SPECIAL ARTICLE

Migration, cultural bereavement and cultural identity

Dinesh Bhugra[1], Matthew A. Becker[2]

[1]Section of Cultural Psychiatry, Institute of Psychiatry, De Crespigny Park, London, UK
[2]Department of Psychiatry, Southern California Permanente Medical Group, San Diego, CA, USA

Migration has contributed to the richness in diversity of cultures, ethnicities and races in developed countries. Individuals who migrate experience multiple stresses that can impact their mental well being, including the loss of cultural norms, religious customs, and social support systems, adjustment to a new culture and changes in identity and concept of self. Indeed, the rates of mental illness are increased in some migrant groups. Mental health practitioners need to be attuned to the unique stresses and cultural aspects that affect immigrants and refugees in order to best address the needs of this increasing and vulnerable population. This paper will review the concepts of migration, cultural bereavement and cultural identity, and explore the interrelationship between these three aspects of the migrant's experience and cultural congruity. The complex interplay of the migration process, cultural bereavement, cultural identity, and cultural congruity, along with biological, psychological and social factors, is hypothesized as playing a major role in the increased rates of mental illness in affected migrant groups.

Key words: Migration, cultural bereavement, cultural identity, cultural congruity, ethnic density

Mental health practitioners work in an increasingly multicultural world, shaped by the migrations of people of many different cultural, racial and ethnic backgrounds. People migrate for many reasons, including broadly political, socioeconomic and educational. The richness of this diversity of cultures, ethnicity, races and reasons for migration can make understanding experiences and diagnosis of illness challenging in people whose background and experience differ significantly from the clinician. Culture has an important role in the presentation of illness, and cultural differences impact upon the diagnosis and treatment of migrant populations in part due to linguistic, religious and social variation from the clinician providing care. Additionally, it appears that the incidence and prevalence of psychiatric disorders varies among people of different cultural backgrounds due to an interplay of biological, psychological and social factors.

The provision of healthcare is necessarily influenced by the demands of people of many different cultures, but relies on economic, social and political factors, and it is important that cultural differences be appreciated and understood to arrive at a correct diagnostic impression and treatment plan. The migration process itself can be stressful, depending upon the type and cause of migration, and can affect the mental health of migrating individuals and their families. Issues of cultural bereavement and identity occur with increased frequency among migrants and their families. This paper will review these concepts and how they impinge upon mental health and psychiatric care and, by so doing, help the clinician to identify and address these issues in a culturally sensitive way.

MIGRATION

Migration can be defined as the process of going from one country, region or place of residence to settle in another. The duration of this new settlement varies, but for the purposes of this paper the focus is on individuals who relocate either semi-permanently or permanently to another country. Also, urban-rural migration within the same country is not being discussed here. Migrants may move en masse or singly. For example, people who migrate for economic or educational reasons may move singly and at a latter date be joined by their families, whereas people who move due to political reasons may move en masse but with or without their families (1). Although not all people who migrate are from ethnic minority groups, it is of note that a significant proportion is. The multicultural nature of British society is supported by the 1991 census. Ethnic categories were first used in the UK in the 1991 census, at which time over three million people, or approximately 5.5% of the general population, were from ethnic minority (non-white) groups (2). Of these, 30% described themselves as black, black African or other and 28% described themselves as Indian; however, by the 2001 census the categories of ethnic ascription had increased and the proportion of ethnic minorities had increased to 7.9%. The minority ethnic population in the UK grew by 53% between 1991 and 2001, from 3 million people to 4.6 million people respectively. Indians were the largest minority group, followed by Pakistanis, people of mixed ethnic backgrounds, black Caribbeans, black Africans and Bangladeshis (3).

The history of migration to Britain highlights some of the reasons why people migrate. Significant migration to Britain started in the nineteenth century. Irish immigration has been marked by periods of influx and efflux to and from Britain, as people have come to either settle permanently or work temporarily with ultimate return to Ireland as a goal. Eastern European Jews came at the latter part of the nineteenth century to escape both religious persecution and poverty, with additional numbers arriving in Britain both before and after World War II. In the 1960s, employers, especially in urban areas, recruited people

from the West Indies to fill low paying jobs which were less attractive to the local population. People from the Indian subcontinent migrated to Britain for educational and economic reasons, the peak of which occurred about the same time as the West Indian migration. Asian people expelled by Idi Amin's government came from Uganda in the late 1970s. The 1980s saw a change in the immigration laws limiting the numbers of people allowed to relocate to Britain (4). Today, people from around the globe choose to migrate to the UK as well as other developed countries, both legally and illegally, for better educational and employment opportunities, to escape persecution, to relocate after catastrophic events, including terrorism, disasters and war, and/or to join relatives who migrated at an earlier time.

Migration can be classified in a number of ways; e.g., by the reasons for the migration, the social class and education of the migrating people, the duration of relocation and the geographic distribution of the resettlement. Further, a distinction can be made in the classification of migrants according to whether their contact with the 'majority' or 'dominant' culture is deemed voluntary. Migrants can be classified as immigrants and sojourners when the change in their location results in contact voluntarily, whereas refugees are deemed to change their location involuntarily (5). For example, immigrants choose to migrate, and thus be in increased and regular contact with the 'majority' culture in preparation for migration, for potential economic and/or educational advancement, whereas refugees are forced to migrate, and thus be in contact with the 'majority' population involuntarily, to escape persecution. Additionally, rural-urban migration has been associated with economic and educational reasons for relocation, whereas migration across nations has been associated with economic, educational, social and political reasons (6).

The process of migration has been described as occurring in broadly three stages. The first stage is pre-migration, involving the decision and preparation to move. The second stage, migration, is the physical relocation of individuals from one place to another. The third stage, post-migration, is defined as the "absorption of the immigrant within the social and cultural framework of the new society". Social and cultural rules and new roles may be learnt at this stage (4). The initial stage of migration may have comparatively lower rates of mental illness and health problems than the latter stages, due to the younger age at the initial stage of migration and the problems with acculturation and the potential discrepancy between attainment of goals and actual achievement in the latter stages (7). It is worth noting that the stages are often not discrete and merge into one another.

It has been hypothesized that social adjustment and the prevalence of mental illness in migrants may be influenced by the duration of the relocation, the similarity or dissimilarity between the culture of origin and the culture of settlement, language and social support systems, acceptance by the 'majority' culture, access and acceptance by the expatriate community, employment, and housing (4). If the individual feels isolated from his or her culture, unaccepted by the 'majority culture' and has a lack of social support, a consequent sense of rejection, alienation and poor self-esteem may occur. During the stages of migration, there may be factors that predispose individuals to mental disorders. Pre-migration factors include the personality structure of an individual, forced migration, and persecution, among others. Migration factors include bereavement, culture shock, a discrepancy between expectations and achievement, and acceptance by the new nation are potential post-migration factors (8,9). These factors can be thought of as vulnerability factors along with biological, social and psychological variables. For example, personality structure can be thought of as a biological factor as well as in cultural terms. Personality is influenced by cultural factors and influences patterns of child rearing, responding to stress and accepting social support. National character and personality factors are interlinked.

Bhugra (6) reviewed four hypotheses explaining the relationship between migration and mental illness, specifically the higher rates of schizophrenia among some migrant groups in the UK, and proposed a fifth hypothesis. His hypothesis argues for an ethnic density effect on the rates of mental illness in migrant groups. Additionally, individuals who migrate from collectivistic or socio-centric societies, who themselves are socio-centric, into individualist or egocentric societies may experience feelings of alienation and mental distress, with consequent difficulty in settling into the new society. Social change, assimilation and cultural identity may be significant factors in the relationship between migration and mental illness (6,7).

CULTURAL BEREAVEMENT

The loss of one's social structure and culture can cause a grief reaction, as has been described by Eisenbruch (10,11). Migration involves the loss of the familiar, including language (especially colloquial and dialect), attitudes, values, social structures and support networks. Grieving for this loss can be viewed as a healthy reaction and a natural consequence of migration; however, if the symptoms cause significant distress or impairment and last for a specified period of time, psychiatric intervention may be warranted. Eisenbruch (11) has defined cultural bereavement as "the experience of the uprooted person – or group – resulting from loss of social structures, cultural values and self-identity: the person – or group – continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead, and feels

stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life".

The expression of such bereavement is influenced by many factors, among which are social, cultural and economic. In a study of the palliative care experience of Bangladeshi patients and their carers in east London, recent migration, linguistic barriers, religious beliefs and financial issues impacted the ability to optimise pain control in patients and the grieving process of family members; burial of the deceased in Bangladesh and social support from family and friends were potentially helpful in the grieving process (12). The importance of culture in the expression of grief was highlighted by a case report of bereavement in an Ethiopian female refugee. Her symptoms of grief were complicated by her inability to perform her culturally sanctioned purification rituals because of her relocation. Compounding her problem, she was erroneously diagnosed at various times due to the use of Western derived diagnostic criteria and a lack of appreciation of the cultural differences in the presentation of grief by clinicians (13). The symptoms of cultural bereavement may be misdiagnosed due to problems with language, culture and the use of Western diagnostic criteria in non-Western peoples. Schreiber (13) noted that traditional healing and purification rituals as well as supportive psychotherapy, after the correct diagnosis was made, were essential in the treatment of this patient's syndrome.

Western constructs of bereavement may prove to be of only partial or limited value in explaining expressions of grief when applied to people from other cultures; however, this is an area worth further study. All human beings get bereaved, but the cultural norms are essential in dealing with bereavement. Western views of bereavement include the progression through stages of grief, psychoanalytic theories of loss, and behavioural theories. Davies and Bhugra (14) refer to Bowlby's contribution to the understanding of loss and the function and course of grief. In application of his attachment theory, Bowlby described four phases of mourning, including numbing, yearning and anger, disorganization and despair, and reorganization. Psychoanalytic theorists have described the role of the unconscious and ambivalence in grief; abnormal grief reactions are felt to be unconsciously driven and involve ambivalent feelings to the lost object with resultant depressive symptoms including significant decline in self-esteem (15,16).

The DSM-IV notes that the "duration and expression of 'normal' bereavement vary considerably among different cultural groups". A major depressive episode is diagnosed, instead of bereavement, if symptoms of depression are present two or more months after the loss or the following symptoms are present: a) guilt about things other than actions taken or not taken by the survivor at the time of the death; b) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; c) morbid preoccupation with worthlessness; d) marked psychomotor retardation; e) prolonged and marked functional impairment; and f) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person. These symptoms are based on a Western construct for the diagnosis of abnormal grief and as such do not take into account different cultural expressions of grief. In many cultures, it is normal to be visited by spirits and ghosts, and people of non-Western culture may describe conversations with supernatural spirits. The importance of placing these expressions of grief in the appropriate cultural context is essential in differentiating between abnormal and normal reactions to loss. Inappropriate diagnoses of psychotic disorders, post-traumatic stress disorder (PTSD) and mood disorders have been made in people of non-Western backgrounds when clinicians ignore cultural differences in the expression of grief. The misdiagnosis and subsequent inappropriate treatment will at best not address the issue for the affected person and, at worst, cause harm.

Eisenbruch (10), in his work with Southeast Asian refugees, devised a cultural bereavement interview as a means to help with the validity of the diagnostic interview, clarify the "structure" of the grief reaction, and start the process of healing for the affected individuals. The interview takes into account the language and cultural constructs of the bereaved individual. During the interview, the clinician explores the following: a) memories of family, based on the construct of thoughts and perceptions of the past; b) continuing experience of family and the past, including ghosts and spirits, based on the construct of communication with the past; c) dreams, guilt, clarity of recall of the past and structuring of the past in the homeland, based on the construct of survivor guilt; d) experiences of death, based on the construct of the violence of separation or death and the absence of leave-taking; and e) response to separation from homeland, based on the construct of anger and ambivalence (10). The cultural bereavement interview incorporates exploration of religious belief and practice, stressing the importance of 'traditional' treatments in the bereaved immigrant population. As noted above and continuing Schreiber's (13) notion, the collaboration of the Western psychiatrist with a traditional healer can represent for affected individuals the best treatment approach, which is one that embraces and integrates the non-Western belief system when using Western psychiatric approaches.

Bereavement has been associated with psychotic, anxiety and mood disorders; however, this association is complicated due to the misinterpretation of the cultural expressions of grief by Western trained clinicians and the Western diagnostic criteria of psychiatric disorders that may not be applicable in people of different cultural backgrounds. Undoubtedly, people who have migrated due to political upheaval or war may have witnessed or participated in combat and torture; thus, affected individuals may have PTSD and bereavement, as these diagnoses are not mutually exclusive. Culturally appropriate mani-

festations and expressions of bereavement may include Western constructs of PTSD and psychosis, including hearing voices, seeing ghosts and feeling the presence of the dead; therefore, it is important to recognize the symptoms of bereavement within the cultural constructs of the affected individual and be open to the possibility of additional psychiatric disorders. Cultural bereavement is an important aspect in the understanding of the migrant's experience. Our hypothesis is that such an experience will be mediated through and influenced by cultural identity. The concepts of individual identity are likely to affect the understanding as well as working through the bereavement process.

CULTURAL IDENTITY

It is important to define basic sociologic terms of identity to understand cultural identity. Culture is learned and passed through generations and includes the beliefs and value system of a society. Culture has been described as features that are shared and bind people together into a community (17). Identity is the totality of one's perception of self, or how we as individuals view ourselves as unique from others. Bhugra (6,7) notes that racial, cultural and ethnic identities form part of one's identity, and identity will change with development at a personal as well as at a social level along with migration and acculturation. Social identity can be thought of as the culturally defined personality characteristics, which are ascribed to social roles, such as the role of being a father, mother, friend, employer, employee, etc. Ethnicity is a source of social identity. Ethnic groups are composed of people who may or may not share the same race but do share common cultural characteristics, including history, beliefs, values, food and entertainment preferences, religion and language. Ethnicity typically incorporates both race and culture (17). Race is based on biologic constructs, such as sharing certain physical attributes; it may or not be also a social and political construct (17). For example, people from the West Indies, Africa and parts of North and South America may share the same race but have different beliefs, value systems, social norms and idioms of distress.

Bhugra (6) notes that components of cultural identity include religion, rites of passage, language, dietary habits and leisure activities. Religious rituals and beliefs, even if not followed as an adult, make up a key component of an individual's cultural identity. Religion can preserve values within the community and foster a sense of belonging. Rites of passage are important in the development of an individual's cultural identity; following these rites or rituals is bound to influence the degree to which an individual will be accepted within the cultural group. Language, both written and spoken, is a cultural marker. Bhugra (7) writes of the importance of linguistic competence and economic stability as determinant factors prompting individuals to eventually leave their non-dominant cultural group, which typically is geographically bound, and venture into the dominant culture. Attitudes to food and food preparation, including religiously driven taboos and the symbolism of food, are a component of cultural identity that can be influenced by religious teachings. Leisure activities, including music, movies, sports, and literature, are important components, along with language and religion, in allowing an individual to feel part of their culture while living in a place with a different culture and may or may not change during the acculturation process. Social and cultural qualities and attitudes are typically more resistant to change and are usually last to adjust during acculturation (18).

Psychosocial changes experienced by immigrants include assimilation, which can be viewed as a process by which cultural differences disappear as immigrant communities adapt to the majority or host culture and value system. An individual's cultural identity may be lost during the assimilation process as he or she moves within the host society. Acculturation, a process that may be voluntary or forced, requires contact between culturally divergent groups of people and results in the assimilation of cultural values, customs, beliefs and language by a minority group within a majority community (8). During the acculturation process, both the immigrant and host cultures may change. Changes in attitudes, family values, generational status and social affiliations can occur in both the majority and minority cultures as the two interact; however, typically one culture dominates (7).

Cultural changes in identity can be stressful and result in problems with self-esteem and mental health. Contact between the immigrant, or minority, community with the dominant or host community may lead to assimilation, rejection, integration or deculturation (8). Rejection, in which the individual or minority group withdraws from the majority group, can lead to apartheid or segregation in extreme cases. Deculturation, in which the individual or minority group experiences a loss of cultural identity, alienation and acculturative stress, can lead to ethnocide (6). Post-migration stresses include culture shock and conflict, both of which may lead to a sense of cultural confusion, feelings of alienation and isolation, and depression (8). Host societies' attitudes, including racism, compounded by stresses of unemployment, a discrepancy between achievement and expectations, financial hardships, legal concerns, poor housing and a general lack of opportunities for advancement within the host society, can lead to mental health problems in vulnerable individuals.

Acculturation may help the culturally bereaved individual to gain a semblance of equilibrium. Migrants who experience the loss of their culture and guilt over leaving their homeland may find that, as the acculturation process proceeds, a sense of belonging in their new homeland occurs. The majority culture may seem less threatening and more inviting as the individual becomes more linguistically and socially fluent in this new culture. Social sup-

port can ensue in the forms of friendships, employment opportunities, and medical care. Integration and assimilation can help reduce feelings of loss and grief as the migrant starts to incorporate aspects of the majority culture. In acculturation, the interaction of the migrant's culture with the majority culture of the new homeland is a dynamic and reciprocal process that can result in changes in the broader cultural group, enhancing the ability of people of the dominant culture to better appreciate and understand aspects of the immigrant's culture and recognize some of the needs of those who have migrated.

CULTURAL CONGRUITY

Migrating people come from diverse cultural backgrounds, with already formed cultural identities. As noted above, cultural identity is influenced by various factors both during and after the migration process, and cultural bereavement is a potential inherent consequence in people who have migrated. Cultural identities interact, as people who have migrated come into contact not only with people of the majority culture but also with immigrants of both similar and disparate cultures. Resultant feelings of a sense of belonging and comfort or a sense of alienation and distress may occur. Bhugra and Jones (9) proposed that various personal and relational factors during the migration process impact the mental well being of migrating people. During the post-migration phase, personal factors of importance in coping with adversity include cultural identity, social support networks, self-esteem, and self-concept. Achievement, racism, ethnic density, social isolation and unemployment are among the relational factors of importance in migrants during the post-migration phase (7,9).

Ethnic density, the size of a particular ethnic group in proportion to the total population in a specified area, may be a factor that influences the rates of mental illness in ethnic minorities. Additionally, a sense of alienation may occur if the cultural and social characteristics of an individual differ from those of the surrounding population, whereas a sense of belonging tends to occur if the individual and surrounding population have similar cultural and social characteristics. Bhugra (6) writes of the importance of ethnic and cultural congruity, interaction patterns and cultural identity in the genesis and maintenance of mental distress in migrants. Cultural congruity may be thought of as the congruence or dissonance of an individual's culture, beliefs and expectations with the surrounding population. The surrounding population may be made up predominantly of people from the same or different cultural background compared to the migrant. An increase in ethnic density may improve the social support and the adjustment of some individuals who have migrated, yet increase distress in others, in particular if there exists a cultural conflict between the individual and his culture of origin (9). This may account for some of the conflicting results from studies of the relationship between ethnic density and the incidence of mental illness in ethnic minority groups. For example, an inverse correlation between the incidence of schizophrenia in non-white ethnic minorities in London and the proportion of those minorities in the local population was found; it was hypothesized that increased exposure to or a lack of protection from stress may increase the rate of schizophrenia in non-white ethnic minorities (19); however, a previous study failed to support the ethnic density hypothesis for the increased incidence of schizophrenia in immigrant groups to England (20).

In a review of multiple studies, Shah (17) found that common mental disorders were more prevalent in people of ethnic minority groups who lived in areas of low density of their own ethnic group. His findings showed that common mental disorders were at least as prevalent in ethnic minority groups as in the indigenous population and, in some ethnic minority groups, more prevalent. Depression may be more prevalent in the Caribbean and African populations compared to the majority population, with phobias more common in Asian groups. Risk factors for common mental disorders in ethnic minority groups include poverty, unemployment, migration before the age of 11, racism, a perceived lack of social support, social isolation, absence of a confidante and absence of parents in law (17). The incidence of schizophrenia was higher in an urban area of south-east London compared to rural areas in south-west Scotland, due to the larger proportion of non-white ethnic minority groups living in the urban area compared to the rural area (21), with an overall increase in the incidence of schizophrenia in south-east London between 1965 and 1997 (22).

It is important to consider the nature of the society an individual has migrated from and to, and the social characteristics of the individual who has migrated, in determining how well a person will adjust during the migration process. Socio-centric, or collectivistic, societies stress cohesiveness, strong ties between individuals, group solidarity, emotional inter-dependence, traditionalism and a collective identity. Egocentric, or individualistic, societies stress independence, loose ties between individuals, emotional independence, liberalism, self-sufficiency, individual initiative, and autonomy. Bhugra (6) has hypothesized that individuals who migrate from predominately socio-centric, or collectivistic, societies into a society that is predominately egocentric, or individualistic, are likely to have problems adjusting to the new culture, especially if the individuals are socio-centric in their own belief system. A consequent lack of an adequate social support system, a disparity between expectations and achievements and a low self-esteem may result from this dissonance in culture between the individual and the surrounding population. An increase in ethnic density may help decrease the distress of the individual in this situation, especially by providing a social support system. For example, a person who migrates to the United States, a predominately egocentric

society, from Vietnam, a predominately socio-centric society, may feel isolated and alienated, especially if the individual is socio-centric in outlook. Feelings of isolation and alienation may be decreased, and social support improved, if other people from Vietnam, with socio-centric views, surround this person in the area of resettlement; however, the socio-centric individual may remain on the periphery of his/her new homeland's society since linguistic and social fluency of the dominant culture may not be attained. Cultural bereavement may also be minimized if the immigrant is able to maintain ties to the culture of origin, either through increased ethnic density, improved social support or maintenance of religious beliefs and practice. On the other hand, individuals who migrate from a predominately socio-centric culture into a society that is predominately egocentric in nature may experience little in the way of problems, and a relatively easy transition to the new culture, if the person who has migrated is mostly egocentric, or individualistic, in his/her outlook. In this case, an increase in ethnic density may be disadvantageous and exacerbate or cause cultural conflict and mental distress.

CONCLUSIONS

The proportion of ethnic minorities in the UK has been increasing at least in part due to the migration of individuals from all over the world. Migration is a complex process, involving a heterogeneity of causes, experiences, cultural adjustment and stages, that influence the mental health of migrants. The stresses of the migration process itself combined with a lack of social support, a discrepancy between achievement and expectations, economic hardships, racial discrimination and harassment, and a lack of access to proper housing, medical care, and religious practice can lead to poor self-esteem, an inability to adjust, and poor physical and mental health. Social and cultural factors have been implicated in the aetiology of mental illness in immigrants and refugees, and further study is needed to better understand the role of culture as pathogenic or patho-protective (7).

Cultural bereavement, a paramount aspect of the migrant's experience, is influenced by, and mediated through, the interplay of the migration process, cultural identity and cultural congruity, along with biological and psychological factors. To appropriately guide diagnosis and treatment interventions, mental health practitioners must appreciate and recognize the socio-cultural factors that influence the manifestation of grief in people who have migrated. Cultural identity and congruity will affect the ability of the affected person to understand and work through the grieving process, and disturbances of identity and congruity are likely to lead to a pathologic, or complicated, bereavement.

Rates of depression, phobias and schizophrenia are elevated in some migrant groups. The understanding of race, ethnicity, social isolation and a lack of social support, racism, unemployment and poverty, poor housing and a lack of access to appropriate medical care is important in explaining the increased rates of mental illness in ethnic minority groups. Additionally, cultural congruity and ethnic density, cultural identity, and biological and psychological factors are likely important influences in the development of mental illness in migrants. With further study, a better understanding of the complex interplay of these potential vulnerability factors may eventually lead to preventative measures and lessen the burden of mental illness in this growing population.

References

1. Bhugra D, Bhui K. Cross-cultural psychiatry: a practical guide. London: Arnold, 2001.
2. Nazroo J. Ethnicity and mental health: findings from a national community survey. London: Policy Study Institute, 1997.
3. UK Office of National Statistics. Census, April 2001. London: UK Office of National Statistics, 2001.
4. Bhugra D. Acculturation, cultural identity and mental health. In: Bhugra D, Cochrane R (eds). Psychiatry in multicultural Britain. London: Gaskell, 2001:112-36.
5. Berry J, Poortinga Y, Segall M et al. Cross cultural psychology: research and applications. Cambridge: Cambridge University Press, 1992.
6. Bhugra D. Migration, distress and cultural identity. Br Med Bull 2004;69:1-13.
7. Bhugra D. Migration and mental health. Acta Psychiatr Scand 2004;109:243-58.
8. Bhugra D, Ayonrinde O. Depression in migrants and ethnic minorities. Advances in Psychiatric Treatment 2004;10:13-7.
9. Bhugra D, Jones P. Migration and mental illness. Advances in Psychiatric Treatment 2001;7:216-23.
10. Eisenbruch M. The cultural bereavement interview: a new clinical research approach for refugees. Psychiatr Clin North Am 1990;13: 715-35.
11. Eisenbruch M. From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. Soc Sci Med 1991;33:673-80.
12. Spruyt O. Community-based palliative care for Bangladeshi patients in east London. Palliative Medicine 1999;13:119-29.
13. Schreiber S. Migration, traumatic bereavement and transcultural aspects of psychological healing: loss and grief of a refugee woman from Begameder county in Ethiopia. Br J Med Psychol 1995;68(Pt. 2):135-42.
14. Davies D, Bhugra D. Models of psychopathology. Berkshire: Open University Press, 2004.
15. Freud S. Mourning and melancholia. In: The standard edition of the complete psychological works of Sigmund Freud, Vol. 14. London: Holgarth Press and Institute of Psycho-Analysis, 1953.
16. Freud S. Totem and taboo. In: The standard edition of the complete psychological works of Sigmund Freud, Vol. 13. London: Holgarth Press and Institute of Psycho-Analysis, 1953.
17. Shah A. Ethnicity and the common mental disorders. In: Melzer D, Fryers T, Jenkins R (eds). Social inequalities and the distribution of the common mental disorders. East Sussex: Psychology Press Ltd, 2004:171-223.
18. Bhugra D, Bhui K, Mallett R et al. Cultural identity and its measurement: a questionnaire for Asians. Int Rev Psychiatry 1999;11: 244-9.
19. Boydell J, Van Os J, McKenzie J et al. Incidence of schizophrenia in ethnic minorities in London: ecological study into interaction with the environment. Br Med J 2001;323:1336-7.

20. Cochrane R, Bal SS. Ethnic density is unrelated to incidence of schizophrenia. Br J Psychiatry 1988;153:363-6.
21. Allardyce J, Boydell J, Van Os J et al. Comparison of the incidence of schizophrenia in rural Dumfries and Galloway and urban Camberwell. Br J Psychiatry 2001;179:335-9.
22. Boydell J, Van Os J, Lambri M et al. Incidence of schizophrenia in south-east London between 1965 and 1997. Br J Psychiatry 2003;182:45-9.