Culture and Urban Mental Health

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Mostly because of increased speed and decreased costs of communication and transportation, cities are growing increasingly diverse in their population. Consequently, cultural factors have taken center stage in the understanding of urban mental health. This article will focus on the main approaches to urban mental health and briefly summarize the 3 lines of research in this area. It will then discuss the main themes of a vast body of literature on the cultural aspects of urban mental health.

Urbanization is probably the world's single most important demographic shift over the past century. In the early nineteenth century a mere 5% of the world's population was urban. In 1996, 46% of the world's population lived in urban areas. It is expected that in 2007 half of the world's population will be living in urban areas, and by 2030 the urban population will double and reach 5.1 billion. This massive growth is particularly evident in developing countries, especially in Africa and Asia (Figure). In Asia, the urban population currently constitutes 37% of the total population.

Megacities—cities with over 10 million inhabitants—are rapidly increasing in number. Currently, 15 cities of this size exist but more are expected to proliferate over the next 3 decades, especially on the Asian continent. Although population growth is found in cities of all sizes, the fastest growth is in cities with populations in the 1 to 5 million range. The urban explosion affects mostly poor populations because growing cities fail to match the population expansion with proper infrastructure, housing, services, job opportunities, and economic expansion. This demographic change is significantly affecting both cities and rural areas. Today's cities are studies in contrast. They are agents of change—centers of finance, entertainment, and culture—offering opportunities for recreation, employment, and access to services; however, they are also reservoirs of crime, violence, poverty, and inequality.

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**Approaches to urban mental health**
The 4 most frequently cited methods of conceptualizing urban mental health are the urban health penalty, urban sprawl, urban living conditions, and urban health advantage.

- Urban health penalty concentrates on unhealthy environments of inner cities, particularly in the United States where, over the past 50 years, the departure of the middle class and jobs to suburbs has left behind impoverished and increasingly segregated populations.
- Urban sprawl concentrates on the adverse effects of growth on health. A rise in obesity, sedentary lifestyle, and social isolation have been associated with urban sprawl.
- Urban living conditions focuses on physical and mental health as shaped by a variety of contexts. This is an integrated model that sees urban health as a function of individual factors affected by local, social, and physical environments.
- Urban health advantage views urban living as an advantage when it comes to health. Some health indicators are better in urban than rural areas, especially in developing countries. In essence, the urban poor often fare better than the rural poor. In a demographic and health survey, infant mortality in poor populations was found to be lower in the urban setting than in the rural.

**Research models**
The literature on urban mental health can be divided into 3 main categories, comparisons of urban versus rural, comparisons between cities, and features of urbanization and mental health. The urban-rural comparisons that were popular in the 1960s and 1970s, have recently become less
frequent, in part because of conflicting results—some investigators found differences in prevalence of psychopathology while others did not—and also because they can only provide a snapshot of cities whose realities often change over time. For example, higher rates of mental illness have been described in urban compared with rural areas in the United Kingdom, while no differences were found in a similar study in Canada. The between-the-cities approach attempts to identify features that may have an impact on mental health, but by and large, findings may be hard to generalize to other cities or even to the rest of the city's populations. The third and currently in-vogue approach is to study discrete spatial units (neighborhoods or communities) to identify specific characteristics in small areas that are associated with specific physical and mental health problems. Because this approach is also context-specific, findings from this type of research are also not easy to generalize. Yet, this model, compared with the other 2, has the advantage of looking at discrete features of urban living; this approach leads to the ability to identify health outcomes and allows for a more focused, and therefore more likely to succeed, plan for intervention.

**Cultural patterns in today's cities**

**Cultural diversity**

The increased opportunities for geographic mobility have produced an unprecedented multiethnic influx to cities. In New York, first-generation immigrants compose almost 10% of the population (50% of them from the Americas). In the borough of Queens, with its 250,000 inhabitants, there are 80 different languages spoken from 123 different countries. The United States' cultural and ethnic composition is rapidly changing. Demographers project that by the year 2050, 1 of 4 US inhabitants will be of Spanish decent. The complexities of cultural aspects that impact psychopathology and mental health are producing both challenging and beneficial changes in the way psychiatry is practiced. The negative aspects of such multiethnic migration, however, may include lack of familiarity with illness presentation, culturally specific belief systems, and reluctance to rely on medical systems—all of which may significantly delay proper assessment and treatment. The multiculturalism of today's cities contributes to increased tolerance, better quality of life, and sociocultural stimulation; at the same time, it often contributes to heightened social tensions, interethnic striving, and cultural conflicts—all of which undoubtedly carry mental health ramifications.

**Migrations, acculturation, cultural adaptation**

Migration to cities, which in the past, was mostly intranational and more recently transnational, has increased dramatically over the past few decades. Most migrants come from rural areas, bringing values, beliefs, and expectations about mental health that are often very different from the ones they encounter in their new location. In many instances, people coming from rural areas have endured years of isolation, lack of technologic connection, poor health, poverty, unemployment, and inadequate housing. They need to acculturate and adapt not only to a new challenging urban environment but also to alternative systems of symbols, meanings, and traditions. Khoa and Van Deusen, in their study of communities with different traditions and customs, describe 3 patterns of acculturation.

- Rejecting pattern: often noted in elderly immigrants, characterized by the unwillingness to adapt to the new cultural reality.
- Assimilative pattern: frequently seen in young persons, in which the immigrant embraces the new culture.
- Bicultural pattern: the immigrant is able to integrate cultural values from the 2 cultures.

The rejecting and assimilative patterns can often be fraught with isolation, anxiety, and confusion about identity. Biculturality, on the other hand, has been seen as leading to more adaptive outcomes by reaching a compromise in a process of acculturation between 2 contrasting cultural identities. Effective mental health care of immigrants needs to consider the impact of cultural frictions on their lives. An increasing number of people that are migrating to cities are refugees from other countries (approximately 18 million worldwide), with a significant number suffering from posttraumatic stress disorder (PTSD) and other disorders. Westermeyer has comprehensively and prospectively studied a large number of east Asians at the center for refugees in Minneapolis. The findings from one 10-year study show that some of the refugees' symptoms, such as depression, low self-esteem, phobia, and somatization, improved; however, other symptoms, such as paranoid and anxiety disorders, tended to persist and often interfered with the process of acculturation. As indicated by Kirmayer, it is important for the clinician to recognize the wide variety of meaning.
that different cultures assign to manifestations of distress after a traumatic experience. For example, in many cultures, dissociation and somatization are considered normal reactions to a traumatic experience. As a rapidly growing number of traumatized refugees from war-torn areas move to cities, mental health professionals need to become attuned to the cultural aspects of PTSD.

**Major Urban Problems**

**Violence** Violence, an endemic reality for most cities in the world, is estimated to claim at least 3.5 million lives a year. The burden of injuries related to violence is a significant public health issue. A glaring example of how social tensions due to social polarization lead to urban expression of aggression comes from the South American and Caribbean regions, where the highest rates of homicide and criminal victimization in the world are found. In a World Bank study, Moser\(^\text{14}\) has demonstrated that increasing inequalities in urban areas in 4 Latin American countries were associated with increases in youth, gang, and community violence. Children and women are especially vulnerable to interpersonal violence in urban areas, especially in developing countries, where cities are populated by a large percentage of children and adolescents. By 2025, 6 of 10 children will live in cities. As a result of rural-urban migration and high fertility rates, it is estimated that about 50% of the urban population in developing countries is younger than 25 years, and in Latin America, 35% of the population is younger than 14 years. In addition, there are approximately 30 million street children worldwide, and most of them are involved in illegal activities in urban areas.

Violence against children and among children is a growing urban phenomenon. Often, cultural norms determine the form violence takes and its acceptance by the urban community. Culture-specific parental attitudes towards corporal punishment range from it being viewed as child abuse to it being considered part of a healthy upbringing. A study by Baron and Straus\(^\text{15}\) in the United States found a correlation between cultural norms and extreme forms of violence. Huesmann and Guerra\(^\text{16}\) demonstrated that mass media also significantly influence children's beliefs about what constitutes accepted violence.

Children and adolescents in socioeconomically deprived urban areas are often drawn to gangs. Although not exclusively an urban phenomenon, gangs thrive in inner cities where degradation, poverty, drug use, and unemployment result in an explosive blend favoring violent solutions. The rules and behaviors of gangs vary considerably from culture to culture and within the same culture. They exist in 3300 cities across the United States and account for an important percentage of crime. Some gangs have morphed into powerful transnational organizations that take advantage of the hypermobility of members and their culture. Glamorized by music and the media, gangs frequently control entire cities and their communities. Given the considerable impact of gangs on physical and mental health in urban areas, it is important for mental health professionals to familiarize themselves with their code of ethics and normative rules, as well as their relationships with the community.

Domestic violence is also highly prevalent in urban areas. In both developed and developing countries, women living in urban settings are at greatest risk to be assaulted by intimates.\(^\text{17}\) The multiplicity of roles women play in society, including sexual, reproductive, marital, and family, makes the multidimensional phenomenon of violence against women heavily influenced by cultural beliefs. In addition, women have a subordinate role in many cultures that renders culturally sanctioned violence more likely to be accompanied by coercion, humiliation, and deprivation. Social support and the presence of close relationships appear to be protective against violence. Conversely, poor social relations are associated with poor health outcomes.

**Homelessness**

As cities grow bigger and more populated, they are often unable to match inhabitants' needs. With an estimated 30% of the urban population living in slums, homelessness and inadequate housing pose a major threat to urban physical and mental health.\(^\text{18}\) Cultural barriers based on the notion that informal settlements are part of the normal landscape of a city are frequently at the basis of officials' resistance to transform slums into healthy environments. For these reasons, agencies such as the United Nations Center for Human Settlement work on rebuilding communities rather than just structures.

**Work and mental health**

The World Health Organization (WHO) has recently issued a report that outlines the considerable obstacles faced by cities in the reintegration of mentally ill patients.\(^\text{19}\) Culturally mediated factors, such as prejudice and stigma, systematically and significantly preclude access to adequate work for relatively functioning persons. Research findings on potential predictors of successful participation in employment programs show that the most relevant variables are work expectation and attitude.
about work as a source of pride and accomplishment. Culture exerts a tremendous influence on how mentally ill persons are perceived, and this can be the difference between failure and success.

**Cultural considerations in psychopathology**

Using a composite diagnostic interview, WHO investigators studied cross-national comparisons of the prevalence and correlates of mental disorders. They found a consistent pattern of higher prevalence of mental disorders in urban areas than in rural areas. Low socioeconomic status is known to be associated with a higher prevalence of major depression, substance abuse, personality disorders, and schizophrenia.

Cultural determinants, such as attitude towards persons with mental illness, play a major role in the drifting of untreated individuals toward the lower layers of society, which may significantly hamper chances of reintegration. The relationship with social rank is also an important determinant of physical and mental health and is heavily influenced by cultural dynamics. Gilbert and Allen studied the role of entrapment and defeat in depression within the framework of the social rank theory. Feelings of inferiority, shame, low self-esteem, and being of low rank are commonly found in depressed people. This promising area of research bridges the gap between the social and cultural dimensions in urban mental health.

Research on the relationship between urban living and schizophrenia has yielded culturally intriguing findings. The international pilot study for schizophrenia compared 1200 patients in 9 countries. The investigators found that patients with schizophrenia in developing countries tended to have a less severe course and better outcomes than those in developed countries and that outcomes may be more favorable in rural settings. Favorable outcome was associated with vertical mobility, extended families, psychiatric services that included active family participation, and absence of specific community stereotypes of mentally ill persons. These findings point to the importance of cultural expectations, support systems, and stigma. High tolerance for mental illness appears to have a significantly positive impact on patients with schizophrenia in developing countries.

Similarly, in the Outcome of Severe Mental Disorders study in patients with schizophrenia, all measured indices had better outcomes in developing countries than in developed ones. A particularly striking finding was that 41.6% of the sample from the developed-countries cohort had impaired social functioning throughout the follow-up period, compared with 15.7% of the sample from developing countries. How much of this large difference can be accounted for by the local cultural expectations for functioning remains an unanswered question that awaits further inquiry.

**Conclusions**

The panoramic view discussed in this article is meant to provide sufficient evidence that understanding the impact of cultural factors on urban mental health is necessary for a successful approach to mental health in cities. Clearly, each city has a variety of unwritten cultural norms that permeate all aspects of mental health. In addition to understanding the blueprint of a city, we need to shed our cultural assumptions when considering the complex contextual factors for each city. Finally, we need to adapt our Western views of cultural norms and how citizens function within the urban environments. It is our hope that research based on culturally attuned interventions leading to positive outcomes in urban mental health will form the basis for policy changes that will address both cultural and mental health needs of those living in cities.

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