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REVIEW

Mental health care of Western expatriates in Tokyo

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Abstract This paper describes the current state of mental health care for Western expatriates in Tokyo, Japan. Types of therapists, patient demographics, illness breakdown, and psychiatric medications in Japan are discussed and problems in the system and potential remedies are presented.

Western mental health therapists and credentialing in Japan

A large number of non-Japanese English speakers in Tokyo require psychiatric care and mental health counseling. These persons prefer this care from fellow Western therapists vis-à-vis the local Japanese therapeutic community because of both real and perceived cultural and language differences.[1,2]

This population is served by a potpourri of Western therapists ranging from aroma therapists, body energy therapists, and life coaches, to Ph.D. psychologists and an occasional M.D. psychiatrist. Psychotherapy is not regulated in Japan, and while few of the Western therapists have any official Japanese qualifications, most all of these therapists are qualified to practice in their country of origin. There is the rare Westerner who may have a certificate from the Japan Clinical Psychologists Association, or a Ph.D. from a Japanese university. There are also a couple Japanese psychiatrists who have done residency or have a medical license in the United States, and who will see some Westerners for medication, and sometimes psychotherapy.

Western patients who need psychiatric medicine will either be referred by a therapist or present themselves directly to a medical clinic. There are a handful of Western GPs and internists in Tokyo who have either taken the Japanese medical license test or who are from a country that once had a reciprocal treaty with Japan to accept the license from their country of origin to allow medical care in Japan of non-Japanese (e.g., U.K., New Zealand) who care for these persons. Many Western persons will also go directly to see a Japanese physician, especially if they are in the Japanese National Health Insurance plan.

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It has been rare to hear of a charlatan therapist, however, there has been the occasion of someone claiming to have been a U.S. surgeon who had done psychotherapy, and in the 90's a client, whose daughter was seeing a French therapist that seemed inappropriately close with her, investigated the therapist and found that they had skipped out on parole from San Quentin State Prison in California where they had done time for pedophilia. Interestingly, even when informed, for unknown reasons the Japanese police did not act on removing this person from Japan.

A group of therapists have formed and attempted to validate the credentialing paperwork of its members, however, they do not require official letters from universities or credentialing boards; and while they will do an ethics evaluation of a member if there is a complaint, the evaluation committee and the members in question are competitors in a small market, making the ethics review process itself a conflict of interest. The ethics review also provides a conclusion letter to the complainant, thus providing the complainant with a document they could use against the therapist in a lawsuit, or against this organization in a suit for accepting this therapist into the organization. Thus, these non-governmental self-policing organizations have huge logistic and legal issues to face in fulfilling their mandate properly. There is also no malpractice insurance system for non-Japan credentialed therapists leaving a legal void in terms of malpractice responsibility.

The body energy therapists and life coaches are usually a sink for persons who have some form of anxiety/depression or personality disorder, but who do not want to accept that they have mental illness and they use the ''non-medical'' paradigm as a defense to deny personal weakness. The main risk of these therapies is if the therapist does not know when to refer the patient with psychiatric illness to a specialist, or does not want to because of monetary incentive. Most of the professional non-medical therapists (e.g., psychologists) do have some idea when a patient needs to see a psychiatrist for medication; but this is not always the case for mild illnesses like dysthymia, cyclothymia, or bipolar disorder type II, etc.

Demographics of Western patients seen in a typical Western mental health clinic in Tokyo

Including all nationalities, there are almost 354,000 foreign residents in Tokyo which has a total population of about 12.6 million (Japan Ministry of Internal Affairs and Communications). There are more Western men in Japan than women. While there is no hard demographic data available, this intuition is reflected in the ratio of Western males to females attending a Western counseling clinic in Tokyo of about three to one. This is probably because many jobs Westerners have in Tokyo are largely with the foreign corporations that are in industries that typically more males gravitate toward (software and IT, law, finance trading and broking, etc.) In support of this idea, the roster of Western lawyers at a large international law office in Tokyo was reviewed and found to list 30 males and 9 females. A large portion of the Western expatriates are single, or have married locally, as it is more difficult for an entire family to move out to Japan (although there are certainly a number of corporate expatriate families in central Tokyo). The highly demanding nature of the international corporate environment in Tokyo results in a large proportion of highly educated and intellectually talented persons attending therapy.

Another large area of employment for Westerners is that of teaching English; and these account for a much larger percentage of Westerners who live outside the major urban areas of Tokyo and Osaka where the majority of international corporations are located. While it seems that the male female ratio is near one for young teachers who have recently graduated university and who want to gain some overseas experience, the male proportion grows significantly as these teachers get older and the females tend to return to their country of origin. This is probably due to a number of males marrying or socializing locally, while for females, they may find that the career opportunities for women are more limited in Japan because the culture has strong role expectations for men to work and for women to stay home and care for a family.

The structure of the Japanese family also has a role in the tendency for Western women to leave Japan. Traditionally, Japanese men expect their wives to stay home and care for household duties. The family itself tends to revolve around the wife and child unit, the wife being closely involved in many of the child's scholastic activities, while the husband is usually working long hours at a company. The husband also spends a lot of time involved with his corporate duties that entails late evenings and may also encroach on weekend time. So the pattern that emerges is that of a warm and mothering wife, and a husband content to leave the family to the wife's charge and delve into his work duties. It is evident that if you are a Western woman you may have trouble accepting a husband busy with so much outside activity; while the warm household is more acceptable for the Western man. There are of course many individual exceptions to the traditional paradigm, and tradition seems to be slowly changing, probably less so in the countryside.

This discussion would not be complete without noting the number of local Western persons who have started their own companies or professional practices, those working in Embassies, as well as a group of students who come from abroad to study in Japan. There are also about a dozen international schools catering to the Expatriate community, certainly the ratio of boys to girls in school is closer to one.

Types of disorders seen in a typical Western mental health clinic in Tokyo

It is rare to find a Westerner with severe mental illness in Japan. This is because persons who are seriously ill with schizophrenia, psychotic depression or difficult to control bipolar disorder, usually will not have a career which may send them abroad, and ongoing symptoms will impair the ability to travel overseas and negotiate the complex logistics and finances of living in Japan if one tries to come on their own accord. Highly functioning bipolar disorder, alcoholism, and even drug abuse (cocaine, amphetamine) are not uncommon in some successful expatriates, particularly in the finance industry.

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For persons already in Japan who become seriously ill, this may be controllable and treatable as an outpatient. However, if psychiatric hospitalization is necessary, then unless the person is extremely fluent in Japanese and has the Japanese National Health Insurance, the hospital is likely to coordinate with the respective Embassy to have the person repatriated as soon as possible. Persons who are not easily hospitalized may be helped by SOS International who can often escort the person (usually medicated) on a plane back home. Unfortunately, the Japanese police will not usually bring even floridly psychotic persons to the hospital unless there is an actual action of some damage to property or others. Consequently, psychiatric hospitalization in Japan, especially for a Westerner who the police may not easily be able to communicate with, is often not easy and these persons may fall thru the cracks in the system. Complex coordination with one's employer, the embassy, the police, and significant others may eventually result in hospitalization or outpatient stabilization and repatriation.

The major disorders seen in Westerners attending an outpatient psychiatric clinic are similar to any middle-class neighborhood psychiatrist's office: depression and dysthymia, anxiety disorders, personality disorders, and couples' conflicts being most common. Bipolar spectrum disorders, ADD, drug and alcohol abuse are also seen, but are less common. Schizophrenia is rare in Westerners in Japan as noted above. Treatment resistant depression, drug—drug interactions, medication side-effects, reluctance to accept the nature of one's illness or see how one's personality effects their life, etc. are the standard challenges as in any psychiatrist's office.

While there is some stress of being in a country with another language, many signs in Tokyo are in English and the vast majority of Japanese will speak enough English to help you out in the street, the subway, bank, etc. The city is extremely modern, perhaps more so than most Western cities, certainly violent crime is very low, and the vast majority of the people are clean and polite. While there is a lot of underlying insularity, serious alienation and discrimination might only be felt in Tokyo if one is trying to ''fit-in'' to a Japanese corporate organization where actual responsibility and comradery may not easily be obtained. Alienation and isolation might be more common for a Westerner living in the Japanese countryside; but different people have different social supports and may experience the stress of being a foreigner differently depending on a number of factors.

There are some disorders, however, related to the lifestyle of living in Japan. One is due to the culture of heavy drinking in business dinners and with one's colleagues after work, especially for those in the finance industry. Disturbed sleep cycles, use of harder drugs, and other consequences of binge drinking may often be seen.

Another is the development of a disorder of sexual control in men. Some men collect a number of girlfriends having multiple sexual partners, and some frequent the many erotic massage parlors where manual and oral sex is legal and widely available. The mix of a high population density, the largely young age of women in the work force, and the combination of interest in speaking English with the lure of having less social restrictions with Western men who are seen as a way out of the traditional Japanese lifestyle, leads to significant interest in these men among some groups of Japanese women. Both the heavy drinking and the sexual indiscretions are often subjectively distressing, and may lead to significant problems in work and occupational functioning, not to mention marital conflict.

An additional issue that one might say has some relationship to being in Japan is that, because it is relatively easy for a native English speaker to obtain employment teaching English in a ''English Conversation School'', some persons who otherwise have significant talents may not reach their full potential. If one is anxious or has low self-esteem due to a personality disorder or depression, then it may be less anxiety provoking or less of a challenge to one's fear of failure to teach English than to take the risk of failure in a more challenging career path and the studies necessary for this path which they might otherwise have pursued if they were in their native country and felt the pressure to strive for employment. Some persons who have an oppositional or rebellious style may have had trouble fitting into a conventional career path and also gravitate to English teaching in these schools. It is also common to see persons with untreated ADD, dysthymia, or bipolar spectrum illness who do not want to accept they are ill and thus they function below their potential. Not all English teachers are below their potential of course, and a number of these persons obtain Master's or higher level degrees in teaching or linguistics and enjoy the challenges of language teaching in Universities, etc.

As a final note for this section, many Western-Japanese couples (usually the husband is Western but not always) also present for psychological help. Infidelity, power struggles, depression or personality disorder in one partner etc., are common themes. Most of the time these are the same themes as seen in same-culture couples, however, there may be some tendencies specific to these couples, discussion of which is beyond the scope of this article.

Psychiatric medications and prescribing practices in Japan

In terms of psychiatric medications, while Japan lags behind the West in the approval of psychiatric medications, there are now a number of SSRIs, SNRIs, atypical antipsychotics, and mood stabilizers on the market.[3] Notably missing drugs, however, include the antidepressants mirtazepine, bupropion, and escitalopram (all of which have clinical trial programs ongoing in Japan), and fluoxetine (Prozac which terminated a clinical program); the antipsychotics clozapine and, ziprasidone, paliperidone (clozapine had reportedly been in development and discussion with the Japanese Authorities since the late 70's, ziprasidone has discontinued its Japan development, and paliperidone is said to be in development in Japan); the mood stabilizers oxcarbazepine, topiramate, and lamotragine (all have ongoing clinical programs in Japan).

The reasons for the lag in drug approval includes a variety of causes including business decisions based on development costs and perceived market size, difficulty in conducting clean clinical trials for psychiatric illnesses, high regulatory hurdles and thus costs placed by the Japanese health

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authority to prevent the market from exploding, etc. Just for reference, sertraline (Zoloft) had been in development in Japan from the late 80's until its final approval in 2006 as J-Zoloft, and paroxetine (Paxil, Seroxat) had been in development also for well over 10 years.[4,5]

For stimulants, the situation is more dire, partly because of the fear by the Authorities of stimulant abuse spreading throughout Japan. Methyphenidate (Ritalin) immediate release was on the market in Japan since the 1950's and approved for intractable depression and narcolepsy, however, in 2007 a few medical clinics in Tokyo were closed for dispensing large numbers of indiscriminant prescriptions of Ritalin (''Ritalin Factories''), and the Ministry of Health summarily removed the depression indication and now only allows a few registered sleep specialists to prescribe Ritalin for narcolepsy. Many patients with depression and ADD (given a diagnosis of depression in order to use off-label) were now stranded without their Ritalin. Many of these were changed to the only other stimulant readily available on the market indicated for narcolepsy and depression, pemoline, however, it is often felt to have lower efficacy than methylphenidate and there is a risk for liver toxicity (it has been taken off the market in the US).

Concerta (sustained-release methlyphenidate) did gain approval in late 2007, however, it is only approved for pediatric ADD and closely regulated only to be dispensed by psychiatrists who take a course in its proper prescribing. Thus, adults with depression or ADD are still left with taking pemoline. It is assumed that children who had taken Concerta will be able to continue their prescriptions as adults, but that leaves society with the paradox for adults who did not start taking Concerta as children. Because of the fear of stimulant abuse, tight regulations, and thus real limitations to expected earnings for pharmaceutical companies, neither mixed amphetamine salts (Adderal), nor other extended release methylphenidate compounds are in development or on the market in Japan. Methamphetamine is approved for narcolepsy, comatose states, and depression, but there is a strict procedure to obtain prescription rights and it is almost never used.

The Authority will allow a 1-month supply of a controlled drug like methylphenidate to be brought into airport customs for personal use with a prescription from the overseas doctor, and some Westerners who frequent abroad may start doing this. The reason Ritalin is allowed to be brought in through customs but not through the mail is probably to avoid multiple mailing imports that could be used on the black market.

More importantly, other non-controlled medications like antidepressants, antipsychotics, mood stabilizers, etc, may be imported in a 1-month supply for personal use without a prescription by mail order (benzodiazepines, zolpidem, etc are not allowed). Many Westerners are happy to pay cash for their medications rather than wait in a doctor's office every month just for a prescription renewal where they have to pay travel cost to/from the doctor's office, and one-third out of pocket for the doctor visit and the medications anyway if they use the Japanese National Health Insurance. If there is no prescription, there is no way to determine exactly what a 2-month supply is, and it is assumed that the authorities are more concerned with what might look like an amount for reselling rather than the exact amount for 2 months. For Ritalin, as long as the amount is clearly just for one person the authorities will not likely disallow a personal import for Ritalin thru airport customs.

In terms of drug regimen and dosing, it is not uncommon for Japanese psychiatrists to use multiple medications of the same class at low doses. For many years polypharmacy was anathema to many U.S. psychiatrists, but this has changed with the understanding that hitting on multiple neurotransmitter systems may be beneficial for many difficult to treat patients that require a methodical addition of medications to their regimens. The problem with starting polypharmacy simultaneously from the get-go as is often practiced in Japan, is that one cannot be sure what drug is bringing on effect or mal-effect, and that the doses tend to be subtherapeutic. Japanese physicians accustomed to treating persons with low body weight or questionable poor metabolism (Japanese have a three to fourfold increase in CYP 2C poor metabolizers-5–6% vs. 23%) often do not raise the dose adequately in Japanese patients, and this can be a source of limited efficacy, or the need to continue sleeping or antianxiety medication for prolonged duration as the underlying depression is not treated, etc. Having patients with depression on 10 mg three times daily of a tricyclic antidepressant, starting manic patients on 100 mg of lithium a day, having patients with schizophrenia who are on 2 low-potency and 2 high-potency antipsychotics, and 3 different benzodiazepines at night also take valproic acid on an as-needed basis etc., are some concrete examples of inadequate dosing and polypharmacy that often needs to be rationalized.

While there are many talented Japanese psychiatrists and a number of larger universities with psychiatric residencies,[6] the problem of a high variance in practice skill may stem from the lack of a Board-Certification program in Japan for psychiatry, as well as the practice where a new medical graduate who finished perhaps a 1-year rotating internship then obtains employment in a psychiatric hospital garnering the title of psychiatrist (psychiatric residency in the U.S. is 4 years). It is not uncommon for a psychiatric patient in Japan with depression to be told they have ''autonomic nervous system dysfunction'', either because the doctor is (usually unreasonably) fearful of precipitating a suicide, or because the doctor is not familiar with modern DSM nosology, and this lack of knowing their actual diagnosis on the patient's part may cause them to stop their medications too early, etc.

Use of the Japanese National Health Insurance only allows visits to licensed psychiatrists (not counselors or therapists), and these visits are usually limited to 10–15 min long because of the crowded nature of the clinics. Even assuming no language barrier this is usually not adequate. These factors result in a number of difficulties for the Western person to receive adequate psychiatric care in Japan making the availability of modern Western psychotherapy and psychiatric care all that more important for the international community in Tokyo.

Approval of modern psychiatric drugs in stride with the West, standardized psychiatric residencies, Board-Certification for psychiatrists, and mobile crisis teams with on-call English staffing in urban areas would greatly help the provision of psychiatric care in Japan. For the

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foreseeable future, the few mental health clinics staffed by and catering to Westerners in the major cities will provide the brunt of the care for the international community, and with e-mail and video Internet telephony gaining popularity these clinics can further outreach to international residents in the Japan countryside.

Conflict of interest

No conflict of interest has been provided by the authors.

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