In several of the world’s most revered travel destinations, over the last few decades, a cluster of psychiatric syndromes has emerged – what I will call “city-syndromes.” These disorders strike tourists, usually shortly after their arrival in a city, and appear to be triggered by the historical, aesthetic, or spiritual intensity of the place. Symptoms range from anxiety and panic attacks, through visual and aural hallucinations, to full-blown psychotic episodes. Outside the cities in which they occur, the syndromes have attracted little serious interest. Newspapers around the world periodically run “News of the Weird” stories about them, with headlines like “Visiting Jerusalem Can Spark a Psychotic Reaction”\(^1\) or “Florence's Art Makes Some Go to Pieces”\(^2\), but scholarly articles are rare. This paper will consider how and why these syndromes arise as psychiatric diagnoses, and why they are regarded with suspicion or disinterest by much of the psychiatric community. Ian Hacking, in his book *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*, notes that mental disorders sometimes arise in a specific historical time and place, and lays out a set of “vectors” which allow this to happen. City-syndromes can be mapped onto these vectors; the vector of medical taxonomy is of particular interest, as the disagreements about city-syndromes tend to hinge on how they fit into our psychiatric taxonomy, or if there is a place for them at all.

**Overview of the syndromes**

City-syndromes are acute, (usually) short-lived disorders that have in common a similar set of symptoms and pattern of onset and recovery\(^3\). Each is associated with a specific city that is popular as a tourist destination, and has been identified and named by psychiatric clinicians working in that city’s hospitals. They include Paris syndrome, Stendhal syndrome (Florence), and Jerusalem syndrome.\(^4\) Of these, the Jerusalem syndrome has been studied and discussed in greater depth than the others. The majority of patients have some previous psychiatric history, but for each syndrome there appears to be a significant minority who do not. The nature and severity of the symptoms vary widely, from relatively minor affective disturbances through full psychotic episodes.

*Paris syndrome* is unique among the city-syndromes in that it is reported to affect only one cultural group: tourists from Japan. A 2004 paper in the French psychiatry journal

\(^{1}\) Oakland Ross, *The Toronto Star*, June 7, 2008.
\(^{3}\) It should be noted that for all these syndromes, it is difficult or impossible to track patients’ long-term progress, because they return to their home countries as soon as they are well enough to travel; language barriers also pose a problem. However, there appears to be a rough consensus among researchers that patients without a history of serious psychiatric problems tend to recover quickly.
\(^{4}\) A laguna syndrome (Venice) has also been proposed, but will not be discussed in this paper, as no detailed information on it is available. (Steiner et al.)
Nervure reports that 63 Japanese patients have been hospitalized with the condition since 1988; the Japanese embassy in Paris has arranged for a Japanese psychiatrist to work with the staff of the Hôpital Sainte-Anne in dealing with these cases (Viala et al, 32). The authors of the 2004 paper note that Paris holds a “quasi-magical” attraction for many Japanese tourists, being symbolic of all the aspects of European culture that are admired in Japan (31). They report that patients stricken with the syndrome arrive in Paris with high, romanticized expectations, sometimes after years of anticipation, and are unprepared for the reality of the city. The language barrier, the pronounced cultural differences in communications styles and public manners, and the quotidian banalities of contemporary Paris – the ways in which it is like any other 21st-century Western city – induce a profound culture shock which, the authors contend, triggers the syndrome. Symptoms range from anxiety attacks accompanied by feelings of “strangeness” and disassociation, to psychomotor issues, outbursts of violence, suicidal ideation and actions, and psychotic delusions on themes of paranoia, megalomania, erotomania or mysticism (31-32).

The Paris authors identify two types of the syndrome: type 1) classic, and type 2) with delayed expression. Type 1 patients have a history of psychiatric problems, and may travel from Japan to Paris for “strange” or delusional reasons, but they do not present with symptoms until arrival. Once they reach Paris, however, the onset of symptoms happens immediately, sometimes while the patient is still in the airport. The authors give as an example the case of a 39-year-old female patient who suffered a psychotic break upon her arrival in Paris, and was hospitalized. In interviews she declared that she was going to be queen of “Sweden, Finland or Denmark.” Further investigation revealed that she had been hospitalized for schizophrenia repeatedly from the age of 19, and that she had traveled to Paris because an advertising campaign in Tokyo built around the slogan “France is waiting for you” had convinced her that she had a special destiny there (33). Type 2 patients do not necessarily have any personal or familial psychiatric history; their reasons for traveling to Paris are usually unremarkable. Their symptoms do not appear until 3 months or longer after arrival. As an example of this type, the authors cite the case of a 30-year-old man with no previous psychiatric history who came to France to study at Reims. After 3 months he ceased to attend classes; after 2 more months, he moved to a hotel in Paris. Hotel staff had him admitted to hospital shortly thereafter; he was experiencing severe anxiety, anorexia, and insomnia, and he heard voices threatening to kill him and his family (33).

Stendhal syndrome (Florence) has been named and studied in depth by Graziella Magherini, a prominent Florence psychiatrist and psychoanalyst. Magherini frames the syndrome as a response to an overwhelming aesthetic experience, which, in theory, could happen in any place where tourists are immersed in environments that are intensely beautiful to them: “La confrontation du sujet avec la cité d’art, avec son image écrasante, demure l’élément constant [The subject’s confrontation with the city of art, with its overwhelming image, remains the constant element]” in these cases (51). Nonetheless, it is only in Florence that Magherini has studied and treated the syndrome. The name she has chosen for it reflects this, referring to an emotional disturbance reported by the French novelist Stendhal during a visit to Florence in 1817. Upon leaving the Basilica of Santa Croce, he was so profoundly aesthetically moved that he experienced a racing
heartbeat, and a feeling of exhaustion, as though he was about to collapse (31). Stendhal’s experience is at the mild end of the spectrum of symptoms Magherini has observed in her patients at Santa Maria Nuova Hospital. She breaks down the 106 cases observed from 1977 to 1986 into 3 types: 1) patients with predominantly psychotic symptoms (“troubles de la pensée”), representing 70 of the 106 cases; 2) patients with predominantly affective symptoms, of which there were 31; and 3) patients whose predominant symptoms are somatic expressions of anxiety, eg. panic attacks, of which there were only 5 (171, 178). Only 38% of Type 1 patients had a prior psychiatric history, while 53% of Type 2 patients did (179). In many of the case histories presented by Magherini, patients report some sense of disintegration or fragmentation of self: A 53-year-old male patient, stricken after gazing for a prolonged time at Caravaggio’s Bacchus, had a sense that he was suspended between two major phases of his life, in an undefined, transitional state (“il n’y a alors plus rien de défini précisément”) (54). A 20-year-old female patient, after spending some time in the Uffizi Galleries, was seized by a terror that she was breaking into pieces (“l’angoisse de se casser en mille morceaux”), screamed, “Help me!” over and over, and was so agitated she had to be physically restrained (103).

Jerusalem syndrome was first named in the 1930s by pioneering Israeli psychiatrist Haim Herman (Kalian and Witztum 2002, 15), but psychiatrists did not begin keeping comprehensive clinical and statistical information on these cases until 1979 (Bar-El et al, 1991, 239). Here, tourists become overwhelmed by the religious and spiritual significance of being in the Holy City. A 2000 paper (Bar-El et al) lays out 3 main categories of the syndrome. In type 1, the syndrome is “superimposed on a previous psychotic illness” (86); much like patients with the classic form of Paris syndrome, patients with this diagnosis often travel to Jerusalem for strange or delusional reasons, and begin presenting with symptoms shortly upon arrival. In type 2, the syndrome is “superimposed on and complicated by idiosyncratic ideations” (87). Here, the patient does not have a history of psychosis, but does have a history of religious and/or ideological thinking that is extreme or bizarre by the standards of her society; no clear mental illness is present, but the patient may have a personality disorder, or an “obsession with a fixed idea.” The patient’s behaviour upon arrival initially falls within the bounds of normal (if extreme) religious expression, then veers into the pathological. As an example the authors offer the case history of a 45-year-old male patient who had been obsessed for some years with “the idea of finding the ‘true’ religion.” He came to Jerusalem to study at a Jewish religious seminary, but soon rejected Judaism in favour of “primitive Christianity.” He was hospitalized after suffering a breakdown in a church, where he had “an attack of psychomotor agitation,” shouting at the priests and destroying artifacts. (88) Type 3 patients have no prior psychiatric history when they arrive in Jerusalem, but once there, the syndrome develops according to an unusually consistent and specific sequence. The patients first become anxious and agitated, then separate themselves from any traveling companions. They begin to bathe and groom themselves compulsively. They then devise toga-like garments from white hotel linens, and, shouting out hymns or passages from the Bible, proceed to a holy site, where they deliver confused and rambling sermons. The authors saw 42 cases fitting the diagnostic criteria of Type 3 between 1980 and 1993 (88).
Discussion

None of these syndromes have been studied outside their locales, and in most cases, the reports from the clinical teams who first named and collected data on the syndromes are virtually the only scholarly articles about them to have been published. Partly, this is a function of the highly localized nature of the phenomena – it would be impossible to do independent clinical research on Paris syndrome outside of Paris, for example – but there is also a reluctance to accept these syndromes as legitimate, “real” disorders. Media coverage of the disorders usually includes commentary from skeptics, who point to the fact that most patients have a previous psychiatric history as evidence that their city-specific syndrome attacks are, in fact, merely manifestations of an already-present disorder, and that the connection to the city is not clinically significant.

Interviewed for a 1989 New York Times article on Stendhal syndrome, New York psychiatrist Elliot Wineburg takes this line, arguing that the patients were already sick and their psychotic symptoms "would have come out sooner or later" (Haberman). Similarly, in an online article about Jerusalem syndrome, American psychiatrist Melissa Hunt is quoted as saying that “Jerusalem syndrome does not actually exist as a distinct diagnosis in any formal nosological system,” and that sufferers are simply psychotic (Oltuski).

This skepticism has fueled an ongoing debate between two groups of researchers who have studied the Jerusalem syndrome. A 1991 paper, “Psychiatric Hospitalization of Tourists in Jerusalem,” examines data on tourists admitted to Jerusalem’s Kfar Shaul Psychiatric Hospital since 1979. The cases discussed resemble those associated with city syndromes, as described above. The authors conclude that “tourist psychopathology” is a specialization worthy of study (238), and that “religiosity” seemed to function as both a risk factor and a “stabilizing” factor in the cases considered (243), but the phrase “Jerusalem syndrome” is never used. The 2000 paper “Jerusalem syndrome,” cited above, builds on the research used in the 1991 paper, but here the authors explicitly state that their aim is “to describe the Jerusalem syndrome as a unique acute psychotic state” (86). In a response to this article, M. Kalian and E. Witztum – two of the authors of the 1991 paper -- write: “In view of our accumulated data, Jerusalem should not be regarded as a pathogenic factor, since the morbid ideation of the affected travelers started elsewhere. Jerusalem syndrome should be regarded as an aggravation of a chronic mental illness, and not a transient psychotic episode.” (492) When they wrote a similar response to a case history published by the Jerusalem syndrome group, those authors wrote a reply in which they pointed out that their original paper clearly acknowledged that Type 1, the most common form of the syndrome, is “superimposed on a previous psychotic illness,” adding, “As a syndrome rather than as a distinct nosological entity, Jerusalem syndrome may appear in the context of other major psychiatric disorders or as a de novo psychotic condition” (Fastovsky et al).

Note that the debate is not over whether the patients are ill – both sides agree that their symptoms are real. It is also not an argument about the course of the illness. Both sides agree that there is usually a pre-existing, sometimes latent condition that is aggravated in some way by the intensity of the patient’s response to unfamiliar surroundings. Kalian and Witztum seem inclined to deny that the symptoms may appear
de novo, but Hunt points out that such cases may simply be classified as Brief Psychotic Disorder, which is often triggered by stress and sleep deprivation, both common afflictions of tourists (Oltuski). The debate is really over what to call the phenomenon – whether to give it a name of its own, and whether to give it a place in the taxonomy of disorders, or to classify it, as Kalian and Witztum propose, as a “cultural phenomenon” instead (2002). It is this kind of question that Ian Hacking finds at the core of debates around what he calls “transient mental illnesses.”

In his book Mad Travellers, Hacking closely scrutinizes an outbreak of fugue – compulsive traveling, with amnesia – in France in the late 19th century, in order “to provide a framework in which to understand the very possibility of transient mental illnesses” (1). These are illnesses which arise abruptly in a specific historical and geographical context, persist for some time, then seem to fade away. To Hacking, the question of whether these illnesses are “real” is difficult to answer, because “our conceptions of real illnesses are of necessity being…renegotiated at present” (95), in large part because of confusion over the implications of recent advances in our understanding of the role biology plays in these illnesses. He focuses instead on the social and historical factors that allow a diagnosis to take hold in a particular time and place. He uses the “metaphor of an ecological niche in which mental illnesses thrive” (1). An outbreak of an illness like fugue happens when the diagnosis strikes a chord both with disturbed people in a society, and with clinicians searching for patterns and meaning in patients’ symptoms. Hacking lays out four “vectors” which contribute to the formation of such an “ecological niche”; the circumstances in which city-syndromes arise can be mapped onto these.

Observability: “In order for a form of behaviour to be deemed a mental disorder, it has to be strange, disturbing, and noticed,” Hacking notes (82). City-syndromes certainly fit this requirement. The theatricality of Type 3 Jerusalem syndrome is an extreme example, but victims of Paris and Stendhal syndromes are highly visible as well: as foreigners, they stand out, and they tend to have attacks in busy public places. In most case histories, patients are brought to hospital by police or by hotel staff.

Release: The disorder must, in some way, offer “an inviting escape” to people who feel trapped and alienated within their circumstances (82). Again, this applies to city-syndromes. It is not hard to see how, thousands of miles away from friends, family and co-workers, individuals who have been struggling to repress unacceptable ideations and behaviours may feel suddenly freed from the threat of social consequences. The Paris authors, in particular, note that patients are often fleeing stiflingly conservative home environments in search of an “ideal elsewhere [ailleurs ideal]” (33).

Cultural polarity: Hacking proposes that the behaviours associated with a transient mental illness tend to fall between “two social phenomena…one virtuous, one vicious” that preoccupy the society in which the illness arises. As an example, fugue lay between “romantic tourism and criminal vagrancy” – admired and feared activities, respectively, in late-19th-century France (81). Such a polarity is strikingly present with Jerusalem syndrome, which falls between passionate spirituality and religious fanaticism, both phenomena of intense interest to citizens and visitors of that city. It is less obvious with
the other, correspondingly less-notorious city-syndromes, but it can still be detected. Stendhal syndrome falls between an expression of refined aesthetic sensitivity – good – and an excessive, voluptuous preoccupation with beauty – bad, although not the focus of a prevalent social anxiety to the extent that fundamentalism is. Magherini does emphasize, in many of her case histories, that patients tend to come from emotionally repressed backgrounds where an intense interest in beauty is frowned upon. A similar polarity seems to be at work in Paris syndrome, although a proper analysis would require a thorough familiarity with Japanese culture.

Medical taxonomy: This vector is in place when a diagnosis fits into the current system of classification, but there is controversy over how it does so. In Hacking’s example, fugue was regarded by some experts as a form of hysteria, and by others as a form of epilepsy, making it a point of contention between two of the major research communities of the day, and therefore “theoretically interesting” (81). In the case of city-syndromes, the debate is over whether the syndromes belong in the current psychiatric taxonomy as discrete illnesses, or whether they are simply instances of established disorders and not representative of any clinically interesting new pattern, or whether they are not discrete disorders but are worthy of recognition and study as cultural phenomena.

What is behind the debate over medical taxonomy? What motivates researchers in some cities to argue for the inclusion of city-syndromes in our taxonomy of disease? There are almost certainly many cities where similar events occur but no such arguments have been made. “Talk to the guards who work at Elvis’ tomb year-round about people who are overcome when visiting an emotionally evocative site. If we worked at it, we could probably define a ‘Graceland Syndrome,’” remarks Hunt (Oltuski).

One factor is likely to be the psychodynamic orientation of many city-syndrome researchers. Looked at from a strictly biomedical perspective, the patients’ aesthetic or spiritual responses are epiphenomenal. That is, the meaningful content of the “stress” that brings about the pathological episode is not really part of the causal explanation of the event. In a psychodynamic explanation, however, meaningful content is paramount; an intense aesthetic response may induce a crisis within the patient’s personality, a threat to the integrity of the self, precisely because of the meaning it has in the context of that person’s life history. Furthermore, such a crisis may become part of a therapeutic narrative in which the patient is led, finally, to a strengthened and enhanced self-understanding. As such, although it is painful and dangerous, it has an ultimately positive value. This is evident in the work of Magherini, whose analysis of the Stendhal syndrome is psychoanalytic (and deeply romantic). Repeatedly, in the case histories she describes, tourists who have had emotionally repressed upbringings in northern Europe, or aesthetically impoverished lives in the U.S., suffer breakdowns when they are immersed in the extravagant beauty and sensuality of Florence. During these crises, they experience a kind of fragmentation of personality; if they are able to tolerate a period of ambiguity and uncertainty (“un intervalle d’incertitude”) in a treatment facility, they are rewarded with “the restoration of order, and a broadening of mental range [la remise en ordre et l’élargissement du champ mental]” (169). For example, the male patient from Bavaria who, after gazing at Caravaggio’s Bacchus, had a sense that his inner self was
fragmenting, and experienced strange perceptual distortions – “colours never seen before” – subsequently was able to recognize his own latent homosexuality (53-56).

It is unclear whether the Paris and Jerusalem researchers have any psychodynamic orientation, although the Paris authors hint at this when they describe Type 2 of the syndrome as a “crisis of identity” that manifests in individuals with “fragile, limited personalities” (33), and the Jerusalem authors make note of Freud’s “sense of derealization while visiting the Acropolis” (89). However, the skeptics, Kalian and Witzum, do employ a psychodynamic approach in examining the Jerusalem syndrome phenomenon; a 2002 paper, “Jerusalem Syndrome as reflected in the pilgrimage and biographies of four extraordinary women from the 14th century to the end of the second millennium,” closely examines the personal histories of its subjects “to reach a deeper understanding of the dynamics of their eccentric behaviour” (1). In rejecting the validity of Jerusalem syndrome as a unique psychiatric diagnosis, Kalian and Witzum seem to be rejecting, not the idea that the experience of being overwhelmed by Jerusalem is meaningful in these cases, but the idea that it is causal. The “religious atmosphere of the Holy City” – the experience of being immersed in an environment of historical and spiritual significance – is “not the primary cause” of the illness (1), but it seems to have contributed to the symbolic idiom these women used to express their inner turmoil. The authors characterize the syndrome as “an outcome of deep individual psychological needs, at times reflecting a production of psychopathology coloured by the individual’s cultural background” (1-2). They read their historical subjects’ behaviours as attempts “to translate delusionary ideations into earthly endeavor,” and see “creativity” in them (14-15). Their position appears therefore to preserve the positive narrative value of the patients’ Jerusalem crises, while locating this aspect of the phenomenon outside a psychiatric taxonomy.

To Hacking, transient mental disorders offer “a way to be mad, or to be thought of as mad” to people in their geographical and historical context (55). Kalian and Witzum’s position on Jerusalem syndrome can be read in this way as well. To Hacking (92), as well as to Kalian and Witzum, these disorders are not “real” mental illnesses, although the patients’ symptoms are real enough. Hacking takes an ultimately negative view of fugue, noting that now that it has faded from view, his “hope is that the vector of medical taxonomy never succeeds in making space for it again” (94). If we adopt Kalian and Witzum’s view of Jerusalem and other city-syndromes, should it be our hope that these “cultural phenomena,” too, will be eliminated? Certainly, it is the job of psychiatry to reduce the suffering caused by mental illness, and in that sense, it should seek to prevent attacks of the kind experienced by these “mad tourists.” But psychiatric prevention is far from perfect, and in cases where these attacks cannot be prevented, reading them as incidents of city-syndromes may invest them with a certain dignity and meaning. To be overwhelmed by the beauty of the art in the Uffizi galleries, or by the spirituality of the Holy City, or even by a wounding sense of alienation in the streets of Paris, is less humiliating than to simply crack up under the stress of travel, and perhaps more likely to lead the patient to worthwhile self-reflection. Whether this meaning – the content of the stress that triggers the incidents – is taken as part of the causal history of the illness, or whether this cultural reading of the illness is separate from psychiatric accounts of it, is the larger issue underlying the question of whether city-syndromes are “real.”
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Tourists with the third subtype of Jerusalem syndrome succumb to a sequence of identifiable stages that are consistent, characteristic, and highly specific. First, such sufferers exhibit Òanxiety, agitation, nervousness and tension.Ó They then announce that they wish to split off from their tour group or family and explore Jerusalem on their own. Ó The mere existence of these Òcity syndromes,Ó as Nadia Halim dubs them, is controversial. Many voices have weighed in to argue that these episodes are merely exacerbations of preexisting psychiatric disease or the initial onsets of mental illnesses that happen to occur in foreign cities. Still others have chalked up the circumstances to jet lag or some other mundane variety of travel-related disorientation.