepatitis is a viral disease in which the liver becomes inflamed and unable to function properly. The symptoms are like persistent flu and a yellowing of the skin takes place. There are two types of hepatitis: Hepatitis A, which appears to be transmitted when food, water and utensils are contaminated and Hepatitis B which is transmitted by the transfusion of infected blood and by the sharing of contaminated needles by drug addicts. The traveller is more at risk of developing hepatitis A, infectious hepatitis. A possible preventive measure is vaccination before the onset of the journey. Again, it can be said that one should be careful with contaminated food and water.

Sexually transmitted diseases (STD) form another category of preventable diseases sometimes associated with holiday making. Lately there has been an increased interest in the sexual behavior of holidaymakers and expatriates based on concerns related to the HIV/AIDS pandemic (De Graaf, Van Zessen, & Houweling, 1996; Gillies & Slack, 1996). AIDS is an infectious disease caused by the human immunodeficiency virus (HIV) and it is spread through shared contact with blood and semen. This viral agent attacks the immune system, most notably the helper T-cells. AIDS is an epidemic, its annual mortality rate is alarming. Many millions of people around the world are already infected with the HIV virus and a great majority of these people will eventually die as a result of AIDS (Osborn, 1988). There is the fear in regions of relatively low incidence of HIV/AIDS that travelling to areas of higher incidence may have a substantial impact on the spread of the disease. In the United Kingdom approximately 75% of the heterosexual AIDS/HIV patients have acquired the disease abroad. Although these figures are extremely high for blacks and Asian/oriental males (> 97%), the figures are also impressive for white males (66.8%), while only 26.8% of the white female patients had been exposed to the virus abroad. Studies in the United Kingdom have revealed that the following factors are associated with sexual risk behavior while abroad: travelling without a sexual partner, being male, of the younger age group, increased alcohol consumption and recreational drug use, travelling abroad for longer periods, and having a sexually active

lifestyle (Clift, 1996). The spread of STD has thus become associated with travel and tourism. Travelling induces a feeling of freedom and this results in less responsible behavior among tourists (cf. Eiser & Ford, 1995). Especially where alcohol is involved, people seem to forget the risks of HIV/AIDS.

A number of countries, especially in South-East Asia, are well-known for their sex tourism. It is not exactly known why so many sex tourists travel to these countries, but one can think of reasons like the sexual novelty and being away from the social constrictions of home. The prevalence of HIV/AIDS is very high among prostitutes in these regions because they lack knowledge on preventive measures for STD. Having unprotected sexual intercourse with these prostitutes is highly risking. Although sex tourism is a significant source of foreign currency income for many of these countries, the severity of the increasing health problems, especially where AIDS is concerned, has forced governments to take action. In Thailand, for example, large scale health education programmes have been set up for prostitutes in order to promote the use of condoms. Up until now, little can be said about the effectiveness of the campaigns.

To summarize, there is ample evidence that for a subgroup of holidaymakers there is a significantly increased tendency to engage in unsafe sex (cf. Gillies & Slack, 1996; Eiser & Ford, 1995). Later on we will argue that the risk of disease might be even greater during holiday periods than in the home situation if the immune system has been weakened by an unhealthy lifestyle and the possible stress of adaptation to the holiday situation.

#### *Climatic and atmospheric conditions*

Although it is somewhat beyond the scope of this chapter, we nevertheless want to mention briefly the possible effects of (excessive) heat and cold on the human body. Among the most important effects are heat exhaustion, heat stroke, heat asthenia, and myocardial infarction, resulting from excessive demands made by the body's cooling mechanism on the cardiovascular system. Exposure to extreme cold can lead to conditions such as frostbite and hypothermia. Additional health risks are associated with stays in high-altitude areas and activities like diving under high air-pressure conditions. Alcohol and drugs may significantly interact with these conditions to result in clinically significant health problems (Lange & McCune, 1989).

#### *Acute and serious health conditions*

The health problems listed above - except for AIDS - mainly concern acute and less serious threats to one's health or else the possible negative health effects may manifest themselves in the long run. However, data from Dutch emergency centers indicates that tourists also contract more serious diseases. Heart diseases, fractures and concussion are among the most frequently mentioned reasons for contacting the emergency services. Within this category, myocardial



infarction is the foremost diagnosis and reason for repatriation. Myocardial infarction is caused by atherosclerosis, narrowing of the arterial walls due to plaque formation that reduces the flow of blood through the arteries and interferes with the passage of nutrients from capillaries to the cells. The temporary deprivation of oxygen supply and nutrients causes chest pain or angina pectoris. The occurrence of an infarction can best be seen as an interplay between biological, psychological and social factors (Vingerhoets & Rigter, 1994). Myocardial infarction is a condition that results from months or years of narrowing of the arteries. However, what is more important in the context of this contribution is the fact that recent publications show that certain acute factors may also play a role in triggering these cardiac events. These acute factors not only include physical environmental factors, but also psychosocial triggers (Mittleman et al., 1995).

In collaboration with emergency centers we are currently comparing the psychosocial profiles of patients who develop the first symptoms of myocardial infarction when on holiday and those of cardiac patients who manifest their first symptoms in the normal home situation. In addition to personality aspects and vital exhaustion, the focus is also on lifestyle variables, vacation motives, and on preparing for the trip. In this way, we hope to find out whether a holiday trip can trigger myocardial infarction.

### **Psychosocial factors and vulnerability to disease**

We have summarized above the potential health threats when one is on holiday. These health threats are partly connected to the new environment (e.g., to new pathogens) and partly to 'typical' vacation behavior (alcohol abuse, sexual promiscuity) and to the typical holiday stressors. In the remainder of this chapter we want to argue that the transition to a new environment may have additional negative effects on a person's natural resistance to disease. It may thus be speculated that an individual engaging in drinking and promiscuous sex in the familiar home environment may be less at risk health-wise than when on holiday. Our arguments are mainly based on current evidence on the effects of life changes and other health status psychosocial factors. In addition, attention will be devoted to topics like daily stressors, but also to the further social demands and to unmet expectations.

#### *Why people go on holiday*

People might differ quite a lot in their wishes, desires and motives for a holiday, depending on their underlying needs. The behavior that is shown on holiday is directed to satisfy these needs (Maslow, 1970; Iso-Ahola, 1983; Mill & Morrison, 1985; Pearce, 1982; Rubenstein, 1980). Several investigators have assessed the motives for going on holiday. Some of the most important and most

frequently mentioned reasons for going on holiday are the following (Clift & Clark, 1995; Mill & Morrison, 1985; Rubenstein, 1980):

1. *Relaxation*. Physical or mental relaxation is for many people the most important motive for going on holiday. One needs time off to take rest, to recharge one's batteries, and to get revitalized.
2. *Protection*. Security reasons can also be a reason. People who do dangerous work (e.g., police officers, firemen, military servicemen) seek feelings of peace and protection during their holiday.
3. *Affection*. People may go on holiday because they want to meet new people or because they want to strengthen existing friendships. Couples with marital problems may want to revitalize their relationship or get to know their children better.
4. *Status*. One's status might be heightened by choosing exclusive destinations. Such holiday destinations might give such people greater prestige in particular social circles.
5. *Self discovery*. Some want to explore their (unknown) capacities and try to find themselves.
6. *Intellectual enrichment*. Some travellers want to know and learn more about the world. These travellers have a genuine interest in the places they visit and they want to explore those places. They may be interested in the food, the culture or the way of life of the local people.
7. *Vacation for beauty*. Aesthetical experiences may be a further important motive for holidaymakers. Both the splendid nature and the architecture and culture of a given holiday destination may be attractive to subgroups of tourists.
8. *Exotic adventure*. People who seek excitement, exotic adventure, danger and sexual escapades.
9. *Health*. Health tourism can be defined as the deliberate choice of destinations or tourist facilities that offer health care services, such as medical examinations, special diets, special medical treatment (spas!) and examinations (Goodrich, 1993).

On the basis of these motives and preferences, the following categories of tourists can be identified (Pearce, 1982). The *exploitative travellers* are those who are hardly aware of their vacation environment. They only seek shallow contacts with the locals. Neither nature, culture nor the local population is the reason for choosing a specific destination. What is most important to them is that everything is much cheaper than in the home country.

By contrast, for the second group of tourists, the *high contact travellers*, social contact with the locals is the most important aspect. These kinds of holidaymakers want to know more about the local people, their habits, behavior and daily life. They do not join guided tours and tend to avoid places and events especially designed for tourists. Their main aim is to interact with the local

population and to go their own way. Travellers who do not spend much money, who are not status minded and who are in search of the meaning of life are referred to as *spiritual travellers*. The 'hippie' belongs to this category, as do all the volunteers who work in developing countries during their holidays. The *environmental travellers* are holidaymakers whose focus is on adventure, social interaction and the environment. They are physically active but do not forget the needs of others. The fifth and last group of travellers are the *pleasure-first travellers*, who want status, souvenirs and pleasure. These are the 'real' prototype tourists, who take many pictures, prefer to eat what they eat at home, buy presents in the souvenir shops, and spend a lot of money on tourist attractions and activities. In short, there would appear to be important differences between individuals where their motivation for going on holiday is concerned. In addition, many holiday destinations have their specific profile. For example, some destinations focus on the night-life, others on nature, others on culture.

Rubenstein (1980) argues that "few of us succeed in achieving any remarkable transformations while on vacation and, alas, we carry the same psychological baggage with us, wherever we go." This is illustrated by the finding that workaholics take their work with them, health nuts engage in health activities and sports, but that those who enjoy their work most also appreciate their vacations best. Most holidaymakers thus usually fail to undergo any remarkable psychological transformations while on holiday, which would imply that it is important for tourists, choosing their destination, to take into account their personality and motives. As in any other domain of our social world the aim in this context should also be to have an optimal person-vacation environment fit. In the next paragraph, we will devote some attention to this issue.

French, Caplan, and Van Harrison (1982) have formulated their Person-Environment Fit approach, which, especially in the occupational setting, has been studied extensively. Later on, the model was applied in a wider and more general context to psychosocial stress (cf. Howell, Krantz, & Barnard, 1995; see also Buffum, 1987-88; O'Connor & Vallerand, 1994). The interaction between specific characteristics of the person and specific features of the environment is so important and unique that it is considered to be the most relevant variable in the development of health problems. Hettema (1979), as an advocate of the interactionistic approach to personality, also dwells on the importance of the relationship between the individual and his/her environment, in particular the strategies that may be applied to restore the possible disequilibrium between the environment and the person. Within public health, it is more common to include in the model the variables agent, host, and environment (e.g., Susser, 1973).

Another approach within the stress research field is to focus on life events. Although the original theoretical position taken by Holmes and Rahe (1967) has been challenged, it is nevertheless important to devote attention to it. Holmes

and Rahe regarded adjustment as the critical factor: how many 'units' of adjustment does exposure to a certain situation require, independently of whether it is appraised as negative (e.g., the death of a spouse, job loss) or positive (e.g., marriage, holiday). Their hypothesis is that the more effort one puts into adjustment processes, the more vulnerable one will be to contracting disease. Thus, the more adjustment a certain holiday destination requires, the more likely it is that the general resistance to disease is diminished. The results of more recent studies further suggest that the negative health effects may be even worse if the individual does not receive adequate social support from his or her network, which of course is often limited when one is on vacation abroad or if the individual concerned does not possess adequate coping strategies (see also the contribution by Monden in this volume).

The items in the Social Readjustment Rating Scale further refer to changes in living conditions, recreation, residency, social activities, and in eating and sleeping habits. In addition, there is specific itemization of vacation. This list was based on data which would indicate that these kinds of events relatively often preceded the onset of disease and/or the seeking of medical advice.

Since the early eighties there has been increased interest in the measurement of daily stressors and their impact on physical and mental health. Evidence shows significant correlations between daily stressor exposure and distress (e.g., DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982) and more objective indices of disturbed biological functioning (e.g., Brantley, Dietz, McKnight, Jones, & Tulley, 1988; Jabaaij et al., 1993). There is no reason to assume that typical minor vacation stressors should have a different impact from everyday stressors. Although systematic research is lacking, the following list presented by Rosenblat and Russell (1975) may give a good impression of the kind of problems that may arise during holidays.

1. Family members are forced to spend much of the time together, whereas in the home situation the different family members engage in many different activities like going to school, working, shopping, attending meetings, taking exercise, etc. At home, each family member has greater space to live in. This separation insulates family members from one another's moodiness, noises, distracting activities, and preferences for temperature and specific stimulation.
2. Sharing territories. Whereas in the home situation there are often implicit or explicit rules about functioning in the family and one's place in the household (e.g., where to sit at the dinner table, etc.), entering into a new living space means that everybody has to struggle for their own territory. Disputes may arise over who may sit where, who has the right to switch the radio on or off, who has to sleep where and with whom, etc. Research suggests that people travelling with nuclear family members generally experience less difficulties than those who are accompanied by non co-resident relatives or friends.

3. Another aspect is that families have usually worked out the division of labour. During a vacation those responsible for typical household activities may want a rest from such daily routines. In addition, there may be new activities that need to be allocated to someone.
4. Travelling with children. Many parents know from firsthand experience the problems and inconveniences that are inextricably linked to travelling with children, like the lack of interest children may have for some tourist attractions, inconvenient toilet timing, etc.
5. Travellers may be confronted with 'typical' holiday problems that may tax their adaptational demands. Some of the most frequently reported problems are: car breakdowns, illness, crowded camp sites and touristic attractions, noise and other disturbances created by fellow campers, etc. Much to their surprise, Rosenblatt and Russell (1975) found that holidaymakers experiencing bad weather reported less anger and tension than people who had good weather. They wonder whether this result may have to do with collectively blaming the weather for the disappointment, having to make fewer decisions, do less fast driving, having fewer physical demands and getting more sleep.
6. In addition to the above-mentioned issues, one should not forget the daily problems related to feelings of loss (Fisher, 1989) concerning a pet, family, friends, or loved objects. Loss of identity may be another important determinant of health problems during holidays (Monden, 1988).
7. A vacation is something that is, to a very large extent, idealized. It is associated with high expectations, like seeking total revitalization, wanting ideal weather and anticipating a coming together of all the good things in life. Such expectations can easily lead to great dissatisfaction, which in turn may initiate a blaming of self or family members. When going on holiday it is thus better to have realistic expectations and so ward off potential problems. Many people consider their vacations to be very important and attach much value to traveling. They are regarded as necessary, vacations provide an essential escape valve (Rubenstein, 1980). You should rejoice at having a holiday: a break from one's boring daily life. By definition almost, vacations are not associated with accidents, problems and ill-health. However, there is often a significant gap between vacation fantasy and reality. Nevertheless, by far the majority of people are very optimistic about vacations and report having great expectations.

There is accumulating evidence to suggest that experiencing these kinds of events and accumulating daily stressors may disturb endocrine functioning (catecholamines, cortisol, neuropeptides). Affected hormonal processes may in their turn influence cardiovascular and immune functions that may then mediate changes in health status (Vingerhoets & Rigter, 1994). Which specific disease one will be confronted with depends on genetic, lifestyle (smoking, alcohol

consumption, etc.) and environmental factors (exposure). Recent developments in psychoimmunology have yielded evidence to suggest that the susceptibility to immune related diseases, including infectious diseases, some kinds of cancer, allergies, and autoimmune disease may be increased after exposure to demanding and emotional situations. Spending one's holiday in exotic countries may thus (a) facilitate unhealthy behavior in specific groups; (b) lead to an increase in the vulnerability to disease, in particular where there is a misfit between the personality and the environment, and (c) result in the exposure of the person to unfamiliar pathogens. These three factors put together may facilitate pathophysiological processes that may seriously endangering one's health status.

## Conclusion

In this chapter we have dealt with international tourism from the perspective of health psychology. Travelling carries with it some inherent risks for minor and major health problems. Most of them are preventable, because they are associated with specific risk behaviors, e.g., exposure to ultraviolet rays, unprotected sexual behavior, which are not specifically related to vacations (cf. Dembert et al., 1986). In addition, there are (mental) health problems which are specifically related to travelling, such as jet lag and exposure to unfamiliar pathogens. We would further argue that going on holiday implies making adaptive efforts, which may render the traveller more vulnerable to disease.

Making adequate preparation and adhering to good health habits can prevent a lot of problems. This does not merely mean having the right vaccinations and using sun blocks, but also carefully choosing a destination that fits your personality best. The better the traveller-environment fit, the better the well-being will be and the lower the risk of disease. The value of a vacation will increase significantly when the balance between the positive experiences outweigh the avoidable (health) problems and difficulties. This may be a new challenge for both health promotion teams and travel agents.

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