—Original—

Psychiatric Intervention for Japanese Nationals in New York

Yuko Katsuta[1], Yoshiko Nishimatsu[2], Takuya Saito[3] and Shunkichi Endo[1]

[1]Department of Neuropsychiatry, Nippon Medical School
[2]Department of Psychology, Risho University, Tokyo
[3]Department of Psychiatry, Albert Einstein College of Medicine, New York, USA

Abstract

This study examined the characteristics of Japanese patients who required psychiatric intervention through the Consulate-General Japan in New York. The findings show that 61.5% of cases were tourists in contrast with 38.5% who were residents. Seventy three point one percent of all cases had psychiatric disorders prior to traveling to the United States. Seventy one point two had schizophrenia, and 48.1% required intervention within one week stay in the United States. The study indicated cultural elements had little influence on their psychiatric crises. The dominant cases, which were schizophrenics who traveled because of their delusional symptoms, were consistent with cases of "voyage pathologique". It was also suggested that cases with personality disorders are increasing in number. And we inferred that cases with substance-related disorders, particularly among young illegal residents, must be present in greater numbers. (J Nippon Med Sch 2003; 70: 141–150)

Key words: psychiatric intervention, Japanese Nationals in New York, cultural adjustment, voyage pathogenique, the Consulate-General Japan in New York

Introduction

Along with the development of modern technology, e.g. the Internet and satellite broadcasting, we have begun to share information with people around the world much more easily and faster than before. We can exchange information with each other and visit many countries. We move across countries and interact with others whose cultural backgrounds are different from ours. We can observe and participate in foreign environments, and are exposed to them. It can be inferred that this contemporary situation has some influence on mental health. We live in a flux of encounter with foreign environments. Japanese are no exception. The aim of this study was to investigate the picture of Japanese patients who had mental crises in New York.

According to statistics issued by The Japanese Ministry of Justice, the total number of Japanese residents of foreign countries was 811,712 as of October, 2000. This number has been increasing in recent years, and the United States has a large number of Japanese, totaling 297,968. In particular, New York City has the largest population of Japanese citizens (57,780) followed by Los-Angeles (35,898) and London (23,560). In addition to these numbers, New York City receives many tourists every year. The average number of Japanese visitors to New York City each year from 1995 to 1999 was 415,200, according to a survey by The

Correspondence to Yuka Katsuta, MD, Department of Neuropsychiatry, Nippon Medical School, Sendagi 1–1–5, Bunkyo-ku, Tokyo 113–8603, Japan
E-mail: yuko@super.email.ne.jp
Journal Website (http://www.nms.ac.jp/jnms/)

Japan National Tourist Organization. In spite of the fact that the United States, particularly New York City, has an immense number of Japanese residents and tourists, there has been no statistical review of Japanese patients with psychiatric diseases in New York. Therefore, we think this study may present a real picture of this population, and thereby present problems to consider.

Among the many tasks of Japanese Consulates, helping people cope with mental problems is one of their objectives regarding the protection of Japanese citizens. Since April 2001, one of our authors (Saito) was assigned to be a consultant for these individuals in New York, because the Consulate-General of Japan in New York, hereafter referred to as the Consulate, had begun to notice that the number of persons with psychiatric problems was gradually increasing, and their psychiatric features were becoming more complicated. Some of those with mental problems visit The Consulate voluntarily, and the others eventually establish contact through third parties like their friends, their acquaintances, domestic Police Department, and the domestic psychiatric hospitals. In this way, the Consulate contributes to psychiatric intervention for Japanese abroad. But the characteristics of patients who required its intervention have scarcely been studied. In this respect, this presentation is innovative.

Method

Participants

All documents from the Consulate relating to psychiatric intervention between January 1997 and August 2001 were reviewed. These included references to people who called the Consulate only once to get some advice concerning their mental health. We had to eliminate those cases from which we could not get enough information to evaluate their situation. The group which was studied was selected on the basis of the following criteria: 1) sex, 2) age, 3) status of stay, 4) with or without previous psychiatric treatment either in Japan or in the United States, 5) onset of psychiatric disease, 6) time interval between intervention and their arrival in the United States, 7) diagnosis. When cases had no diagnosis recorded in the documents, we made a "retroactive" diagnosis based upon any given information. Also we excluded cases with organic diseases like brain tumors and dementia. The final number of subjects who met the conditions for the study was fifty-two.

Since one of the aims of this survey was to investigate cultural factors relating to mental crisis, we divided the study group into four subgroups: tourists, residents with valid visas, students, and illegal residents. Students in this study means those persons who came to New York specifically to study or attend school, so it does not include students living with parents or spouses with working visas. These categories were created on the assumption that each group has a different exposure to the foreign culture qualitatively and quantitatively.

Statistical Method

For statistical analysis, Pearson Chi-Square exact test was performed using a statistical software package, StatXact (Cystel).

Furthermore, it must be noted that this paper was written under the condition that the patients would not be identified and that no data on them would be used for other purposes besides this study.

Results

Demographic Characteristics

As **Table 1** shows, the tourist group was the largest segment at 61.5%. And male and female subjects were almost evenly distributed in each group, except the student group. In the student group, 5 were male (83.3%), and 1 was female (17.7%). In terms of age, those in their 20 s and 30 s were dominant, and the combination of these age groups formed 73.1% of the total subjects.

Clinical Characteristics

Table 2 demonstrates that 38 cases (73.1%) had onset prior to their arrival in the United States as opposed to 14 cases (26.9%) with no previous symptoms before their arrival. There was a statistical significance between status of stay and onset of disorder ($p < 0.01$). And 48.1% of cases

Table 1 Demographic Characteristics (All Figures in Numbers, except mean ages)

Variable	Tourists (N = 32)	Residents (N = 5)	Students (N = 6)	Illegal Residents (N = 9)	Total (N = 52, 100%)
Age					
11—20 years old	0	1	2	1	4 (7.7%)
21—30	10	1	4	6	21 (40.4%)
31—40	14	2	0	1	17 (32.7%)
41—50	5	1	0	0	6 (11.5%)
51—60	2	0	0	1	3 (5.8%)
61—70	0	0	0	0	0 (0.0%)
71—80	1	0	0	0	1 (1.9%)
Mean Age	36.0	34.4	23.5	28.8	33.5
Sex					
Male	14	2	5	5	26 (50.0%)
Female	18	3	1	4	26 (50.0%)

Table 2 Clinical Characteristics (All Figures in Numbers)

Variable	Tourists (N = 32)	Residents (N = 5)	Students (N = 6)	Illegal Residents (N = 9)	Total (N = 52, 100%)
Onset of disorder:					**
Prior to arrival	31	2	0	5	38(73.1%)
After arrival	1	3	6	4	14(26.9%)
Previous treatment of psychiatric disorder:					NS
Positive	20	3	2	5	30(57.7%)
Negative	12	2	4	4	22(42.3%)
Diagnosis:					*
Schizophrenia	25	1	4	7	37(71.2%)
Mood Disorder	2	3	0	0	5(9.6%)
Adjustment Disorder	0	0	1	0	1(1.9%)
Substance-Related	0	0	1	2	3(5.8%)
Personality Disorder	5	1	0	0	6(11.5%)
Time interval between The arrival and intervention:					**
Within one week	24	0	1	0	25(48.1%)
From 1 to 4 weeks	7	0	0	0	7(13.5%)
From 4 weeks to 1 year	1	1	1	0	3(5.8%)
From 1 to 3 years	0	1	3	5	9(17.3%)
More than 3 yearss	0	3	1	4	8(15.4%)

(* = $p<0.005$, ** = $p<0.001$, NS = not significant)

required intervention within one week of their arrival in the United States. There was a statistical significance between status of stay and time interval for intervention ($p<0.01$). With regard to diagnosis, schizophrenia spectrum disorders (corresponding to DSM-IV codes 295, 297.1 and 298.8) were dominant, and the number accounts for 37 cases (71.2%). These were followed by personality disorders (11.5%). Adjustment disorder was seen in only one case. In this case, his mother's death precipitated his psychiatric disturbance with little relevance to cultural adjustment. There was a statistical significance between status of stay and diagnosis ($p<0.01$).

Thirty cases (58%) required intervention from the domestic Police Department and/or psychiatric hospitals. The Consulate intervened in 10 cases (19.2%) when asked by their families, friends, or therapists. Among the 12 cases who sought help voluntarily, 11 were schizophrenic. Many of these

Table 3 Clinical Characteristics in each Diagnosis (All Figures in Numbers)

Variable	Schizophrenia	Mood Disorder	Adjustment Disorder	Substance-Related	Personality Disorder
Status for stay					**
Tourist	25 (67.6%)	2 (40.0%)	0	0	5 (83.3%)
Resident	1 (2.7%)	3 (60.0%)	0	0	1 (16.7%)
Student	4 (10.8%)	0	1 (100%)	1 (33.%)	0
Illegal resident	7 (18.9%)	0	0	2 (66.7%)	0
Onset of disorder					**
Prior to arrival	29 (78.4%)	3 (60.0%)	0	0	6 (100%)
After arrival	8 (21.6%)	2 (40.0%)	1 (100%)	3 (100%)	0
Previous treatment of Psychiatric disorder					NS
Positive	27 (73.0%)	3 (60.0%)	1 (100%)	1 (33.3%)	4 (66.7%)
Negative	10 (27.0%)	2 (40.0%)	0	2 (66.7%)	2 (33.3%)
Time interval					*
Within one week	20 (54.1%)	1 (20.0%)	0	0	4 (66.7%)
From 1 to 4 week	5 (13.5%)	1 (20.0%)	0	0	1 (16.7%)
From 4 weeks to 1 year	1 (2.7%)	0	1 (100%)	0	1 (16.7%)
From 1 to 3 years	6 (16.2%)	1 (20.0%)	0	2 (66.7%)	0
More than 3 years	5 (13.5%)	2 (40.0%)	0	1 (33.3%)	0
Total (N = 52)	37 (100%)	5 (100%)	1 (100%)	3 (100%)	6 (100%)

(* = $p < 0.05$, ** = $p < 0.01$, NS = not significant)

Table 4 Onset of illness, time interval between arrival and intervention, and diagnosis for tourists (All Figures in Numbers)

Variable	Schizophrenia (N = 25)	Mood Disorder (N = 2)	Adjustment Disorder (N = 0)	Substance-Related (N = 0)	Personality Disorder (N = 5)	Total (N = 32)
Previous Treatment:						NS
Positive	16	1	0	0	3	20 (62.5%)
Negative	9	1	0	0	2	12 (37.5%)
Onset of illness :						NS
Prior to the arrival	24	2	0	0	5	31 (96.9%)
After the arrival	1	0	0	0	0	1 (3.1%)
Time interval :						NS
Within one week	19	1	0	0	4	24 (75.0%)
From 1 to 4 weeks	5	1	0	0	1	7 (21.9%)
From 4 weeks to 3 months	1	0	0	0	0	1 (3.1%)

(* = $p<0.05$, ** = $p<0.01$, NS = not significant)

cases who came to the Consulate asking for their "problems" to be solved were suffering from delusional ideas, e.g. only the United Nations could solve the problem of poisoned ingredients in Japanese food, or only the FBI could rescue them from persecution by Japanese political parties. Even though the requests were inappropriate and would not endure reality testing, it is significant that they chose the Consulate as the final recourse out of desperation.

Table 3 shows the clinical features of each disorder. There was a high incidence of schizophrenia in tourists (67.6%of all schizophrenics). With regard to mood disorder, it must be noted that all of the residents with mood disorders (3 cases) were in depressive states in comparison with the 2 tourists who were in manic states. And these cases developed depression after one year's residence. And 5 out of 6 cases with personality disorders were tourists requiring early intervention,

Table 5 Association between admission in New York and previous treatment history (All figures in Numbers)

	Not admitted	Admitted
No previous treatment of Psychiatric disorder	8	14
Previous treatment of Psychiatric disorder	8	22

Chi-square = 0.5630, Exact p = 0.5482

Table 6 Association between admission in New York and onset of disorder (All figures in Numbers)

	Not admitted	Admitted
Onset of disorder: After arrival	4	6
Onset of disorder: Prior to arrival	12	30

Chi-square = 0.4952, Exact p = 0.7045

as opposed to substance-related disorders, which required later intervention after more than a one-year stay. There was a statistical significance between diagnosis and status of stay ($p<0.01$). There was a statistical significance between diagnosis and onset of disorder ($p<0.01$). There was a statistical significance between diagnosis and time interval ($p<0.05$).

Tourists and their characteristics

Table 4 shows the clinical characteristics of tourists as the largest subgroup in the current study. It shows that their onset of psychiatric illness was prior to travel in the majority of cases (96.9%), and that 75% required intervention within one week of arrival. Also it shows a high incidence of schizophrenia (78.1%), and cases of personality disorder are noticeable, although the number was small.

Admission and its association with previous treatment and onset of disorder

Sixty nine point twenty three percent (36 cases) of the total 52 were admitted to the psychiatric hospitals in New York. **Table 5** shows that there was no statistical significance between admission and previous treatment history. Furthermore, as **Table 6** demonstrates, there was no statistical significance between admission and onset of disorder.

Discussion

Experiences in a foreign country can cause mental distress. The main cause is the loss of a familiar environment, and it requires some flexibility in adjusting to a new environment. It is almost impossible for any individual to be cut off from their home society and to acculturate to a foreign society without experiencing some difficulty. In terms of the differences between the original society and the new one, many components can be considered. For example, the linguistic barrier must be considered. Also, the variety of attitudes based upon culturally bound concepts regarding mental health, gender roles, and family structure may contribute to their mental dysfunction, forcing them to encounter conflicts between the old and the new sets of values. So do the potential conflicts between religious and spiritual belief systems. In addition, their financial and legal status will inevitably have an influence. Ultimately, these differences are likely to form barriers to early entry into primary health care, which could have helped prevent the person from psychiatric deterioration in the first place. Above all, isolation from former networks of family and community greatly discourages them from exercising their potential ability to adjust to the new environment. Newcomers to a foreign country who

have strongly internalized the values of their original culture can be very vulnerable, when they feel that these values are challenged. Oddly enough, the opposite situation, in which they did not internalize their home values, does not necessarily indicate an ideal course. Since optimal psychological internalization of social values is a prerequisite for healthy psychological development, we can assume that people with little internalization of them must have some developmental psychological problems. As shown later, these persons are likely to bring their unfinished psychological issues into the new environment. Another component, which can influence their process of acculturation, is whether the migration or travel has been forced or is of their own free will. As we can speculate, persons who have moved freely are likely to experience less emotional difficulty. There is also the time factor, which is how long they are supposed to stay in the foreign country. If they think the stay is temporary, and they can foresee their return to their original country, it is less likely to cause mental stress. With respect to the conditions in a new environment, the size of the community of the immigrant's own minority group is significant. When the community is large and developed enough, it helps the immigrants to have high accessibility to their familiar culture and community. Accordingly, it can reduce their inclination to mental crisis.

It is possible to lay out several constituents of mental health for immigrants and travelers, as we presented above. However, it is more problematic to determine elements contributing to the mental dysfunction in any particular individual. The process of developing psychiatric disorders as well as that of the migration process itself is too complex to verify the determinant factors. Murphy[1] proposed, "the mental health of a migrant group is determined by factors relating to the society of origin, factors relating to the migration itself, and factors operating in the society of resettlement". He noted that "generalizing about the mental health of migrants without specifying the cultural origin, the conditions of migration, and the type of disorder being referred to is likely to be both misleading and unhelpful". Taking these factors into consideration, we can assume that it is significant to know where people came from, where they are going, and under what conditions. In this study, our subjects were Japanese who traveled from Japan to New York under various conditions.

Travel and its influence on mental health seem to be much less studied than immigration and its mental health implications, though there have been several research studies concerning jet lag. Strelzer[2] investigated travelers to Hawaii who had psychiatric crises, and proposed the reference of jet lag to the travelers' mental crisis. Since then, this subject has been investigated. Katz and others[3,4] offered the theory that jet lag may play a role in triggering exacerbation of psychosis and even schizophrenia in predisposed individuals. But this study seems to have yielded little consensus. Regarding another idea, Kimura and others[5] hypothesized a common dynamism among travelers who developed psychiatric crises. The traveler having problems and being compounded by stresses tried to escape from those stressful situations by traveling and relocation. Strelzer[2] explored this theme dividing travelers into two groups: one was travelers with plans to depart in the near future, and the other was transients with no specific plan to leave. He concluded that the hypothesis made by Kimura and others[5] applied more to the transients group, and that travelers with plans to depart in the near future had mental crises which seemed to occur as a result of or in conjunction with their travel instead of carrying over from their problems at home. As the other specific aspect regarding the interrelation between travel and psychiatric disorder, there is the concept of "voyage pathologique". "Voyage pathologique" was coined by Briand and others[6] and it indicates cases that take a trip based on their delusions. Thus, these cases' psychiatric crises are not caused by the travel itself, but the travel is a result of their psychiatric disorders. This subject has been investigated from psycho-pathological perspectives by several authors (Caroli and Masse[7]; Sapiro[8]; Akiyama and Gomibuchi[9]).

There have been many studies done purporting to examine the mental health of immigrants and refugees in Europe and the United States (Selten

and others[10,11]; Harrison and others[12]; Mortensen and others[13]; Sayil[14]; Hurh and Kim[15]; Hoppe and others[16]; Rumbaut and Rumaut[17]). Among surveys of immigrants, there has been controversy on the "selective migration" hypothesis, which was proposed by ϕdegaard[18]. This hypothesis proposes that people with a high risk of schizophrenia tend to immigrate more than others. Consequently, he concluded that a high occurrence of schizophrenia among immigrants does not explain that the immigration process is a determinant risk factor, but that it indicates the schizophrenia-prone is disproportionately liable to migrate because of his difficulty in forming attachments to his native community. As an alternative, a theory emphasizing social causation was presented mainly by American social scientists (Mahan and Woods[19]; Kleiner and Parker[20]; Brown and Birley[21]; Bagley[22]). This subject has developed into several assumptions about the etiology of psychotics among immigrants. Zolkowska ad others 23 support a genetic factor of psychotics, as opposed to Bhugra[24] who regards environmental factors as contributing to schizophrenia in immigrants.

The subject of psychiatric intervention for Japanese patients who stay abroad has been studied, though not frequently. Sato[25] reports on Japanese overseas travelers who became psychotic while abroad and required hospitalization after coming back to Japan. And some studies have been done about the treatment of Japanese in foreign countries (Uemoto and others[26]; Onishi[27]; Kuramoto and others[28]; Ota[29,30]; Tamura[31]). Some of these studies analyzed cases from viewpoints of cultural conflict and/or failure to adjust to foreign environments. But there was almost no statistical survey among these studies, with the exception of Ota's[30].

Along with these studies, there are several reports about non-Japanese patients who were treated in Japan (Arai and others[32]; Tamura[33]; Onishi and others[34]; Ehata[35,36]; Simazaki and Kamizuki[37]; Nakayama[38]; Sugiyama and others[39]; Akiyama and Gomibushi[9]). Though most of them were case reports, Ehata[35] and Sugiyama and others[39] surveyed from a statistical viewpoint, and found very little relation between cross-cultural factors and mental crises in this population.

In surveying the various studies regarding the mental health of patients in foreign countries, we can see a polarization: the genetic vs. the environment (including cultural adaptation) as the determinant factor of mental crisis. In other words, there are researches observing little association with cultural relevance on the one hand, and those focusing upon cross-cultural aspects on the other. And this theme should be a long lasting inquiry of psychiatry beyond the realm of patients in foreign countries. In fact, there is no simple cause-effect relationship between the psychiatric disorder and the environment. Thus, this paper does not intend to solve this dual perspective. Instead, it tries to reveal the real picture of the psychiatric crises of Japanese in New York and to explore these two elements by examining cases which required intervention by the Consulate.

The current study shows that a high proportion of subjects who required intervention by the Consulate were tourists with schizophrenia preceding travel, and who needed the intervention within one week of their arrival. This predominant population appeared consistent with cases of "voyage pathologique". These cases in the present study were drawn to the United States on the basis of their delusional ideas. One patient came to NY saying he suffered from electric waves radiated from NASA, and attempted to seek help from The CIA. After finding nobody to take his plea seriously, he attempted suicide. Another patient had been in a Japanese psychiatric hospital for months, and then after discharge he went to the US Consulate in Japan seeking refuge. This action brought him back to the same hospital and he stayed there again for months. And ten days after his second discharge, he was kept in custody at the Immigration Office of JFK airport because his disorganized behavior and speech got the attention of an immigration officer. He was sent to the psychiatric hospital through the intervention of the police and the Consulate.

To summarize these cases of "voyage pathologique", these persons felt that they had not been helped by the Japanese people or the government, and that American authorities (e.g. CIA,

FBI, the White House, or the leaders of religious groups) would rescue them. Several studies have been done attempting to classify this type of case according to the underlying pathology, e. g. flight, grandiosity, or persecution mechanisms (Chmiel and others[40]; Strelzer[2]; Caroli and Masse[7]). Although the present study did not focus upon psychopathological investigation, it was difficult to select cases that had simple persecution delusions without an element of grandiosity. After all, their sense of being persecuted in Japan, their despair in Japan, and their wish to make a flight and to be rescued by the United States were all tightly interwoven. And their delusional grandiosity was always present whether it appeared at the forefront or not. Sugiyama and others[39] showed that only American nationals showed voyage pathologique in their study dealing with non-Japanese patients in Japan. And they suggested that Japan, as a Far-Eastern country might be a suitably exotic object to foster their idealization. The opposite may be applied to Japanese: America can represent the West and become invested with their desires and needs which could not be met in Japan.

In comparison with the 38 cases (73.1%) with prior onset coming to the United States, 14 cases (26.9%) had their onset after the arrival. And among these cases, there was only one case which had an evident connection between the crisis and encounter with a foreign culture/language. This case, who came to New York with the purpose of studying English, developed a brief psychotic disorder with persecutory ideas after a one week stay in a neighborhood whose environment is frequently reported as providing the worst security in New York. In the other 13 cases, cultural adjustment issues played a minor role, if not being entirely irrelevant. Particularly with respect to cases having mood disorders, their mental crises were mainly caused by losses of significant others like family, boyfriend, and girlfriend with little pertinence to the struggle of adjusting to a foreign culture. Although sufficient data was not derived about schizophrenics who developed their illness after their arrival, it was hard to determine how much their exposure to a foreign culture had an impact on their etiology. All of them were young enough to be considered as belonging to a high-risk age population for developing schizophrenia.

These findings suggested that there is likely to be little relevance between their psychiatric disturbances and the foreign environment. And this result is consistent with those of Ehata[35] and Sugiyama and others[39]. Ehata[35] investigated non-Japanese in Japan who required psychiatric intervention, and found no case whose onset or recurrence had been triggered by language barrier and/or cultural conflict. Sugiyama and others[39] also reported about the same population as Ehata[35], though in different years, and reached the same result regarding factors of cultural conflict. The present study as well as the studies of Ehata 35 and Sugiyama and others[39] dealt with cases which required psychiatric admission in most instances, so that it is inappropriate to conclude that cultural conflicts play little role in the mental health of people who live in foreign countries. But with regard to schizophrenia, the foreign situations turned out to be not so much a cause as a result.

Five cases out of the 7 schizophrenics with illegal status had onset prior to arrival, and 3 of these 7 took more than 3 years to need intervention. This must account for a finding (Table 2 & 3) in which there were two peaks in the time interval between their arrival and intervention: one was an early phase which was within one month of their stay, and the other was a late phase which was more than 1 year. And it was noteworthy to see that the mean age of this illegal residents' group was 28.8, which was as young as that of the students' group (23.5). We assume that there are a large number of illegal Japanese residents with psychiatric illnesses, and that the cases we encountered were just the tip of the iceberg of this invisible population. In addition, taking into consideration the fact that both cases of substance-related disorders were illegal residents, we must take seriously a prevailing social phenomenon of substance abuse in America and its influence on Japanese residents. Three out of the total 9 illegal residents had been homeless and protected at shelters for homeless people. One of them had a traffic accident, which brought him to a

general hospital. But he presented himself in a delusional state so that workers at the hospital could not know even his nationality. He was sent to a shelter for homeless people, and continued psychiatric treatment there. It was years later when he had another traffic accident that he finally made contact with his father in Japan through the help of the Consulate. After these processes, the patient became able to go back to Japan accompanied by the psychiatrist in charge.

Though the number is not so large, cases with personality disorders drew our attention. We can see that this group of cases has been growing through recent years by examining some previous years' data, which were not included in this study. And this result is consistent with that of Ota[30], which shows a high occurrence of personality disorders among Japanese in Paris. In our study, 5 out of 6 with this disorder were tourists, and 4 cases with borderline personality disorder were admitted for suicide attempts. Their heterosexual relationships directly triggered all of them.

In conclusion, the present study did not indicate cultural and environmental factors as a determinant of mental crisis. Rather, their precedent mental disorders facilitated them to travel away from Japan. However, our results must be considered in the context of the methods used. We can assume that patients with sufficient support systems like business organizations and school counseling programs might have dealt with their mental problems within their systems without recourse to intervention by the Consulate. Furthermore, patients with less severe symptoms might have been able to cope with their problems by consulting with individual professionals. In fact, unlike many foreign cities, New York is fortunately equipped with Japanese speaking therapists and organizations of mental health service. So the findings of this study must be regarded in light of limitations. Regarding our method, another issue concerns the feature of retrospective information. More than half of the original cases were short of enough data to be included in this study. Prospective studies must be done in the future to examine our findings.

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