Cross- Cultural Contact: psychosis and the city in modern life

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# Abstract

The city is a focus of modern social, economic, and political life. In both developed and developing contexts, schizophrenia has been shown to have a higher urban incidence. The approach in social psychiatry so far has been to concentrate on the impact of the urban environment on psychosis and to associate, correlate and classify factors of interest. This paper goes back to the basics in thinking about the ecology of mental illness. I propose that the social sciences are needed to understand the experience of the city, and an elucidation of the process is necessary to fully interpret epidemiological findings. The individual’s experience of the city can be conceptualised in terms of cross-cultural contact across constructed boundaries of identity, ethnicity, and class. Acculturation is a useful beginning in thinking about how the modern city causes illness.

# Introduction

This paper began as a series of questions about the ways in which humans interact within the modern city: What are the processes through which the individual engages with its institutions? How can we understand urban culture, the experience of cities across time, and the city as a rapidly growing unit of social organisation? Ultimately, how does the city impact an individual’s mental health ­– in particular risk of psychosis?

Urban sociology, anthropology, and geography answer these questions by studying the modern city as a focus of economic, social, and political life. Parallel to this, the city has been studied in terms of its impact to our physical (Harpham 2001) and mental health (De Silva, McKenzie et al 2005). Schizophrenia has higher incidence in urban settings in both developed (Allardyce 2001; Verma et al 1997) and developing (Harpham 1993) countries.

Social psychiatry has focussed on the impact of the urban environment on psychosis and associating, correlating, and classifying factors of interest. Explanatory frameworks of the city as an aetiological factor for psychosis have mainly centred on differences in high density and high paced living, resulting in a loss of community and social capital with subsequent increase in social fragmentation. I argue that this is a limited perspective, which misses insights about psychological processes gained from looking beyond the epidemiology and thinking about the city in terms of an individual’s experience. We need to take a combined approach, where epidemiology is understood within a historical, sociocultural, and psychological context.

This paper reconsiders the ecology of mental illness. It will first explore definitions of the city and its historical development as a background to understanding the complexities of the modern metropolis across cultures. Second, it will examine the theoretical and methodological advancements in studying the city and review the literature on psychosis and the city. Third, it will explore the individual’s experience of the city in terms of underlying social and psychological processes, with comparisons drawn from work on migration. Ultimately, the city is conceptualised as a global hub of migration, where individuals encounter the other and where boundaries intersect. We can understand the individual’s experience of the city in terms of identity formation and cross-cultural contact. This should inform our explanatory and interpretive frameworks of psychosis epidemiology.

# What is a city?

Defining the city sets the boundaries of the discussion. Common themes underlie an academic conceptualisation of the city and its changing social, cultural, and political significance.

Archaeologists define the ancient city in terms of size, population density, and complexity – a city is ‘a community with a significant degree of division of labour that makes it part of a network of cities’ (Modeski 1997; Cowgill 2004). Modeski (1997) distinguishes the city from a settlement of farmers that is ‘protected […] by a wall, not operating in a system of cities.’ The idea of the city therefore combines two components: population size, and a particular structure, where the city is a set of social relations that have global reach.

The idea of the city as a polis, literally defined as ‘an ancient Greek city-state’ (Collins English Dictionary 2012), has embedded meanings of citizenship, governance, and politics. Cowgill (2004) emphasises the importance of individual experience, the ‘practices, perceptions, experiences, attitudes, values, calculations and emotions’ of the city beyond considerations of size and complexity. Cities did not simply ‘happen’ out of technological, political, and economic innovations, but were purposely created. The city’s infrastructure and institutions act as ‘active instruments for shaping behaviour, attitudes and emotions.’ Therefore, an understanding of the city should consider size and social relations as well as individual experience.

# Growth of the modern city

Since the industrial revolution, cities have been associated with modernity, progress, and industrialisation. Cities grew in conjunction with the social, economic, technological and political changes that shaped the modern world, changes described as ‘a widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life’ (Held et al 1999). In thinking about the processes of urbanisation, modernisation, and westernisation, globalisation is a useful framework for understanding the growth of the modern city and its impact on nations, communities, and individuals. The modern city is not homogeneous but global and multicultural, and its form, structure, and character are specific to its particular contexts. Understanding both the theoretical progressions and the actual historical changes is necessary in understanding the modern city.

The trend towards urbanisation has been marked by a few key events. There are significant differences between and within developed countries and developing countries, in terms of infrastructure, governance, jobs, and population make-up. London is an example of a developed city with a global outlook. From its beginnings as a Roman town, the city industrialised in the 18th century into divided neighbourhoods based on class and industry, and expanded to incorporate its peripheral towns and villages. Immigration and emigration expanded rapidly after the fall of empire, with mass migration into London of people from across the former colonies, forming diverse communities and identities. All of these forces have shaped the urban landscape and cosmopolitan feel of this metropolis as a global hub of economics and innovation. However, this is not the story across the board. In regions of Africa, there are lower initial and total levels of urbanisation (Harpham 1993). Equally, cities have different political contexts ­– e.g. the creation of Israel reshaping Jerusalem – and different opportunities or the lack thereof – e.g. the slums of India. Both global geo-political and historical forces shape cities, as well as individual sociocultural contexts. Finally, the city may offer socio-political and economic benefits, but can also host ‘concentrated impoverishment and human hopelessness’ (Harvey 1996).

# Studying the city – historical to current

Psychosis and the city are traditionally studied in terms of the impacts of the wider social environment on mental illness and human wellbeing, which ran parallel to the development of the social sciences. Early social psychiatrists combined sociology and psychology, and used both epidemiological and symbolic approaches. In *Suicide* (1951), Durkheim laid the groundwork for studying the effects of societal factors on mental illness across urban populations of different countries. Rates of suicide were not constant across societies or throughout time. Durkheim grouped the outward expression of suicide as mental distress into the egoistic, altruistic, and anomic, which related to the expectations and adjustment of the self to society. It was the role of the sociologist, Durkheim argued, to look at the social factors of suicide, and the clinician to look at the individual’s psychology.

Faris and Dunham (1939) used epidemiological approaches, and were very much interested in rates of psychosis across different neighbourhoods. They drew heavily on Burgess’s typology of the city – a system of concentric zones with business zones in the centre surrounded by industrial zones, workingmen’s homes, and commuter zones. Here, they divided the city into distinct populations with transitional boundaries, and compared rates of psychosis. Smith et al (2010) extended this study of neighbourhood characteristics by emphasising a multidimensional approach, whereby neighbourhoods were characterised by a continuum of factors rather than dichotomies such as urban/rural, affluent/nonaffluent. They argue that cities cater for more than ‘just the human need for shelter,’ and aim to describe neighbourhoods in terms of visual, functional, socio-economic, and demographic characteristics. Current social psychiatric study of the city still relies on measuring key neighbourhood dimensions including deprivation, community organisational structure (such as family composition and housing characteristics), and ethnic composition (Allardyce and Boydell 2006).

In opposition to sociology’s focus on refining measurements of neighbourhood characteristics, anthropology focuses on the individual’s experience of socio-political and economic processes, as well as on the cultural meanings of the urban environment. Low (1996) argues beyond ‘essentialising the city as an institution… through population density, unique physical qualities or appearance, and styles of social interaction’. He does not subscribe to a purely symbolic analysis, but argues that ‘urban’ should be considered a process rather than a category. This articulation of the urban as a process supports the argument of my paper: an understanding of psychosis and the city needs to go beyond the purely sociological and epidemiological, taking into account the social and psychological processes of an experience of a city. In short, we need to see beyond subject boundaries.

# The city and psychosis

In looking at the city as an aetiological factor in the development of psychosis, the key question asked by psychiatrists is, ‘Does the city increase the incidence of psychosis?’ This section reviews the key conclusions from current work, starting from epidemiological findings and unpacking the underlying theoretical and methodological assumptions. The idea of the city is complex, so this section disaggregates neighbourhood factors, urban and rural differences, and developing and global metropolises. The social psychiatric literature has not made such divisions clear, and thus is too universalising in its conclusions.

## Developed contexts

For developed contexts, research focuses on either intra-city or urban-rural differences. Both aim to characterise the impact of the urban ecology on schizophrenia. Populations living in urban areas have greater risk of psychosis (Allardyce et al 2000; Lewis et al 1992; Marcelis et al 1998; Mortensen et al 1999). The effect size of urban environments has been difficult to quantify. Faris and Dunham (1939) and van Os et al (2001) measure psychotic symptomology, while others measure schizophrenia incidence (Allardyce 2001). For specific cases, the extent of urban-rural difference has been quantified as a 61% increase in the UK, but was insignificant when corrected for ethnicity (Allardyce 2001). Temporal aspects of exposure have also been studied: urbanicity at birth and during upbringing increases risk (Pedersen and Mortensen 2001), but urban residence at onset was not significant when controlling birth (Marcelis 1999). Further differences in urban-rural incidence can be explained by service provision and use (McCreadie et al 1997).

The underlying assumption behind these approaches is that urban living affects ‘the development of normal mentality and normal behaviour’ (Faris and Dunham 1939), and that this maladjustment leads to psychosis. However, by focusing on explaining mechanisms of causation – such as material deprivation, social fragmentation, and neighbourhood dimensions (Allardyce, Gilmour et al 2005; Boydell et al 2001) – ideas about the direction of causality have not moved beyond urban drift and urban shift (Faris and Dunham 1939).

Approaches have been limited by the social data available and the confinements of an epidemiological methodology. It has been difficult to characterise which factors of urban life are most influential, and how they interact are still debated. Allardyce et al (2005) looked at social fragmentation independently from material deprivation and urban-rural category and identified a dose-response relationship. Measurement is often inconsistent, and urbanicity has been characterised in different ways according to various social research traditions. For example, Scandinavian articles’ discussions of urban environments are often reduced to population density (Pedersen & Mortensen 2001, Peen & Dekker 1997). Coghan’s (1996) methodology for measuring social fragmentation used census data on the number of privately rented household, single-person households, and number of unmarried persons. Therefore, social psychiatry has begun sketching a picture of some broad impacts, but lacks a consistent methodology or theoretical understanding of process.

## Developing contexts

Studies in developing countries have primarily focused on health impacts of the urban poor, and emphasised how their disease patterns reflects their existence at the interface between underdevelopment and industrialisation. Ekbald (1990) characterises a triad of these impacts: infectious and gastrointestinal disease; chronic degenerative diseases; and conditions associated with stress precipitated by social isolation, insecurity, dissolution of primary family relations, and cultural conflicts.

Due to the wide range of development strategies and city specific contexts, generalizable conclusions from the literature on psychosis in developing countries are illusive. Harpham (1993) found little work on intra-city differences, perhaps reflecting lack of interest within those countries. There is more work on urban-rural differences in psychosis incidence. In some studies, the mental health impacts of urban settings are attributed to negative living standards, such as noise, low wages, and high population density, contrasted against a supportive rural ideal (Fromm 1973; Greenblatt 1970). This is not universal. Cheng (1989) found no urban-rural differences in Taiwan; Ekblad (1990) attributes this to cultural differences. Xiang et al (2008) recently published a 5926-subject prevalence study of China, drawing attention to the urban and rural heterogeneity in diagnosis and service provision with subsequent public health implications. Lack of social provision is also important in Korea for people with depression (Kim et al 2004).

However, research has mainly focused on mental health outcomes and not on psychosis in particular. Findings suggest that there is a wealth of information to be uncovered in specific contexts. Often even simple prevalence is not known, such as in China where only two national surveys have been done on schizophrenia (Twelve-Region Psychiatric Epidemiological Study Work Group 1986; Chen et al 1998). The new interest in Global Mental Health might be able to redirect focus and fill in the gaps (Patel et al 2011).

## Migration – the global city

‘The global city’ (Sassen 2005), characterised by flows of people, goes beyond physical urban geography. There is still a limited understanding of how these populations encounter each other, but the literature on migration and schizophrenia has been a useful beginning. Odegaard (1932) first observed that the incidence of schizophrenia was much higher for Norwegian migrants to the USA than for those that remained in Norway. Similar findings hold for the Irish, Indian, Pakistani, and Black-Caribbean ethnicities in the UK (Cochrane 1977). Bhugra (2000) stresses that migrants are not homogenous groups, and move between urban-rural settings and between countries for different reasons. Migration increases schizophrenia incidence through direct psychological stress caused by reality-expectation mismatch, acculturation, and cultural bereavement (Bhugra 2000), as well as other confound factors such as low socio-economic status, limited access to services, and day to day racism. The approach used to analyse the effect of migration on psychosis can also be used for the city. Key themes for both are cultural: stigmatisation, social disorganisation, lack of social capital, alienation, and anomie.

# Understanding processes: the city as a hub of cross-cultural contact

This section explores an individual’s experience of the city and how boundaries are formed and crossed. The underlying process, I argue, can be understood in terms of identity formation, cross cultural contact and wider social and cultural change.

## Experience of the city

The city has already been presented as an interwoven series of encounters, places, and spaces that people move through and between. The city was first seen as a completely different experience to smaller units of social organisation such as towns. Simmel (1993) first developed the idea of a ‘metropolitan individuality’ as an ‘intensification of emotional life’ due to changes in ‘external and internal stimuli.’ Further, the depersonalisation of money economies and expectations of ‘punctuality, calculability, and exactness’ is associated with a capitalistic social order. There is a contradiction between the anonymity experienced in the city and expected socialisation. Embedded within this is an idea of an urban-rural difference in the complexity of societal expectations. People are thrown together, yet are quite separate.

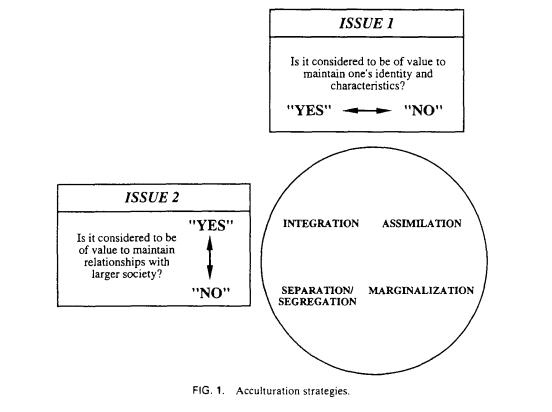
Contemporary ways of understanding the city (reviewed by Low 1996) are more complicated. They think about social relations as multiple layers, but also as multiple divisions – the ethnic city, the gendered city, the traditional city, the deindustrialised city, the global city. The divided city is physically manifested by city walls and divisions between neighbourhoods, the contested city between cultural movements. This anthropological approach centres on how meaning is created through the social construction and social production of space. Rotenberg (1992) describes a ‘subset of knowledge people gain from their lived experience and value’ as a kind of socialisation into city life. Therefore, the symbolic formation of communities and creation of shared social spaces are vital for healthy cities. However, social sciences have not shown this to be the case. Sennett (1992) describes a new kind of urban isolation from the separated of our disparate yet connected lives; a pattern of living is a product of a capitalist and globalised social order. Further, on a neighbourhood level, research into ‘gentrification’ in racially and socioeconomically diverse neighbourhoods show surface changes do not improve perceptions of disorder (Sullivan and Bachmeier 2012). In Butler’s (2003) study in Islington, the reason was given that people gravitate to people like themselves, and a narrative of common belonging is not developed.

## Cultural contact: acculturation, hybridisation, processes of change

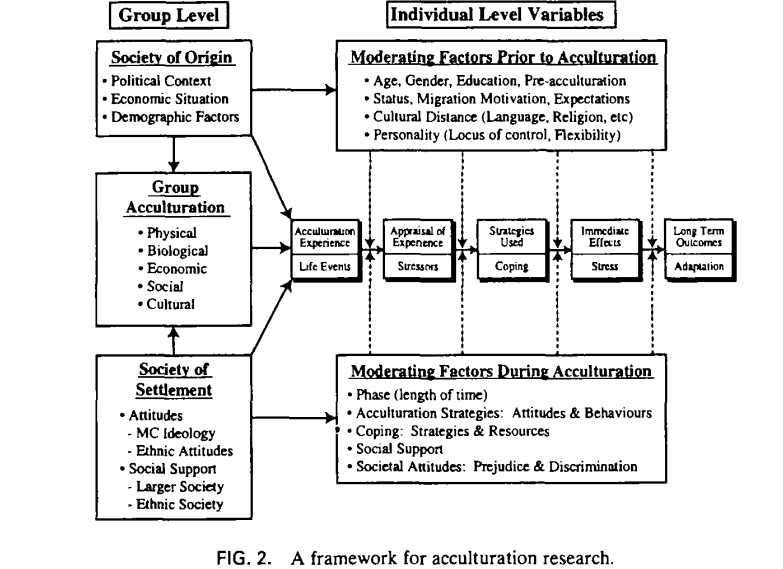
Both social sciences and social psychiatry have shown that the negative impacts of cities are a lack of social capital and social cohesion, and both discuss community level phenomena (Harpham 1993; Sampson 1997). I argue, however, that considering the individual’s experience of the city in terms of complex encounters between different social spaces, identities, and relationships is vital. The city consists of divisions and boundaries, and identities are constructed across class, gender, age, sexuality, ethnicity, and even profession. The individual’s experience of the modern city can be seen as an intensification of cross-cultural contact, where the individual continually meets the other. These ‘meetings’ have already been theorised in the migration and schizophrenia literature as the concept of ‘acculturation,’ used to understand identity formation, socialisation, and such processes can cause psychological stress (Bhugra 2000).

### How does acculturation apply to the city?

‘Acculturation’ was initially used to describe groups coming into first-hand contact with others and ‘subsequent changes in the original culture patterns of either or both groups’ (Redfield et al 1936). The direction of change was unspecified and called assimilation. Later, reactive, creative, and delayed relationships were operationalized (Social Science Research Council 1954). Anthropologists first saw acculturation as a group process that explains how individuals within the group imbibe culture and react to meeting different cultures. Graves (1967) developed the concept of psychological acculturation, ‘the degree to which [individuals] participate in these community changes’ (Berry 1970). Anthropological and psychological acculturation therefore function on both the group and individual level. Both have to negotiate changes in identity, values, and attitudes within wider social, economic, and political trends. In thinking about the city, both concepts of acculturation apply, and are used to explain the interactions of the individual and how they adapt to the expectations of city life.



Berry (1991) developed psychological acculturation to incorporate strategies of integration, separation, and marginalisation, as well as assimilation. Fig. 1 also clearly separates identity from society; in this case, society determines particular social and cultural expectations of a divided city.



The process of acculturation causes psychological stress, through both group level and individual level variables (Berry 1997). Fig. 2 is a good illustration of the modalities of an individual’s transition and the protective and detractive moderating factors. Importantly, the time that it takes for the sub-process of cultural shedding, cultural learning, cultural conflict, and finally assimilation to occur also determines the timescale of psychological stress. During this process, the individual is aware of the negative attitudes of the other. Supportive relationships with people culturally similar are helpful (Berry and Kostovcik 1990), and experience of prejudice has been shown to be negative (Halpern 1993). Within the city, the continual buffering between new cultural values to be learnt and assimilated means that the individual is under continual stress. The concept of acculturation is useful in understanding these reactions of the individual.

### Critique?

Psychiatrists have taken theories such as acculturation on board as an explanatory framework for epidemiological finding; however, this has been done too uncritically. Thinking of acculturation as a psychological process is too unidirectional, and fails to consider other possibilities when an individual encounters a foreign culture. A useful analogy here might be Goffman’s (1959) idea of the dialectical self, and the idea of the reciprocal formation of the self. The city has been taken too much as a series of homogenising forces without a consideration of plurality. The idea of plurality or the possibility of hybridisation is a sociological critique of how the individual assimilates new cultural information, and is a reaction against the view that global cultural forces are essentially homogenising (Pieterse 1994). Local cultures have resistance in their appropriation of western media (Madianou 2005), and Appadurai (1990) suggests that a ‘plurality of imagined communities’ can coexist. Acculturation is not a one-way process, but a complex negotiation, moving us beyond simply dichotomised urban-rural, coloniser-colonised, or Eastern-Western cultural relations.

In terms of psychology, Khoa and Van Duesen (1981) prescribe different levels of readiness to assimilation according to age. The elderly often show a rejecting pattern, characterised by the unwillingness to adapt to the new cultural reality; the young often show an assimilative pattern, where the new culture is embraced; and others show a bicultural pattern, where values from two cultures are integrated. Approaches to understanding how acculturation causes psychiatric distress using a combined psychiatric and anthropological approach are rare but are extremely valuable. Studies such as Mavrae and Bebbington’s (1990) investigation of Greek immigrants are key reminders that different cultures acculturate in different ways due to inherent differences in sociocultural values, and how these change. Therefore, within the city these identities are many and complex, and may be too informal or transient to study. Experience of the city can and should be understood in terms of cross-cultural contact, the exact mechanisms are complex and need further investigation.

### New approaches- the individual within wider societal change

The literature has so far focused on cultural contact, looking at the relationship of the dominant group with the non-dominant group, and has been driven by a search for universals. Cultural identity has been operationalized in terms of religion, rites of passage, language, dietary habits, leisure activities, etc. When boundaries are crossed in the everyday, ‘interactions can be both non-cultural and cultural, and yet the change is cultural’ Bhugra (1999). Both cultural identity in the city on a group level and the psychological process of acculturation are more complex than previously thought. Neither can be reduced to simple processes whereby the individual or ‘society may either become fully homogenized or break into smaller more homogenous independent societies’ (Bhugra 1999). Further work needs to be done to understand the impact on an individual on: 1) the perceived conception of city life; 2) the processes of contact with others; 3) state of having multiple identities; 4) and ways of measuring the objective and subjective levels of change.

# Combining two approaches

Psychiatry, anthropology, and the wider social sciences have always shared an intertwined history. Kleinman (1987) cautions, however, that ‘for all this cross-disciplinary interest […] there is little evidence that anthropology exerts any significant influence in psychiatry.’ This is relevant for the current research landscape of psychosis and the city, where anthropology’s more informal and heuristic approach has not been combined with clinical and epidemiological thinking. Kleinman’s criticism of anthropology as unsystematic in ‘relevant diagnostic, epidemiological or treatment issues’ also holds true.

In thinking about psychosis and the city, I draw together both literatures and clarified their theoretical and methodological orientations. I explore the experience of the city through cultural contact theories, and borrow from work on schizophrenia and migration. The social environment of the city reflects the increasingly complex flows of people, economics, and technology in the age of globalisation. Yet the social physical environment around us always affects the every day, and ultimately has an impact on our psychologies. In order to understand the city and psychosis, psychiatry has to look beyond sociology, its natural companion within the social sciences, and consider the approaches of social psychology and anthropology. We need to look at both the macrosocial level and the level of individual processes.

Kleinman’s (1987) critique finishes with four anthropological questions for psychiatry. It is a good starting point for thinking about how the social sciences can inform the ecological study of psychosis and the city in the future. First, to what extent do psychiatric disorders differ in different societies? Second, does cross-cultural psychiatry exaggerate biological dimensions of disease and de-emphasis the cultural dimensions of illness? Third, what place does translation have in cross-cultural research? And finally, does the standard approach to cross-cultural research in psychiatry commit a category fallacy? Although concerns about translation are less relevant to this topic, these questions should be kept in mind when thinking about culture. Further, the cross-cultural validity of epidemiological findings has not been considered, as the work on cities has mainly concentrated on neighbourhood and urban-rural differences within cities. The disaggregation of psychosis to neighbourhood characteristics follows an inherent drive within the discipline of classification, which errs on the side of being too reductionist. Fundamentally, Kleinman is asking us to be aware of interpretation and to make sure that measurement is coupled with understanding.

# Conclusion

This essay has combined approaches from social psychiatry with those from the social sciences that consider the individual. However, there are always limitations in subject boundaries drawn, the remit considered, and the evidence examined. The primary assumption that underlies current work is that the physical environment affects the social landscape, and in turn people’s psychologies. In the work explored, this is thought to be a significant impact. However, this assumption is limited in negotiating the changing role of the city in the 21st century in our global society facilitated by technological advancements. Media theorists explore the contraction of the sense of place and space, and understand society in terms of cultural flows (Appadurai 1990). New technology has transformed cultural contact into an everyday event, cultures are losing physical separation, and there is constant renegotiation of power dynamics between transmission and reception of culture (Thompson 1995). The modern Internet in particular has transformed the way in which the individual engages, connects with, and contacts others. Individuals can now engage across a number of levels, and form a variety of non-traditional communities (Rheingold 1994) and identities (Turkle 1996). The challenge for understanding the social and cultural aspects of mental health is to be able to account for multilevel and multidimensional analysis of changing social forces. Although understanding psychosis and the city is just one lens through which to view such entanglements, it is an important beginning.

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