MENTAL ILLNESS AND MIGRATION STRESS

An analytical study of a comparative group of German immigrants and Canadian-born patients, hospitalized at the Crease Clinic of Psychological Medicine, Essondale, British Columbia, 1953 - 1958.

by

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ABSTRACT

This study deals with that minority segment of the German immigration population which, as evidenced by hospitalization for mental illness, has failed to make a satisfactory adjustment in Canada. Heavy environmental demands of a new country, or personal and social inadequacies, or a combination of both factors, have been held responsible for such failures. This exploratory study seeks to throw light on either interpretation. It examines clinical information, and suggests ways of analyzing case histories so that environmental and personal factors contributing to mental illness, can be more closely investigated.

For the purpose of intensive study, ten case records of German immigrants were carefully selected, and were compared with those of twenty Canadian-born patients chosen on the same basis of elimination.

The material available was analyzed, and classified with a view to underlining the correlating or diverging factors in the functioning of both groups. The extracted findings led to an assessment scheme in the areas of economic and work capacities, social and personal factors, applicable to individual patients and to comparable groups. A rating scale was designed which could become a measuring tool for present or future functional capacities. In spite of the small numbers used and of the analytical limitations, this attempt resulted in some well-marked similarities and deviations. To supplement this method, two composite examples of patients, reflecting causative influences in the social diagnosis, are presented.

The outstanding result of this study is the emergence of similarities rather than differences between the German and Canadian patient groups. This suggests that the impact of immigration stress cannot be solely responsible for mental illness in the German group. Migration to a completely unfamiliar country, it is assumed, renders certain dormant inadequacies, for example in social relations, more prominent than a pattern of mobility or instability in one's native country would do. However, in both groups there is also the indication of low-grade functioning in economic, social and personal areas, and evidence that personal, as well as precipitating situational forces, could be accountable for mental illness in both. This experimental study strongly suggests the need for further research in this field along the same lines. However, some social work implications can be, and have been drawn from the study.

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CHAPTER ONE

IMMIGRATION AND SOCIAL WELFARE

Since 1945 post-war immigration from overpopulated Europe to Canada has increased at a highly accelerated rate.[1] Economic hardship, social upheaval, and cultural restorations of the post-war era have all contributed to the influx of Central Europeans into Canada - for many the 'Land of Milk and Honey'. Years of curtailed freedom and political dictatorship, of human deprivation, of war, destruction and subsequent prolonged trauma, have caused numerous resolute men and women to leave their home land and seek a New Jerusalem under Canadian skies. Now, after ten years or more, it can be said that most newcomers have succeeded in finding a niche for themselves in this Canada of their voluntary choice. By its very nature, any process of adaptation to a novel environment is laborious. It must be expected that conflicts, open or concealed, have presented themselves to most immigrants at some time. However, most of them can be considered as having successfully completed their apprenticeship. They have been absorbed into the Canadian mode of life and accepted by the wider community after an interim probationary period. There remains, however, the occasional newcomer who, having joined the stream of the dissatisfied, nevertheless has failed to reconstruct an existence for himself in the New World. Why did he become one of the 'minority that failed' ? Did he originally belong to the small but persistent 'sub-marginal' group who, even in their familiar environment[2], never seemed to 'make the grade' ? Or did he succumb to new and heavy adjustment pressures ? It is only this part of the vast immigration population with which this study is concerned; and only with one segment of the 'minority that failed', namely

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[1] Since 1946 the total influx has been 1.387 million. Between 1946 and 1955 the total German influx was 159,000 - the second largest immigrant group according to "Canada 1955", Canada Year Book Section, Dominion Bureau of Statistics, Ottawa.

[2] Environment : As defined in Appendix 'A'.

hospitalized German immigrant patients at the Crease Clinic. There is little doubt that the degree of helplessness in these patients is severe, and that their adjustment[1] must have been defective. However, the patients who show overt symptoms of maladjustment are not the only ones who may require professional help, and who arouse professional concern. Outside the gates of hospitals and social agencies many more newcomers are probably struggling to achieve even a marginal adjustment. By virtue of their personal strength, their resistance, through ignorance or fear of social services available, or by mere coincidence, they may not have found their way to welfare agencies. It is worth remembering at the outset that not all immigrants speak a foreign language and yet still may encounter adjustment difficulties. Reynolds in his study of British immigrants in Montreal states that "..... even the Britisher at first feels himself a stranger in Canada. That he is definitely not Canadian in outward appearance, habits or attitudes is quickly apparent both to himself and the Canadian observer."[2] The author goes on to explain that, psychologically, the "going out from the 'mother country to one of the colonies'[3] " as well as "language peculiarities are ... likely to bring ridicule upon the new arrival"[4] and thus profoundly affect his task of adjustment.

Adjustment - a challenge, or a problem ?

No matter from which part of the globe a newcomer may arrive, what past life experiences he may bring with him, how well motivated and personally equipped he may be, every immigrant without exception will be faced with one vital, initial task. It is that of meeting the unknown and, eventually, by acceptance and recognition, of transforming it into cognitive reality.[5]

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[1] Adjustment : As defined in Appendix 'A'.

[2] Reynolds, L.G., The British Immigrant, Oxford University Press, Toronto, 1935, p. 206.

[3] Ibid., p. 210.

[4] Ibid., p. 207.

[5] Reality : As defined in Appendix 'A'.

For some indivuals this is not a great task; for others it may be a traumatic event. It is at this point that immigration and mental illness may be brought more closely into focus for certain groups of newcomers.

Fenichel[1] writes that psychoanalysis explains mental phenomena as the result of the interaction and counteraction of forces, that is, in a dynamic way. A dynamic explanation is also a genetic one, since it examines not only a phenomenon as such, but the forces that brought it about as well. In the light of this psychoanalytic perspective it must be stated that, no matter how uniform the initial starting-point towards acculturation[2] appears to be, its successful accomplishment will largely depend upon three factors. These are (1) the nature of the physical and psychological environment left behind,[3] (2) that of the setting to be encountered, and (3) the individual potential brought to this task. Although infinite variety in personality make-up allows for a wide scope of deviation in individual behavior, it is generally accepted that a psychologically secure, strong and constitutionally healthy person will, from the outset, be better equipped than a dependent, insecure, passive, and perhaps already disturbed newcomer. His ability to withstand an initial period of stress, to project himself positively and realistically into the future, as well as his psycholo--gical, socio-economic, and religious background will determine the cultural distance the newcomer may have to cover. Past social roles played, the degree of identification, the nature of values adhered to, will decisively affect the extent of readjustment to be tackled.

Dr. Libuse Tyhurst states that an immigrant's initial period of acclimatization, that is his 'physical adjustment', lasts for about two months after his arrival.[4] Such a period would be marked by his 'immediate' adjustment to everyday living conditions, and thus would ensure the fulfillment of a

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1 Fenichel, O., The Psychoanalytic Theory of Neurosis, Norton & Co., New York, 1945, p.11.

2 Acculturation : As defined in Appendix 'A'.

3 Pollak, O. & collaborators, Social Science and Psychotherapy for Children, Russell Sage, New York, 1952, p.31. employ social science concepts, namely social interaction, socialization, cultural relativity, social roles, social status, in order to break down environmental components into working concepts.

4 Tyhurst, L., "Displacement & Migration", American Journal of Psychiatry, Vol.107, No. 8, Feb. 1951, p. 563.

newcomer's basic needs.[1] Acquaintance with employment and housing situations, the observation of clothing and food habits, increasing familiarity with the physical and social setting, experimentation with a different language, - these are the essential 'know-hows' which will occupy the immigrant's first eight to twelve weeks in a new country. However, the psychological reception he may encounter from the community at large will equally determine the pace and nature of his - now psychological - arrival. Friendliness, understanding, and concrete help rendered, may speed up the process of adjustment, whereas overt or latent suspicion and hostility, disapproval and impatience, may severely delay it.

The psychological arrival will be further affected by the personal make-up which the newcomer brings with him. His mental attitude towards change per se, his motivation in coming to another country, and his ability to cope with stress situations are only a few examples. A fairly typical picture of the initial process making the psychological arrival, as offered by Dr. Tyhurst,[2] is that of the immigrant who at first reacts positively and enthusiastically to his new environment which he endows with unrealistically high expectations. As soon as his immediate needs are met he begins to explore more leisurely and objectively the novel surroundings, and a psychological counter-reaction may set in. The immigrant only now becomes consciously aware of existing social and cultural barriers which, he feels, divide him from 'the others'. He is forced to realize that his established frame of reference no longer holds, and he watches his familiar value system crumble under his unbelieving eyes. Physical and sometimes spiritual isolation may be experienced at a time when he needs to identify himself with something, or someone, and when he longs to feel wanted and accepted. In his attempt to liberate himself from the encroachment of an impersonal

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[1] Basic needs : As defined in Appendix 'A'.

[2] Tyhurst, L., op. cit., pp. 562-563.

and alien environment, in his striving to bring meaning and order into this apparent chaos, he frequently reverts to former social roles and responses. In his confusion and insecurity he clings to structural references which are no longer relevant. Since he does not dare express his aggression for fear of further rejection, and subsequent deeper social isolation, he tends to internalize his anxiety and to hide behind withdrawal and suspicion.

The Social Worker's Concern.

At a time when Western man has been endowed with greater personal freedom and scope yet, simultaneously, with less direct control over his human destiny than ever before, the profession is attempting to develop the technique of personal help. In the broader sense, this implies an understanding of man in his striving for a positive, creative interaction with his physical, social, economic and psychological environment. In order to provide a social climate which will foster any individual's search for self-fulfillment, as well as promote the welfare of the community, the complexity and psychological nature of the existing social order will have to be known. A social worker, therefore, has the professional responsibility to remain alert to the constantly changing structure of the highly flexible Canadian social scene. In order to be qualified to bring any resulting impact to the attention of the public, he must have knowledge of society's internal make-up and its various components. This would include the facet of post-war immigration to Canada which, between 1945 and 1957 resulted in a numerical increase of its population of approximately 8%, or 1.4 million.[1] Since this immigrant force may prove vital to the community's well-being, professional interest in its various segments has become imperative in terms of social planning.

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[1] Kage, J., "Welcoming the Newcomer", Canadian Welfare, June 1950, Vol. 34., No. 2, p. 66.

Preventive or Protective Services ?

In particular it is the social worker's responsibility to concern himself with this specific minority group of hospitalized immigrants in order to gain a better professional awareness of the numerous issues resulting from, and affiliated with, the task of adjustment. The kind of services to be rendered, preventive or protective, will largely depend upon the degree of professional understanding which such respective servicesmay bear upon the immigrant. Hospitalization itself can be emotionally harmful to a stranger who may consciously suffer from a 'demotion' to the status of a public charge. In addition, the pending threat of deportation for such newcomers may leave a damaging mark on the insecure immigrant - as much as repatriation may pose - for the originally discharging country - the hard task of replanting a severely damaged, lastingly uprooted person. Whereas protective casework services may be improved and strengthened by a more detailed knowledge of cause and effect of illness in these mentally-ill immigration patients, it is clearly arguable that preventive services, if rendered in good time, and preferably at the moment of entrance, may preclude a severe breakdown in a number of instances. It is hoped, therefore, that a study of the case material will also help to substantiate the plea for wider use, for the strengthening and expansion of services already in existence, so that the adjustment task may lose some of its isolating aspect for the newcomer.

Any such considerations take on a further weight if social work leadership includes desirable forms of social action. Rehabilitative programmes for discharged mental patients, as well as community education, revolving around the newcomer's difficulties in his physical and psychological adjustment, are entailed in such responsibility. The latter implies advocacy of a more enlightened flexible application of the Canadian Immigration Act. Professor Corbett in his

CANADA'S IMMIGRATION POLICY, argues that immigration regulations are still based on Mackenzie King's concept of 1947, i.e. that entrance into Canada is a privilege, not a right. The Immigration Act[1] under the prohibited categories includes "idiots, imbeciles, morons, persons who have been insane at any time, or who have constitutional psychopathic personalities.....". But the most comprehensive prohibition class is "persons likely to become a public charge".[2] In view of such delineations it might be assumed that they have been dictated by a well-defined, concise policy of selection. This, however, is not the case. Professor Corbett states that inquiries, only made at the Port of Entry on Canadian soil, are conducted by a 'Specific Inquiring Officer (who) has the authority to inquire and determine whether any person shall be allowed to come into Canada.[3]' This is done on the basis of 'literacy, medical and other examinations or tests' which aim at the 'prohibiting or limiting of persons who are unable to pass them.[4] This applies, in the Immigration Act, Section 61, Subsection 'C' - IV, to those who demonstrate 'probable inability to become readily assimilated'.[5] As Professor Corbett indicates, 'since the Act does not defile the specific characteristics which make a person likely to become a public charge', and since its requirements are defined most vaguely, 'the administrative officers who apply the Act are left with considerable discretionary authority to exclude people under this clause'.[6] For the purpose of the present study it is important to note that hardly any

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1 Put into force in revised form on 1st June 1953.

2 Corbett, D. C., Canada's Immigration Policy, University of Toronto Press, Toronto, Ont., 1957, p. 41.

3 Ibid., pp. 74-75.

4 Ibid., pp. 70-71.

5 Loc. cit., pp. 70-71.

6 Ibid., p. 41.

professional knowledge appears to guide the assessment even of the immigrant's economic potential, still less his psychological potential towards becoming a useful member of the Canadian family of newcomers. A different emphasis in admission requirements, therefore, might lead to better procedures of selection and thus prevent the entrance of unsuitable applicants into Canada. It thus might indirectly save the Canadian taxpayer unnecessary public expenses which often arise with prolonged hospitalization of the financially-barren newcomer.

This study is also intended to deal with the immigrant patient who has been already hospitalized. A more thorough understanding of the task of his initial adjustment, and of the possible precipitators to mental disease in these New Canadians, may enable the professional case worker to establish a subsequently more accurate social diagnosis, and determine the extent and kind of differential casework treatment to be rendered. Ultimately it would aid the practitioner as well as the patient, who would benefit from greater over-all treatment gains.

Implications for the Present Study.

Although a partial answer to these questions will be attempted, the scope of this study does not permit a detailed consideration of all aspects mentioned. Already at this point it can be stated that further research into the etiology of mental breakdown in this particular group, as well as into the kinds of social diagnoses essential for effective treatment, may be warranted. Beyond this, also the usefulness of available case material for social work research is questioned. Since a minimum of casework services had been provided for those patients studied, the required information was obtained mainly from clinical records. In order to clarify or supplement, any recorded material ought to convey a detailed, intricate picture of the patient, as viewed against his physical/psycho-social situation. It is questioned whether the clinical material examined did serve this purpose, and how much it did reveal information,

having more than mere factual value.

Professional literature reveals how much, historically, social casework at one time was particularly concerned with the individual and his external, social adjustment. Later, treatment emphasis was placed upon the predominantly internal factors determining human behaviour.[1] However, the symbiotic relationship of external and internal forces has always been recognized. The literature from allied disciplines, which deals with mental illness as related to the task of acculturation, shows a variety of accounts by sociologists, economists, other social scientists, and physicians, all proclaiming the view of their own discipline on these matters. However, it is difficult to discern any agreement on the nature of the adjustment task, and its precise implications for the newcomer's physical and mental health.

The psychoanalyst, Ludwig Binswanger, states : "there still remains the great psychiatric problem of what in a behaviour diagnosed as pathological can be reduced from a disturbance in communication to a disturbance in the organism..... This will always be determined by the currents of contemporary scientific fashion.."[2] Ruesch et al discuss horizontal and vertical acculturation in terms of 'cultural distance' to be travelled by the newcomer.[3] Here it is maintained that family structure and attitudes, particularly significant early personal development, and parental identification, will affect and determine the degree of cultural conflict to be encountered by the immigrant. The Norwegian psychiatrist Ødegaard, on the other hand, writes : "The schizoid type of thinking, feeling and social relationship must furnish a far more likely background for emigration than the syntonic make-up.... A complete understanding of the problems of emigrants and

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[1] Garret, A., "Historical Survey of the Evolution of Casework", Masius C., ed., Principles and Techniques in Social Casework, 1953, Family Service Agency of America, New York, p. 394.

[2] Binswanger, L., "The Case of Ilse, Existence of a New Dimension in Psychiatry & Psychology, ed. May, R., Angel E., Ellenberger H.F., 1958, Basic Books Inc., New York, p. 230.

[3] Ruesch, J., Jacobson, A., Loeb, M.B., "Acculturation & Illness", Psychological Monographs, 1948, Vol. 62, No. 5.

their mental health is impossible without introducing the constitutional hypothesis - not instead of, but as supplement to the environmental one."[1] This position corresponds with that of numerous other psychiatrists who maintain that immigration is a selective process per se. Pederson, again, argues that "severe social trauma has a tendency to release paranoidal reactions, regardless of the character structure involved"[2], and Listwan defends the position that "certain paranoidal reaction types occurring in migrants are due mostly to social factors summarized as 'migration stresses'. They are purely environmental....."[3] The most recent branch of medicine, biochemistry, once more shifts the emphasis in determining the etiology of mental illness. Selye takes the position that "bodily changes during stress act upon mentality and vice versa."[4] He maintains that "stress causes certain changes in the structure and chemical composition of the body... Some of these changes are merely signs of damage; others are manifestations of the body's adaptive reactions, its mechanism of defence against stress."[5] Rudnicki, in his Social Work survey, acknowledges a prevailing lack of established causal factors to mental disorders in immigrants. He states that "some people must be regarded as being predisposed to a poor adjustment, ... while others probably succumb to excessive environmental pressures..."[6] The impact of these views on the material examined would require further study. However, as a provocative, closing observation

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1 Leacock, E., "Three Social Variables & the Occurrence of Mental Disorder", Explorations in Social Psychiatry, ed. Leighton, A.H., Clausen, J.A., Wilson, R.N., 1957, Basic Books Inc., New York, pp. 324-325.

2 Pedersen, S., "Psychopathological Reactions to Extreme Social Displacements", Psychoanalytical Review, 1949, Vol. 36, p. 345.

3 Listwan, I.A., "Paranoidal States, Social & Cultural Aspects", Medical Journal of Australia, May 1956, Vol. 1, p. 775.

4 Selye, H., The Stress of Life, McGraw-Hill Co. Inc., Toronto, 1956, p. 253.

5 Ibid., p. 3.

6 Rudnicki, W., Mental Illness Among Recent Immigrants, Master of Social Work thesis, University of British Columbia, 1952, p. 51.

on these controversial issues, let it be mentioned that the United States Immigration Act contains a clause, according to which "persons of constitutional psychopathic inferiority" will be barred from entrance into the United States.[1]

Social Work concepts, assumptions, and premises applied.

While the close relationship between social casework and other related professional disciplines is recognized, and while a shifted emphasis in casework from intrapsychic to intrapersonal factors of human behavior is acknowledged as a by-product of professional growth, the holistic view of man has been reasserted only in recent times. Gordon Hamilton stresses such need when she writes that "... the individual and society are interdependent; social forces influence behaviour and attitudes, affording opportunity for self-development and contribution to the world in which we live."[2] At the same time the premise is advanced that the individual, having his unique way of coping with his personal problems does, in accordance with the demands of his environment, form certain behaviour patterns, the sources of which have been forgotten. In addition to such a premise, this study accepts certain specific, yet by no means all--inclusive, social work principles, of which "recognition of the worth and dignity of every individual"[3] constitutes the philosophical basis from which any social work research will have to commence. It furthermore includes "recognition that individuals differ in their capacity to meet life situations and that they will seek solutions in accordance with their capacities."[4]

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1 Davie, M.R., World Immigration, MacMillan & Co., New York, 1939, p. 387.

2 Hamilton, G., Theory & Practice of Social Casework, Columbia University Press, New York, 1952, p. 22.

3 Ibid.

4 Loc. cit.

Furthermore "respect for cultural variations in peoples and for their potentialities for enriching community life"[1] is acknowledged as a working principle for this study. Reference has already been made to the "recognition of the interdependence of the members of society and to the fact that the welfare of all is dependent upon the wellbeing of individual members",[2] and hence it is maintained that all behaviour is meaningful since it exemplifies the individual's attempt to solve diurnal problems towards the fulfillment of basic needs and the ultimate enhancement of the self.[3] Beyond this it is assumed that long-established behaviour patterns tend to ensure emotional stability by providing a firm frame of psychological references. Such patterns are the realm within which man controls his unconscious, aggressive impulses. As long as the latter are protected by predictability of action and probability of outcome, a sense of equilibrium will prevail. However, once disrupted by a change in emphasis, conflicts frequently result. These normally remain controlled, but under severe emotional pressure tend to assume an overt character. In the case of the immigrant, the native and familiar environment has been exchanged for a strange one. Different qualitative and quantitative demands are placed upon him which readily may threaten, if not fully disrupt his homeostasis. His normally dormant and controlled anxiety, once released, may manifest itself in overt, violent reactions and may result in hostility, the reactivation of repressed feelings, in threat and fear. His need to combat the psychic invaders is vital; it will consume the newcomer's psychic engergy and therefore weaken and possibly further expose him to these inner, threatening, conflicting forces.

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[1] Hamilton, G., Ibid.

[2] Canadian Welfare Council, Financial Assistance, Ottawa, Ont., 1954, p.4.

[3] Self : As defined in Appendix 'A'.

Criteria of Mental Health.

Thus life is a constant involvement in recognizing and adjusting to everchanging demands. Should the individual be able to accept this challenge, and should his total functioning reflect a reasonable degree of personal integration, he will have fulfilled a basic criterion for mental health. A clinical definition of 'mental disorder' includes "those disorders which are the result of a more general difficulty in adaptation of the individual, and in which an associated brain function disturbance is secondary to the psychiatric disorder."[1] In reverse, 'emotional health' has been defined as a "state of relativity rather than absolute. It exists if a person's integration is acceptable to himself and to his social milieu as reflected in the satisfactory nature of his interpersonal relationships, his level of satisfaction in living, his actual achievements, his flexibility, and the level of emotional maturity he has attained."[2] William B. Scott elaborates on this when he equates adjustment to a given social structure with mental health.[3] A variation of such an operational criterion for mental wellbeing will arise, and modification will become essential whenever and wherever social norms fluctuate within or without their own structure. As discussed previously, externally determined sets of rules and regulations will, by virtue of their empirical nature, always constitute a certain obstacle for a newcomer. The North American active, youth and future-oriented social scene will readily decree any kind of functional impairment as an almost certain symptom of defective social adjustment. As a further criterion of mental illness, Dr. Scott mentions subjective unhappiness.[4] He maintains that mental

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[1] American Psychiatric Association, "Diagnostic & Statistical Manual", Mental Disorders, 1952, Mental Hospital Services, Washington, D.C., p. 9.

[2] American Psychiatric Association, A Psychiatric Glossary, 1957, Committee on Public Information, p. 31.

[3] Scott, Wm. A., "Research Definitions of Mental Health & Mental Illness", Psychological Bulletin, Jan. 1958, Vol. 55, No. 1, pp. 31-32.

[4] Ibid.

health presupposes a subjective, genuine sense of wellbeing, of strength, of confidence and morale. Psychodynamically speaking, the individual must possess an adequately strong ego, and his perceived self image must correspond closely to his idealized one. Although such definitions take into consideration criteria of a subjective nature, it is realized that the ultimate criterion of mental health encompasses a person's harmonious development within any adequately stable social system.[1] In order to achieve a satisfactory adjustment in the light of the above criteria, the immigrants in question would have had to be able to realistically assess the social scene when they entered Canada. Disputable and conflicting values frequently may circumvent this and, unless the newcomer brings with him a strong ego which will guarantee some measure of subjective happiness, he will have to struggle severely for a sense of integration and achievement, and thus for a conviction of having arrived psychologically as well as physically.

Why, where, and what ?

The basic questions posed in the present study refer to vital causes in a newcomer's breakdown in personality structure. It has been asked why, in contrast to his fellow men, the immigrant stumbled over the hurdles of acculturation. Why has he chosen pathological tools to solve his problems ? How well adjusted, how integrated had these hospitalized Germans been before they came to Canada ? Did they show a long history of personal maladjustment which might suggest a predisposition to mental disorder ? It was decided that these questions could be partly answered only if a detailed assessment of the environmental factors encountered by the immigrant, as well as his individual

[1] This, of course, would suggest a closer investigation of the nature of our own social setting which lies outside the scope of this work.

potentials brought to this country were attempted. A further concern had centred around the nature of the existing social welfare programme in Canada. What kind of services should be, and what facilities actually are, available to single male immigrants ? Would extra services, geared to specific needs of newcomers, be essential and desirable ? In addition, the possibility of more enlightened admission policies applied by the Canadian Department of Immigration was discussed. Screening practices might want to take more into consideration the applicant's mental and psychological fitness than they do at present. Beyond such consideration, the value of clinical records for social work research has been queried. Do these records reflect a sufficiently descriptive, diagnostic picture of the patient's psycho-social and pathological background ? Could they include further clarifying factors on the immigrant's subjective perception, on cultural lags and deviations to be overcome ? Do they acknowledge factual inconsistencies as a possible outcome of linguistically defective communication ? With a view towards more effective treatment services for mentally ill immigrant patients, the question of their level of resistance has been raised. The latter might determine the degree of benefit the patient could derive from possible casework services. These would have to be based on a social diagnosis which took into account the patient's cultural, social and political background as well as his individual life experiences, such as traumatic war memories. Weinberg reminds us that "we have shown that what appears as hallucinatory or delusional behaviour to us may be accepted as socially normal in other cultures." [1] It could be justifiably asked whether an immigrant patient should have a worker who speaks his own tongue, or whether this may reactivate possibly existing paranoidal tendencies within him. Only once these

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[1] Weinberg, S. K., Society & Personality Disorders, Prentice Hall Inc., New York, 1952, p. 97.

numerous intricate aspects of an immigrant's physical and psycho-social background have been taken into fullest consideration, can it be hoped that the original question of the significance of various personality and environ--mental factors in the breakdown of each patient group may be answered more knowledgeably.

The source of the material examined is the Crease Clinic of Psychological Medicine, operated under the auspices of the Government of British Columbia in Essondale, British Columbia. Here female and male patients may be hospitalized voluntarily or by certification, for a maximum period of four months. In most instances treatment is rendered by a team : psychiatrists, psychologists, social workers, psychiatric nurses, et al. Their professional observations on the patients are recorded on their clinical files. Referral for brief or continued casework services is discussed in conjunction with the team's treatment planning during ward rounds. Some later referral by the patient's doctor is also done frequently. The acceptance of such a request rests with the Social Service Department, and depends mainly upon the patient's amenability to casework services, and upon the availability of workers. The fragmentary nature of admission information obtained from the German immigrant patients reflects the partially high degree of disturbance at that time. Since the majority of them were admitted without relatives or friends, who might have volunteered further factual details, and since all patients have been discharged from the Clinic since, supplementary and clarifying information for the benefit of this study could not be obtained by the writer.

This study will deal with one specific minority segment of the German immigration population, that of mentally ill, hospitalized patients. For the purpose of this study, mental illness will be defined as "a state of mental

disorder warranting admission to a Mental Hospital as requested by one or two medical practitioners." The material used consists of ten case records of single male patients who, being born in Germany, range from twenty-five to forty-five years of age. They all entered Canada five years ago or less prior to this, their first, admission to a mental institution. The second, comparative group of twenty 'Canadian' patients falls into the same age group. These single male patients, who are predominantly of Protestant faith, and of Anglo-Saxon racial origin, were born in Canada and also were patients in a mental institution for the first time. A detailed description of the research methods and principles of selection employed is offered in the following chapter.

CHAPTER TWO

IMMIGRANT TO-DAY ---- PATIENT TO-MORROW ?

The present study is an essay in exposition and in method, and because of the difficulty of the subject it has to aim at more than it can attain. In his Man in the Modern World, Julian Huxley appropriately distinguishes the social scientist's research position from that of the natural scientist, by stating that the former "can at best find a correlation between several variables. In terms of causation, the natural scientist can sometimes find a single definite cause for a phenomenon; the social scientist must always be content with several partial causes. He has to work out a system based on the idea of multiple causation."[1] The present survey can attempt only a partial approach to this objective. It would take a much larger number of cases than have been available to achieve predictive validity. Neither could the qualitative information needed for a really comprehensive case analysis be obtained. And there exists as yet no standard for the analysis of causes, or for the priority area of treatment, which could have been used for reference. It is the major concern of this study, therefore, to examine case material in the hope of clarifying what kind of data would be essential in order to provide a better understanding of the causation of mental illness. In this search the study explores in two directions : (a) a comparison between an immigrant and a Canadian-born group, and (b) a classification of the material which is, or ought to be, in existence for the establishment of social diagnoses. Because of the great difficulty which was experienced in obtaining qualifying material, the possibility of a purely statistical survey was ruled

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1 Huxley, J., "Eugenics & Society", Man in the Modern World, Menton Book, MD 148, p. 30.

out from the beginning. Nevertheless, it is arguable that much work needs to be done on qualitative data as well, before the significance of contributing factors, as being implicit in mental breakdown, can be more knowledgeably assessed. Beyond this, a closer investigation of the adequacy of clinical records will take place. Even from a partial study, it is possible that implications for social work practice towards a healthier interaction between the immigrant and his psycho-social environment may become clear.

Method and Criteria of Selection.

The immigrant group studied is only a fraction of the total German immigrant influx to post-war Canada, just as it is of the total hospital population at Crease Clinic. Since qualitative considerations are more important than quantitative ones, and since time was limited for the study of intensive material, a small sample number of ten German immigrant patients was decided on. In order to obtain a comparative group, this number was doubled for the Canadian-born patients. The latter, delimited on the same basis as the Germans, are distinguished predominantly by the absence of an essential acculturation process during any period of their lives.[1] Both male groups were chosen on the assumption that bachelorhood in men between the ages of twenty-five and forty-five reflected a certain personality make-up. The age group was further determined by the consideration that all German patients between the ages of twenty-five and forty-five, having previously lived in Germany, presumably had been consciously exposed in some degree to Nazi ideology, and thus suffered an additional traumatic experience. According to Kahler, the 'Continuum of Experience'

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[1] It is acknowledged, however, that internal Canadian migration from province to province, and from rural to urban centres, has markedly changed the recent demographic structure. According to the Gordon Commission, one-quarter of the present Canadian population lives in a province other than the one born in. Out of twenty cases studied in this sample, three came to British Columbia from another province less than six months ago, whereas two had arrived twelve months ago. The majority of the other Canadians were born in British Columbia and lived here most of their lives.

will be disrupted in any terrorist society where "the individual does not know what he may experience; and what he has experienced is no longer important for his person or his future. The normal rhythms of youth, manhood and old age, of education, career, success or failure, is completely disrupted.... In a terrorist society, in which everything is most carefully planned, the plan for the individual is to have none; to become and to remain a mere object, a bundle of conditioned reflexes which amply respond to a series of manipulated and calculated shocks."[1] For the purpose of uniformity, only 'First Admissions' to a mental institution were selected; all patients had been hospitalized between 1st April 1953 and 31st March 1958. Since the immigrants, as selected under the above considerations, showed an almost uniform discharge diagnosis of the psychotic kind, a correspondingly diagnosed Canadian group was chosen. In selecting both groups it was possible to pay attention to the month of admission in the hope of diminishing a further important variable, namely Canadian seasonal employment conditions.[2]

The information assembled was obtained directly from reports on the patient, originating with physicians, social workers and other professional groups in the community. Observations from professional clinical staff - psychiatrists, psychologists, social workers, nurses, et al, - as well as other hospital personnel, constitute the actual case records. The latter were supplemented by the patients' own observations during hospitalization, and from information written in by relatives or friends. Additional data was obtained from admission forms, propensity slips, and other routinely-issued papers. Statements of the patients' personal effects, as brought to the Clinic, were revealing, occasionally not only high-lighting the degree of unpreparedness for

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1 Kahler, Erich : The Tower and the Abyss, Geo. Braziller Inc., New York, 1957, p.65.

2 The 'Canadian' cases, approximately every fifteenth out of a total of three hundred, were counted from a list received from the Department of Vital Statistics in Victoria, British Columbia. A similar tabulation of discharged German patients was used for the ten qualifying immigrant cases.

hospitalization, but substantiating the otherwise scanty picture of the financial situation, or of the patient's social contacts (pictures, letters, etc.). Entrances on the admission forms reflected his appearance at the time of admission, such as : 'dishevelled', 'unclean and unshaven', 'looks older than age stated', 'appears undernourished', etc.

Interpretation of Material

With this case material on hand the original question, regarding the factors which might contribute to a failure of the minority, demanded re-consideration and the construction of a number of devices which would aid the answer to such a question.

First of all it was decided that the immigrants' history of adjustment could be assembled and analyzed under three major headings, i.e. (a) his work and earning capacity, (b) his social potentials, and (c) his personality make-up. These areas were selected only after some experimentation with the material available had taken place. Whereas the two latter clearly fall into the scope of social work competence, the first area is given proper weight by the very demands that immigration as such does pose. Although the three spheres are not sufficiently all-inclusive, it is arguable that they are vitally essential in assessing possible causes for mental breakdown. A working sheet was designed to absorb all relevant statements which pertained to the areas discussed, as well as other factual and identifying information.[1]

Then the collected data was interpreted and classified. It has rightly been maintained by previous researchers in this field that 'there is no consistent application of method used in writing the case material which leads to

[1] A sample can be found in Appendix 'B'.

simple comparisons or to ease in collecting analytical material.... Therefore, ... diagnostic statements are counted in terms of whether they are oriented towards psychological, psycho-social, or socio-cultural interpretations of human behaviour."[1] Based on the attempt to determine respective underlying orientations, difficulties arose since it was impossible to establish a conclusive position with regard to such differentiation. It was also found that diagnostic statements occasionally deviated into the realm of description, instead of relating to the possible causes of the patient's illness. Again, data of a subjective nature required specific interpretation in order to qualify for a quantitative classification. Because of these limitations, and the paucity of information on the patients' early developmental and social history, the research focus had to be altered a number of times. Findings concerned with the newcomer's housing and financial situation, with the circumstances of his immigration, his war experiences, attitudes towards relatives and towards rehabilitation, could be established, if at all, only by inference.

'Areas of Influence'.

The three major headings already mentioned finally took shape as distinct areas of influence, or of forces at work. A man's vocational training and experience are basic to any adult's physical survival in a competitive society. A newcomer, even more so, will be faced with this vital reality almost from the moment of his arrival. His work and earning capacity will reflect the degree to which he has already identified himself, as so many do, with the North American value orientation of 'future-directed activity'. His vocational training and skill will determine his occupational status and, with it prestige and security, or its

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[1] Hatcher, Frank Sydney; Social and Cultural Factors in Casework Practice, University of British Columbia, School of Social Work Thesis, 1955, p. 31.

absence. A newcomer's occupational status, furthermore, will reflect the degree of responsibility he holds for himself and others, and their confidence in him, if he is controlling or distributing resources - material or human. The immigrant to Canada may not immediately find the job for which he is qualified, and might have to accept a lower occupational and economic status. This occurred in at least three of the ten German cases studied. Such a necessity may constitute real hardship, materially as well as psychologically, since an immigrant's economic status in a materially-oriented society such as the North American one, may become the almost exclusive measure of his successful adjustment. Choice of housing, financial elasticity permitting recreational participation, plus the need to acquire new clothing and food habits, will be faciliated by his ability to reach quickly an acceptable economic status. The last sector in this 'work-and-earning' pattern, that of the immigrant's mobility experience, partly arises and partly results from these aspects, and it warrants consideration since it might reflect some of his hopes and expectations in coming to Canada; it could shed light on his ability to withstand stress, and it might suggest his degree of flexibility in seeking better living conditions on even newer or more distant shores.

Selection of the next key area, relating to the newcomer's social potentials both qualitatively and quantitatively, was prompted by the necessity for viewing individual behavior against situational forces, since "in order to understand the meaning of a case .... sufficient psychological and social facts, gained through appropriate methods of study, are indispensable."[1] A person's ability to establish and maintain meaningful interpersonal relationships has been proclaimed by numerous experts in the field as a primary criterion of mental health. Clearly, this ability becomes of vital importance to the single immigrant who often starts a 'new life' without relatives or longstanding friends,

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[1] Hamilton, G., op. cit., p. 213.

who otherwise might aid him in minimizing the initial trauma of social isolation. It can be argued that any goal-directed newcomer will seek through some channels, - work, recreational or educational programmes, - the essential support of, and identification with, his new social surroundings. He will take fullest advantage of all possible available tools aiding him in the process of adjustment. The strength of his drive will be reflected in his determination to learn the new language, and in the sustained nature of his efforts to obtain recognition and acceptance.

The remaining sphere of classification for the present study, that of personality factors, is large and can be defined in various ways. In this instance the data on hand is determined to a great extent by what is most typically alluded to in psychiatric case material. The immigrant's personality make-up and his perception of adjustment implications, are particularly relevant to this study. Every newcomer brings certain personality traits with him which will either help or hinder him towards acculturation. His skill in perceiving the novel and diverse nature of a different environment, his attitude towards change, his ability to endure uncertainty, - all these are factors which demand consideration if possible contributors to mental disorders in newcomers shall be assessed. A patient who, 'telling cats his troubles', states that "I have been so lonely - cats are my only friends in the world", reflects a distorted view of reality, and suggests that his expectations of meaningful relationships have been unrealistic. Another immigrant patient, imploring "kill me, I don't want to live" demonstrates a severe lack of motivation for mental recovery. A man's concept of self,[1] depending on, as well as being modified by, success or failure, has a direct bearing on the degree to which he can copy with daily demands, and may determine pace and extent of his recovery. Together with his

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[1] Self :
As defined in Appendix 'A'.

degree of ego strength, it will have a vital impact upon his attitude towards his illness and hospitalization, and thus towards co-operation during treatment and for rehabilitation planning afterwards.

The assessment of the foregoing three key areas clearly indicates that all of them will have to be considered in a survey of significant contributing factors to mental illness in immigrants. They all entail some of those vital aspects which will determine an ultimate, successful adjustment to the Canadian way of life.

The prospective patient in his pre-committal situation - Two illustrative cases.

In order to illustrate the physical, social and emotional environment from which the immigrant came and in which he may be found, the following two detailed, fairly composite cases are presented. They were chosen specifically because they contain above-average qualitative and quantitative data, and because they high-light certain pathological facets which apply to most pre-committal histories.

(A) Hans Nolde.

Hans Nolde is a 35 year-old single German man who was admitted to Crease Clinic by the Royal Canadian Mounted Police in April as a certified patient.[1] He had been on his way to catch a 'plane to Germany because he imagined that his mother was severely ill. Feeling that he was being watched, he jumped off the 'bus and had demanded police escort for protection from physical assault. His admission complaints included persecutive fears from Jews and Masons whom he imagined were after his life. He was found to be agitated, anxious and emotionally flat. He stuttered and showed little insight[2] into his mental condition. Physical

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[1] In order to preserve the confidential nature of information used, changes in identifying statements have been made here, as at some later places in the study. Such changes, however, do not affect the over-all picture of locality, size, or time.

[2] Insight : As defined in Appendix 'A'.

examination revealed that the patient was well built and in good physical health.

Personal History : The patient was born in central Germany as the second youngest of a family of six boys, and a girl who died in infancy. His early development was said to have been normal until the age of two-and-a-half years, when the patient, watching the slaughtering of a pig, developed after-effects of a traumatic nature. He lost his speech for five weeks, after which he began to stutter, to withdraw, and to express previously unknown attachments to animals. During his school years Mr. Nolde was an average, yet dreamy student, to whom school was a 'prison'. Because of his stuttering he seemed to have been ridiculed by other pupils, and therefore often played truant. In order to remedy his speech impediment, his parents had consulted a physician, but without success.

Mr. Nolde left school at the age of sixteen and for a short time was employed as a farm hand. He was described by his brother as a thoughtful, introverted adolescent who would try to over-compensate for his stutter by 'making the impossible possible'. He would judge family members and whole nations in terms of 'the strongest', would ponder about his place in the world, and would express radical, anti-religious ideas. The patient passed his leisure time in swimming, and developed an appreciation of classical music. He neither drank nor smoked. At the age of ten, he had had a homosexual experience about which he still felt very guilty. Mr. Nolde insisted that people talked about this and accused him of similar affairs with his brother. In his contacts with men he felt inadequate, and his heterosexual associations were marked by temporary, fleeting attachments. His delusions included the belief that he had had children by artificial insemination, and that these children were also in danger of being killed.

At seventeen, Mr. Nolde became a member of the German army, but his rank is not known. He managed to rescue a number of comrades during his escapes from Russian prisoner of war camps. However, his reactions to trench experiences, apart

from resulting fright, could not be ascertained. Following a successful escape to the British lines, Mr. Nolde was released in 1946, and lived with his mother until another brother returned from the war. Cramped living quarters necessitated that the patient seek his own living accommodation. This created in him a feeling of resentment. He worked as a farm hand, and intermittently as a landscape gardener until he left Germany, in 1953.

Mr. Nolde came to Canada with one of his brothers, since no wordly goods could be accumulated in poverty-stricken Germany, and since he wanted 'to get away from the hatred in Europe.' Both brothers farmed in Ontario for six months, and have lived in British Columbia for the past three-and-a-quarter years. The patient had worked fairly steadily as a construction labourer and landscape gardener for an average weekly wage of $110.00. He seemed to be economically secure, held a life insurance policy, and, together with his brother, owned a house. The brothers lived together until the patient developed a fear of being accused of homosexual episodes. Although there was no factual evidence for this the brother, eager to help Mr. Nolde, suggested that they separate. Since that time the patient has lived in a number of rooming houses. His last address was that of a mediocre Vancouver hotel. Apart from occasional visits to his brother he did not maintain close social contacts in Vancouver.

Family History : The patient came from a German family in which intellectual pursuits were encouraged, and where academic discussions were part of every-day life. His father was a Lutheran Minister in a rural area, and was said to have been in good health until he died at the age of seventy-nine years. Nothing is known about Mr. Nolde's feelings for his father, although his death was a shock to the patient. His mother, who was living in Germany at the time of his hospitalization, came to Vancouver upon receiving word of his illness and stayed with her other son and his wife. She was described as a middle-aged, lively, energetic person who spoke of the patient's 'high morale', generosity, and helpfulness.

Although Mr. Nolde was unable to openly express hostility towards her, his past delusions had included preoccupations with his mother's death. Of the patient's former siblings only two are now living, since two brothers did not return from Russia. It can be conjectured that a great deal of competition between Mr. Nolde and his brothers might have taken place in the past, because he had always felt inferior to them because of his stutter. Significantly he had formed a particularly close attachment to one brother, 'tall, blonde and strong', who had been a member of the fanatical SS Storm Troopers, and who also had been killed in action. Patient's other brother and his family have made a satisfactory adjustment in Vancouver. Although he verbally expressed a desire to help Mr. Nolde, neither he nor his mother took advantage of visiting privileges while Mr. Nolde was hospitalized.

Assessment : In evaluating this case it becomes obvious that, even during his German days, the patient had encountered a number of disrupting personal experiences which might have negatively affected his psycho-social development. Not only does his childhood environment suggest a competitive and restricting atmosphere, but at least one traumatic experience occurred which might have severely disturbed the patient's subsequent emotional and mental development. Edmund Volkart writes : "The development of schizophrenia in adults has been related to childhood experience with death or separation".[1] It may be surmised that, being sensitive, Mr. Nolde's war experiences imposed additional traumatic effects upon him. It appears that the family's financial situation had no too direct a bearing upon the patient's early development, whereas his seclusiveness, inability to communicate and socialize had prevailed from childhood even in his familiar native surroundings. Mr. Nolde's violent arguments over religious matters and his pronounced retreat into the world of music suggest unhealthy attempts to solve his problems. Although little is known about

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[1] Volkart, E. H., "Bereavement & Mental Health", EXPLORATIONS IN SOCIAL PSYCHIATRY, ed. Leighton, A.H., et al., op. cit., p. 284.

possible clashes between his religion-practising home and its son's membership in the SS, which required full acceptance of Nazi ideology, such a surmise does not seem too remote. Patient's highly coloured delusions indicate to some extent the specific areas of conflict which might well have existed within his immediate family circle.

Since Mr. Nolde's arrival in Canada, stress situations seem to have placed additional emotional burden upon him. The transplantation from a rural, relatively static setting, to the fluid North American urban setting, is one example of a possibly disrupting experience; differences in cultural frames of reference, for an originally insecure, defensive and rigid person, another. The indications that the onset of Mr. Nolde's mental illness may date back to his earlier years are strong. Drastic changes in external circumstances, reactivating latent hostility, well may have precipitated rather than caused his mental disturbance.

(B) William James.

William James, a twenty-five year-old single man admitted himself to Crease Clinic as a voluntary patient. Accompanied by his mother, his complaints included difficulties in interpersonal relationships, 'blues', shyness, apprehension, insomnia and tiredness. He was found to be depressed, anxious, emotionally flat and preoccupied, with apparent chronic constipation. Medical examination revealed a physically healthy young man who, however, suffered from impaired activity in his right foot. His illness had had its onset approximately eighteen months ago. Personal History : The patient, born in a small British Columbian town, came from a family of Irish/Scottish racial origin. He had attended school until Grade X and had been an average student. He had always been shy and nervous in meeting people. Heterosexual associations had been 'unsatisfactory and poor', since the patient had a distorted body image. He had described his maleness as a 'freak' and, in spite of assurance to the contrary, had insisted that his bodily figure more resembled that of a

female than a male. Whereas in his early teens he had copied movie stars, later he joined the Canadian Legion in order to 'learn to socialize'. Recreational interests centred around baseball and hockey. Mr. James did not drink. He had always made enemies quickly, and had had particular difficulties in getting along with people in authoritarian positions. Mr. James had left school at the age of 17, and had worked as a 'carpenter's helper' until the onset of the Korean war. He had then enlisted with the Canadian Army, and was sent to Korea for two years, where he contracted malaria which has only once recurred. He described his army days as 'the best days of my life', because service had given him an opportunity to improve his social skills. At the same time, he admitted to numerous clashes with his superiors, since he had resented discipline orders and imposed responsibility. Following his discharge, and moving in with his mother, he worked for two months when he was involved in an industrial accident which necessitated a four months' stay in one of Vancouver's leading hospitals. The patient is bitter about this accident since it required subsequent operations in 1953 and 1954, and interim periods of eight months during which he did not work. He felt that he could have been 'much further ahead' without these disruptions. In 1954 he enrolled in a vocational course for electricians, yet felt left out by fellow students 'because of my age'. Although Mr. James began his apprenticeship as an electrician, tiredness, frequent crying spells, and nervous tension prevented its completion. Prior to his admission to Crease Clinic he had been given brief psychiatric treatment at the Veterans' Hospital.

On account of a fairly irregular work record, Mr. James' financial situation was poor, and his income at the time of admission consisted of 'spending money' and $20.00. monthly Compensation Pension. However, he carried a life insurance policy in the amount of $2000.00.

Family History : Nothing is known about Mr. James' early development. His father died of tuberculosis when the patient was four years of age. No mention of paternal

relations was made. His mother remarried eight years after her husband's death and once more appears to be widowed. The stepfather was described by the patient as a domineering, stern man, with whom Mr. James did not get along. Ever since her first's husband's death, patient's mother had worked in order to support the family. This resulted in feelings of guilt on the part of the patient, because he believed that he ought to have contributed more to the family budget than he had been able to do. He described his mother as being a 'neurotic, like me', and as having contributed to a feeling of insecurity during his childhood. She reportedly has few friends, seldom goes out, and feels awkward in social situations. Mr. James stated that his upbringing had been inconsistent, and that his mother had vacillated between spoiling him and being exceedingly stern. This, he said, had left him insecure and had not permitted the development of a set personality. He thus believed that he will always suffer from a 'hereditary' set-back and maintained that his future had been destined by his accident. He appeared to have developed excessive dependency on his mother. However, he had made the occasional attempt to emancipate himself from her domination. The patient did not refer to his sister, nor did she visit him during his hospitalization.

Assessment : Mr. James looked back on a childhood during which many of his emotional needs had not been met. In order to support the family, his mother had had to work, and could have spent little time or effort on the patient. His relationship with the stepfather had been poor and might have added to the lack of self-confidence from which he had suffered. His inability to relate to people must be seen as an additional, discouraging disadvantage, since he aspired to positive, meaningful, interpersonal relationships. Physical injuries and poor sexual identification may have contributed further to his already defective self-image, as much as conflicting disciplinarian methods could be partly responsible for his feeling of insecurity and his defiance of authority. In spite of numerous situational set-backs, however, Mr. James had remained aware of his personal problems for which

he had sought the occasional short-lived solution. It appears that he may have unconsciously resorted to illness and hospitalization as a final escape from his own subjective fears, as well as from reality demands as imposed by everyday environmental situations.

In conclusion, it can be said that both illustrative cases reflect remarkable similarities in behaviour patterns and personality disposition. However, to what extent either of these basic factors is responsible for a breakdown in the patients' personality structure can only be assessed after a closer analytical study of the 'forces at work' has been completed in the following chapter.

CHAPTER THREE

FORCES AT WORK

The previous chapter has dealt with the patient as a person in his pre-committal, everyday environment. A closer look can now be taken, not so much at individuals separately, but at the environmental and personal factors which become apparent when a representative number of such persons are examined. Both groups, Canadian-born and German, will be compared, and more emphasis will be placed upon the three 'key areas' which were discussed earlier.

The analysis of the case material available reveals that the majority of the patients held very low-grade records. Many of them had worked as only unskilled labourers, and had held temporary jobs which required a minimum of personal responsibility and vocational training. Only seven out of thirty men had been semi-skilled workmen. An exceptional four claimed some kind of managerial status. Most patients had been employed on farms, as loggers, or in relatively unskilled factory work. Correspondingly, they had held an economic position which, when assessed on the basis of personal property, was only marginal. Although four men had been fully self-supporting, and one had occasionally earned weekly wages as high as $140.00., frequent changes in position, seasonal jobs, and unemployment seem to have contributed to the predominantly uncertain financial situation of these men. There was little indication of careless monetary management, which might result from consumption of narcotics or alcohol. Half of the total group of patients had held some assets - insurance, bank accounts, modest personal effects, - and few of them had financial obligations beyond those of self-support. None of the German patients had been in receipt of Public Assistance, whereas two Canadians had received Department of Veterans' Affairs' benefits. Although none of the men had a record with the Social Service Index, a considerable number of them had at some time drawn unemployment benefits. The analysis disclosed that, in accordance

with their over-all irregular work history, most men had experienced a high degree of mobility. If Canadian-born,[1] they had moved within this province on an average of once a year. Particularly, changes from boarding houses to downtown hotels, and to logging camps by the immigrants reflected such physical instability. In a number of cases no fixed address was available, and one German patient was admitted with cooking utensils in his possession! The Canadians could be distinguished from their German counterparts by the fact that the majority used to reside with close relatives. Background information indicated that the degree of mobility of most Germans had already been high while still in Germany. The picture thus far reveals poor, irregular occupational and economic records, and high mobility experiences for most immigrants. It could be argued that novelty of employment situation and unfamiliarity with housing conditoons may have accounted for this negative finding. However, since similar facts applied to the Canadian group, the reason for a low functioning in such a vital spheresmust be considered to lie outside mere situational circumstances. The majority of the patients were of average intelligence, with at least a Grade VIII education, or its German equivalent. Thus, a lack of educational preparedness could not be solely responsible for their low-grade occupational and financial records. A premature conjecture, derived from these negative findings, would entail a subsequently lowered self-esteem as affecting social and personal functioning on the part of the immigrants.

Any assessment of social potentials and forces, as they might affect the process of adjustment, must be considered quantitatively and qualitatively. Varying degrees of social pursuits and recreational activities showed that the newcomers, as well at their counterparts, had a modest number of social outlets. These included movie attendance, reading, dancing, and outdoor sports; the immigrant

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[1] Internal Canadian demographic changes are discussed in Chapter II, page 19.

patients, significantly, revealed a proportionate preference for 'musical activities'. These are not well defined and may amount to no more than listening to the radio. In both groups little indication of incentive or resourcefulness regarding the choice of social contacts and recreational activities could be detected. Indifference to culture and current events coincided closely with the limited degree of social potentials prevalent in each group. The qualitative assessment, based on the men's intensity of pursuits, reflected that the majority of all patients had been unable to show a healthy degree of self-involvement in any of their social activities. The ability to share and actively participate was conspicuously absent. The patients themselves complained about their lack of skill in establishing and maintaining meaningful social contacts. "I cannot cope with people" was a frequent utterance. The apparent correlation between both groups in this 'area of influence', however, is misleading. In spite of their casual social contacts, four Canadians had been members of clubs, legions, or orders, which did not apply at all to the immigrant group. Furthermore, the quantitative degree of friends and acquaintances enjoyed by both groups varied. With a few exceptions, the Germans had no relatives in Canada, and only a few casual friends. They had all been admitted to the Clinic either alone or with a Royal Canadian Mounted Police escort. In contrast, most Canadians had been accompanied by relatives. This difference extended to the area of visiting during the patients' hospitalization. Although this facet could be assessed only for visitors who resided in Greater Vancouver, the survey showed that almost half of all patients received visitors on an adequate, regular basis. However, this applied predominantly to the Canadian men who also received more frequent invitations for week-end outings. The Canadians, thus, less by personal characteristics than by 'coincidences of birth', appeared to enjoy a distinct advantage over their German counterparts. Although their contacts were casual, acquaintance with work colleagues, and the availability of concerned relatives offered, in addition to shelter, a sense of rootedness, which had been fully absent for the newcomers.

It is argued that environmental forces will be as effective as the individual permits them to become, and hence that an immigrant's personality make-up is as important and vital as the environmental circumstances he may encounter during his adjustment period. It was noticeable that the majority of patients reflected a moderately healthy, strong ego. For most newcomers, the attempt to cope with their illness, prior to hospitalization, had been sincere and of long duration. The prospect of physical and mental disability may well have accentuated - either curtailed or re-inforced- their resistance. At times, the struggle for maintenance of mental health had led to a denial of illness, or to a conscious postponement of hospitalization for as long as from three to six years. The patient's ability to realistically perceive environmental demands was minimal; the degree to which they employed defences was excessive. The survey significantly revealed that the newcomer's concept of self[1] was only moderately healthy. The argument that immigration per se constitutes a selective process might have been substantiated by these findings had not the Canadians subscribed to an even weaker self-perception of being 'shy', 'afraid' and 'uncertain'. "I chicken out" demonstrates this frequently-voiced attitude. Feelings of inadequacy, self-depreciation and defeatism, as well as a minimal 'sense of goal' coincided with the newcomers' indifferent attitude towards their emigration. Hardly any of them could state a definite reason for having come to Canada; none of them seemed to have prepared himself in any way for the different mode of life to be encountered. At the time of admission, the majority of the German patients was described as 'neat and tidy' in appearance. This might shed some light on their self-concept, as well as on their specific, culturally-determined value system. Similar comments had been less frequently made about the Canadian group.

Although an analysis of the patients' attitudes towards illness and

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1 Concept of Self : As defined in Appendix 'A'.

hospitalization was based mainly on pre-committal reports, it was also extracted from the mode of their admission, the length of hospitalization, actual adjustment to, and acceptance of, treatment.[1] It was found that most immigrant patients had required certified admissions, whereas approximately two-thirds of the Canadian men had been admitted voluntarily. A belated admission, however, often deters recovery and indicates a severe resistance to treatment. The analysis, furthermore, showed that two-third of all patients expressed some willingness for self--involvement in therapeutic programmes. They were also able to mobilize, during their hospitalization, some of their individual potentials. "I need help", "I want to get out so that I can go back to work" expressed this over-all, moderate degree of motivation towards improvement and rehabilitation. The newcomers' ability to sustain the fight for maintenance of mental health longer than their Canadian counterparts may indicate ego strength as much as excessive fear and gross resistance to medical help. Once hospitalized, both groups wanted psychiatric assistance. However, the identification of the Clinic with a shelter and retreat appeared to have been more prominent with the immigrants than with the Canadian patients.

The patients compared.

A uniformly-gained impression of both patient groups was their submarginal functioning as reflected in a low occupational status, in an uncertain financial situation, and in a high mobility rate. Their inability to seek solid outlets, to communicate, and to establish satisfactory interpersonal relationships was equally uniform. Adhering, for the present study, to the legitimacy of inference, it can be said that these features present the most obvious and significant

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[1] If voluntarily admitted the patient may request discharge on five days' notice and thus can express his unwillingness for further treatment. It is significantly noticeable that the average stay for the immigrant patient was 2.4 months, and for the Canadian 1.4 months.

correlation for both groups. Canadians and immigrants alike acknowledged their social inadequacy by remarks such as "I'd sooner be more or less by myself", all of which points to the same over-all feature of the lack of drive, purpose and self-confidence.

A similarly high degree of divergence between the groups emerged from the number of relatives and friends they enjoyed. Whereas the Canadians had enjoyed a moderate number of social contacts, and had even resided occasionally with relatives, this did not apply to the immigrant group. The latter's social acquaintances were rarer and of a more fleeting, casual nature, which reflected itself also in the limited number of visitors the immigrants had received. Since, however, any social work assessment does stress qualitative aspects of human behaviour as much as quantitative ones, this finding serves rather as an exposition than as an evaluation. A further difference arose from the mode of admission. In contrast to their counterparts, the immigrants almost uniformly reflected a certified committal which, being an emergency measure, had frequently necessitated the escort of a Royal Canadian Mounted Police officer.

Some additional, highly suggestive, although by no means conclusive differences emerged. These consisted of the nature and content of the delusions manifested by both patient groups. Although such fragmentary findings do not claim significance in their own right, it is argued that, as much as free associations 'are guides to the client's underlying dynamics or motivations',[1] so does an awareness of their delusions 'interpreted with the theoretical framework of the therapist'[2] have its place in this study. The immigrants' predominant delusions consisted of fears of persecution, - by Jews, 'Chinamen', and Freemasons, - of food poisoning and of hostility and discrimination against them as Germans and as spies. In contrast, the delusions of the Canadian patients

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1 English, H.B. & English, A.C., A Comprehensive Dictionary of Psychological & Psychoanalytical Terms, Longman's Green & Co., New York, 1958, p.163.

2 Loc. cit.

were mainly ideas of reference. They centred around conflicting interpersonal relationships, fear of being killed (by no specific agent), preoccupation with sexual perversions, as well as auditory hallucinations : hostile, noisy voices which advised, threatened and ridiculed.

The aggregate impact of these facets tentatively high-lights significant factors towards mental breakdown in the immigrant group. Their limited use of recreational resources indicate that the latter may have been unknown to the newcomer. This would also apply to the emergency admission for most immigrants, which suggests a possible ignorance of services available, unwillingness to admit failure, fear of mental illness and hospitalization, and a threat of deportation. A definitely-prevailing unfamiliarity with the English language, furthermore, might partly explain their scanty social contacts and personal associations. However, the undeniable lack of social skills, and the inability to establish meaningful relations, still must be considered a personal shortcoming in most newcomers. It too will be responsible for a delayed social adjustment, since access to Canadian family life, and acquaintance with the essential 'know-how' depends widely upon the ability to move freely amongst different groups of people. It has been correctly argued that as soon as a person is isolated he develops a hunger for social contacts.[1] Thus the newcomer could readily be perceived as perpetually escaping from ultimate, social isolation. The danger of finally succumbing to persistent stress might have assumed paralyzing proportions, particularly for those newcomers whose social skills always have been defective and minimal.

In summary it can be said that the established divergences between the two groups of patients are not excessively striking. Although the immigrants lacked one of the most vital pre-requisites for any successful adjustment, - that

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[1] Katz, S., "How Mental Illness is Attacking our Immigrants", MacLean's Magazine, January 1958, p. 44.

of a moderate, regular occupational record,-it has become obvious that the novelty of environmental situations cannot exclusively be responsible for their mental illness. The definite correlation between Canadian-born and immigrant patients defeats such conjectures, as much as the recognition of the mutual impact of the various areas of influence, and the fact that such interaction has not been assessed yet. It appears at this point that the newcomer might have brought with him longstanding personality deficiencies, and individual potentials which would permit only a limited degree of satisfactory economic, social and personal functioning. Such tentative conclusions, however, require some further exposition which has been attempted below.

A Possible rating scale.

The kind of findings which have been discussed almost inevitably suggested the use of an assessment system for further comparisons. Such a step might ideally lead towards the device of a scale which would facilitate measure--ments for the individual patient, as well as permit some conclusions at a group average. Furthermore, this device might serve to verify the case illustrations which were presented, as well as substantiate the immediately-preceding analytical discussion. Since certain areas of individual behaviour were not mentioned in the case records, the establishment of any assessment scheme would be only a temporary and preliminary measure. After a number of difficulties had been overcome, an ex--perimental schedule was worked out which was based on the three key areas which have been discussed. However, the latter were now viewed as a blueprint for those forces which may have directly contributed to the immigrant's mental illness. For example, work and earning capacity encompass the fields of financial security and flexibility, of status, of vertical and horizontal mobility, of value orientation, and of acceptance by the community. This aspect, more than any other, reflects the

concrete, overt proof of the immigrant's accomplished adjustment.

Less obvious, yet equally vital, is the pattern of a newcomer's socialization. It extends into the field of group interaction, recreational pursuits, heterosexual relations; it affects habit-forming activities, and facilitates linguistic, cultural and community identification.

The final division, that of personality factors, is even less readily determinable, yet also constitutes a most vital force in the task of adjustment. Personal strength and attitudes, a healthy ego, and a 'sense of goal' will in many instances remain the ultimate, deciding factor which ensures emotional and mental well-being. The mutual interaction of all three spheres has been acknowledged previously and was well expressed by one patient : "I would keep my job if I could find something to do at night."

TABLE I. Proposed (tentative) Assessment Scheme.

AREAS AND GRADES	EXPLANATORY NOTES
I. Work & Earning Capacity	
1. Occupational Status	
A. Managerial, professional	Responsibilities involving distribution and control of human or financial resources; requiring specific training or special experience.
B. Artisans, mechanics, clerical	Responsibilities discharged directly on the job; requiring apprenticeship, some vocational training or definite skills.
C. Manual & others	Responsibilities not directly affecting managerial matters; requiring no specific training
2. Economic Level	
A. Self-supporting	Steady job; fixed income; owning material assets of recognizable value; able to assume partial financial responsibility for dependents.
B. Marginal to uncertain	Irregular income; personal assets of little value; need of controlled budget; some savings; able to assume moderate financial responsibility for dependents.
C. Dependent	Handicapped; low earning capacity; unemploy--ed; no steady income; personal assets of insignificant extent and value; dependent on family, friends, welfare programme.
3. Mobility Rate	
(a) Canada	
A. Low	Change of residence no more than every 3 years
B. Moderate	Change every 1 - 3 years.
C. High	Change at least once per year.
(b) Germany	
A. Low	Change no more than every 4 years.
B. Moderate	Change every $1\frac{1}{2}$ - 4 years.
C. High	Change at least every $1\frac{1}{2}$ years.

continued p. 43.

TABLE I. (continued)

AREAS AND GRADES	EXPLANATORY NOTES
II. Social Potentials	
4. Social & Recreational Activities & Interests	
A. High	Varied kinds and degrees of activities purposely pursued; high level of self--involvement; acute awareness of cultural and current events.
B. Moderate	Restricted kinds and degrees of activities pursued; irregular participation only with encouragement; limited ability to share interests; limited awareness of cultural issues and current events.
C. Limited	Little or no activities pursued; participation only if in supportive company; socially shy and self-conscious; no self-involvement; indifference to cultural issues and current events.
5. Relations with Friends and Relatives	
A. Ample	A large number of friends, acquaintances, or first and second grade relatives frequently contacted.
B. Moderate	Some friends, acquaintances, or relatives; contacts being irregular.
C. Limited	Few or no casual friends or acquaintances or relatives; infrequent, irregular contacts.
6. Visitings	
A. Ample	Regular, at least once weekly; frequent invitations to spend week-ends with visitors.
B. Moderate	Spasmodically, on once weekly average; occasional invitations to spend week-ends with visitors.
C. Limited	Visits less than every other week, or none at all; irregular and brief in duration.

continued p. 44.

TABLE I. (continued)

AREAS AND GRADES	EXPLANATORY NOTES
III. Personality Factors	
7. Ego Strength	
A. High	Good ability to perceive 'reality'; high level of 'insight'; objective attitude towards ill--ness and hospitalization; severe struggle for maintenance of mental health.
B. Moderate	Limited ability to perceive 'reality'; moder--ate degree of 'insight'; vacillating attitude towards illness and hospitalization; previous struggle to maintain mental health erratic, or of short duration.
C. Low	Little or no ability to perceive 'reality'; no 'insight'; defensive towards illness and hospitalization; frequent and excessive use of defences; little or no previous attempt to regain mental health.
8. Concept of Self	
A. Strong	Strong sense of goal and desire for personal achievements; persistent feeling of well--being, strength, self-worth, vitality and confidence.
B. Moderate	Moderate sense of goal and desire for personal achievements; fluctuating feeling of well-being, strength, self-worth, vitality and confidence.
C. Weak	No sense of goal or desire for personal achievements; limited or no feeling of well--being, strength, self-worth, and vitality; self-depreciatory, insecure, uncertain and lacking self-confidence.
9. Motivation	
A. High	High degree of personal involvement in treatment; good adjustment on the wards; own potentials put to fullest possible use.
B. Moderate	Some personal involvement in treatment, may see institution as protective retreat; requires encouragement in order to mobilize own potentials.
C. Poor	Little or no self-involvement in treatment or desire to mobilize own potentials; poor adjust--ment on the wards; overt or latent resistance to treatment.

The main difficulty in working out such a schedule as presented in Table I arose from the attempt to transcribe, particularly for the first two areas, qualitative, descriptive data into measurable terms. In the field of personality factors the assessment of human behaviour based on either a psychological or psycho-social interpreation had to be specially considered. Huxley stated : "The social scientist is himself part of his own material, and the criteria for judging the outcome of an experiment are partially subjective. Thus the social scientist cannot escape bias...".[1]

Beyond such bias, the schedule may reflect a somewhat fragmentary character. This would be less the outcome of negligence in collecting the data, than that of the paucity of the material available from clinical records. It also necessitated an occasional inference regarding fragmentary information. Lack of data on the immigrant's pre-migration background and early development led to the involuntary pre-concern with their post-migration history.[2] Full recognition was givennto a number of other important variables which, although possibly bearing on the 'forces at work', could not be taken into immediate consideration.

Reservations pertaining to the selection and treatment of information are offered inAppendix 'A'. At this point only a few vital, though by necessity omitted, aspects will be discussed. It is argued that, amongst other facets, the impact of the immigrant's past army experience might have deserved more intensive mention. Instead, it could merely be learned that the majority of newcomers had been active in World War II for a number of years and that their counterparts, if in the services at all, had been only in training, or during brief periods over--seas. Such a military episode, however, would leave its impact on anyone, and particularly the young person. It might drastically have curtailed developmental

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[1] Huxley, J., op. cit., p.30.

[2] The newcomers' mobility assessment excluded the process of migration per se, and has been based on the assumption that, traditionally, the mobility rate in Germany, as reflected by change in residence and employment, is still lower than in North America.

processes. Extensive vocational or social training, heterosexual relations, as well as personality growth might have been severely affected. Attitudes towards authoritarian figures, identification with, and reliance on the paternal 'State-surrogate' might have crystallized, had awareness of such possibility prevailed. It is argued that these attitudes could have had their almost exclusive roots, not so much in traditional cultural divergencies, but rather in situational conditions. Besides, the rank the newcomer may have held as a soldier, the prestige and influence with which he may have been endowed, favourable group experiences he may have shared, - all these are part and parcel of those forces which, belonging in the past, still carry important weight in any analytical assessment. Lacking in clinical records, furthermore, was an account of such vital experiences as post-war dislocation, lengthy separation from family members, transplantation from rural to urban settings, encounter with German sub-cultures (through war evacuation), all of which might have contributed to a widely different life experience for each individual newcomer. An assessment of the immigrant's interim period between arrival in Canada and the onset of illness would have been of assistance in the establishment of a more accurate picture of his personality strength. It could have indicated the degree to which, prior to his hospitalization, he had been exposed to adjustment pressures. It might also have suggested the length of his struggle for the maintenance of mental health, and thus indicated his level of stress resistance. No data which would provide an answer to these questions was available. A rough estimate, though, suggests that seven of the total immigrant group had arrived in Canada at least two-and-a-half years prior to their admission to Crease Clinic.

Once the material studied had been classified and assessed, the possibility arose of using it in a summarized quantitative form; however, in view of the limited number of cases examined, any presentation in figures must be considered experimental and approximate in nature, and inconclusive in outcome. It will differ widely

from an idealized statistical exhibit, since it will aim only at a further illustration of the material extracted. It ultimately was hoped to high-light the significance, and thus demonstrate the weight, of individual forces which may work for or against the newcomer's attempt to become an integral part of the Canadian way of life.

TABLE II. Summary of ratings expressed in percentages.

AREAS AND GROUPS	RATINGS					
	10 Germans			20 Canadians		
	'A'	'B'	'C'	'A'	'B'	'C'
I. Work & Earning Capacity						
1. Occupational Status	10	20	70	15	25	60
2. Economic Status	10	50	40	5	55	40
3. Mobility Rate	-	30	70	15	40	45
II. Social Potentials						
4. Social and Recreational Activities and Interests	-	80	20	10	50	40
5. Relations with Friends and Relatives	20	-	80	10	45	45
6. Visiting	20	10	70	20	45	35
III. Personality Factors						
7. Ego strength	10	80	10	-	75	25
8. Concept of Self	-	60	40	5	60	35
9. Motivation						
Average rating for all items	9	44	47	9	48	44

The assessment scale, as shown on page 42, was constructed from the data previously extracted, classified and interpreted. Next, a preliminary table was set up for the German and Canadian groups. It provided for the three key areas and their subdivisions, encompassing groups one to nine. The data for each case, having been aeembled on the working sheet, was then rated for its individual components. These 'A', 'B', or 'C' ratings, based on the rating scale as set out on page 50, were transcribed on to the preliminary table. An addition of individual ratings for each sample group, ten German and twenty Canadian patients, followed. The results were inserted in Table II and, in order to permit comparison, expressed as simple percentages.

A clear result, as illustrated in Table II, is that a majority of both German and Canadian patients fall predominantly into the average or low rating grades. This is reflected particularly in the occupational and economic fields. Both groups, although deriving it from different areas, show an identical proportion of 'A' gradings. A further illustrated similarity between immigrants and Canadians was the correspondence of the 'B' and 'C' ratings. The visit area showed that the immigrants had benefitted considerably less from such experience than had their counterparts. This would confirm the assumption made earlier that they might have failed to establish lasting social bonds prior to their hospitalization. A similarity in ego strength between both groups can be readily deduced from Table II, which also conveys some discrepancy on their respective concepts of self. A further interesting finding showed that the Canadians' high visiting ratings do not correspond sufficiently closely with the strength of their social and recreational activities and interests, or with that of contacts with relatives and friends. This was revealing in view of the fact that the latter's extensive efforts to reach the patient may have exceeded his own ability to respond to them.

[1] Experimentally it might be interesting to revise the Canadians' rating in the area of 'social potentials' by omitting the group of visits.

TABLE III. Individual ratings of the patients who rated highest in the sample groups.

AREAS AND GROUPS	GERMANS (3)			CANADIANS (7)						
	G1	G2	G3	C1	C2	C3	C4	C5	C6	C7
I. Work & Earning Capacity										
1. Occupational Status	C	B	A	B	B	C	A	B	A	A
2. Economic Status	B	B	B	B	B	B	B	A	A	A
3. Mobility Rate	C	B	B	B	B	B	B	A	A	A
II. Social Potentials										
4. Social & Recreational Activities and Interests	B	B	B	B	B	B	A	B	B	A
5. Relations with Friends and Relatives	A.	A	C	B	C	A	B	B	C	C
6. Visiting	A	A	C	C	C	A	B	B	A	B
III. Personality Factors										
7. Ego strength	A	B	B	B	B	B	B	B	B	B
8. Concept of Self	B	C	B	B	B	C	B	C	B	B
9. Motivation	A	B	C	A	B	B	B	B	C	B
Total Ratings* No. of 'A's	4	2	1	1	1	2	2	1	3	3
No. of 'B's	3	6	5	7	6	5	7	7	4	5
No. of 'C's	2	1	3	1	2	2	-	1	2	1

* This relates to all men who were rated 'A' or 'B' in at least two-thirds of the "analysis areas".

The aggregate findings show the strongest distribution in the sphere of personality factors where corresponding tendencies are indicated for both groups. The weakest area for the newcomers is that of social potentials, possibly because of their earlier-mentioned, and now clearly discernible, limited degree of social contacts.

Even an arbitrary assessment of the 'A' and 'B' ratings for the individual patient indicated that only ten out of thirty men rated moderately high in most of the critical areas. These ten, each reflecting at least two-thirds in the 'A' or 'B' ratings, are shown in Table III on page 50.[1] Such findings, provided by seven Canadians and three immigrants, suggest stronger over-all potentials in each case. With regard to the immigrants, this might support Ruesch's hypothesis[2] that the accumulated impact of environmental stress situations is primarily responsible for a newcomer's personality breakdown. The few high ratings hold numerous implications for the case worker. Since these patients might be more promising candidates for treatment, a reconsideration of additional services rendered to them appears warranted. As a lack of social contacts has emerged as the outstanding, negative factor in immigrant ratings, casework services might offer to the amenable patient a valuable substitute for the absence of relatives or friends. Thus an even faster and more effective adjustment to hospitalization might be facilitated, and a more lasting preparation for the post-discharge period ensured. At the same time, the question of casework services rendered also to other immigrant patients would warrant equally serious examination. This study showed that in only four instances, mainly in conjunction with rehabilitation planning, were brief services requested from and rendered by the Social Service Department. These considerations also apply to the seven Canadians who showed individual, over-all

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[1] The individuals are referred to in Table III as 'G1 (German1)etc.,and 'C1' (Canadian1)

[2] Ruesch, J., et. al., op. cit.

'medium-to-high' ratings. The difference in the ultimate casework goals, however, would consist in providing higher treatment benefits for the Canadian patients. Rehabilitation care, however, could be left for most of them to apparently interested and available community members. In contrast, the immogrants would require casework services which would have to reach beyond immediate treatment benefits, and extend into the sphere of rehabilitation and following-up contacts. Since the majority of the clinical records listed no discharge prognosis, higher treatment gains for hospitalized immigrants through additional casework could not even be speculatively assessed.

Two composite examples.

To give more substance to the preceding analytical exploration, a number of the most commonly emerging features can now be put together as two composite cases. The value in constructing such amalgamated 'types' - not arbitrarily, but from a qualitative assessment of the material examined, - is two-fold.
Apart from clarifying they also aim at identifying some uniform features as common to the immigrant, and as extracted mainly from his psycho-social situation prior to and during admission. Secondly, the impact of forces at work, causing or precipitating mental illness, can better be compared from symptomatical behaviour reactions.

The weakness in working out such typical, descriptive cases, rests in the fact that a good deal of isolated, possibly significant data could not find representation. However, some developmental information, not provided for under the three key headings, was included in order to substantiate the picture. Whereas the preceding assessment had taken into account motivational factors as expressed in attitudes towards treatment and rehabilitation, these compositive presentations will confine themselves to the patient as viewed at the time of his admission.

(A) Kurt Neumann.

Being of Lutheran faith, Mr. Neumann had received the German equivalent of a Grade VIII education. He was of average intelligence. Since coming to Canada he had been employed in the construction field, since he had had no specific vocational training. Although his financial situation could not be exactly ascertained, it appears that his irregular wages ran around $200.00. a month, and he had managed to open and maintain a small bank account. Mr. Neumann had not been the beneficiary of any Canadian Public Assistance programme, other than Unemployment Benefits. In spite of his numerous attempts to obtain work, he had been unemployed on a number of occasions. His work records showed that he used to stay in his job for a period of less than one year. His living arrangements reflected an equally high degree of instability.

From his arrival in Canada, Mr. Neumann had led a lonely, isolated existence. His few acquaintances consisted of the occasional recent German immi--grant whom he had met 'in the street', on the job, or in a restaurant. He had no relatives in Canada, and wrote irregularly and seldom to his family in Germany. Mr. Neumann found it difficult to converse, yet was friendly and co-operative. His heterosexual relations were described by him as being unsatisfactory, brief and casual. He appeared uncertain of, and inadequate in his masculine role. He stated that he had been engaged in only a few social activities since his arrival in this country, and could name no specific recreational pursuits. There was no indication of an attempt to seek contacts with people other than of his own nationality. During his hospitalization he received few visits, predominantly by work colleagues. By inference it can be assumed that, up to his admission, he had made no conscious attempt to become acquainted with the North American way of life. At the time of his committal, Mr. Neumann had had no clear idea regarding the function of the Clinic. He had been admitted, escorted by a Royal Canadian Mounted Police officer as a highly-disturbed, certified patient.

He had perceived himself as being a worthless, easily-swayed, weak person. His insight into his mental condition was only moderate, and it can be assumed that his recognition of reality demands had been defective for a long time. The patient had suggested little sense of goal or desire for achievement, as demonstrated by his inability to state any definite reason for his immigration to Canada. He appeared to have had no specific expectations or purpose in coming. He had not prepared himself for a different mode of life.

Mr. Neumann's pre-migration history revealed that he was born into a family of five children in a rural area of Germany. His socio-economic background could not be determined, but it is suspected that it was poor and of a manual labour-er's level. His early psycho-sexual development entailed homosexual experiences, and fears of incest and castration which had resulted in severe feelings of guilt. The patient spoke of a home life disrupted by illegitimacy and divorce, and of emotional deprivations during his childhood. His employment record had been irregular in Germany, which might have been a direct outcome of an unstable war and post-war situation. As a soldier in the German army, Mr. Neumann had been in the trenches and indicated that he had encountered traumatic war experiences. Prior to his migration, the patient appears to have been a withdrawn, socially shy and awkward person who had had meaningful, interpersonal contact with only a few people. His recreational interests had included attendance at an occasional dance, outdoor activity, and musical appreciation.

(B) John Cameron.

At the time of his admission, John Cameron was an unmarried man, thirty-five years old. He came from a Protestant Canadian family of Anglo-Saxon background. He was in good physical health, although handicapped by disfiguration of which he was rather conscious. He appeared withdrawn, anxious and depressed and lacking

affect, yet was desirous of medical help. His delusions centred around ideas of reference, and he complained of a sense of failure, and lacking motivation.

Mr. Cameron had lived most of his life in British Columbia and had moved within the province approximately once every year. He had completed a Grade X education, but although he appeared to be of average intelligence he had rarely ever functioned at his highest potential level. He had not been in the armed forces and had been employed intermittently as an unskilled labourer who would earn a monthly wage of from $150.00. to $200.00. At no time would he have been in receipt of Public Assistance, other than Unemployment Benefits necessitated by frequent waves of unemployment. The patient might also have the occasional bank account, Life Insurance Policy, and some personal property of insignificant value.

Mr. Cameron had a few relatives in this province and, whenever working in the same city, would reside with them. Although he expressed negative feelings about relatives, the latter had accompanied him during his voluntary admission. He would have an occasional, possibly even regular visitor who demonstrated interest in and concern about him, and by whom he was invited for a few week-end outings. The patient could name no long-standing, close friend. In spite of numerous social activities engaged in, he stated that he felt awkward in social gatherings and that he had difficulties in meeting people. Mr. Cameron used to attend outdoor games, movies, television shows, yet did not indicate interest in current events. His heterosexual contacts had been casual and superficial; they had not entailed any self-involvement. Feelings of guilt over homosexual and masturbatory practices, together with complaints over poor heterosexual relations, had been verbalized by the patient.

Mr. Cameron's onset of illness could not be determined, but it can be conjectured that he had wrestled with it for a considerable length of time. His perception of reality and his insight into his illness were poor. He expressed a moderate desire

for achievement, particularly with regard to occupational and financial pursuits. However, a lack in sustainment became apparent. The patient perceived himself as being an undecided, weak, and defeated person who was unable to get along with people, and unsuccessful in his material achievements.

This Canadian's developmental history placed him into a family of five children who were reared under the impact of divorce, separation, or remarriage. Parental interference and excessive expectations of a dominant, rejecting mother, and a firm father were major complaints voiced by the patient. As a child, Mr. Cameron appeared to have felt unwanted, shy and uncertain of himself, and as an adolescent, over-sensitive and insecure in his masculine role.

These two composite pictures reflect a close over-all similarity in most assessment areas. This becomes particularly apparent in the occupational spheres which seem to have been marked by numerous episodes of unemployment. Both patients, being unskilled labourers, show a high degree of residential and occupational mobility, and only moderate financial security.

The similarity between immigrant and native patient can also be seen in the area of unsatisfactory interpersonal relationships, where a lack of social skills and contacts predominated. The frequently verbalized desire to be able to 'get along with people' verified this. Recreational outlets appear to have been more varied and extensive with Mr. Cameron, the Canadian. Again, a lack of satisfactory heterosexual relations are recognized and expressed by both men who, furthermore, had complained of an unhappy, deprived childhood and of guilt-evoking past homosexual experiences. Both patients had held defective, negative perceptions of themselves. They indicated little personal incentive, 'sense of goal', or achievement, and an only moderate degree of ego strength.

The only marked dissimilarity between the groups rests in the quantitative strength of social contacts for each patient. Whereas the immigrant had established a limited amount of social bonds, and had lived an isolated, if not insulated

existence, his counterpart could name a number of casual acquaintances, and some interested relatives. It became apparent that the German patient had been brought to medical attention during a more advanced stage of his illness, and that his delusions differed widely from those of the Canadian. The evidence for both patients strongly suggests that the corresponding nature of forces encountered by each, outweigh the occasional divergence, and that both men, prior to their illness, may have operated on a long-standing, strongly sub-marginal, uncertain and brittle basis.

CHAPTER FOUR

TOWARDS PREVENTIVE SERVICES

The subjects of the present study are a minority group of German immigrants who came to Canada less than five years ago. They are ten single male patients who had been hospitalized at the Crease Clinic for psychiatric treatment.

It has been acknowledged that the transplantation from one culture to another may result in migration stress and a subsequent temporary loss of equilibrium. The impact of the migration stress, however, may vary from individual to individual, and from situation to situation, as has been stated. This would be determined largely by three factors, namely (a) kind, and demands of the new environment, (b) the prevalent psychological climate to be encountered, and (c) individual potentials brought to the task of acculturation.

A concern over the reasons for the failure of the limited, but distinct group of German immigrants who did not adjust in time, constituted the starting point of this study. Consequently, a tentative hypothesis had been established : that either a long-standing history of mental illness, or a predisposition to it, or else excessive adjustment stresses must have been accountable for such personality breakdown. For this reason a search was instigated for possible significant factors leading to a partial answer to this question.

Apart from the basic problem to which reference has been made, this study also aimed at answering other questions directly related to the wider field of social work practice. An increasing awareness that further research would have to precede a definite final answer to the problem of personality disintegration in immigrant patients was the outcome. Beyond this, analytical investigation also queried the nature and extent of preventive and protective social services available to the newcomer, as well as the nature of casework services offered to the immigrant

already hospitalized. Under what circumstances would casework for immigrant patients be helpful ? Would these patients require differential treatment and specific, sharper skills ? What place does a social diagnosis hold in a clinical setting ? These questions were posed, and a side glance taken at the Canadian Immigration legislation, which appeared to select applicants predominantly on the basis of physical and economic fitness. Tentatively it was argued that selection of applicants under greater emphasis of psychological fitness in the long run may benefit the prospective patient as much as the Canadian community as a whole.

A final query, regarding the nature and usefulness of medical records as a tool in social work research had been raised. It had been asked whether the material studied conveyed, beyond factual information, psycho-social aspects of the newcomer's pre-migration and pre-pathological life, so vitally important to social work research. Did it reflect a recognition of cultural and linguistic lags, or did it deal with predominantly surface observations ?

Having explored various research methods, re-focused, and experimented with repeatedly recurring aspects in the case records, three key "areas of influence" - physical, social, and personal - were chosen as a working basis for the present study. Because of a small sample number used, certain shortcomings in research methods were acknowledged as being inevitable. Once the information had been classified according to the working areas, its interpreta-tion by means of a rating scale was undertaken. Although this device had been worked out only after a considerable experimentation, it has become one of the basic tools for this study. More a means for assessment than for comparison, it was intended to add a modest contribution to social work research undertaken in future. The methods applied, possibly more 'impressionistic' than conclusive, were necessitated partly because of the kind of clinical records available. Since

the latter lacked vital information in a number of areas, interpretation had partly to be done by inference. After the initial research approach had been modified, an analytical examination of the case material became possible. In spite of the comparatively small number of cases studied, some value could be seen in presenting the resulting findings figuratively. However, this again was more a method in exposition than a statistical presentation. The two cases at the end of Chapter II served the purpose of presenting a fairly typical, detailed picture of the immigrant prior to his admission. The composite 'types' in the following chapter, in contrast, would provide a more uniform version of the German immigrant as encountered while already in the grips of pathology. They are also reminders of the fact that this kind of ambulatory illness may be met with in people anywhere, at any time, without necessarily being brought to the attention of a social agency or a hospital. It was hoped that this composite presentation, as well as serving as a measuring device, would aid some future social work research in this area. The need for further investigation became alarmingly obvious when it was realized that for this study only a minimum of qualitative information existed. It became even more apparent in view of the fact that, on numerous occasions, research methods had to be drastically altered because of the restrictions of case material available. Not only had the original, exclusively comparative method to be completely abandoned, but a number of revisions in approach became essential as the survey progressed. The survey, then, is not merely an essay in exposition, but equally a study in method and experimentation, which finally led to the present stage where a more definite answer to the initial questions becomes possible. In the light of the preceding methods and findings, a clearer over-all picture of the immigrant in his pathological, psycho-social situation has emerged.

Facts in the social diagnosis.

A strong, over-all impression gained from the analytical study of the ten immigrant patients is that of long-standing, sub-marginal functioning applicable to all. This manifested itself in each of the three 'areas of influence', and was exemplified by a lack of occupational skill and experience, uncertain financial situations, as well as a high degree of mobility. Inadequate social potentials, such as inability to communicate and to express interest in wider social issues, was a feature as distinct as a marked desire for closer, more numerous and meaningful personal contacts. The immigrant's social immaturity was manifested further in his few and irregular activities, in unsatisfactory heterosexual relations, and in the temporary nature of his living arrangements. He had only a limited number of casual friends and did benefit little from visits and outings during his hospitalization. A lack of personal incentive, and an inability to accept challenge was prevalent with the group of newcomers. The close relationship between a lacking skill to converse in English, and an inertia regarding integration into the new way of life, became strongly apparent. The German patient's personality structure reflected an only moderately strong ego and a negative, defective concept of self. Little "sense of goal" prevailed, and a feeling of well-being, self-worth, strength, vitality and confidence was generally absent, as much as the skill to perceive and to accept reality. The majority of the newcomers had been admitted in an advanced, serious state of mental disorder, and had little insight into their illness. A willingness for medical help was demonstrated throughout, and most of the newcomers participated co-operatively during their treatment period. None of them had benefitted from continuous casework services prior to, or during their hospitalization, and thus no planning for after-care had taken place.

Exceptions to the foregoing findings were discovered in three immigrant

patients who, in eight of our nine fields, revealed some higher over-all functioning ability. To what extent this, however, was a direct outcome of those environmental variables which had to be ignored in this study, and how much was due to that of invididual disposition, will have to remain open to further investigation.

The newcomer's pre-migration background, mainly determined by inference, suggested a similarly negative functioning in the physical and social areas. Although it included the additional significant feature of participation in the war, the immigrant's past life experiences and personality development had found little mention in the clinical records and thus could not be ascertained.

A comparative analysis of the Canadian patient group indicated a close correlation between both. Occupational and economic situations reflected a striking resemblance, social skills were equally undeveloped, and the degree and kind of activities and outlets emerged as being uniformly one-sided. The Canadian patients, however, reflected potential for perceiving and verbalizing their inability to establish interpersonal relations somewhat beyond that of their German counterparts. Such minor differences also resulted from the latter's more distinct social isolation. It developed, however, into a marked dissimilarity in the field of quantitative interpersonal associations, and factually existing interest in the patient. A fairly distinct correlation between both groups emerged with regard to their personality make-up, since the Canadian patients also reflected a weak ego structure, and a lacking sense of self-worth and strength. They used defences excessively, and adhered to incorrect perceptions of reality. Their motivation for, and attitude towards psychiatric help corresponded with that of the newcomers. In contrast to the immigrant group, the Canadians patients appeared to have sought professional help earlier, and by voluntary admission. Their develop-mental history could be assessed in somewhat more detail yet indicated a deprived, unhappy and lonely childhood as did the German group from the conjectively derived

material.

Evaluating these findings in the light of forces contributing to mental illness in immigrants, it appears that the physical situation, as encountered at the point of arrival, may have offered some initial major obstacles to the newcomer. The latter's failure to become integrated into the over-all employment process must have had severely damaging repercussions - not only materially, but also psychologically. Apart from this fact it would also seem that physical facilities, such as adequate shelter and recreational and counselling services, may not have been sufficiently available to the newcomer who appears to have encountered the additional threat of financial insecurity from the beginning. The psychological atmosphere met with seems to have held for most of them an element of suspended expectation : there are no indications that, prior to or during their hospitalization, community members attempted to help the immigrant to overcome his sense of 'being forgotten', by offering supportive,friendly visits. The Canadian men who benefitted from such strengthening experiences did so predominantly by virtue of circumstances, rather than because of individual merit. This factual social isolation appears in numerous instances to have spread and contaminated all areas of the newcomer's pre-committal functioning : it might well have curbed his incentive and desire to become an integrated part of an unknown Canadian community.

However, as little as physical and social situations might have offered the maximum support and advantage desirable, the immigrant's apparent inability or unwillingness to recognize and accept the challenge of novelty adds its distinct weight to this evaluation. This applies to the majority of all German patients who had brought limited human potentials into the task of acculturation. The exception of two higher operating immigrants would not be sufficient evidence towards dismissing the conclusion that the impact of personality disposition

outweighs that of external environmental forces. The apparent differences between the groups, i.e. belated admission,[1] the Canadians' greater ability to verbalize their concerns, and their distinctly stronger qualitative community contacts, are still maintained to have resulted predominantly from coincidental, peripheral circumstances. The divergency in delusional contents, however, may suggest some deeper, culturally-determined forces which find their manifestation here.

In order to offer a conclusion as derived from these findings, the forces of environmental and personality factors, recognized as having been undeniably strongly at work, will have to be carefully weighed. Both groups have shown negative functioning in all areas. Since, however, the immigrant can be granted the additional handicap, as resulting from exposure to the unknown, it must be assumed that the Canadian, backed by relative economic and social homogeneity, must either be an even poorer performer, or else the impact of external, and hence migration stress, cannot be all-decisive. The writer tends to side with this latter position, since the majority of German immigrants have proved that, in spite of additional adjust--ment demands, a satisfactory functioning, and eventual adjustment, was possible. The prevalence of numerous variables, influencing such conclusion either by modifying or accentuating, is acknowledged. However, this still does not dispel the most striking over-all feature present in both patient groups, of persistent and similarly pathological malfunctioning, whether exposed to the particular experience of migration or not. The close similarity of symptomatology prevalent in all areas investigated, justifies the impression that the impact of personality disposition over-rides that of environmental forces, despite a different psycho-social background for each.

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[1] Belated admission might reflect fear of hospitalization, of deportation, and of mental illness per se, as much as ignorance of services available.

In view of these considerations, the conclusion is advanced that individual personality factors have contributed most significantly to mental illness, as examined in these two groups. The physical and social forces are recognized in their vital, yet secondary, peripheral nature. To what extent they acted predominantly as precipitating agents remains to be investigated at some other time.

At this point a revaluation appears appropriate. - The present study was undertaken, not in order to establish a finite, sole pattern of cause-effect relations, but rather to discover and expose the significance which environmental and personal forces assume during the process of mental disintegration in immigrants. This goal has been achieved, since a clearer, over-all picture of the newcomer's situation has emerged. The value of the present study should thus be seen in its expositive nature which reasserts the basic assumption, rather than establishing a completely new version of immigration and its psycho-social implications. The original assumption that environmental factors play a vital part in any individual's struggle for a psychological equilibrium still stands. However, by virtue of this study, a further dimension, that of a deeper understanding of the importance of individual personality potentials, could be added.

Implications for social action and community organization.

The implications which result from the analysis of Chapter III for social work are numerous and varied. They encompass the social scientist's concern with the modification of the social environment which the newcomer will encounter. A desirable professional channel towards such attainment is the process of social action, and particularly the advocacy of revised immigration legislation. If the prospective immigrant applicant to Canada proves to be psychologically weak, it would be advisable to discourage him altogether from the

stress-producing experience of a transplantation from one culture to another. Prevention of the experience of possible failure, however, would require a revision of the admission and screening policies applied by the Department of Citizenship and Immigration. Not only would those administration officers whose power is as broad as "to be almost unlimited"[1] have to be replaced by qualified experts in human behaviour, but a closer investigation of the motivation for immigration would be required. Also, a more specific system of classification, which would include detailed information on the applicant's social and psychological background, would need to be applied. Simultaneously, the Department of Citizenship and Immigration would have to expand its function beyond that of a welfare agency in theory, to that of a far-sighted, professionally staffed, actual centre of co-ordination and services. It might instigate social services not offered at the point of disembarkation, but, ideally, at the time when immigration status is granted to the applicant. Orientation programmes, covering employment and housing conditions, climatic and geographic peculiarities, as well as other distinct features of the country to be entered would provide the immigrant with a feeling of potential familiarity. Beyond this, an advisory body, consisting in part of social workers, might be installed in order to solidify working experiences in this field towards the ultimate materialization of specific welfare policies and services estab--lished for the newcomer to Canada.[2]

The dealings with those newcomers who have already arrived on the Canadian doorstep require more direct, preventive measures. Community organization, with its various aspects of educational and recreational programmes here finds a vital and rewarding field of application. Community education

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[1] Corbett, D., op. cit., p. 91.

[2] I am indebted to Kage, J., "Welcoming the Newcomer", Canadian Welfare, June 1958, pp. 66-7), and Kage, J., "Immigration & Social Services, Canadian Welfare, March 1949, for a stimulating consideration of the above-discussed aspects.

towards lessened prejudice, and interpretation towards increased understanding of the specific needs and problems associated with immigration will ensure an ultimate, more receptive attitude on the part of the Canadian public. The awareness that, beyond a job and other tangible help, the newcomer will require personal interest, acceptance and recognition, as much as sufficient time in order to arrive psychologically as well as physically, will have to be fostered and strengthened. Programmes sponsoring citizenship education, facilitating acquaintance with a variety of social institutions, as well as encouraging instruction in the language, would aid towards the ultimate diminution of the feeling of isolation that invariably exists. Ignorance of the available social services, unfamiliarity with the functions of a voluntary agency, - in contrast to the dispensation of European welfare programmes exclusively by the State, - a stigma attached to the acceptance of 'welfare programmes', are all factors which may prevent the single male immigrant from seeking help ahead of time.

However, any such programmes will be put into effective practice only if the already existing welfare services can be further co-ordinated and integrated. Ethnic sub-groups, as well as private and public agencies, must on a national and international basis pool their experiences and resources towards stronger working capacities in aid of the newcomer to Canada. It appears desirable that social services be publicized and avertised for everyone who may require them. This becomes essential from the fact that most Germans studied were not aware of the existence of helping agencies. Special services for immigrants, developed from a more thorough knowledge of their cultural background, and catering to their specific needs, would serve a highly preventive purpose. They should be rendered by skilled, alert workers, who would require assistance from qualified, full-time interpreters. The ultimate aim of such preventive aid would include professional social work counselling for all newcomers to Canada.

Implications for casework treatment.

Apart from the modification of environmental situations, the already hospitalized immigrant patient will require immediate, protective social services. Although medical treatment covers all mental patients alike, the present study has demonstrated that additional casework treatment may ensure higher gains for the immigrant patient. Such services would be based on a social diagnosis as obtained from an assessment of the newcomer's whole psycho-social background. If essential information shall be extracted, sharpened diagnostic skills are required. In order to render casework treatment effective, the practitioner will have to display readiness and flexibility in using differential methods, in accordance with individual needs as determined by the patient's socio-cultural background. A deeper professional awareness of the practical difficulties existing, as discussed with regard to the newcomer's occupational and financial situation, becomes of equal importance for an effective diagnosis and treatment. The case worker's better understanding of the emotional demands made upon the newcomer, and particularly the impact which language barriers may evoke, must be developed and will find their reflection in the application of differential treatment techniques. The advocacy for qualified interpreters in settings which deal with immigrant patients might be an outcome of such increased professional awareness. Whether a worker who speaks the patient's language ought to work with him will ultimately depend on the particular case. However, it can be stated that the bond of a common language promotes incentive, and sustains motivation longer than is usually recognized.

A lack of vital information pertaining to the immigrant's psycho-social background in clinical records has been discussed at length in Chapters II and III. Since, however, an understanding of his developmental, dynamic, psycho-social history is indispensable for a medical diagnosis and subsequent treatment, social service which would provide detailed social diagnoses seemshighly desirable.

Beyond this, more interpretation of the function of a case worker in a clinical setting would ensure not only an understanding of techniques applied by the profession, but also eventually a stronger reliance on the case worker as a treatment practitioner by the referring staff.

The present study has clearly demonstrated that the socially isolated, single, male immigrant would benefit during his hospitalization from additional casework support. As high-lighted in the previous chapters, a definite lack of outside contacts does exist for him and will hinder more effective rehabilitation planning. After discharge these men not infrequently return to unemployment, financial exhaustion, and without a place in which to live. Thus after-care and follow-up services become vitally important should treatment gains be maintained. The immigrants' attitude towards discharge is in part reflected in their perception of the Clinic as a retreat and shelter. Therefore, effective plans for casework treatment should include the cyclic application of admission, - ward, - rehabilitation plus after-care services. Let it be remembered that "Too often, as the psychosis subsides, social crippling remains".[1] This applies particularly to the single male immigrant who might find himself discharged into an alien psycho-social environment. Thus again, the community should be called upon for direct and tangible positive services, and for an accepting, supportive attitude towards the ex-patient. Volunteers have an important part to play in rehabilitation programmes and this role is all too frequently under-estimated by laymen and experts alike. They constitute the link with the wider community, the resources of which can be utilized to their fullest only if they are actually available for the purposes for which they were ultimately designed.

This terminates the cyclic survey. Advocacy for social action and improved, progressive social legislation will remain one of the most vital tasks, not only

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[1] Padula, H., M.S.W., "A Social Worker's Responsibility for Social Change", The Mental Hospital - Psychiatric Quarterly Supplement, 1956, Vol.30, Part 1, p.24.

for the professional social worker, but also for any responsible lay member of the community. A closing thought for the worker in the clinical setting is offered by Karl Stern who writes that "anyone who has been able to gain psychoanalytic insight must feel humbled .... and all the time you feel, 'But for a trivial difference of circumstances, not at all merited, there go I'."[1]

The social worker, as a helping, strengthening agent in his local community and as the advocate for "a state of complete physical, mental and emotional health", ultimately to be gained for all members of the Family of Man, should remember that any complex organism will function at its highest and best only whenever all its individual parts are fully integrated. For generations to come the immigrant, and with him the 'failing minorities', will continue to constitute such a vital component in Canada's population make-up. Since the ultimate criterion for a people's mental health, however, lies in the degree to which its members recognize and accept responsibility for those who cannot help themselves, it is here that the spheres of professional duty and human stewardship merge. It is here that the road ahead does not end, but merely begins.

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[1] Stern, K., The Third Revolution, Harcourt, Brace & Co., New York, 1954, p.175.

APPENDIX 'A'

Definitions, and comments on the material

(a) Definitions

Acculturation : "The process of becoming adapted to new cultural patterns". Webster's New World Dictionary, Nelson, Foster & Scott Ltd., Toronto, 1957, p.9.

Adjustment : - in social pathology - "The relations of the person to his family, community, political state or economic order in reference to some assumed standard or norm". Encyclopaedia of the Social Sciences, Vol. 1., Macmillan & Co., New York, 1950, p. 439.

Basic Needs : - equated with Common Human Needs - include "being well fed, properly clothed, adequately housed; need for education, for recreational and religious opportunity ... towards the furthering of physical, mental and spiritual growth". Charlotte Towle, Common Human Needs, American Association of Social Work, New York, 1953, p. 37.

Concept of self : - equated with Self Perception - "A particular totality of experiences, unique for each individual, having a peculiar quality of intimacy... Included in the perceived self are bodily feelings and sensations, the perception or imagine of one's bodily appearance or manners, and certain of one's attitudes, beliefs and ideas. Horace B. English & Ava Champney English, A Comprehensive Dictionary of Psychological and Psychoanalytical Terms, Longmans, Green & Co., New York, 1958, p. 488.

Environment : "All the conditions, circumstances and influences surrounding and affecting the development of an organism or group of organisms". Webster's New World Dictionary, op. cit., p. 486.

Insight : "Reasonable understanding and evaluation of one's own mental processes, reactions, abilities". Horace B. English, op. cit., p.264.

Maladjustment : - psychologically - its criterion "The failure of an individual or individuals to attain some norm of behaviour". Encyclopaedia of the Social Sciences, op. cit., Vol. 1., p.60.

Reality : "A function of communication and agreement.... It refers to the individual's ability to share and to evaluate the viewpoints of his immediate group". Weinberg, ibid., p. 93.

Self : "The individual subject revealed to his own observation as the identical and persistent centre of psychological processes". Horace B. & Ava C. English, op. cit., p. 485.

(b) Comments

Some relevant reservations, even though they cannot be further explored in this study, need brief mention. First, there is evidence that a basic difference in motivation, expectation and adjustment ability between the pre-war rural European immigrant and the post-war German newcomer to Canada, exists. This may partly be a reflection of the different social, economic and cultural climates prevailing in post-war Germany. Secondly there would be room, if time permitted, for the more detailed discussion of the psychologically vital kind of reception the Canadian public may give to Central European immigrants. These responses - negative or positive, - will reflect a highly complex situation, for example the social climate, the nature of prevailing public opinion towards the newcomers, and economic conditions existing in Canada. A third consideration is that 'German' patients per se are commonly, though erroneously, believed to represent cultural, religious or national homogeneity. Actually, however, their native country is as compact, complex, and diversified as Germany's internal social and cultural structure. Cultural infiltrations have been legion; they have varied greatly over centuries and in different geographical areas, and they have left their diversified patterns on people who, up to recently, have remained more stationary than the majority of the highly mobile North American population.

APPENDIX 'B'

Sample of working sheet for ad hoc information from clinical files at Crease Clinic.

ALL patients : single, male, German-born(who arrived in Canada between one and a quarter and five years ago prior to admission,)between the ages of twenty-five and forty-five, with this their first admission,
OR Canadian-born, with the same basic characteristics.

File #.....
Age at admission.....
Month of admission.....

GENERAL
Length of time in Canada (a) for Canadians in British Columbia
(b) for Germans in
i. Canada
ii. British Columbia
Racial background
Religion
Discharge diagnosis
Social work contacts during hospitalization
Social work services prior to hospitalization (SSI)

OCCUPATIONAL & SOCIAL
Education, grade, linguistic abilities
Occupation (status)
Work history, length, degree of responsibility
Financial situation, income, earnings, supportive
Housing district, ethnic components, size, length
Mobility degree, job and housing
Social contacts, friends, recreational activities, hobbies
Family in British Columbia or in Canada, visiting chart from Clinic

PERSONAL
A. Objectively (Staff reports)
Physical condition,
appearance, bearing,
personality description,
ward reports (activities, socialization),
social prognosis.

B. Subjectively (Patient's report)
'Cause' of illness, 'reason' for hospitalization
Self awareness on admission & at discharge
Attitude towards illness during hospitalization
Own previous plans to remedy illness
Attitude towards discharge - ? motivated
Concrete plans for future (work, repatriation, etc.)

Sample of working sheet (continued)

PAST HISTORY

Hardly any information, since German patients were not admitted with relatives or long-standing friends. Patients themselves often unable, or too hostile to submit information. Also little relevant information regarding motive for immigration.

PRE-MIGRATION HISTORY (for Germans)
FAMILY HISTORY (for Canadians)

Socio-economic background
Family - size, relations, constellation
Developmental History
Psycho-sexual development

IMMIGRATION

Attitude towards and motivation for immigration
Any beforehand knowledge ?
Alone or in company ?
Post-migration impressions, etc.

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