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FOCUS ON SAFE THIRD COUNTRY

The Safe Third Country Concept: Deflection in Europe and Its Implications for Canada

Nazare Albuquerque Abell

This article focuses on the recent emergence of new procedural requirements developed for determination of refugee status which have resulted in apparent violations of applicable international standards. One of those procedural requirements is the "safe third country concept" (STC) developed in Western Europe. The STC concept provides that asylum-seekers coming from a member state of the European Union (EU), or from a third country that is party to the Convention Relating to the Status of Refugees, and the Convention for the Protection of Human Rights and Fundamental Freedoms, may not claim asylum on account of political persecution. The article begins by mapping out the concept of STC and placing it in the context of the broader institutional framework of determining the state responsible for an asylum claim. It examines critically the various repercussions of this concept, and attempts to provide a rationale for its popular acceptance in the Western world. It asks whether the reluctance to grant asylum-seekers permission to enter or to remain in the Western world is compatible with international instruments, such as the 1951 United Nations Convention on the Status of Refugees,[1] or the 1967 New York Protocol, which supplemented the 1951 Convention.[2] Finally, in the light of enhanced cooperation in the European Union against asylum-seekers, this article examines and evaluates the new refugee policies of Canada.

1. Determining the State Responsible for an Asylum Claim

The STC has developed in Western Europe, within the EU, as a means to devise more expeditious and accelerated asylum procedures and stricter refugee status criteria, to reduce the overall number of new arrivals, and to prevent the access of asylum-seekers to their territory. The basic principle underlying the STC concept is that the asylum-seeker has already been granted protection in another country, or had an opportunity in another country or at its borders to present an application for asylum. Therefore, it precludes asylum-seekers from presenting several claims in different states. It reflects the idea that asylum should be denied on the grounds that the asylum-seeker already enjoyed,

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could or should have requested and, if qualified, would actually have been granted asylum in another country.

This concept has been developed into a variety of sub-species: "safe country of origin"3 or "countries in which there is generally no serious risk of persecution;" "safe country of transit" or "safe country of return" or, more officially, "host third country." EU member states have also developed another sub-specie called "country of first asylum." It can be found in the Dublin Convention4 and Schengen Agreements.5 It says that the first country within the EU entered by a claimant will accept responsibility for considering the refugee claim. Both agreements, with slight variations, contain rules designed to allocate responsibility for determining the country responsible for an asylum claim. According to these texts, responsibility for consideration of asylum requests is determined as follows:

> If the applicant has a visa, the state which issued the visa or, if he has several visas, the state which issued the visa with the longest period of validity, is responsible;
>
> If the applicant has no visa, the first of the member states of the Schengen Agreement or the Dublin Convention at whose frontier the applicant
>
> presents himself is responsible.6

In all cases it means that there is a state considered by other states to be responsible for examining the application for asylum. Some would say it is the state with a special link with the claimant, of the kind that no other state is more appropriate to deal with the request for refugee status.

Furthermore, the third state should be considered "safe." This is a more ambiguous requirement. For most European countries, 'safe' means any country which has signed and ratified the 1951 Geneva convention, or the 1967 New York Protocol and the European Convention for the Protection of Human Rights?

In any case, it is considered that the asylum-seeker should not be sent to a country where his or her life or freedom would be threatened on account of race, religion, nationality, membership in a particular social group, or political opinion, i.e. a country where the asylum-seeker is not in fear of persecution according to the terms of Article 1 of the Geneva Convention.8

"Safe third country" appears to simplify and resolve some of the refugee problems of today. First, the asylumseeker can only submit one application for asylum in one member state of the European Union, and if the immigration agreement between Canada and the U.S. is concluded, the asylumseeker can only ask for asylum in one of these two countries. This means that there will be a reduction of asylum claims and therefore a reduction of costs at a time of economic recession in the Western world. Second, the concept operates as a commitment to burden-sharing amongst the Western countries. Third, STC insulates the Northern states from refugee flows and, ironically, it allows for an inequitable allocation of the burden of supporting refugees between the North and the South. Countries closest to the site of refugee movements will bear a disproportional responsibility. Finally, according to the states involved in this process, determining the state responsible for an asylum claim will help to differentiate between bona fide refugees and economically motivated migrants, at a time when the asylum adjudication systems of wealthy countries are overwhelmed by the mass of economically motivated migrants, who abuse the asylum process.

The number of asylum claims has declined significantly in Western Europe. In Germany alone, the number of asylum-claimants dropped by 70 per cent between 1993 and 1994.9 However, that does not mean that the refugee problem is declining; it means that the Western world is succeeding in deterring refugees from seeking asylum in the West.

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1.1. Repercussions

First, the application of country of first asylum means that the most restrictive EU practices will became generalized, thus eroding the rights of asylum-seekers and reinforcing a lower standard of protection for refugee claimants. When governments compete with one another to keep asylum-seekers out, those that have maintained more generous policies are soon forced to meet the restrictive lowest common denominator, out of fear that they will be left alone to bear the refugee burden as other countries close their borders.

Furthermore, it is a serious violation of human rights to compel an asylum-seeker to find refuge in the first country in which he or she sets foot, and strict assignment of responsibilities on the basis of which state authorized entry could lead to rejection of individual claims which, in another state, might have been recognized.

1.1.2. Violation of the Principle of "Non-Refoulement"

Second, the use of the STC concept often leads to the breach of a fundamental rule of international refugee law, namely, the principle of non-refoulement. This principle in embodied in article 33 of the Geneva Convention:

> No contracting state shall expel or return a refugee (refouler) in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.

The principle of non-refoulement is, beyond any doubt, the main safeguard available to refugees and asylum-seekers, and is regarded as a fundamental principle of public international law.

The STC concept often leads to violation of the principle of non-refoulement because refugees are sent back to so-called "safe" countries, which in turn send them back to the countries they have fled from. A number of Western European countries do not even consider their claims; for example, Spain is one of several countries introducing asylum laws which authorize immediate expulsion for "manifestly unfounded" applications.[10] The principle of non-refoulement prohibits all ratifying states from taking indirect as well as direct measures of return; otherwise, the phrase "in any manner whatsoever" would be unnecessary.

The principle of non-refoulement must not be confined to prohibition from sending the asylum-seekers back to their country of origin, but must also apply to any other country where they are in danger, particularly because they could not settle there and would be liable to be handed over to the authorities of their own country.

States favouring the STC concept, such as those of the EU, would say that asylum-seekers are not sent back to the countries where they face persecution but to a third country, where the asylum-seeker is protected from refoulement; however, practice has shown that, in some cases, refugees have been sent back to their countries of origin through the use of the STC concept. Furthermore, the states involved have been aware that once the refugees are sent back to certain third countries they will be immediately returned to the countries where they face persecution.

For example, Greece[11] (a EU member) has been accused of sending back to Pakistan and Turkey (the so-called first countries of asylum) refugees fleeing from Iran, which Turkey and Pakistan then return to Iran. According to Greek law, asylum-seekers are sent back to the first country of passage. On the other hand, Turkey has often declared that it should not be deemed responsible for examining asylum requests merely because of the first entry having been made on its territory, for the purpose of proceeding to another country.[12]

The United Nations High Commissioner for Refugees (UNHCR) Executive Committee Conclusions has, in Conclusion No. 58 on irregular movements, accepted that an asylum-seeker may be returned to the country where they had already found protection if the applicant can enter and remain there, is protected against refoulement, and is treated in accordance with basic human rights standards.[13] In practice, refugees who travelled through countries deemed "safe" are summarily turned back to those countries in blatant breach of Conclusion No. 58. Although the Conclusions are not legally binding on states, one cannot forget that the Executive Committee of the High Commissioner Programme is a body comprised of government representatives from 46 nations to provide guidance in applying the terms of the Convention and Protocol. The purpose of the Conclusions is to ensure consistency on the part of the states when applying the Convention. The Conclusions have been called soft law because they are not legally binding on states; however, because they are approved by consensus, they help to develop the Convention where there is a lacuna, being a legal recourse in certain instances.

Thus, as D. Pretasek has stated, one of the main problems in the existing international system for the protection of refugees is the lack of an effective enforcement mechanism. While the Executive Committee was not explicitly set up to enforce the provisions of the Geneva Convention and Protocol, its past conclusions did indicate some effort to fill this gap. In the absence of any other international body which can point to accepted standards of treatment of refugees and asylum-seekers, the Executive Committee is the only available forum, although the latest Conclusions provided a less than hopeful sign of the likely success of such efforts.[14]

The UNHCR also expressed concern about the use of the STC concept in Europe, insofar as shifting the responsibility for examining applications for refugee status to other countries, through which the applicant may have passed, sometimes involves the risk that refugees may be placed in situations that could ultimately lead to refoulement to their country of origin or other places where their life or freedom was threatened.[15] However, the

UNHCR is still, to a certain extent, dependent on those same governments for financing, and its appeals have come across as mere exhortations.

2. The Choice of the Country of Asylum

When determining the responsibility for examining an asylum request, states do not take into account the intentions of the asylum-seeker. The question is thus the right of an asylum-seeker to choose the country of asylum. Some argue that the asylum-seeker does not have a right of choice, and this position is supported by Article 31 of the Geneva Convention, which states:

> The Contracting States shall not impose penalties, on account of their illegal entry or presence, on refugees who, coming directly from a territory where their life or freedom was threatened in the sense of Article 1, enter or are present in their territory without authorization, provided they present themselves without delay to the authorities and show good cause for their illegal entry or presence.

Some authors regard this article as showing that the Convention is not based on any rule of free choice of asylum countries, because exemption from penalties in case of illegal entry is dependent upon a direct route from the persecuting country.[16] This raises the question of what is meant by "directly." Transit through countries lying between the point of departure and the point of arrival, stop-overs in ports or airports, and brief stays with no intention to settle, should not be interpreted in terms of indirect arrival from the country of origin. However, in the EU, under the Schengen and Dublin Agreements it is enough for an asylum-seeker to have spent a few hours in transit at a third country airport to be returned to that country.

Furthermore, compelling an asylum-seeker to find refuge in the first country in which he or she sets foot is a violation of that person's human rights. The main objective of article 31 is to ensure that states would not refuse admission to refugees on the pretext that they had entered its territory illegally, which would have endangered the aim of the Convention. Furthermore, nowhere in the Convention is it said that, because asylum-seekers have travelled through a state other than the one of destination, they are precluded from applying for asylum in the state of destination. On the other hand, there is no principle of international law that recognizes foreigners', including asylum-seekers', freedom to settle in a country of their choice; but to impose the opposite principle would be unacceptable.

In practical terms, travelling through a state other than the one of destination might reduce the chances of an asylum-seeker for a successful recognition of refugee status. But it does not mean that the claim is unfounded in terms of the Geneva Convention. The intentions of the asylum-seeker should be taken into account, since he may prefer one country to another for such legitimate reasons as language, family ties, or cultural bonds.

This has been the view taken by the UNHCR EXCom No. 15,[17] which also says that asylum should not be refused solely on the ground that it could have been sought from another state, and that before an applicant for asylum is sent to another country there should be full assurance that the asylum-seeker will be admitted and the asylum application examined in fair procedures.

The UNHCR also notes that, in line with the relevant Executive Committee Conclusions, states should take into account any links which the applicant has with them as compared with a third country, and special regard should be given to cases where the asylum-seeker has close family links with the country concerned.

In Canada, the Federal Court has followed this approach. In *Charles Kofi Owusu Ansah* v. *Minister of Employment and Immigration*,[18] the Federal Court reversed the decision of the Immigration and Refugee Board that denied asylum status to a Ghanaian native on the grounds that, before applying for asylum in Canada, he had opportunity to claim asylum status in Togo, Nigeria, and Brazil. The Court declared that the explanations given by the asylum-seeker were credible and sufficient to account for his failure to seek asylum in the three previous countries.[19]

In the EU, and according to the terms of Schengen and Dublin, the asylum-seeker does not have the right to choose the country of asylum. Furthermore, if the first country of asylum declines protection, the asylum-seeker does not have the right to return to the chosen country in the European Union.[20] For example, in July 1994, a national from Togo, who had arrived at the Munich airport, was sent back to Belgium on the grounds that he had previously spent a few hours in transit at the Brussels airport en route to Germany and, despite the fact that the applicant had a relative in Germany. In Belgium, he was then denied asylum on the grounds that his claim had been looked at in Germany, and he was removed back to Togo. Unfortunately, this is not the only such case.[21]

In practical terms, travelling through a state other than the one of destination might reduce the chances of an asylum-seeker for a successful recognition of refugee status. But it does not mean that the claim is unfounded in terms of the Geneva Convention. The intentions of the asylum-seeker should be taken into account, since he may prefer one country to another for such legitimate reasons as language, family ties, or cultural bonds.

3. The Safe Third Country in Canada

The process of collective deterrence in Western Europe will necessarily have an effect in Canada. The result may be

a deflection of claimants from Europe to Canada. Some have said that a fair and open determination system, such as the Canadian, will not be able to cope with the pressures generated by the diminution of asylum opportunities in Europe, and therefore Canada will end up joining the European "club." This argument is based on the fact that Canada is not geographically a country of asylum. Asylum-seekers arrive in Canada via Europe or the United States. Therefore, if conditions in Europe are not favourable for asylum-seekers, there is the belief that they would try to reach Canada where they might be recognized as refugees.

The above argument does not take into consideration the fact that deterrent measures such as strongly enforced visa controls and airline sanctions will deter asylum-seekers from reaching Canada.[22]

Nevertheless, Canada has pursued this topic in diplomatic forums. These include the Intergovernmental Consultations on Asylum, Refugee and Migration Policies in Europe, North America and Australia, which comprises 13 European governments, Canada, Australia, and the United States. The Consultations largely focus on removals, prevention of asylum-seeking, and information sharing on individuals seeking asylum in order to avoid asylum shopping. In this regard, the Minister of Immigration and Citizenship has now the right to forge agreements with other states for the "purposes of facilitating the coordination and implementation of immigration policies and programs."[23]

Under the recent amendments, Bill C-86 made provisions allowing the government to prescribe a country as a STC.[24] Thus, at the first stage of a hearing for refugee status, the panel (a member of the Convention Refugee Determination Division and an Immigration Adjudicator) may refuse a claim if the asylum-seeker can return to a safe third country. This could affect asylum-seekers who came to Canada after spending time in a first asylum country in Europe or in the United States.[25] Bill C-86 sets forth the conditions for the prescription of a country as a STC to allow Canada to send asylum-seekers back to that country without an examination of the claim if the claimant arrived such a route.

Paragraph 114(1)(s) permits the Governor in Council to prescribe a country as a STC. The conditions for prescribing a safe third country are:

1. Whether the country is a party to the Convention;
2. The country's policies and practices with respect to Convention Refugee claims;
3. The country's record with respect to human rights;
4. Whether the country is a party to an agreement with Canada concerning the sharing of responsibility for examining refugee claims, notwithstanding that this factor is not a requirement for a country to be prescribed.

In addition, the Governor in Council is required to monitor activities in prescribed countries. Most important, the state must demonstrate incontestable evidence of strict adherence to the principle of non-refoulement. Clearly, the Canadian system of STC, if implemented, would be fairer that the European one.

Safe third countries have not yet been listed by Canada. The problem in listing STCs is that involves an *a priori* determination about the conditions in these countries vis-à-vis asylum-seekers. For example, can Canada consider the US a safe country, especially in view of its policy towards the Haitian asylum-seekers[26] and its track record in denying asylum to certain nationalities? But, at the same time, is Canada in a position not to consider it safe? To a certain extent, the STC provisions in the United States are far more generous to the claimant than those proposed in the Canadian legislation and in the EU. In the United States, the criteria for determining a STC are dependent on the fact that the asylum-seeker was firmly settled in another safe country, and did not simply sojourn there or merely had an opportunity to claim refugee status. Furthermore, the onus of proof is on the state and not on the asylum-seeker.

Gordon Fairweather, former chairmen of the Immigration and Refugee Board, explained the non-implementation of the STC provision in Canada as reflecting recognition that unilateral measures were unlikely to work, and that such measures are not conducive to good neighbourliness or effective, international co-operation in the resolution of problems of refugees and asylum-seekers.[27]

3.1. The Canada-U.S. Memorandum of Understanding for Cooperation in the Examination of Refugee Status

While Canada has not listed safe third countries, it has forged a bilataral administrative agreement with the United States, the Memorandum of Understanding (MOU).[28] The agreement would prevent asylum-seekers from transiting through one country to apply for asylum in the other.

The MOU has been described as placing Canada in a position to ensure better and faster protection for those who choose Canada as their first country of asylum,[29] and ensuring that the cost of refugee determination will not be wasted on someone "taking two kicks at the can."[30] From a practical point of view, due to Canada's geographic position, few would be able to choose Canada as their first country of asylum; one-third of the asylum-seekers coming to Canada arrive via the US.

Currently, asylum-seekers entering Canada from the United States can be turned back if they have resided there. Under the MOU, arriving from the United States would in itself be sufficient ground to turn the claimant back.

The Canadian Council for Refugees has been extremely critical of the MOU, especially because of the U.S. policy towards the Haitians, the fact that the United States is not bound by as many international human rights treaties as is Canada, and the fact that many refugee claimants have fled regimes that have historically been supported by the United States and may

have legitimate reasons not to wish to ask for refugee status there.[31]

The MOU is significant because it shows that Canada is interested in establishing bilateral agreements in order to protect its territory from large numbers of asylum-seekers. Furthermore, it has been estimated by Canadian and U.S. officials that, under current circumstances, up to 10,000 asylum-seekers would be affected by this new rule, and thus would be required to submit their claims through the US asylum procedure instead of the Canadian one.[32]

One of the main consequences is also the fact that, once an asylum-seeker who had previously had a refugee status claim determined by one of the Parties makes a claim in the territory of the other Party, that person will be returned to the country where the initial determination was made. This means that a person denied status in one of the countries in question is to be returned to that country for enforcement of the prior denial. This may provoke an increase in false documentation, asylum-seekers destroying their documents, and illegal entry, in order to get asylum status in Canada. Furthermore, the MOU may lead to indirect refoulement because of the American authorities' strict interpretation of non-refoulement, such as in the case of the Haitian refugees. Family reunification and ties should also be acknowledged. The current version of the draft Memorandum fails to recognize international standards of family reunification.

4. Conclusions

There are both a lack of uniformity in the application of the Geneva Convention and a breakdown of the consensus on which the international refugee system was built. States' current interests are to limit the number of refugees and, if possible, to prevent asylum-seekers from reaching their frontiers. This state of affairs is reflected in the use of the STC concept, and in the increasingly restrictive interpretation of the Geneva Convention, straying from its humanitarian spirit. The original objective of the Geneva Convention has been violated, as well as that of other human rights treaty obligations, such as the Declaration of Human Rights, where article 14(1) states that everyone has the right to seek and to enjoy in other countries asylum from persecution. Furthermore, the cardinal principle of non-refoulement is being flouted in some parts of the world by those very states which created and have supported the Geneva Convention.

Apparently, the Safe Third Country concept is here to stay. Therefore, serious efforts should be put into harmonizing it with the principles of international refugee law, the spirit of the Geneva Convention, and international human rights law, which protect asylum-seekers. ■

Notes

1. 189 U.N.T.S. 2545, entered into force April 22, 1954 [hereinafter Geneva Convention].
2. 606 U.N.T.S. 8791, entered into force on October 4, 1967.
3. The member states of the EU have determined by law countries where the occurrence of persecution on political grounds or of inhuman or degrading punishment or treatment is unlikely. A national from one of those countries is considered as not being persecuted on political grounds, and is therefore precluded from invoking the right of asylum. The classification of a country as "safe" is a matter of governmental discretion in each member state of the EU and not subject to any public control.
4. The Dublin Convention is a multilateral Convention for Determining the State Responsible for Examining Applications for Asylum Lodged in One of the Member States of the European Community [text in 2 I.J.R.L. 469 (1990)]. It is an intergovernmental Convention acceded to by the twelve members of the European Community. Because it was deliberately created outside the supranational framework of the EU, there is no jurisdiction either for the EU Court of Justice or for any other international court. Furthermore, it falls outside the competence of the EU Parliament. Thus, there is a lack of democratic and judicial control.
5. Convention Applying the Schengen Agreement of 14 June 1985 Between the Governments of the Benelux Economic Union, the Federal Republic of Germany and the French Republic on the Gradual Abolition of Checks at their Common Borders, June 19, 1990 [text in 3 I.J.R.L. 773 (1991)]. Italy, Portugal, and Spain have signed both Schengen Agreements. The Convention covers detailed arrangements for improved police co-operation, for common visa policies, for data transmission, and for data protection.

   The Schengen Agreements are, as the Dublin Convention, characterized by the lack of democratic and judicial control.
6. Both the Dublin Convention and the Schengen Agreements do not attempt to coordinate the different laws on asylum of the EU Member States. Their purpose is limited to the elimination of successive and duplicated applications in various member states of the EU. This is based on the premise that all EU members are contracting parties to the 1951 Convention on the Status of Refugees or the New York Protocol, and thus every applicant who applies in the territory of the EU will be given a fair chance.
7. The European Convention for the Protection of Human Rights and Fundamental Freedoms of 4 November 1950 is probably the best-known European treaty. Its effectiveness is largely due to the provisions of Article 25, which allows "any person, non-governmental organization or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in this Convention" to lodge a petition with the Commission addressed to the Secretary General of the Council of Europe in Strasbourg.
8. Article 1(A)(2) of the Geneva Convention, as amended by the New York Protocol, defines a refugee as any person who "...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events is unable or, owing to such fear, is unwilling to return to it."
9. "Fortress Europe?" Circular Letter No 30. December 1994/January 1995, at 2.
10. *Ibid.*
11. Greece has been accused of deporting more than 70,000 refugees to country of their persecution: *Ibid.*
12. See "Draft Agreement on responsibility for examining asylum requests," Ad Hoc Committee of Experts on the Legal As-

pects of Territorial Asylum, Refugees and Stateless Persons. (CAHAR) Strasbourg, 25 January 1989. E 14.547 at 4. Four Iranians were sent to Iran after being returned to Turkey by West Germany to where they had been returned by Denmark. In Joly & Nettleton, *Refugee in Europe*. The Minority Rights Group, October 1990, at 14.

13. Conclusions on the International Protection of Refugees. Adopted by the Executive Committee of the UNHCR Programme. Published by the Office of the UNHCR. The full text of Conclusion 58 (f) states:

    Where refugees and asylum-seekers nevertheless move in an irregular manner from a country where they have already found protection, they may be returned to that country if

    i.) they are protected there against refoulement and

    ii.) they are permitted to remain there and to be treated in accordance with recognized basic human standards until a durable solution is found for them. Where such return is envisaged, UNHCR may be requested to assist in arrangements for the readmission and reception of the persons concerned;

14. Petrasek, D. "The 44th Session of the UNHCR Executive Committee: A View from the Side." I.J.R.L. Vol. 6 (1), 1994, at 65.

15. U.N. Doc E/1993/20, 26 April 1993, at 7–8.

16. See K. Hailbronner. "The Concept of 'Safe Country' and Expeditious Asylum Procedures." I.J.R.L., 5 (1), 1993, at 58–59. Milander, G. "Refugees in Orbit" A.W.R. Bull. Vol. 16, 1978, at 60.

17. Part of Conclusion 15 (h) reads:

    An effort should be made to resolve the problem of identifying the country responsible for examining an asylum request by the adoption of common criteria. In elaborating such criteria the following principles should be observed:

    (i) The criteria should make it possible to identify in a positive manner the country which is responsible for examining an asylum request and to whose authorities the asylum-seeker should have the possibility of addressing himself;

    (ii) The criteria should be of such character as to avoid possible disagreement between States as to which of them should be responsible for examining an asylum request and should take into account the duration and nature of any sojourn of the asylum-seeker in other countries;

    (iii) The intentions of the asylum-seeker as regards the country in which he wishes to request asylum should as far as possible be taken into account;

    (iv) Regard should be had to the concept that asylum should not be refused solely on the ground that it could be sought from another State. Where, however, it appears that a person, before requesting asylum, already has a connexion or close links with another State, he may if it appears fair and reasonable be called upon first to request asylum from that State.

18. Federal Court of Appeal Decision A-1265-87. See Hathaway, *The Law of Refugee Status*, Butterworths Canada Ltd. 1991, at 46-50.

19. Owusu Ansah explained that he did not ask for asylum in Togo due to the fear of being kidnapped by Ghanaian authorities, in Nigeria due to the political instability of the government, and in Brazil because he did not speak the language.

20. The European Consultation on Refugees and Exiles (ECRE), a forum for cooperation between more than 50 nongovernmental organizations in Western Europe concerned with refugees and the rights of asylum, has repeatedly spoken against this state of affairs in Europe, recommending that, as a minimum, European States should:

    i. before taking a decision to return an asylum applicant to another state, take into account as far as possible the intentions of the asylum seeker as regards the state in which s/he wishes to request asylum;

    ii. after taking the decision to return an asylum applicant to another state:

    a) inform the applicant, in a language s/he understands, of the decision to transfer him/her to that other state;

    b) provide the applicant with an opportunity to appeal, with suspensive effect, to an independent body against the decision to transfer him/her to another state.

    iii) not return an asylum seeker to another state before determining that the following requirements are fulfilled:

    a) the receiving state is party to the 1951 Geneva Convention and the 1967 New York Protocol, and complies with the UNHCR Executive Committee Conclusions;

    b) the applicant will be admitted to the receiving state under conditions of safety and respect for the individual;

    c) the applicant will be protected by the receiving state against refoulement in the meaning of Article 33 of the 1951 Geneva Convention;

    d) the applicant will be provided by the receiving state with full access to a fair and efficient refugee determination procedure;

    e) the applicant will be treated by the receiving state in accordance with human rights standards and international principles of refugee protection.

21. See ECRE, Provisional Report on the Safe Third Country Monitoring Project, 1994.

22. See Hathaway, J. "The Conundrum of Refugee Protection in Canada: From Control to Compliance to Collective Deterrence." In *Refugees and the Asylum Dilemma in the West*. Ed. by Gil Loescher, 1992; Joly, D. "The Porous Dam: European Harmonization on Asylum in the Nineties." I.J.R.L. Vol. 6 (2), 1994.

23. "108.1 The Minister, with the approval of the Governor in Council, may enter into agreements with other countries for the purpose of facilitating the coordination and implementation of immigration policies and programs including, without restricting the generality of the foregoing, agreements for sharing the responsibility for examining refugee claims and for sharing information concerning persons who travel between countries that are parties to such agreements." *Immigration Act* c.49, s.98.

24. See *Immigration Act*, R.S.C. ch. 1–2, amended by ch.49, 1992, 46.01, 114(1)(s).

25. See the *Immigration Act*, as modified by Bill C-86, ss. 46.01, 114(1)(s).

26. See the "Haitian Refoulement Case" I.J.R.L. Vol. 6 (1), 1994.

27. In Hailbronner, *supra* note 16, at 41.

28. At the time of writing, the MOU was not yet signed, but according to media reports its signature may be imminent. See the Toronto Globe & Mail, Tuesday, February 14, 1995.

29. See "Canada Tightening Refugee Law, Takes Step Toward Turning Asylum Seekers Back to the U.S." *Refugee Reports*, September 30, 1992. At 7.

30. Words by Sergio Marchi, Minister of Immigration and Citizenship, in an interview for *The [Toronto] Globe & Mail*, Feb. 14, 1995.

31. See Canadian Council for Refugees, Resolution 23, June 1994

32. See *Refugee Reports, supra* note 29, and Helton, A. "Toward Harmonized Asylum Procedures in North America: The Proposed United States-Canada Memorandum of Understanding for Cooperation in the Examination of Refugee Status Claims from Nationals of Third Countries." Cornell Int'l L. J., 26, 1993. ◻

The Demographic Psychosocial Inventory: A New Instrument to Measure Risk Factors for Adjustment Problems Among Immigrants

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Abstract

Objective—The purpose of this study was to develop and test the Demographic Psychosocial Inventory (DPSI), a self-report questionnaire that assesses demographic and background characteristics of immigrants, and psychosocial risk factors of demoralization.

Method—Based on a review of instruments used to study immigrants, and researchers' experience in this area, an 85-item questionnaire was developed that includes 10 scales and three general indices. Subjects are asked to indicate their level of satisfaction with various aspects of their lives, their reasons for immigration, and problems they had encountered since they immigrated.

Results—DPSI (Demographic Psychological Inventory) was tested on 1,200 adult immigrants who came to Israel from the former USSR since 1989. The reliability of the scales and general indices was generally high as measured by Cronbach's Alpha. For one general index and two scales it was above .78, for one general index and two scales it was between .60 and .73, for one general index and two scales between .41 and .55, and for one scale .23. The general indices were highly correlated with the Psychiatric Epidemiology Research Interview Demoralization Scale (PERI-D) and the Brief Symptom Inventory (BSI). The results suggest that the greatest risk factors of demoralization are a greater number of distress sources, difficulty in dealing with conflict, greater discrepancy between actual difficulties encountered and those expected, and more reasons for immigration. The single most important variable in predicting a demoralization case was the number of distress sources. We developed DPSI cutting points for *caseness* based on comparisons to BSI and PERI-D. For the BSI, DPSI cutting points are .44 for males, and .48 for females. These cutting points recognize about 61% of those who are cases according to BSI, and about 72% of those who are not cases according to BSI. For the PERI-D, DPSI cutting points for caseness are .42 for males and .44 for females. These cutting points recognize about 63% of those who are demoralized according to PERI-D and about 68% of those who are not demoralized according to PERI-D. DPSI tends to recognize slightly more cases as being at risk of demoralization than those who are demoralized according to PERI-D, and slightly less than those identified as cases according to BSI.

Conclusions—DPSI is a promising instrument for gathering demographic and background characteristics of immigrants, and for studying psychosocial risk factors for development of demoralization. DPSI is available in English, Hebrew, and Russian.

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Background

Immigration and Mental Health Problems

Immigration is a stressful event than can have long-lasting and far-reaching consequences leading to an increased risk of psychosocial problems (Rack 1988, Williams et al. 1991). Research has found that immigrants have higher rates of schizophrenia (Wijesinghe et al. 1991), hospitalization for mental illness (Dean et al. 1981, Glover 1991, Harrison 1990), and increased risk of suicide (Stack 1981, Trovato 1986) and suicide ideation (Ponizovsky et al. 1994). Grove, Clayton, and Endicott (1986) found a stable connection between primary affective disorder and familial immigrant status. Beiser (1988) reports a similar connection between immigration and depression. Others have not confirmed this relationship (Noh et al. 1992).

Yet, while immigration unsettles the external and the internal world of the individual, it does not always lead to maladjustment (Grinberg et al. 1989, Scott et al. 1989). Rather, individual factors moderate the level of adjustment in immigration. Among these factors are: personal and social premigration problems, e.g., refugees who went through traumatic experiences and psychological distress (Grinberg et al. 1989, Scott et al. 1989); post-migration factors (i.e., unemployment and economical problems) (Jayasuriya et al. 1992); and the culture gap between the country of origin and the country of immigration (the greater the gap, the greater the risk of adjustment problems) (Berry 1979). An additional risk factor is the loss of occupational status, which may affect the self-esteem of immigrants and often result in depressive reactions (Berry 1979, Grinberg et al. 1989, Itzigsohn et al. 1989, Jayasuriya et al. 1992, Scott et al. 1989).

The resilience factors include the immigrant's attitude towards migration and towards the host country, motivation for immigration, and the extent to which immigration was voluntary (Grinberg et al. 1989, Jayasuriya et al. 1992, Scott et al. 1989), the level of identification with the host culture and

its values (Epstein 1992), and re-establishment of a social network (Kuo et al. 1986).

The recent increase in immigration has been accompanied by studies of psychiatric symptomatology associated with immigration. For example, recent studies have focused on Iranians in Canada (Bagheir 1992), Arabs in the United States (May 1992), Latinos in the United States (Ring et al. 1991), Greeks in London (Mavreas et al. 1990), Mexicans in the United States (Rodriguez et al. 1990), Turks in Germany (Weyerer et al. 1992), and Koreans in Canada (Noh et al. 1992).

Proportionate to the size of the country, the mass immigration of Jews from the former USSR to Israel, which started in 1989 and has been ongoing since, has been one of the largest immigrations in modern history. It presents the State of Israel with the challenge of integrating about 500,000 new immigrants, which is over 10% of Israel's original population. As the influx of immigrants grew, it became evident that in addition to catering to employment and housing needs, attention had to be given to the psychological adjustment and wellbeing of the immigrants. Elevated levels of psychological distress among these immigrants were first noted through informal community channels and through the mass media. Increasing numbers of immigrants applied for treatment in mental health clinics, despite their culturally-determined reluctance to seek help from mental health professionals (Brodsky 1988, Levav et al. 1990).

The yearly psychiatric admission rate for new immigrants to Israel in 1990–91 was about 35% higher than for the general population (Horowitz et al. 1992). According to clinical reports, emotional reactions of depressive colouring, ranging from mild to severe, seemed prevalent among Soviet immigrants. Indeed, 20.6% of the new immigrants admitted during 1990–91 into psychiatric hospitals were diagnosed as suffering from depression, as compared to 13.4% of veteran Israelis admitted during the same period (Horowitz et al. 1992). About twice as many Soviet immigrants to Israel have sought mental health services than they had when they were still in Russia (Levav et al. 1990).

Several studies have focused on Soviet Jewish immigrants to Israel and the United States. The studies suggest varying degrees of negative effects and some positive effects. Many of these studies have measured levels of demoralization using the Psychiatric Epidemiology Research Interview Demoralization Scale (PERI-D), which is a measure of nonspecific psychological distress. Soviet immigrants in Israel and the U.S. were found to be more demoralized than the indigenous population (Flaherty et al. 1986, 1988; Lerner et al. 1991; Ritsner et al. 1993). Soviet immigrants to the U.S. were more demoralized than those to Israel (Flaherty et al. 1988). Flaherty (1986) found that demoralization levels among Soviet immigrants to Chicago increased during the first three or four years in the U.S. and then tapered off, and that they were highest among older individuals, women, and those with weak social support systems. Similarly, Ritsner and Ginath (1994) found higher levels of demoralization among Soviet immigrants aged 55 to 64 than immigrants younger or older, and higher levels among females than males. The effect of age on increased demoralization was confirmed in another study that also found concomitant increases in depression and somatization (Kohn et al. 1989).

The relationship between depression and psychosomatic disorders among immigrants, and how such problems by parents affect children's adaptation, was explored among Soviet Jewish immigrants to Canada (Barankin et al. 1989). Immigrants with depression and psychosomatic illness reported greater behavioural, academic, peer-interaction, and child-parent difficulties in their children. Those who were married, were proficient in English, were professionals, and had supportive friends, were more likely to adapt well. Among the positive effects of immigration was greater cohesiveness among married couples as they faced common difficulties in a strange environment (Hartman et al. 1986).

Mental health professionals in Israel have become alerted to the needs of Soviet immigrants and growing efforts are being devoted to providing treatment, primary prevention, and to research (Lerner et al. 1993). Much of this work focuses on immigration as a crisis situation (Hertz 1988) that can result in demoralization due to maladjustment and culture shock. Typically, these problems begin in the first year following immigration.

Instruments used in Studies of Immigrants

Previous studies on immigration have used instruments that tap psychological distress and psychiatric symptomatology but, for the most part, collect little demographic and social information and make no attempt to examine the social and demographic risk factors. The instruments used in previous studies have included: (1) PERI-D, Psychiatric Epidemiology Research Interview Demoralization Scale (Flaherty et al. 1988, Kohn et al. 1989, Zilber et al. 1993); (2) standardized Symptom Check List-90 (SCL-90) (Roskin 1986, Westermeyer et al. 1983) and its short form, Brief Symptom Inventory (BSI), (Aroian et al. 1989); (3) Midtown Psychiatric Impairment Index (Kuo 1976); (4) CES-D scale (Center for Epidemiological Studies Depression scale) (Kuo 1976, Vega et al. 1986); (5) Cornell Medical Index-Health Questionnaire (Sayil 1984); (6) the Bradburn Morale Scale (Lipson et al. 1989); (7) GHQ General Health Questionnaire (Fichter et al. 1988); (8) Self-Rating Depression Scale (Westermeyer et al. 1983); (9) Cornell Medical Index and Social Readjustment Rating Scale (Masuda et al. 1980); (10) Langner 22 Item Screening Scale of Psychopathology (Cochrane et al. 1977); (11) Social Readjustment Rating Questionnaire (SRRQ) (Schleifer et al. 1979); and (12) Self-Reporting Questionnaire (SRQ) (Upadhyaya et al. 1990). These instruments have been useful in producing descriptive profiles of the psy-

chological state of immigrants. However, since they do not include questions about current living situation and circumstances before immigration, they have not been able to identify risk factors for psychological distress.

The current study attempted to build the Demographic Psychosocial Inventory (DPSI) as an instrument: (1) to provide a reliable and standardized measure of demographic and background characteristics of immigrants; (2) to measure some dimensions related to psychological distress among immigrants; and (3) to identify immigrants who may need help or who are at risk. This paper describes the instrument, how it is scored, and the results of reliability and validity studies.

Method

Instrument Development and Description

Items in the DPSI were derived from the experience of helping many immigrants, and from a review of instruments used in immigrant studies. After two years of pilot testing, DPSI was revised. DPSI consists of 85 self-report questions, 10 scales, and three general indices. The questions ask about demographic variables, life satisfaction and health before immigration, reasons for immigration, and problems encountered since immigration. There are 14 general demographic questions. The remaining 71 items are grouped into pre-migration and post-migration scales and three general indices in Table 1.

Four scales concern pre-migration: (1) Professional Level (2 items), which assesses vocational level, (2) Immigration Reasons (10 items), which is an inventory of possible reasons that the person immigrated, (3) Pre-migration Life Satisfaction (6 items), which gauges the extent to which the person was satisfied in life before immigrating, and (4) Pre-migration Health Problems (1 item), which asks about pre-migration health.

Six scales and five single items concern post-migration: (1) Distress Sources (17 items), which is an inventory of facets of everyday life that cause distress, e.g., housing problems, family problems, language problems, climate, and some personal dimensions such as family problems, personality problems, depression, and anxiety of the future, (2) Commitment to new country (4 items), which assesses a person's commitment to remaining in the country, (3) Job Adequacy (2 items), which asks about current employment, (4) Health-Seeking Intentions (15 items), which asks respondents if they are in need of help from any of 15 different health care professionals, (5) Help-Seeking Behaviour, which asks whether a person sought the help of any of five different helping professionals, and (6) Current Health Problems. The single items ask about Conflict Reaction, i.e., distress level when faced with conflict, Unexpected Difficulties, i.e., extent to which difficulties encountered in adjustment were as expected, satisfaction with medical care provider, social support upon arrival in Israel, and whether the person takes sedative or hypnotic drugs. There are three summary indices: Global, Family Strain, and Health Problems.

Scoring, Reliability and Validity

Scoring of each scale and index is described in the scoring guide that comes with the DPSI. DPSI was tested for reliability of indices and for convergent validity as compared to the PERI-D (Psychiatric Epidemiology Research Interview Demoralization Scale (Dohrenwend et al. 1980), and the BSI (Brief Symptom Inventory) (Derogatis et al. 1982, 1983).

The PERI-D is a 27-item instrument developed by Dohrenwend and colleagues that measures demoralization. Demoralization has been defined as a predicament for which the person sees no solution (Frank 1973). PERI-D was designed, and has been used, as a screening instrument to measure psychological distress among a wide spectrum of populations (Dohrenwend et al. 1980, 1986; Levav et al. 1991).

PERI-D was designed to tap nonspecific indicators of distress and includes items common to rating scales measuring anxiety, depressive, and psychoso-

Table 1. DPSI Scales and Indices Among Russian Immigrants (n=966)

Scale	Mean	Std. Dev.	Min.	Max.	Cronbach's Alpha	Number of items
Pre-migration Scales						
Professional Level	.94	.13	.38	1	.87	2
Immigration Reasons	.69	.16	.18	1	.41	10
Pre-migration Life Satisfaction	.71	.24	0	1	.60	6
Pre-migration Health Problems	.16	.28	0	1	—	1
Post-migration Scales						
Distress Sources	.52	.18	0	1	.73	17
Commitment to New Country	.26	.28	0	1	.45	4
Job Adequacy	.60	.18	0	1	.23	4
Health-Seeking Intentions	.20	.19	0	1	.79	15
Help-Seeking Behaviour	.17	.19	0	1	.44	5
Current Health Problems	.21	.30	0	1	—	1
General Indices						
Global	.46	.11	.16	0.84	.55	70
Family Strain	.47	.17	0	1	.64	6
Health Problems	.22	.15	0	0.84	.81	25

matic symptoms. It is composed of fixed-format items about the frequency of psychological complaints in the past year. Responses are given on a 5-point scale ranging from "never" to "very often." The higher the PERI-D score, the more pronounced the demoralization.

Reliability and validity tests of PERI-D in the United States and Israel have found satisfactory results (Dohrenwend et al. 1986). It has been widely used in Israel (Fenig et al. 1991, Flaherty et al. 1988, Gilboa et al. 1990, Lerner et al. 1991, Zilber et al. 1993).

The BSI (Brief Symptom Inventory) provides a finer assessment of the severity and nature of psychological distress than the PERI-D. A shortened version of the better known Hopkins Symptom Checklist, SCL-90 (Derogatis et al. 1982, 1983), it is a 53-item self-report inventory. The subjects respond on a 5-point scale from "not at all troubled by ... during the last year" to "troubled a lot by ... in the last year" to a list of psychological symptoms. The analysis of BSI scores supplies quantitative indices of severity of distress and profiles that correspond to standard clinical syndromes.

Reliability and validity tests of BSI have found satisfactory results. Reliability of the 9 symptoms and the three global indices have been tested for internal consistency that ranged from Alpha 0.71 to 0.80. Test-retest coefficients ranged from 0.68 to 0.90.

Subjects

The DPSI, PERI-D, and BSI were administered to two groups of adult immigrants who came to Israel since 1989. The first group consisted of a convenience sample of 966 immigrants aged 18 to 87 in Jerusalem, Tel Aviv, and Beer-Sheva. They were administered study instruments between 1991 and 1993. Respondents were from typical immigrant gathering places, e.g., professional retraining courses, temporary accommodations at hotels, social services for immigrants, and Hebrew-language instruction courses. At each site data were collected from approximately 75% of the immigrants present at the time. On average, respondents were 39.3 years old (st. dev. 12.9). About 54% had immigrated within 12 months of the study, 42% within 1 to 2 years, and 4% within 25 to 30 months. The average time in Israel was 12.5 (st. dev. 7.8) months. The male/female ratio was 1:1.4. About 67% were married, 13% single, 19% divorced and widowed, and 1% unknown. About 80% were university graduates, 13% had vocational training, 5% were high school graduates, and 2% had grade-school education.

Table 2. DPSI Items with Gender Differences in Responses

	Males		Females			
Scale	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**t**	**p**
Pre-migration Scales						
Immigration Reasons	.67	.17	.71	.15	3.50	.000
Post-migration Scales						
Distress Sources	.49	.18	.53	.18	3.60	.000
Job Adequacy	.62	.19	.58	.17	3.73	.000
Health-Seeking Intentions	.17	.20	.21	.19	3.48	.001
Help-Seeking Behaviour	.15	.19	.19	.19	2.81	.005
General Indices						
Global	.44	.11	.47	.11	3.50	.000
Family Strain	.44	.15	.49	.18	4.60	.000
Health Problems	.18	.29	.23	.31	2.68	.007
Single Items						
Use Sedative Drugs	.21	.41	.32	.46	3.50	.000
Conflict Reaction	.66	.35	.76	.31	4.99	.000
Unexpected Difficulties	.50	.47	.56	.47	2.05	.040

The second group consisted of 125 psychiatric outpatient immigrants with mental disorders, and 250 respondents who were matched with outpatients for age, gender, and time in Israel. Most of the outpatients had had at least one psychiatric hospitalization. In addition to completing the study instruments, patients had a complete physical examination, and were interviewed by two psychiatrists who used psychiatric rating scales (Brief Psychiatric Rating Scale, Hamilton Depression Scale).

Results

The mean scores, range on indices, and reliability as measured by Cronbach's Alpha are presented in Table 1. As can be seen, Professional Level, Pre-migration Life Satisfaction, Distress Sources, Health-Seeking Intentions, Family Strain, and Health Problems indices had Cronbach's Alpha reliability coefficients of at least .60, indicating a high degree of internal consistency. The Global Index almost reaches .60 level. Subjects found the DPSI easy to use and understand.

As shown in Table 2, there are statistically significant gender differences on six scales and three general indices and on two single questions. Females had more Immigration Reasons, Conflict Reactions (a measure of emotional reactivity to conflict situations), Distress Sources, Health-Seeking Intentions, Help-Seeking Behaviour, Family Strain, Health Problems, Unexpected Difficulties, i.e., greater discrepancy between actual difficulties encountered and those expected, use of sedative drugs, and a higher global index, than males. Females had less Job Adequacy than males.

Pearson's product-moment correlations between all DPSI scales, indices, and single items with correlations greater than .30 are presented in Table 3. Where differences in correlations for males and females existed, they were indicated with female correlation preceding male correlation. For example, Pre-migration Health Problems were less highly correlated for women (.37) than for men (.49) with current health

Table 3. Selected Correlations (>0.30) of DPSI Scales and Indices

DPSI Dimensions	PL	PMH	DS	HSI	HSB	CHP	HPI	GI
Pre-migration Health	—/-.31	1	—	—	.39	.37/.49	.48/.37	.41
Distress Sources	—/.30	—	1	.34	—	—	.41	.56
Commitment to New Country	—	—	—	—	—	—	—	.34
Health-Seeking Intentions	—	.33/—	.34	1	.33/—	—	.92	.43/.30
Help-Seeking Behaviour	—	.39	—	.33/—	1	.46	.60	.42
Current Health Problems	—	.42	—	.40	.39/.49	1	.46	.42

Notes: Coefficients for females/males presented if there is more than .10 difference between them, or the appropriate coefficient is missing. Single coefficients are males and females together. **PL**–professional level, **PMH** – premigration health, **DS** – distress sources, **HSI** – health-seeking intentions, **HSB** – help-seeking behaviour, **CHP** – current health problems, **HPI** – health problem index, **GI** – global index

problems. In a few cases, e.g. Professional Level and Pre-migration Health and Distress Sources, there was only a meaningful correlation for females. As can be seen, Global and Health Problem indices were the most highly correlated with the other indices. This was expected since these indices include many of the scales.

We examined the relationship between the DPSI items, scales, indices, age, and length of time in Israel. The following had correlations with age greater than r=.25: Pre-migration Health Problems (r=.40), Current Health Problems (r=.29), Global Index (r=.32), and Health Problem Index (r=.30). Only Job Adequacy Index was correlated with time in Israel (r=.25).

Comparison of Psychiatric Outpatients and Non-patients

We compared the results of scale and single items for 125 psychiatric outpatients and 231 immigrants who were not known to be in psychiatric treatment. (Because of some minor changes in the DPSI scoring, these means cannot be compared to the first group means as presented in Table 1.) We found the following significant differences ($p<.05$) in means using t-tests: patients had fewer Immigration Reasons (.27) than did controls (.29), lower Pre-migration Life Satisfaction (.56 vs. .39), more Pre-migration Health Problems (.66 vs. .39), more Distress Sources (.57 vs. .51), more Current Health Problems (.92 vs. .49), and more Help-Seeking Behaviour (.50 vs. .2). In general, the outpatients tended to have had more life difficulties prior to immigration and more difficulties since coming to Israel than the non-patients.

Validity

To validate the DPSI we compared it to concurrent PERI-D and BSI scores. We used both instruments because the BSI measures specific symptoms and the PERI-D measures generalized distress. We examined correlations between DPSI scales and PERI-D. Five scales correlated greater than r=.25 with PERI-D. These were: Distress Sources (r=.49), Help-Seeking Intentions (r=.30), Help-Seeking Behaviour (r=.28), Global index (r=.53) and

Table 4. Selected Pearsonian Correlations (above r=.3) of DPSI and BSI Dimensions.

DPSI/BSI Scales	Smzn	Obs. C.	IS	Depr.	Anx.	PI	Host.	Psych.	PA	GSI
Distress Sources	.37	—	—.35	.41	.43	—	.30	.31/—	—	.44
Health Seeking intentions	.38/—	.31/—	—	—	—	—	—	—	—	.32/—
Help Seeking Behaviour	.34	—	—	—	—	—	—	—	—	—
Pre-migration Health	.37	—	—	—	—	—	—	—	—	—
Health Index	.45	.36	—	.30/—	.34/—	—	—	.32/—	.32/—	.39
Current Health Problems	.34/—		—	—	—	—	—	—	—	—
Global Index	.46	.38	—/.38	.48	.49	.33	.32	.35/—	—	.50

Notes: Coefficients for females/males presented if there is more than .10 difference between them, the appropriate coefficient is missing. Single coefficients are males and females together. **Smzn** – somatization, **Obs. C** – obsessive compulsive, **IS** – Interpersonal sensitivity, **Depr.** – depression, **Anx.** – anxiety, **PI** – paranoid ideation, **Host** – hostility, **Psych** – psychotocism, **PA** – phobic anxiety, **GSI** – global severity index.

Table 5. Sensitivity and Specificity of DPSI Risk of Demoralization
(As compared to the PERI-D demoralization cutting points and BSI caseness cutting points.)

	DPSI at Risk of Demoralization			
	Males (N=397)		Females (N=569)	
Demoralized[1]	No	Yes	No	Yes
PERI-D				
No	72% (N=134)	36.5% (N=77)	65.4% (N=170)	36.6% (N=113)
Yes	28% (N=52)	63.5% (N=134)	34.6% (N=90)	63.4% (N=196)
BSI Case[2]				
No	70.7% (N=130)	29.3% (N=54)	75.0% (N=231)	25.0% (N=77)
Yes	36.6% (N=78)	63.4% (N=135)	40.2% (N=105)	59.8% (N=156)

Notes: 1. For males kappa=.35, for females kappa=.29
2. For males kappa=.34, for females kappa=.35

Health Problem index (r=.41). An analysis of the correlation of DPSI and BSI scales is presented in Table 4. As can be seen, the Global index, Distress Sources, and Health Index were the most highly correlated with BSI scales. The BSI Somatization index is the most highly correlated with DPSI scales, followed by the BSI Global Severity Index.

DPSI Risk Cutting Points

To see to what extent DPSI was helpful in identifying people who were at risk of being demoralized, or at risk of psychopathology, we established DPSI cutting points relative to the PERI-D demoralization cutting points [1.23 males, 1.51 females (Fenig et al. 1991, Gilboa et al. 1990) based on Shrout et al. (1986)], and psychopathology cutting points of BSI [GSI=.58 males, .78 females (Derogatis et al. 1982, 1983)]. For the PERI-D, we found that the optimal DPSI Global index cutting points were .42 for males and .44 for females, which we call "at risk of demoralization." According to PERI-D, 47% of males and 50% of females were demoralized. According to DPSI, 53% of males and 54% of females were at risk of demoralization. The comparison in identifying cases between DPSI and PERI-D is presented in Table 5. It will be seen that DPSI cutting points recognize about 63% of males and females who are demoralized according to PERI-D, and a combined average of about 68% (males=72%, females=62%) of those who are not demoralized. DPSI tends to recognize slightly more cases as being at risk of demoralization than the number of those who are demoralized according to PERI-D.

We developed similar cutting points relative to the BSI psychopathology cutting points. The DPSI Global index cutting points that best corresponded with BSI cutting points were .44 for males and .48 for females. According to BSI 46% of males and 54% of females were "cases." The comparison in identifying cases is presented in Table 5. As can be seen, DPSI cutting points recognize a combined average of males and females of about 61% of those who are cases according to BSI, and an average of about 72% of those who are not cases according to BSI. DPSI tends to recognize slightly fewer respondents as being cases than those who are cases according to BSI.

Table 6. Multiple Regression Models Predicting PERI-D Score and BSI Global Severity Index
(Using DPSI Indices and single items not included in indices)

	PERI-D Score				BSI Global Severity Index			
	Model 1 Males		Model 2 Females		Model 3 Males		Model 4 Females	
	R=.62	R^2=.38	R=.59	R^2=.35	R=.60	R^2=.36	R=.57	R^2=.33
Variable or Index	**B**	**Beta**	**B**	**Beta**	**B**	**Beta**	**B**	**Beta**
Distress Sources	.95	.30	1.04	.29	.86	.31	.78	.25
Conflict Reaction	.36	.22	.37	.17	.31	.21	.28	.15
Take sedatives or hypnotics	.14	.09	.19	.13	—	—	.13	.10
Help-Seeking Behaviour	.45	.14	.37	.11	.44	.16	.44	.14
Unexpected Difficulties	.16	.13	.16	.11	.10	.09	.14	.11
Immigration Reasons	—	—	—	—	.49	.17	.34	.09
Health-Seeking Intentions	—	—	.39	.11	—	—	.35	.11
Commitment to New Country	—	—	.26	.09	.16	.09	.22	.11
Pre-migration Life Satisfaction	—	—	—	—	-.24	-.11	—	—
Relatives in Israel	.19	.15	—	—	.16	.14	—	—
Pre-migration Health Problems	.19	.10	—	—	—	—	—	—
Professional Level	—	—	—	—	—	—	-.48	-.10
Constant	.29	—	.32		.27		.10	

The next two models predict the BSI Global Severity Index based on DPSI scales and single items not included in scales. As can be seen in Table 6, using 9 variables for males and 8 for females, we obtained an R^2 above 0.32. The models for males and females are similar.

Discussion and Conclusion

The results suggest that DPSI is a promising instrument for collecting descriptive information about immigrants and for detecting psychological distress. The strong relationship between DPSI, PERI-D, and BSI suggests that DPSI is able to tap levels of psychological distress in the process of assembling a psychosocial profile of immigrants. The results suggest some factors that are particularly salient in developing psychological distress. The greatest risk factors of demoralization are a greater number of distress sources, difficulty in dealing with conflict, greater discrepancy between actual difficulties encountered and those expected, and more reasons for immigration. The single most important variable in predicting demoralization caseness was the number of distress sources.

The major difference between the DPSI, PERI-D, and BSI is that PERI-D and BSI measure a person's state of being based on behaviour, while DPSI helps to identify reasons for a person's state of being and thereby helps to identify at-risk groups because it taps items that are precursors of demoralization. DPSI is designed to help learn about stressors and life events specific to immigration, and their relationship to demoralization.

DPSI is a promising instrument for gathering demographic and background characteristics of immigrants, and psychosocial risk factors for development of demoralization. We are constantly adding new subjects to our database of immigrants. Future research is being planned to learn more about the psychosocial adjustment of immigrants. ■

Notes

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