MENTAL ILLNESS AMONG RECENT IMMIGRANTS

A social work study of a sample group of hospitalized patients in British Columbia.

by

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School of Social Work.
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Understanding the social, psychological, and physical dynamics involved in mental illness is difficult enough because of the many intangibles involved. However, when mental illness occurs among immigrants, the problem becomes even more complicated. Some of the difficulty stems from the tendency to say that these people are mentally ill because they are newcomers, or that they are immigrants because of their mental or emotional instability. This study is intended as a small contribution to bringing some order to the confusion which seems to distinguish present day approaches to mentally ill newcomers.

The material for this study was derived from a thorough perusal of newcomers' hospital files. Because these files, in most cases, included the observations and impressions of psychiatrists, social workers, psychologists, nurses and others, together with a full transcription of any interviews held with a patient, it was possible to get a fairly full picture of any newcomer's personality, behaviour, and general circumstances. On the basis of the information available in these files, a rating scale was evolved, being designed to assess the newcomers' prevailing and potential adjustment.

In part, this study is an experiment in scientific method, pointing the way towards indentifying mentally ill newcomers who could be rehabilitated, and those for whom deportation appears to be the only alternative. Such a method involves a differential approach to mentally disturbed immigrants, and the assumption that deportation legislation should not apply to people who, with proper assistance, can become proper citizens.

Without doubt, because the sample of immigrants studied required hospitalization for mental and emotional disorders, they may be regarded as a special group in the total immigrant population. Nevertheless, the enquiry establishes the fact that some offer distinct rehabilitation possibilities while others should not have been permitted to migrate in the first place. A verification of the existence of these two kinds of newcomers leads to appropriate recommendations concerning the application of deportation legislation and the screening of potential citizens. It suggests both the employment of qualified social workers who are well equipped to assess a person's emotional or mental stability, and the use of methods on the lines of those developed in this study for evaluating and predicting the kind of adjustment newcomers are likely to experience in this country.
MENTAL ILLNESS AMONG RECENT IMMIGRANTS.

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CHAPTER I

INTRODUCTION.

Perhaps the factor common to all migrations to Canada in the past fifty years is the prevalent requirement that newcomers be of strong body and willing to work hard. It is only necessary to consider the emphasis that legislation concerning immigration places on the ability of the potential immigrant to support himself and remain economically independent to find obvious support for this factor. This has meant that strong-armed labourers have often been accompanied to Canada by paunchy but wealthy immigrants. Section 40 of the Immigration Act insists that no immigrant become economically, physically, or mentally dependent for survival by saying in part, "an inmate of a penitentiary, gaol, reformatory, prison, asylum, or hospital for the insane, or mentally deficient, or an inmate of a public charitable institution", is immediately deportable.

The fact that a few immigrants do become problems as defined in the act, and in many cases are deported, perhaps bears witness to nothing more than a possible leak in screening procedure, or else, excessive and unbearable environmental pressures upon the newcomer concerned. A newcomer who ends up in a Canadian mental hospital, for example, has suffered this fate for two possible reasons. Either he was mentally unstable before he migrated or he had to face and overcome more problems than he could possibly handle. Whatever the case in a particular instance, the fact nevertheless remains that when a prospective immigrant expresses his willingness to do a particular job in Canada for the allotted time, and appears to be in excellent physical health, this does not constitute any guarantee whatsoever that he will have the
personality strengths and mental health to cope with the new circumstances in which he finds himself after migrating. It is therefore important to consider the immigrant not only as a member of a particular group, but also as a person with a fairly unique background, and equipped in his own individual way to cope with economic, social and psychological pressures he experiences in his new land.

The Immigrant as an Individual.

Today, when one is stopped by a person on a street who speaks with a marked foreign accent, wears clothing that seems to have some slight deviation from prevailing styles, and is perhaps seeking directions to his destination, there is a tendency to categorize him as a European immigrant. Depending on the person whose help is being sought, the reaction may be one of suspicion and hostility, one of casual indifference, or one of reassurance and helpfulness. To the immigrant, the reaction of the person of whom he is seeking help, constitutes one of the many first impressions of his homeland, and contributes in some measure to the sum total and quality of his adjustment.

Although it is easy for the native to generalize on the basis of accepted and preconceived ideas, the newly arrived person has no such easy recourse when it comes to finding order and meaning in his new surroundings. The immigrant finds that customs, values, and behavior patterns of former days which he took so much for granted, are completely alien in his new environment. He therefore feels different because he speaks, behaves, and appears differently. And, having such a strong desire to feel a part of his new environment, to feel wanted and accepted, any indifference or intimation of rejection on the part of members of his new community assumes enormous significance for him. Unlike earlier immigrants, the newcomer of today cannot look back for security to the country he left because he often is a person
without a homeland. The fact that the contemporary immigrant has to accept his new environment unconditionally was indicated in a study of recent immigrants who were psychiatric and medical patients made by Dr. L. Tyhurst, Dr. Tyhurst concluded that the newcomer of today "cannot return physically; and, in addition to this physical rootlessness, there is also the psychological rootlessness - the awareness that the social norms and values he believed in at home have been destroyed, whether or not he actually witnessed the destruction." Thus, without an avenue of physical or psychological retreat, the newcomer must make the best of the situation he finds himself in in his new country. And, the German immigrant for example, who has had a mental breakdown in his new country, and says that "all the people who worked in the Y.M.C.A. are German", not only has lost contact with reality, but also is trying to resolve the difference he feels to exist between himself and the rest of the community. Many immigrants do make a successful adjustment in the sense that they find a satisfying niche for themselves in their new homeland. Others are thrown into a state of mental confusion and anxiety which drives them to continually change jobs, to move from city to city, and regard their surroundings with increasing suspicion and disillusionment. Then there are the few persons who suffer complete mental breakdowns and are committed to Canadian mental hospitals. The psychotic newcomer who remarks that "nobody likes me, I want to hide all the time. People are going to kill me", or the one who says, "I want to die. Let me go. I have no place to go", are each expressing in their own way that they have no further resources or alternatives left anywhere to make a continued attempt at living.

What the factors are which make ready adjustment possible is difficult to say. One can only speculate that in cases of good adjustment, the newcomers

themselves had carefully planned their move, had some knowledge of what they wanted to do after becoming citizens in a new land, and either by means of their own initiative or good fortune, encountered suitable resources in their new country to help them over the various obstacles they were sure to meet. A great deal remains to be learned in this area.

It is equally difficult to say what contributes to a poor adjustment. Some immigrants become dependent on social assistance, others cannot get along with fellow employees and employers, and a percentage suffer a sufficient degree of disorientation to require confinement in a mental hospital. Whether the new environment contributed primarily to a poor adjustment, or whether the immigrants in these cases arrived as unstable people who could never make a successful living anywhere, is a matter for conjecture. If, among the maladjusted, it could be shown that the environment precipitated many of the difficulties, then it would be fairly certain that certain services and resources for immigrants are a dire necessity. On the other hand, if among the maladjusted there are some who evidently were suffering from severe personal maladjustment before coming to Canada, and perhaps, whose migration would appear to be one expression of their general instability, then one could wonder about the effectiveness of prevailing screening methods and the emphasis on physical health. In any case, this is another matter about which a great deal more could be known.

This knowledge is particularly necessary because of immigration laws which make the penalty for maladjustment virtually mandatory deportation. It is indeed unfortunate if Canada is losing some potentially good citizens who, because of circumstances beyond their control, have found it impossible to manage their lives in a way acceptable and desirable to all concerned. It is equally unfortunate if some persons, who may have been too unstable to make a successful adjustment before migration, had to be subjected to the
further stresses and strains of migrating and being deported in turn.

As the situation exists today, Canadian communities have both those recent immigrants who are making a successful adjustment to their new way of life, and those who are experiencing varying degrees of difficulty. However, this does not preclude that the latter group alone should be the recipients of services and suitable assistance to facilitate their adjustment. The task of successfully transferring one's nationality is a great and difficult one, and it would not be too much of a generalization to say that all newcomers could undoubtedly use to good advantage any help they could get in fitting themselves to a new way of life.

Without considering the many personal aspirations and needs which distinguish the personality of each individual immigrant, they can be said to have a multitude of very basic needs to fulfill before they can be considered a part of the new community. Today's newcomer often has to overcome malnutrition of body and mind and the terrible experiences he lived through in a war-torn Europe. He has to make a living, and eventually, to find a suitable and satisfying vocation. Finally, he has to develop that personal stability which would reflect his acceptance of the new culture.

Recognition of the fact that newcomers do need specialized services to facilitate their adjustment however, still leaves the problem concerning the kind of services and the best manner they can be utilized in working with recent immigrants. There is also the problem of making known to newcomers what services are available to them in a particular community.

Although it is the responsibility of all agencies in a community concerned with the health and welfare of individuals to gear some of their services to meet the needs of newcomers, treatment through the media of casework skills and techniques when necessary, must come within the jurisdiction of qualified social workers. Moreover, a treatment approach by
social work agencies, if it is to be successful, must be based on a clear knowledge and understanding of the kind of problems the immigrant has to cope with today, and the sort of person he is.

**Some Treatment Problems.**

A person who has just arrived from abroad is, perhaps for the first time since childhood, undergoing experience for which no precedents are available to him to suggest a suitable course of behaviour. Thus, when a newcomer approaches a Canadian social agency for the first time in his life for assistance, he may be at a complete loss to comprehend the agency's routine techniques and explanations. Words customarily used with clients may have no meaning to a newcomer even though he may be able to converse in English. He may consequently leave completely bewildered and without availing himself of the help he needed.

Even if the initial problem of intake could be overcome, there arise further potential problems in the kind of casework relationship which would arise between a worker and a client who each are differently oriented culturally. The social worker, if he is unfamiliar with the cultural background of his client, could easily confuse a customary behavior pattern with a neuroticism. Moreover, just as the social worker may not be able to evaluate properly the interplay between culturally influenced habits and neurotic needs in the newcomer, so the recent arrival may completely misinterpret the social worker's efforts to help him with his problems. It is conceivable that a newcomer who, up to that time, had received help in a very authoritarian setting, could easily see the social worker's interest and permissiveness as the behavior of a person who will protect him from a harsh and unknown environment at any cost. There is consequently the danger of a relationship building up where the newcomer becomes extremely dependent and demanding on
this one worker for all his needs. A recent arrival does not know that most social workers in Canadian agencies are permissive and understanding.

Because the newcomer has so many great and immediate problems of adjustment, it is often very difficult to find out when the recent immigrant's problems really do stem from such things as language difficulty for example, and when language difficulty is used as a rationalization for deeper personality problems. As Joseph Klage\(^2\) pointed out, "too often the immigrant interprets his difficulties as something outside himself". Thus, he may come to a social agency blaming not only language difficulty for his problems, but also the landlord, his employer, or the store keeper. Such a focus on an adjustment problem can seriously obstruct a newcomer's ability to make constructive use of agency services, particularly if the problem is a personality one which would require casework service.

Although these treatment problems confront family, child and assistance agencies primarily, similar problems face social workers in the medical and psychiatric fields. Dr. L. Tyhurst\(^3\), referring to newcomers who have been to physicians for treatment of physical ailments, writes that, "all patients... felt that their illness had not been understood. Some of them accused doctors of not showing any interest or having made them worse by treatment. All patients who had undergone surgery stated that their complaints had not improved, had become worse, or that others had developed since the operation".

On the other hand, in a psychiatric setting, a social worker might not only witness a multitude of somatic complaints in patients who are recent immigrants, but have to handle extreme anxiety, depression, and feelings of hopelessness. Stefi Pederson\(^4\) writing on refugee neuroses says that, "In those

\(^2\) Klage, Joseph, "Immigration and Social Service", Canadian Welfare, March, 1949

\(^3\) Tyhurst, op. cit.

cases in which the experience of flight is essentially traumatic, it seems as though acute dissociations of consciousness, hallucinations, depersonalization, and amnesia assume a central position among psychopathological reactions.

Social workers therefore, in their various specializations, have to help newcomers who in many ways have similar problems and complaints to the general clientele. The primary difference however, is the fact that this particular group of people are immigrants. And, being an immigrant connotes an experience and a meaning to the person concerned which is quite unique. Therefore, not only the application of traditional social work principles to immigrants is indicated, but also the development of specific techniques to cope with the feelings and experiences which distinguish the immigrants as a group. What these specific techniques should be is something into which very little research has been done to date.

**Material and Method:**

People who are immigrants experience numerous problems in the course of attempting to adjust to their new land. Success or failure in the new country not only affects the future well-being of the newcomer himself, but also can contribute to or detract from the welfare of the community as a whole. Since "casework has traditionally been concerned with the client and his social adjustment," it is a part of the social worker's responsibility to seek a better understanding of the following, where the newcomers are concerned:

(1) Who are these newcomers?

(2) What kind of personality and environmental problems do they

---

tend to manifest? 

(3) What can social workers do to alleviate some of these problems? The subsequent enquiry will attempt to provide tentative answers to these questions for a sample group of severely maladjusted newcomers, namely, for those persons who immigrated from continental Europe and became patients at the Crease Clinic or the Provincial Mental Hospital in British Columbia within four years of coming to Canada. Roughly half these patients had either been discharged or deported at the time of this enquiry and consequently, their files were used as the prime source of information.

The files include the doctors' ward notes in which are recorded the patient's tentative diagnosis, the kind of behavior, delusions, and hallucinations which were manifested, the patient's response to treatment, and other pertinent observations and impressions. In addition to these ward notes, the files often have a full social history obtained by psychiatric social workers from relatives, friends, employers, and the patients themselves. Such a social history would contain as full a picture of the newcomer's life experiences and the onset of his illness as possible. A percentage of hospitalized immigrants also are given psychological tests which bring into further focus their personality, the content of their thinking, and the level of their intelligence. The patients are under continuous observation by nurses, occupational therapists, and other persons concerned with their supervision, care and treatment. These observations are recorded regularly throughout a newcomer's stay in hospital and provide additional diagnostic and prognostic information for the psychiatrists. Finally, all of the non-voluntary patients are committed under the medical certificates of two doctors. The doctors are required to record on these certificates the patient's own words and behavior at the point of committal. A verbatim report is therefore available concerning each patient's feelings about his
illness and his general circumstances. For example, a patient who says, "I have headaches all the time. It is because I work too long hours", obviously has a little more insight into his condition than a person who states that, "I feel happy and well. People are after me and want to kill me."

Information recorded on each newcomer's file by doctors, social workers, psychologists, nurses, etc., has served as a basis for devising a rating scale (used in Chapter 5) as a method of organizing and assessing the material. This rating scale is so important to the subsequent analysis of the sample group, that it is reproduced herewith.
<table>
<thead>
<tr>
<th>FACTOR</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATTITUDE TO SELF</strong></td>
<td>Problems Belong to Environment: patient blames himself, employer, Canada, etc. Feels he is always a victim.</td>
<td>Problems Belong to Self: patient admits specific fears, conflicts, etc. Sees himself as having been responsible for the situation. &quot;I am not good enough for the job&quot;, etc.</td>
<td>Problems Belong to Self: patient admits specific fears, conflicts, etc. Sees himself as having been responsible for the situation. &quot;I am not good enough for the job&quot;, etc.</td>
</tr>
<tr>
<td></td>
<td>No Understanding: problems experienced are completely foreign to self while evidence points to contrary. Problems neither accepted nor admitted. &quot;My headaches are the cause of this or that&quot;.</td>
<td>Recognition: patient has clear understanding of his situation and ways to remedy it.</td>
<td>Recognition of Illness: patient sees illness as part of his own history. Knows he is sick and often has some understanding of why.</td>
</tr>
<tr>
<td><strong>UNDERSTANDING OF CHILD'S PROBLEM</strong></td>
<td>Denial of Illness: &quot;I am healthy and happy&quot;. Denial of tensions, conflicts, etc.</td>
<td>Doubt about Illness: patient knows something is wrong. Blames &quot;nerves&quot;, etc. Illness appeared &quot;without reason&quot;.</td>
<td>Recognition of Illness: patient sees illness as part of his own history. Knows he is sick and often has some understanding of why.</td>
</tr>
<tr>
<td><strong>MENTION OF CHILDHOOD AND FAMILY</strong></td>
<td>No Spontaneous Mention: patient avoids subject - evidence that past experiences repressed.</td>
<td>Defensive Mention: background described as &quot;normal&quot;, &quot;happy&quot;, &quot;perfect&quot;, etc. Nothing critical at all mentioned. Compensatory concern.</td>
<td>Spontaneous Mention: ability to talk about unhappy childhood. Need to paint idealized picture. &quot;My father drank a lot&quot;, &quot;We were very poor&quot;, etc.</td>
</tr>
<tr>
<td><strong>RELATIONSHIPS IN OWN COUNTRY</strong></td>
<td>Only One Love Object: patient refers to a specific sibling, lover, parent to the exclusion of other relationships. Usually a history of isolation and deprivation.</td>
<td>No Satisfying Relationships: no mention of friends, etc. Usually a history of isolation and deprivation.</td>
<td>No Satisfying Relationships: no mention of friends, etc. Usually a history of isolation and deprivation.</td>
</tr>
<tr>
<td><strong>RELATIONSHIPS IN CANADA</strong></td>
<td>Actively Seeking: Relationships - has had Canadian friends. Has joined clubs, etc., in this country.</td>
<td>Desiring Relationships: expresses wish for friends - misses companionship. &quot;I want someone to talk to&quot;.</td>
<td>Selection of Relationships: expresses no desire for friends - avoids contact with other people, prefers to be alone.</td>
</tr>
<tr>
<td><strong>ATTITUDE TO PEOPLE</strong></td>
<td>Individual Appraisal: patient recognizes that assistance, advice or companionship possible from some people. Is able to reject others.</td>
<td>Caution about People: patient mildly suspicious of people. Relationship established only after some blocking. A tendency to become over-dependent on specific people - doctor, etc.</td>
<td>Suspicion and Hostility: patient fears and distrusts all people - thinks they will harm or punish him.</td>
</tr>
</tbody>
</table>
After considerable experimenting, a set of seven factors were decided upon as the best means whereby a mentally ill newcomer could be rated for degree of maladjustment. Among the personality components rated were attitude to self, understanding of problems, attitude to illness, and mention of childhood and family, (factors 1 to 4 on the rating scale). Among the relationship components rated were relationships in own country, relationships in Canada, and attitude to people, (factors 5 to 7 on the rating scale). These factors were divided into three degrees of maladjustment, A, B, and C. The extracts used on the rating scale to illustrate the three degrees of maladjustment do not relate to any one case but serve merely to exemplify the kinds of material read.

Factors 1 to 4 under personality components have the following three degrees of maladjustment. Under "A", the psychosis is usually of long standing, insight is non-existant, and the prognosis is poor. Under "C", the psychosis is usually acute and precipitant, the patients seem to respond to medical treatment and casework services, and prospects for a successful rehabilitation are good. Under "B", the patient is intermediate between the two extremes, "A" and "C".

Factors 5 to 7 similarly are broken down into three degrees of maladjustment. Where relationship components are concerned, "A" offers hopeful prognosis, "C" represents poor prospects for recovery and rehabilitation, and "B" is again the intermediate between the two extremes. The reason for this particular arrangement of degrees of maladjustment is that any correlation between personality components and relationship components will become clearer when graphically illustrated (see Chapter 5, page 2).

The subsequent discussion is, in essence, an essay in method, directed to testing the rating scale as a device for more systematic screening and analysis of newcomers. There is also some possibility that a rating scale
similar to the one described in this study, might find application as a useful prognostic tool to predict which persons are likely to adjust successfully to their new surroundings, and which will likely continue to remain maladjusted and a burden to their communities.
WHO ARE THE NEWCOMERS?

Under the Canadian Immigration Act, every patient who becomes an inmate of a mental hospital is immediately liable for deportation. To carry out this provision of the Act, the Provincial Mental Hospital and Crease Clinic in British Columbia lay a formal complaint with the Minister of Mines and Resources, Immigration Branch, immediately an immigrant is admitted. Consequently, there is available at the hospital a list of names of those newcomers who became patients there.

A list of names of all patients was obtained who came from continental Europe, and who were in Canada four years or less prior to hospitalization. From a list of about forty names, twenty-five were selected at random and their files studied. In this chapter, various data will be presented which will serve primarily to identify these newcomers.

All the immigrants chosen for this study had been admitted to the mental hospital for fairly severe mental disorders. In a majority of cases, there had been attempts at suicide, and in all instances, behaviour which had become so deviant that employees, relatives, or friends had seen the necessity of contacting a doctor and arranging for hospitalization. These patients may therefore be said to represent the extremely disturbed and maladjusted members of the immigration population. There are undoubtedly many more immigrants whose disturbance or maladjustment is largely unnoticed by others, or at least
not considered severe enough to warrant hospital care.

Various data concerned with identifying the sample studied is presented in tables 1 to 5. This data suggests several factors which may have contributed to the poor mental health of these newcomers.

**TABLE I**

Distribution of Sample by Age, Marital Status and Sex.

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>30-40</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>40-50</td>
<td>2</td>
<td>2</td>
<td>4</td>
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Marital Status

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>12</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

| Total  | 15  | 10    | 25    |

The slight difference in the distribution of sexes in the sample studied, may perhaps reflect the proportion of men to women among newcomers coming to British Columbia. Since most male immigrants coming to this province would be employed in primary industries such as logging, farming and mining, and because there appears to be more job openings for men than for women in these occupations, it is very likely that more men than women would come here.

Proximity to hospital does not appear to have influenced the distribution of sexes in the sample studied. That is, because the men tend to be employed in the more outlying districts while women would usually work as domestics in urban areas, it is logical to assume that more women than men
might find hospital facilities accessible to them. In the group of patients studied, however, hospital care appeared to be equally available to both sexes.

The immigrants studied can be described as belonging to the younger age group, with thirteen of the total patients being between 20 and 30 years old. The fact that most of these newcomers are young people perhaps indicates nothing more than a preference by the Canadian Government for youthful, healthy persons who could do the work required of them in the various industries.

Because these people also are suffering from mental disorders, another reason is suggested why this particular group are young in years. Various types of mental disorders seem to have a predilection for specific age groups. Dr. Malzberg concluded after having devoted some research to the question of age and mental disorders that an illness such as schizophrenia is found predominantly in people between 15 and 30 years old. A glance at the diagnoses of the sample studied reveals that more than half of the patients were suffering from various kinds of schizophrenia. It is to be expected therefore, that they be persons in a younger age group.

Most of the men and women in the sample are unmarried. This may be indicative of the fact that unmarried persons are far more mobile than those who bear the responsibilities of providing a living and security for their families. However, this may not be the only reason why the hospitalized patients are predominantly single. It is an established fact that mental illness tends to strike the single person more often than the married individual. In a recent study of ninety thousand admissions to mental hospitals in the United States, Dr. Neil Dayton concluded that, "the single marital group admissions are 140 per cent higher than those of the married".7

5 Malzberg, Benjamin. Social and Biological Aspects of Mental Disease. New York, State Hospital Press.
6 Dayton, Neil, M.D., M.C. New Facts on Mental Disorders. Study of 89,190 cases. Charles C. Thomas, Publisher.
TABLE 2.
Distribution of Sample by Cultural Background, Social Class of Parents, Rural or Urban Origin, and Education.

<table>
<thead>
<tr>
<th>Cultural Background</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
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<tr>
<td>Czechoslovakia</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Estonia</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Germany</td>
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<td>Holland</td>
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<td>1</td>
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<td>Italy</td>
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<td>0</td>
<td>1</td>
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<tr>
<td>Latvia</td>
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<tr>
<td>Hungary</td>
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<td>Poland</td>
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<th>Social Class of Parents</th>
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<td>Lower</td>
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<tr>
<th>Rural or Urban Origin</th>
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<tr>
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<tr>
<td>Rural</td>
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<table>
<thead>
<tr>
<th>Education</th>
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<tbody>
<tr>
<td>University</td>
</tr>
<tr>
<td>Entered high school</td>
</tr>
<tr>
<td>Elementary</td>
</tr>
</tbody>
</table>

| Total                   | 15  | 10  | 25  |
Table 2 indicates that the sample group immigrated from countries which were directly involved in the last war. It is therefore not too much of a generalization to say that most of these patients have, at one time, been in a concentration camp, in a displaced persons' camp, or caught in some traumatic way in the conflict which recently had raged through Europe.

The men in the sample represent mostly the lower class, that is, unskilled urban and rural labour. A majority of the women, on the other hand, come from the middle class which includes the professional, business, and white collar groups. This distribution can probably be related to the fact that the men, on the whole, have a lower educational level than the women.

Similarly, most of the men in the group studied, originated in rural areas, while the women come from a background of large cities and towns. It might be interesting to note that this group as a whole evidenced considerable mobility from rural to urban areas. Almost all of the male patients who were born and raised on farms in their own countries, subsequently worked as manual workers in various European cities and often outside the borders of their own country. The fact that the mobility these newcomers evidenced finally included emigration from Europe, might bear some relation to their mental health. A study of this problem in Norway by Ornulv Odegaard led to the conclusion that, "among those who emigrate one would expect to find a relatively large number of restless and socially maladjusted individuals. Traits like these are very often signs of a predisposition toward mental diseases (particularly toward schizophrenia: the schizoid personality)."

---

<table>
<thead>
<tr>
<th>Occupation before Migration</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soldier</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Teacher</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Artist</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stenographer</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Carpenter</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Farm Labourer</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Chauffeur</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Unskilled Labourer</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Photographer</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mechanic</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Nurses' Aid</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dependent</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

| Occupation in Canada         |      |       |       |
| Farm Labourer               | 5    | 0     | 5     |
| Unskilled Labourer          | 6    | 0     | 6     |
| Mining                      | 1    | 0     | 1     |
| Logging                     | 4    | 0     | 4     |
| Bus Boy                     | 1    | 0     | 1     |
| Stenographer                | 0    | 1     | 1     |
| Domestic                    | 0    | 7     | 7     |
| Housewife                   | 0    | 2     | 2     |

| Income                      |      |       |       |
| Less than $100              | 1    | 6     | 7     |
| $100 - $200                 | 12   | 2     | 14    |
| $200 - $300                 | 2    | 0     | 2     |
| Unemployed                  | 0    | 2     | 2     |
| Total                       | 15   | 10    | 25    |
The occupations in which the persons in question were employed before migrating to Canada, are given as the patients themselves described them. These occupations may not be completely accurate therefore. For example, although two men stated that they had been mechanics before coming to Canada, there is some evidence which suggests that they were merely employed by the American occupation authorities to keep vehicles clean and presentable. Consequently, all the occupations given by these newcomers may not be strictly accurate and must serve only as a general indication of their preferences or aspirations.

Eight persons in the sample are shown as being dependent before coming to Canada; that is, they were not employed or self-supporting in any way. These eight immigrants had been either at school, living with parents or relatives, or relying on marriage partners for support. Only one man falls in the dependent category while seven women are indicated as not being self-supporting before coming to Canada. This seems to be consistent with the fact that most of the women in the sample studied come from middle class homes, have spent more years in school, and on the whole, are younger than the men. The experience of seeking economic independence and security is therefore a new one for most of these women.

The occupations followed by these patients seem to reflect generally the fact that they entered primary industries as required by the regulations governing their migration to Canada. In a few cases, these people had attempted to return to the kinds of employment they had held in their own countries after their obligation to work in primary industries in Canada had been discharged. However, in all these cases, the attempt was brief and unsuccessful. In a majority of instances, the newcomers became mentally ill before they had an opportunity to become established in the occupation of their preference.

The income of these persons averaged between $100 and $200 per month. All except one who made less than $100 per month were women employed as
TABLE 4

Distribution of Sample by Command of English, Relatives in Canada, and Time in Canada Before Committal to Mental Hospital.

<table>
<thead>
<tr>
<th>Command of English</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Poor</td>
<td>14</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relatives in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents or Spouse</td>
</tr>
<tr>
<td>Uncles or Cousins</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in Canada Before Committal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under one year</td>
</tr>
<tr>
<td>1 - 2 years</td>
</tr>
<tr>
<td>2 - 3 years</td>
</tr>
<tr>
<td>3 - 4 years</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Table 4 offers a comparison between the patients who had some medium of contact with their new land, either through language ability or relatives, and those who did not have this advantage. It is significant that the majority of these people had little or no command of the English language and no relatives of any description in Canada. Considering the fact that most basic avenues of becoming acquainted with a new way of life did not exist for these newcomers, and in most cases, they could not fall back upon their former countries for psychological support, the isolation and hope-
lesseness experienced by them in Canada must have been extreme. In any case, such a situation would be very detrimental to good mental health.

The fact that all except one of these newcomers had to be hospitalized for mental disorders between the time of arrival and three years of coming to Canada suggests two possibilities.

(1) Some patients were mentally ill on arrival in Canada, but managed to get along in a logging camp or with a disinterested employer for a few months before manifesting severe behaviour deviations, such as attempted suicide, which would be considered extreme enough to warrant committal to hospital. Also, a new arrival's "queer" behaviour could easily be confused with unfamiliar cultural patterns, and consequently, psychotic symptoms might be overlooked for a long time.

(2) The other possibility would be that some of these people were fairly well-integrated on arriving in Canada, but the social, economic, and psychological pressures which they encountered were so great that a mental disorder resulted.

Whether the onset of mental illness is dated prior to migration to Canada or subsequent to it no doubt determines to a great extent a newcomer's capacity for a good adjustment in his new country. However, the mere dating of a patient's illness is not sufficient to provide a completely valid index of how good his general prognosis is. Considerable supportive evidence is necessary concerning his personality, the quality of his relationships with others, and the peculiar manifestations of his illness. The whole question will be dealt with in all its ramifications in the subsequent chapter.
## TABLE 5

### Distribution of Sample by Diagnostic Categories.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychoneuroses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaction Depression and anxiety</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Psychoses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid Schizophrenia</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Catatonic Schizophrenia</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hebephrenic Schizophrenia</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Schizo-affective Psychosis</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Unclassified Schizophrenia</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
</tbody>
</table>

The psychiatric diagnoses for the sample studied were based on a classification of mental disorders prepared in 1947 by a committee of experts set up by the Interim Commission of the World Health Organization. The particular psychiatric classification which each patient was given was derived largely from the predominant symptoms rather than the personality dynamics involved in each case. Such a compromise between classification based on symptomatology and individual personality is perhaps a necessary one since classification, as a method of generalization, seems best suited for statistical purposes. The point is, however, that the diagnostic categories themselves probably reflect little if any of the particular kind of personality which distinguishes each patient. For example, "hysteria" is classified as a mental disorder in which amnesia, anorexia, blindness, and conversion, among other symptoms, are the main manifestations.

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In most of the cases studied, a preliminary diagnosis was assigned by the doctor responsible for the patient. Subsequently, a case conference among the doctors might modify or confirm the original tentative diagnosis. Also, the social worker's social diagnosis contributes to and supports the findings of the doctors.

Although there is no method whereby the reliability of a psychiatric diagnosis can be measured, most of the doctors would agree that there is some unreliability. Not only are diagnostic categories too broadly defined to make allowance for individual peculiarities, but also, symptoms can be extremely variable, and, from day to day, could suggest entirely different diagnoses. For example, it is often difficult to decide whether a case should be described as "unclassified schizophrenia" or whether one symptom stands out enough to justify a diagnosis of "paranoid schizophrenia" or "simple schizophrenia".

Since psychiatric diagnoses tend to describe a patient only at a single point in time, and also, because these diagnoses are sometimes influenced by subjective judgments, it is unlikely that there would be any valid relation between diagnoses as such and other variables. Consequently, for purposes of this enquiry, the patients can be described generally on the basis of the most outstanding and persistent symptomatology. In the sample studied, there appeared to be two such trends distinguishable: paranoid delusions and morbid suspicion; and, depression, anxiety, and some suspicion.

Of the sample studied, thirteen immigrants were described by their doctors as evidencing distinct paranoidal delusions and were diagnosed as paranoid schizophrenia. Six other newcomers were diagnosed as different types of schizophrenia. However, this does not discount the fact that a large element of suspicion and paranoid delusions were present in these patients also. For example, a patient may have withdrawn completely into a catatonic state, but the responses that had been evoked from him at various times strongly
suggested paranoid content in his thinking.

Another six patients in the sample were listed as being psychoneurotic. These persons manifested severe depression, great feelings of anxiety, and in all cases, one or more attempts at suicide. In spite of the fact that these patients did not appear to be psychotic at the point of committal, they all evidenced some paranoid trends. They either felt they would come to some harm, they were convinced their employer intended to fire them without any basis for this fear in reality, they had a desire to strike out at people, or they felt others were not to be trusted. These feelings seem to suggest that suspicion and paranoid thinking were not wholly confined to the other patients who were designated as psychotic.

Because of the manifest unreliability of diagnostic categories, and because it is evident that such symptoms as suspicion and paranoid ideas are common to both the groups diagnosed as psychotic and psychoneurotic, it is quite possible that the division between psychosis and psychoneurosis itself is not too clear in some of these cases. This may be particularly true for this sample because language barriers and different cultural orientations in the newcomers would make it more difficult to decide whether some border-line cases were psychotic or psychoneurotic. With this consideration in mind, it would be valid to classify a case diagnosed as paranoid schizophrenia with a case diagnosed as reactive depression if the variables measured by the rating scale followed a similar pattern in each case.

SUMMARY:

The immigrants who constitute the case material in this study are all recent arrivals from continental Europe who, on the average, were in Canada from two to three years before being committed to Grease Clinic or the Provincial Mental Hospital in British Columbia. There are three men to every two women in this group of patients, the women on the whole being somewhat
younger than the men. The majority of these patients, however, may be described as belonging to the younger age group.

The men in this sample come primarily from the lower economic class and from a rural background. The women, on the other hand, come from urban settings and represent the white collar occupations. This difference in socio-economic backgrounds appears to be verified in the fact that the women are better educated than the men, have a better command of English, and, in most cases, did not have to work for a living till coming to Canada.

Most of these newcomers were unmarried and had no relatives of any description in Canada. They therefore had no resources which could serve as stepping-stones, so to speak, to becoming acquainted with their new surroundings.

The immigrants in the sample came from occupations varying from professional to skilled and unskilled labour. All of the men worked in Canada in primary industries such as farming, logging and mining. A majority of these people could not or did not wish to return to the occupations they were in before emigrating. Most of the women were employed as domestics in Canada, this being, in many cases, their first experience with any employment. Unlike the men, the women appeared to have suffered a considerable lose in social and economic status.

Although a majority of the patients were diagnosed as suffering from paranoid schizophrenia, there seemed to be distinct paranoid features in the thinking and behaviour of all these persons. Consequently, no significant correlations can be sought between diagnostic categories per se, and such variables as personality and relationship components. Instead, it seems more valid to seek contrasting trends between personality components and other variables such as quality of relationships with people, and then test the trends against the particular diagnosis of each patient.
The analysis is pursued with special reference to the personality difficulties these men and women evidenced, the environmental problems they experienced, and the content and history of mental instability in each case.
CHAPTER 5

NEWCOMERS IN TROUBLE.

On the basis of the rating scale discussed in Chapter 1, the sample was assessed as to quality of relationships overseas and in Canada, understanding of problems and illness, attitude to self and others, and the predominant symptoms and acuteness of illness in each case. As two different groups became recognizable in terms of these components, they are discussed for convenience under two headings, Group 1 and Group 2.

Group 1.

According to the rating scale, the eleven patients constituting Group 1 showed a distinctly different pattern of factors than the fourteen newcomers in Group 2. Figure 1a represents an average distribution of the factors measured by the rating scale, among the persons in Group 1. In individual cases, there were marked variations in the pattern which the factors rated took. This suggests that in this group there is considerable individuality in personality, relationships, and illness.

Attitude to Self and Understanding of Problems.

The patient's attitude to himself is significant because it often suggests the extent to which he has distorted his limitations, capacities, and his role in various relationships. For example, a patient who denies any psychological difficulty and blames his employer, his landlady, or the corner store keeper for all his problems, may be regarded as a person who sees himself continually as a victim of his surroundings. In other words, his attitude to himself is that he is a person who is sometimes rewarded by his environment
and at other times punished. When problems become so externalized, there seems to be a tendency in such a person to minimize any feeling of personal responsibility for what happens to him.

On the other hand, a person may blame some aspect of his environment for his difficulties, but also concede the fact that he himself might play a vital role in altering his circumstances. Then again, there might be the extreme point of view held by a person that his problems stem from personal defects or limitations. Whatever a newcomer's attitude is concerning himself, the extent to which it is realistic must be assessed in relation to whether or not he has any real understanding of his circumstances. A person who is convinced that all his woes represent a personal inadequacy can be quite unrealistic if it is obvious that his external circumstances have made good adjustment difficult if not impossible.

**Figure 1a**

Average Distribution of Factors Measured by Rating Scale for Groups 1 and 2.
In the sample studied therefore, a patient's attitude to himself is his own evaluation of his limitations, capacities, and his role in various relationships. An assessment of a person's understanding of his problems, on the other hand, is derived from the impressions which psychiatrists, social workers, psychologists, nurses, etc., have formed of the patient. On the basis of these two ratings, it is possible to measure a person's maladjustment in terms of how much he has distorted his reality.

In Group 1, six newcomers felt that their problems resulted both from external circumstances and from personal inadequacies. Of these six patients, four had a superficial understanding of their problems while two had no understanding. For example, one young girl felt herself to be very inadequate and feared that people were critical and judgmental of her. She also recognized the role a rigid and domineering uncle in Canada had played in creating these feelings in her. This girl had only a superficial understanding of her problem however, because she could not establish the obvious connection between her prevailing circumstances and her feelings about even a more rigid and domineering person in the form of her father whom she had left behind overseas.

In another case where more insight was present, a young man complained that he was ill because his employer made him work eighteen hours a day on the farm. This patient was able to recognize his own weaknesses and limitations and to specify the area of endeavour in which he could function best. This person was consequently rated as having a good understanding of his circumstances and a fairly realistic attitude about himself.

The remaining five patients of this group of eleven tended to blame their environments as being the sole cause of their difficulties. Three of these five persons were rated as having some understanding of their problems and therefore, a certain justification for their attitude. For example, one
woman had been an overt homosexual in her own country and had been apparently accepted as such by the community in which she lived. In Canada, however, she found that her sexual behaviour evoked only abuse, ridicule and rejection. Consequently, although this woman had, in effect, adjusted herself to her homosexuality in her own country, she became very disturbed when her behaviour could not be accepted by people in Canadian communities. She therefore blamed her surroundings for her difficulties with a certain amount of justification.

**Attitude to Illness.**

The immigrants' attitude to their illnesses was rated because it was considered necessary to discover what degree of insight they had into their disorders. Thus, a person who denies his illness, or states that it appeared very suddenly at a specific time and that before then he had been "healthy and happy", very likely has very little if any insight into his affliction. On the other hand, when a newcomer sees his prevailing circumstances as being related to his life history and can talk in terms of conflicts, frustrations, and anxiety, there is a possibility that insight is good.

Of the eleven patients in Group 1 two recognized that they were ill. Two other persons had doubts about their illness, feeling that they might be ill but having some reservations about this. The remaining seven newcomers denied their illness completely. They described their symptoms as belonging to their body rather than to the mind; they insisted that they had no complaints whatsoever; they maintained that a doctor's care was unnecessary; or they blamed the hospital for making them "nervous".

A denial of illness by these seven patients might be construed as a complete lack of insight into their condition. This conclusion, however, would contradict the fact that these seven patients, on the whole, had a fairly good understanding of their problems and a realistic attitude about themselves. It is therefore possible that these people were denying their illness in a
desperate effort to avoid being "sent back." Most of the patients in Group 1 were painfully aware that becoming mentally ill made them candidates for deportation.

**Mention of Childhood and Family.**

This factor was rated for the sample studied because it might suggest an overall pattern fitting into the other assessments. For example, a person who is defensive about his background might describe it as being uniformly happy and be unable to think of a single deficiency in it. Such a person might also be expected to deny his illness, show no understanding of his problems, and tend to externalize all his difficulties. A patient who is completely unable to talk about his childhood and family in any terms has probably repressed most of his earlier experiences. On the other hand, the immigrants who are able to talk spontaneously about their childhood and family, without showing a great need to present an idealized picture of their past, might be expected to have some insight into their illness and problems and show some sense of responsibility for their future.

Of the eleven persons in Group 1, three were able to talk spontaneously and realistically about their backgrounds. Three other newcomers tended to be defensive about their backgrounds, stressing their "breeding," status, or maintaining that everything had been "wonderful" during their childhood. Five patients were unable to talk about their backgrounds at all, suggesting considerable repressed material in this area.

In summary, the following may be said to be personality components characteristic of Group 1.

1. Generally, the persons in this group had a fairly realistic attitude about themselves and some understanding of their problems.

2. Group 1 included four persons who either recognized their illness or had some doubt about it. Another seven newcomers denied the fact that they
were ill. It is unlikely that these two attitudes concerning mental illness represent two different patterns. These newcomers were, in most cases, terribly fearful of being deported and would understandably enough deny their illness if they felt this would keep them in Canada.

(3) More than half the patients in this group were able to express their feelings about their childhood and family experiences. Those that could not talk about their background probably had repressed their earlier experiences.

**Quality of Relationships in Group 1.**

In addition to being rated for some personality components, Group 1 was also assessed for the quality of relationships in their former country, in Canada, and their attitude to people generally. Thus, if a newcomer stated that he had many friends in his own country and had enjoyed various social activities before migrating, while in Canada he has not been able to make any friends, it can be assumed that external circumstances such as place of employment, language handicap, or lack of relatives in this country served to isolate him. This can be further confirmed if the patient has been actively seeking friendships in Canada, and if he exhibits positive feelings to people such as recognition that he can receive assistance, friendship, or understanding from some people in this country.

On the other hand, if a patient has had no friends in his former country, has not sought or expressed interest in friends in Canada, and feels distrustful and suspicious of all persons, then it can be assumed that he has a very lengthy history of isolation from other people and of poor relationships.

There were some newcomers who apparently did not have many friends in their former country or a great deal of interest in social activities. However, these persons are different from others in the sample because they had
experienced a close attachment to some particular relative, lover, parent or friend. These patients may be described as having some capacity for relationship which is perhaps undeveloped.

Seven of the newcomers in Group 1 had enjoyed many close friendships and relationships in their own country. All of these seven patients described themselves as having had participated in many social activities in their own country, and maintained that they had enjoyed the company of others and mixed well with people. Five of these seven newcomers were either actively seeking or desiring relationships in Canada, while two others expressed a preference to be alone in their new homeland. Those who preferred to be alone considered their associates in this country to be beneath the social status to which they were accustomed. All of these seven newcomers tended to be overly cautious about people in this country, being suspicious of others' motives or being puzzled by the demands of others upon them.

The remaining four patients in Group 1 had no evident history of satisfying relationships. However, in Canada, one of these patients expressed a desire for "someone to talk to", another two became greatly attached and apparently over-dependent on a friend, and the fourth became very dependent on her doctor. These patients evidenced some suspicion and distrust of people as did the other persons in Group 1.

In summary, the relationships of the newcomers in Group 1 seem to follow this pattern:

(1) The majority of the patients in this group had enjoyed satisfying relationships in their own countries. The four patients who showed no apparent history of satisfying relationships in their own countries, nevertheless evidenced a certain capacity for relationship in Canada.

(2) Most of the patients in Group 1 were either actively seeking friendships in Canada, or expressing a great desire to meet people and make
friends. A reference to factor 6 in Figure 1 confirms the fact that these people have experienced one of their greatest difficulties in making friends in this country and becoming involved in social activities. One reason for this is probably language barriers and the fact that most of these newcomers had no relatives whatsoever in this country to bridge the gap between two cultures.

(5) All of the persons in Group 1 showed varying degrees of suspicion and distrust of people in their surroundings.

Group 2.

The rating scale revealed a different pattern of factors for the newcomers in Group 2 (see Figure 1b). The fourteen patients comprising Group 2 manifested an almost uniform consistency in the distribution of factors for which they were rated. In the discussion of this group, the same headings are used as for Group 1, since the factors rated are the same in both groups. Although there is a little overlapping, the differences appear to be significant enough to warrant the distinction between the two groups.

Attitude to Self and Understanding of Problems.

Thirteen of the fourteen persons in Group 2 were convinced that they had been victimized in some way by others, and insisted that their problems belonged wholly to the environment. Also, it was the opinion of the psychiatrists, social workers, and others, that these newcomers had no understanding whatsoever of their difficulties. Some patients in Group 2 generalized by blaming "Canada" for everything that had happened to them, some blamed their doctors, and a few were convinced that everybody was "after them" and was "planning to harm them." There was, in other words, a very marked distortion of reality in this group of immigrants; much more so than was evident in Group 1.
The one individual who seemed to be the exception in Group 2, was able to say that he might be somehow involved in his problems and was able to describe specific incidents which were disturbing to him. However, there is some suspicion that this patient was intellectualizing, because, generally speaking, he had no insight into his part in the problem, he had a long history of mental instability and could not accept the fact that he was ill.

Attitude to Illness.

All fourteen patients in Group 2 uniformly denied the fact that they were ill or needed treatment. Since a few of these expressed a wish to be deported, it is unlikely that their denial stemmed from fear. These patients either explained away their behaviour as something that had been provoked by enemies, or they insisted that they were well and happy. In all cases, it can be said that no degree of insight was present, even in those cases where psychosis had been alleviated by treatment.

Mention of Childhood and Family.

Twelve of the fourteen patients in Group 2 were not able to talk about their childhood or family experiences at all. The two remaining patients in this group were able to refer to their backgrounds only after some persuasion, and then only very defensively and with considerable tendency to present an idealized picture.

In summary, the following may be said to be the personality components characteristic of Group 2:

1. All the patients in this group assumed no personal responsibility for their problems whatsoever, and showed no insight into their circumstances.
2. All patients denied the existence of their illness.
3. Most patients could not talk about their childhood or family. The two patients in this group who did give some information about their background
did so only after persuasion and then painted an idealized picture of their childhood and family experiences.

Quality of Relationships in Group 2.

As far as could be judged from the records, seven of the fourteen patients in Group 2 had experienced no satisfying relationships in their own countries. Most of them had apparently been completely alone and friendless before migrating. The remaining seven patients claimed that they had either a lover, a sibling, a spouse, or some other person in their former country to whom they claimed inordinate attachment. However, the idealized way in which these relationships were described suggested that they were seen as satisfying to those patients in retrospect. Two of these patients idealized their former way of life — one war-time Germany, and the other Italy. Because these last two patients could not speak in terms of specific relationships it must be assumed that they were non-existent.

All of the fourteen patients in Group 2 rejected relationships completely in Canada, and showed no desire or interest in making friends or getting to know their new community. Also, all of the patients in this group evidenced excessive distrust and suspicion of their new environment.

In summary, the relationships of the patients in Group 2 seem to follow the following pattern:

(1) Half of Group 2 had no satisfying relationships whatsoever in their own country. The remaining half referred in a highly idealized way to one love object or to a general way of life.

(2) All patients in Group 2 rejected relationships in Canada.

(3) All patients in Group 2 showed excessive distrust and suspicion of their new surroundings.
Further Comparisons Between Group 1 and Group 2.

The sample studied had been divided into two groups on the basis of similarities and differences revealed by the rating scale. It is interesting to note that, even though the initial division into Group 1 and Group 2 had been done primarily on the basis of personality and relationship components, a subsequent comparison of mental illness factors seems to substantiate the original division. Thus, a comparison of psychiatric categories, of acuteness and persistency of illness, and of predominant symptoms in the two groups seems to confirm the differences originally noted.

Psychiatric categories.

In Group 1 (Fig. 2a) five out of eleven newcomers are described as being depressed and non-psychotic. The remaining six patients are diagnosed as schizophrenic. However, unlike the psychotic patients in Group 2, the six schizophrenic patients in Group 1 either recovered completely or experienced considerable improvement during hospitalization.

All newcomers in Group 2 (Figure 2a) except one fall into various categories of psychosis. Of the fourteen patients in this group, only two recovered, five were slightly improved after treatment, and seven showed no improvement at all. Paranoid schizophrenia dominates all the other diagnostic categories in Group 2 with eight out of fourteen patients receiving this diagnosis.

History of Illness.

Group 1 included seven cases which could be described as acute; that is, the illness had occurred suddenly after the person arrived in Canada and the newcomer's background did not reveal any history of previous mental disorders. In another five cases, it could not be definitely established how long the person had his illness. These were designated as unknown. In Group 1,
GROUP 1

GROUP 2

PSYCHIATRIC CATEGORIES

ACUTE  CHRONIC  UNKNOWN

ACUTE  CHRONIC  UNKNOWN

HISTORY OF ILLNESS

PREDOMINANT SYMPTOMS

FIGURE 2A

FIGURE 2B

FIGURE 2C
of the cases where the onset of the illness was established, there were no cases that could be described as chronic; that is, where a patient revealed a long history of mental illness dating back prior to migration.

In Group 2, there were four cases which seemed to be suffering from an acute mental disorder. Four other cases had to be designated as unknown. The remaining six cases were definitely of a chronic nature, the patient himself or collaterals having disclosed previous committals to hospitals in other countries, or at least a long history of instability and psychotic episodes.

**Predominant Symptoms.**

It was assumed that predominant symptoms which the patients manifested during their mental illness was an area well worth consideration. The physical and psychological symptoms which distinguish a particular mental patient may be regarded as attempts on his part to make his needs and desires known. In other words, many symptoms have a meaning, and can provide clues to the nature of physical and psychological disequilibrium in a person.

Dr. M.J. Hornowski, writing on this subject, stated, "according to holistic theories, any communication is indicative or symbolic of the sum total of a patient's disturbed equilibrium, and any symptom is a communication about this disturbance".10

The sample studied appeared to evidence five main kinds of symptoms (Figure 2c). Some revealed considerable physical anxiety, i.e., headaches, dizziness, and pains for which no physical cause was evident. Others tended to show conscious anxiety about such things as "coming to some harm", not knowing what was expected of them, and being fearful generally without specific cause. A large number of these newcomers had either attempted to

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commit suicide, or else showed a strong inclination to do so. Some patients expressed a morbid fear of people and went to great extremes to avoid contact with persons. Other newcomers revealed very destructive behaviour, attacking people, breaking furniture, tearing clothes off their backs, and using abusive language.

The differences which so far have set Group 1 apart from Group 2 seem to be further confirmed by looking at the predominant symptoms each manifests (Figure 2c). In Group 1, there appears to be no particular pattern of symptoms just as there is no uniformity evident in the personality and relationship components. In this group there are considerable differences in symptomatology. Considering the fact that in this group the illness is mostly of an acute nature, and the persons involved seem to have some capacity for relationship and a relatively stable history, the predominant symptoms are probably more an expression of individual attempts to adjust or to communicate personal difficulties in adjustment, than a sign of a deteriorating disease process.

Unlike Group 1, there is a fairly consistent pattern of symptoms in Group 2. As Figure 2c illustrates, the persons in Group 2 manifest very similar symptoms, suggesting perhaps that the more severe and chronic disease processes in this group produce a levelling effect in personality and response to environmental stimuli.

Summary.

Using a rating scale designed to provide a rough picture of each mental patient's personality, and the quality of his relationships, sufficiently significant differences and similarities were noted to make a division for the sample into two groups possible. After this division was made, further comparisons were observed in psychiatric categories, acuteness and persistency of illness, and in the predominant symptoms in each group.
These latter comparisons seemed to corroborate the differences evidenced originally between Group 1 and Group 2. It should be noted that some relation was obtained between psychiatric diagnosis and the personality and relationship components for which the patients were rated, (Figure 2a). Because psychiatric diagnosis sometimes has a tendency to be tentative and is frequently governed by subjective elements such as the psychiatrist’s skill and orientation, the relation which was obtained assumes some significance.

Generally speaking, Group 1 had a better appreciation of their problems, greater insight into their illness, a history of fairly satisfying relationships in their own countries, and a desire to meet people and make friends in Canada. This group was made up of patients diagnosed as depressed and also of schizophrenic patients who recovered rapidly under treatment. Moreover, acute mental disorders and highly individualized symptoms distinguished Group 1 from Group 2.

Group 2, on the other hand, appeared to be comprised of people who had no understanding of their problems, no insight into their illness, and a history of poor or non-existent relationships in their own country and in Canada. This group included persons who were diagnosed as various types of schizophrenics and whose illness was primarily of a chronic nature. In Group 2, a certain amount of stereotyping was reflected in the symptoms of newcomers concerned. This suggests a levelling of personality in these patients which comes with a chronic, deteriorating psychosis.
The differences in personality factors, relationships, and mental illness components, which have served to set Group 1 apart from Group 2, suggest that the former newcomers have a greater potentiality for rehabilitation than the latter. The high index of recovery in Group 1 alone would support this contention. However, a comparison of the casework services which these two groups received and their respective dispositions under the Immigration Act, points to the fact that there seems to be no real selection from among these persons for rehabilitation services.

Casework services with these patients may be considered in terms of three general areas. In some cases, a social worker would obtain a social history from relatives, friends and others for the psychiatrists to facilitate diagnosis and assessment of prognosis. In other cases, the social worker would compile a social history and remain with the case, providing casework services to patient and relatives, and implementing a suitable rehabilitation plan in cooperation with medical staff. In a very few cases, there would be no social work services given at all, mainly because there were no relatives or collaterals for the caseworker to interview.

Figure 3a indicates that both Group 1 and Group 2 received similar proportions of social work services.

Similarly, there was no apparent discrimination between Group 1 and Group 2 where discharge from hospital or deportation were concerned. Under the Immigration Act, all persons who become patients in a mental hospital are
GROUP 1

SOCIAL WORK SERVICES

GROUP 2

DISPOSITION UNDER IMMIGRATION ACT.
deportable. In all cases, as a matter of policy, deportation is recommended by local immigration authorities and confirmed by the Immigration Department in Ottawa, regardless of whether the patient concerned appeals his deportation or not. However, an immigrant's doctor might recommend to the immigration authorities that a patient is suitable for probation. A patient may therefore be discharged into the community on probation for a period of six months. If the newcomer concerned adjusts well, he may stay in Canada indefinitely, although he must continue to remain on a probationary basis. That is, the deportation order is merely pigeon-holed and can be made effective any time in the future if it is deemed necessary. Consequently, such a person may spend the rest of his life in Canada with a deportation order hanging over his head.

As Figure 5b illustrates, both Group 1 and Group 2 have received very similar dispositions under the Immigration Act.

The fact that there seems to be a slightly higher percentage of deportations in Group 2 as compared to Group 1, suggests that the generally poor rehabilitation possibilities which the former shows might be influencing the doctors' recommendations to the immigration authorities. However, on the whole, both groups seem to have received very similar treatment where deportation and discharge are concerned.

There appeared to be no difference between Group 1 and Group 2 in the social work services each received. This is mostly because the Social Service Department at Crease Clinic and the Provincial Mental Hospital provided a one hundred percent coverage for all patients at the time of this study.

An amendment to the Immigration Act is presently being considered by the Canadian Government, which would permit certain classes of immigrants who become mentally or physically ill after migration, to become citizens of this country.
The apparent lack of selection where disposition under the Emigration Act is concerned, implies perhaps that the doctors are willing to give all their patients an opportunity to become rehabilitated and recommend deportation only for those they consider completely hopeless.

The analysis in this enquiry raises several pertinent questions. In the first place, there seems to be some evidence now in favour of confirming the existence of immigrants, in mental hospital at least, whose mental health was very poor before they migrated to Canada. Secondly, there appear to be some persons who experienced a train of circumstances in Canada which brought about poor mental health. Patients whose illness seems to be a condition of long standing, and whose migration was likely an expression of that illness, obviously need a different sort of disposition than patients whose illness has been precipitated by environmental stresses in Canada. Such a differential approach to these patients has certain implications for screening, deportation, and social services.

Conclusions and Recommendations.

It would not be valid to draw conclusions concerning the whole immigrant population in Canada today from the relatively few who suffer mental disorders. The small percentage who become hospitalized can be studied and various conclusions concerning the type of personality and environmental problems which distinguish them can be reached. About the majority, however, who never are hospitalized, these conclusions really reveal nothing. It is perhaps possible, however, to draw some general and indirect inferences about the group of newcomers who never appear in a mental hospital.

It is recognized by both the medical and social work professions today that personality as well as physical factors play an important role in the etiology of mental disorders. The personality components may be
partly constitutional, determined by heredity and the person's predisposition in terms of body function; and partly environmental, stemming from the mental stresses and strains which were encountered during the person's lifetime. Therefore, the statistical fact that within a certain group such as the immigrants, a certain percentage become mentally ill, may be taken as evidence that they do so either because of an increased mental strain on the immigrant group, or a decreased ability to cope with mental strain. The former implies that the newcomers may have led a fairly integrated and satisfying life prior to migration and encountered insurmountable obstacles in their new culture. The latter suggests that the newcomers may have been mentally unstable before migrating, and the increased pressures they met in their new surroundings accentuated their mental instability.

The test of such a hypothesis is the usual one, namely, it is in keeping with social work and psychiatric experience. Most social workers would agree that persons who emigrate are subjected to greater stresses and strains than native Canadians or compatriots who remain at home. One social worker who is interested in this subject, Rita G. Spaulding, put the point simply when she wrote: "We know that uncertainty and insecurity tend to produce anxiety in the individual. It is normal to react with anxiety to anxiety-producing situations, and the process of immigration is such a situation." It would therefore seem quite plausible that some newcomers, who may have been reasonably stable and well-integrated in their own country, nevertheless find the pressures of immigration and adaptation to a new environment too great to handle.

On the other hand, there has been some suggestion, particularly from psychiatrists, that immigration might be in many respects a selective process. That is, there might be periods when migration is particularly attractive

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to people who are essentially restless, mentally unstable, and socially maladjusted. Thus, Dr. Benjamin Malzberg, questioning whether immigrants in the United States represent random samples of the populations from which they were derived, writes that "selective factors were clearly at work, some of which favoured emigration of hardy individuals; other factors may have encouraged a poor selection".12 Such a selective process would also apply to Canadian immigration. In any case, there is some validity to the assumption that at least a small percentage of immigrants might have expressed their general instability through migration.

Unfortunately, it has not been possible to conclude from the resources available for the present study, whether the persons who have been hospitalized in a mental hospital belong to a group who were reasonably well integrated before migrating but who were subjected to great environmental pressures in Canada, or to a group who had a long history of instability and maladjustment. If any generalization is possible from the twenty-five patients studied, it is likely that today's immigrant group in Canada contain elements of both. The sample studied appeared to have included people whose illness could be traced to environmental pressures in Canada, and some persons whose illness appeared to be of a fairly long duration, having its onset well before migration.

Where deportation for this group of patients is concerned, it appears obvious that some sort of differential application of the deportation clause in the Immigration Act is warranted. A patient who is found to have had psychotic episodes in his own country, who is completely disinterested in becoming established in his own community, and whose psychiatric prognosis is not good, has not much to contribute or receive from his new homeland. On the other hand, a patient whose illness was apparently precipitated in

12 Malzberg, Benjamin, op. cit.
this country, who shows a fairly stable history up to his arrival in Canada, and who continues to manifest a desire to become a part of his new community, has something to offer as a potential citizen once he can receive proper rehabilitative services. Clearly, the former type of patient would appear to be more subject to deportation than the latter.

What happens in practice? The present study shows that patients from both Group 1 and Group 2 have been discharged into the community on a probationary basis, and have been given an opportunity to become established, even though, as this study has pointed out, most of the patients in Group 2 seem to have a decidedly poorer prognosis. It can be anticipated that the patients discharged from hospital who belong to Group 2 will sooner or later be returning to a mental hospital, because their mental health seems such that they are less capable of coping with personal conflicts and environmental pressures. A follow-up study would be necessary to confirm this, and, obviously, it would be worth making.

Of the group of twenty-five patients studied, anyone who is discharged into the community has to bear the burden of possible deportation as long as he remains in this country. The fear and anxiety which these people experience because of this threat of being "sent back" cannot but be detrimental to their ultimate recovery and adjustment. For example, one of the patients in Group 1 was on the point of discharge when an immigration official appeared to take a passport picture as a matter of routine. The person in question immediately suffered a relapse, and, undoubtedly, had to remain in hospital longer than would have been necessary otherwise. It would only be a humane gesture to relieve some of the people of the added pressures which the provisions of the Immigration Act create for them.

One way of limiting deportation to those patients whose future in this country does not look very promising, and of offering rehabilitation services
to those who seem likely to become useful citizens, would be to screen all patients in a way similar to this study. The decision as to whether a person should be deported or not, more than any other decision, influences his whole future. Such a decision should not remain the sole responsibility of an immigration official, nor should it be at the discretion of an individual doctor. A valid decision for each case can come only from a case conference in which the psychiatrists and social workers can weigh all the evidence available in the patient's personal and mental illness history. Moreover, disposition of such cases would probably be much more in keeping with enlightened welfare practices if there was a provision in the Immigration Act which would recognize the considered decision of a psychiatric team. Thus, it would be possible for a patient's good prognosis to be recognized in more constructive ways than by placing him indefinitely on probation in the community. For example, if a patient has made a successful adjustment after a six months probationary period, he should not be liable to deportation.

Such an arrangement would do a great deal towards alleviating anxiety in those cases where successful rehabilitation is a distinct possibility. For example, patients of the type which comprised Group 1 in this study would undoubtedly find a good adjustment much easier if the threat of deportation could be removed after a six month probationary period. By the same token, the classification inherent in a careful screening of these cases would make it possible for social workers to direct all their skills and resources towards those patients who would benefit the most.

Perhaps the most effective steps which can be taken to alleviate some of the suffering and disappointment experienced by many persons who are deported, would be to screen potential immigrants more thoroughly for psychiatric disorders before migration is permitted. In most of the cases in Group 2, there was evidence that these patients had experienced psychotic
episodes in their own country, and, generally speaking, were unstable enough to make their future adjustment in Canada questionable indeed. As the situation seems to exist, a prospective immigrant is merely asked by an immigration official whether or not he himself or any member of his family had ever had mental illness. It is understandable that many immigrants would give a negative answer, regardless of the truth, if their desire to come to Canada is great enough. A more intense screening for psychiatric disorders, possibly made by a qualified social worker, would provide a more valid index of a potential immigrant's future value as a Canadian citizen than appears possible with existing methods.

Screening of potential newcomers would also become more effective if a rating scale similar to the one utilized in this study was developed. Outside of the many external factors which influence a person's adjustment, such as employment, housing and location, each person is equipped with a psychological combination of factors which would determine how he would get along in his new country. For example, a person who evidences a long history of withdrawal from social contacts and of distortion of reality, is, without a doubt, a poor risk as a potential immigrant. This is particularly true because the very essence of becoming a part of one's new surroundings is the willingness to make new friends and contacts and to see one's circumstances realistically. A rating scale along the same lines as the one used in this study, probably would be quite effective as a sort of prognostic tool whereby a person's adjustment potential could be measured. Although the particular rating scale developed in this enquiry is as yet tentative and in need of considerable revision, it can be regarded as a step in the right direction.

A final implication may be drawn from the fact that the patients studied represent the extremely maladjusted group, among whom, as this
study has indicated, some appear to be excellent candidates for rehabilitation in Canada, while others seem to be deportable. If mental illness may be regarded as an extreme form of maladjustment, then it can be assumed that lesser degrees of maladjustment, such as an inability to hold employment, a withdrawal from social contacts, or a tendency to become economically dependent, claim even a larger number of immigrants. Thus, the problem of becoming useful and happy Canadian citizens does not belong to the mentally ill immigrants alone.

Explanations for the reason that some immigrants fail to live up to the requirements of their new homeland probably are similar to those suggested for the group of patients studied. That is, some people must be regarded as being predisposed to a poor adjustment no matter what assistance they receive, while others probably succumb to excessive environmental pressures, and probably could use assistance from others to good advantage.

In any case, immigration to Canada is increasing in scope and numbers yearly, and a research unit certainly seems warranted. A thorough study of the immigrant group as a whole would provide much needed information on what has happened to those already in Canada, what social services are available to them in relation to their physical and psychological needs, and what principles outside the economic should govern the selection of prospective newcomers to Canada.
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