PSYCHOPATHOLOGY AND LONG-TERM ADJUSTMENT AFTER CRISES IN REFUGEES FROM EAST GERMANY

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SUMMARY

Objective: In this study we examined psychopathology, diagnoses, social adjustment and the course of symptoms over two and a half years in East German refugees who suffered a crisis immediately after migrating to West Berlin just prior to or shortly after the breaching of the Wall in autumn 1989.

Methods: One hundred and twenty two refugees seeking crisis intervention in a psychiatric outpatient unit after arrival were investigated. Six months later 59% and two and a half years after migration 30% of the patients were re-examined.

Results: The patients had been exposed to prolonged stress situations in East Germany and were suffering from anxious-depressive syndrome with vegetative complaints. Sixty patients required more than one crisis intervention during the first six months after resettlement. During the follow-up period symptoms decreased significantly. At the second follow-up interview 81% of the patients had a satisfactory job, and 89% acceptable accommodation.

Conclusions: Satisfactory classification of the psychiatric disorders induced in East German refugees by prolonged stress was not possible according to the DSM-III-R criteria. Initial crises are not necessarily associated with poor long-term adjustment after migration.

INTRODUCTION

Following migration social problems and psychological complaints may develop during the process of adjustment to the new environment. Empirical studies have found a greater prevalence of psychiatric disorders among refugees than among the general population (Eitinger, 1959; Malzberg, 1969). Buchwald *et al.* (1993) reported frequent psychiatric disorders (most commonly adjustment reactions, marital/family problems and paranoid schizophrenia) among recently arrived Eastern Europeans receiving treatment at a refugee counselling service in Seattle, USA. There is empirical evidence that mental disturbances may not only be influenced by migration itself or subsequent adjustment problems but can also be induced by political stress situations prior to migration. These include measures used by totalitarian regimes such as psychological and physical torture, repeated imprisonment, deportation and traumatising threats (Westermeyer *et al.* 1983; Kinzie *et al.* 1984, 1990; Mollica *et al.* 1987; Allodi, 1991; Carlson & Rosser-Hogan, 1991; Pribe *et al.* 1992; Bauer *et al.* 1993; Gorst-Unsworth *et al.* 1993; Hauff & Vaglum, 1993).

The Second World War led to the division of Germany into two parts with completely different political systems. East Germany became the German Democratic Republic

(GDR), except for the western part of Berlin, which remained attached to the rest of West Germany, the Federal Republic of Germany (FRG). In 1961 a wall was built between East and West Germany and around West Berlin in order to prevent people from leaving the German Democratic Republic. From then on East German citizens were unable to travel freely or to visit West Germany, including West Berlin or other Western countries.

In 1989 there was a dramatic change in the political situation in Eastern Europe and the "Iron Curtain" began to rise. In September 1989 the Hungarian Border was opened to East Germans and later the Czechoslovakian border, and thus East Germans could travel from East to West Germany via Hungary and Austria with little difficulty. On November 9, 1989 the wall between the two Germanies was breached. Taking advantage of these unexpected changes during the autumn of 1989, several thousand people left the GDR each day. For various reasons many of these people intended to live in West Berlin. It was suggested that they might be at risk of developing crises situations because of overstimulation in Western life and adjustment problems. This led us to conduct a prospective longitudinal study in refugees who had left the GDR just prior to or shortly after the breaching of the Wall, and who sought psychiatric help on an outpatient basis in crises situations within six weeks of arrival in West Berlin. The objectives of this study were to investigate a) psychopathological symptoms; b) diagnoses; c) clinical course; and d) long-term social adjustment in these East German refugees at follow-up examinations after six months and after two and a half years.

METHODS

Setting

The study was carried out in an outpatient unit (costs were covered by health insurance). This unit is situated in the centre of West Berlin and was particularly well known among persons who had fled from East Germany to West Berlin during the previous ten years. At that time four psychiatrists and two psychotherapists were working in the practice, which was usually open from 7.30am. to 10.00pm.

Procedure and crises interventions

The refugees were accepted for the study in the order in which they presented for psychiatric help during a crisis within six weeks of their arrival in West Berlin between November 13 (four days after the breaching of the Wall) and December 7, 1989. A crisis was defined as any situation in which the patient considered that he or she required immediate therapeutic interventions (Caplan, 1964). Patients who sought psychiatric advice or help but did not consider themselves in a crisis as defined above were not included in this analysis (Priebe *et al.* 1990; Parad & Parad, 1991). In the present case crisis intervention always comprised an interview of between 30 and 60 minutes with a psychiatrist. If necessary, medication was prescribed at the end of the interview. The patients were also informed how they could find social support in the Western system. Patients were offered the opportunity to come back to the practice whenever they felt they needed advice, emotional support or medical help.

Patients with schizophrenia, bipolar disorders, organic mental disorders, substance dependencies, chronic or severe physical disorders, and those younger than 18 or over 60 years of age were excluded from the study. Participation in the study was voluntary and not associated with any obvious advantages for the patients.

Patients' past medical history and clinical assessment

The patients' sociodemographic data, employment career, previous mental health problems, motivation for the migration, and psychological distress before, during and after migration were assessed in a semistructured interview schedule developed specifically for the study. The interview contained open questions, pre-coded answers, and clinical rating scales. Psychopathology was evaluated using the Hamilton Anxiety Rating Scale (HAMA: Hamilton, 1959), the 21-item Hamilton Rating Scale for Depression (HAMD: Hamilton, 1960) and the Global Assessment of Functioning Scale (GAF, according to Axis V of the DSM-III-R). Diagnostic classification was made on Axes I and II of the DSM-III-R system (American Psychiatric Association, 1987). The current life situation and psychopathological ratings were assessed three times: the first examination was carried out after the crisis intervention during the first six weeks after arrival in West Berlin, and two follow-up examinations after six months and two and a half years respectively. At the follow-up interviews the patients were seen by the same psychiatrist who had made the first evaluation (for further details see Priebe *et al.* 1990, 1993).

RESULTS

Subjects

Overall, 122 patients (79 women, 43 men) were included in the study; 15 patients who otherwise met the inclusion criteria refused to take part in the study. The ages of the participants ranged from 18 to 59 years (mean = 31 ± 8.1). The mean time between departure from East Germany and the first interview in West Berlin was 16 days (SD = 10.8; range: 4-40 days). Seventy-nine percent had completed 10 or more years of schooling. Eleven percent held university degrees, 80% had completed other kinds of occupational training, and 9% had no vocational qualifications. At the time of the first interview 66% were living with a partner and 59% with children.

Exposure to stressful events before and during migration

The patients reported that they had made the decision to leave East Germany between 24 hours and 8 years before they were able to do so. On average the time between the decision to leave and actual departure was 21.8 ± 20.3 months. Following the decision to leave most patients either attempted to cross the border, failed and were subsequently imprisoned (18%), or made an official application for permission to leave (53%). Thirty-four percent had fled to other Eastern bloc countries (Hungary, Poland, Czechoslovakia) on their way to West Berlin. In the meantime those people who placed an application for permission to leave were subjected to unpredictable and arbitrary acts of repression by state authorities, eg. confiscation of their identity cards, frequent summonses and interrogations, exclusion of their children from higher school education and university

study, surveillance at home and at work, job degradation, prohibition from travelling to other Eastern bloc countries or even within the GDR, and other forms of harassment. The decision to leave the GDR was followed by a period of uncertainty because no one was certain when he or she would be allowed to leave. The duration of imprisonment, which often included psychological torture, varied between four and 160 weeks (mean = 34.7 ± 38.2). Thirty one percent had been forced by the state authorities in the GDR to do jobs that were clearly beneath their level of qualification because they had placed an application to leave the country or for other political reasons. The motives spontaneously reported by the patients for leaving East Germany were mostly their desire to travel freely (88%), political oppression (74%), family links in the West (57%), economic reasons (50%) and problems at work (41%).

Previous mental health problems and treatment in the GDR

Asked when the symptoms had occurred for the first time, 88% of the patients stated that they had suffered from the same symptoms in the GDR as they were having after migration. Sixty-six percent reported having had the same symptoms even immediately before they left. Only 12% stated that they had had the symptoms for the first time in their lives in West Berlin. In view of the fact that the decision to leave had been made on average 21 months before the actual departure, the patients were also asked whether the symptoms had started before or after they had made the decision. Fifty-two percent reported that their symptoms had begun at the time when or after they had made the decision to leave. Thirty-six percent of the patients had been receiving primary medical care or psychiatric treatment in the GDR because of their psychiatric symptoms. Five percent had been treated in a psychiatric hospital.

Stressful events on arrival in West Berlin

The first crisis occurred on average 16 days after arrival in West Berlin ($SD = 7.5$; range: one day to six weeks). On arrival in West Berlin 11% had nowhere to live and were housed in large numbers in sports halls; 37% were living in hostels for refugees, 34% in a flat together with friends or relatives, 10% in a small and unacceptable flat of their own, and 7% in a satisfactory flat of their own. Eighty-nine percent of the patients were without a job. Eighty-nine percent had left members of their family behind in East Germany and 24% had been separated from their partners during the migration process. Forty-four percent had no private contacts in West Berlin. The type and frequency of major stressful events before, during and after migration to West Berlin are summarised in Table 1.

Crises and psychopathology (first examination)

One hundred and seventeen patients presented for the first time at the psychiatric practice in West Berlin in a crisis. Five patients were not in a crisis when they first contacted the psychiatrist. These five patients later experienced a crisis and were then included in the study. The symptoms most often spontaneously reported by the patients during the first crisis are summarised in Table 2. Disturbed sleep, nervousness, headache, sadness, repeated crying, sweating, aggressiveness and exhaustion were the complaints most frequently mentioned at the first examination.

Table 2 also shows the mean values of the psychopathological evaluation. The score on the Hamilton Rating Scale for Depression (HAMD) ranged from 2 to 27

Table 1
Stressful events/factors in refugees from East Germany before and after migration to West Berlin

	%
<i>East Germany/Flight</i>	
Imprisonment	18
Repression by state authorities following official application to leave the GDR	53
Flight to Eastern European countries	34
Job degradation	21
<i>Postmigration/West Berlin</i>	
Adaptation to a completely different socioeconomic system	100
Separation from partner	24
No contact with other people	44
Unemployment	89
Nowhere to live (eg. accommodation in sport halls)	11
Living in hostels for refugees	37
No suitable flat	35

Table 2
Frequency of spontaneously reported symptoms¹ and mean ratings on the Hamilton Depression Scale (HAMD) and Hamilton Anxiety Scale (HAMA) at the first interview and 6-month and 2.5-year follow-up interviews

	First interview (N = 122)	6 month follow-up (N = 72)	2.5 year follow-up (N = 37)	P (McNemar Test) (1st-3rd interview)
Patients reporting > 1 symptom	100%	77%	42%	< .001
Disturbed sleep	81%	21%	11%	< .001
Nervousness	53%	35%	6%	< .001
Headache	48%	32%	14%	< .001
Sadness	37%	35%	12%	< .10
Repeated crying	35%	0%	0%	< .001
Perspiration	24%	11%	6%	< .005
Aggressiveness	24%	6%	5%	< .05
Exhaustion	24%	7%	6%	< .05
Agoraphobia	20%	10%	6%	< .05
Worries about future	19%	11%	0%	< .01
Loss of appetite	19%	1%	0%	< .05
Poor concentration	16%	5%	6%	NS
Loss of weight	16%	2%	0%	< .05
(paired t-test; (1st-3rd interview))				
HAMD	14.4 ± 4.7	9.0 ± 6.8	3.3 ± 4.4	< .001 (t = 12.8)
HAMA	16.9 ± 5.8	11.1 ± 7.7	3.8 ± 4.8	< .001 (t = 14.7)
GAF	59.6 ± 7.1	69.4 ± 10.1	76.2 ± 7.8	< .001 (t = 13.6)

¹ reported by more than 15% in the first interview; all tests were two-tailed

Table 3
Diagnoses according to DSM-III-R (N = 136)¹

	N
<i>Depressive disorders</i>	50
Major depression, single episode	22
Major depression, recurrent	7
Dysthymia	18
Depressive disorder not otherwise specified	3
<i>Anxiety disorders</i>	29
Anxiety disorders, not otherwise specified	5
Panic disorder, without agoraphobia	1
Generalised anxiety disorder	6
Panic disorder, with agoraphobia	1
Agoraphobia without history of panic disorder	3
Social phobia	6
Posttraumatic stress disorder	7
<i>Adjustment disorders</i>	41
Adjustment disorder with depressed mood	4
Adjustment disorder with anxious mood	6
Adjustment disorder with mixed emotional features	25
Other adjustment disorders	6
<i>Other diagnoses</i>	16
Sedative or hypnotic abuse	5
Eating disorder, not otherwise specified	1
Hypochondriasis	1
Somatoform disorder	8
Primary insomnia	1

¹ 14 patients received two diagnoses

(mean = 14.4 ± 4.7) and the score on the Hamilton Anxiety Rating Scale (HAMA) from 3 to 27 (mean = 16.9 ± 5.8). The mean GAF value was 59.5 (SD = 7.1, range: 40-75) at the first interview and highest 69.5 (SD = 10.9, range: 50-90) for the year before migration. Eighteen patients (15%) expressed suicidal thoughts during the first crisis intervention. However, no patient reported an actual suicide attempt at any of the three interviews.

Diagnostic classification

A total of 136 diagnoses were made on Axis I for the DSM-III-R after the first interview (Table 3). The most frequent diagnoses were: adjustment disorders (N = 41), major depression (N = 29), anxiety disorders (N = 22), and dysthymia (N = 18). Seven patients received a diagnosis of posttraumatic stress disorder (PTSD; trauma: political imprisonment with psychological torture). Fourteen patients were given two diagnoses. We classified 19 patients as having personality disorders on Axis II of the DSM-III-R: histrionic and avoidant (N = 5 each), schizoid, compulsive, narcissistic, personality disorder not otherwise specified (N = 2 each), and schizotypal (N = 1).

Six diagnostic groups were formed according to the principal DSM-III-R diagnoses and their psychopathologic symptoms compared with each other. These were: major

Table 4
Psychopathological ratings¹ in different diagnostic groups according to DSM-III-R at the first interview

	N	HAMD	HAMA	GAF
Major depression	29	18.1 ± 3.3	19.5 ± 4.5	53.8 ± 5.7
Dysthymia	17	15.1 ± 5.6	19.0 ± 5.7	57.2 ± 7.0
Anxiety disorders	19	12.5 ± 4.3	15.9 ± 6.1	58.9 ± 6.2
PTSD	7	15.0 ± 5.2	16.4 ± 4.9	59.1 ± 7.8
Adjustment disorder	41	13.4 ± 5.8	15.4 ± 5.8	63.5 ± 5.2
Somatoform disorder	7	11.7 ± 4.2	15.1 ± 6.8	65.3 ± 4.8

¹ mean scores of the clinical ratings

depression (N=29), anxiety disorders (N=19), dysthymia (N=17), somatoform disorders (N=7), adjustment disorders (N=41) and posttraumatic stress disorder (N=7). Table 4 summarises the mean values of the psychopathologic ratings for these groups. The degree of symptoms was moderate to severe in all of the groups, and the differences between the groups were neither striking nor specific.

Prediction of further crises

In 59 patients (48%) only one crisis intervention was carried out within six months of the first contact. Twenty-eight patients (23%) underwent crisis intervention twice, 11 (9%) three times and 10 (8%) four times. Four patients (3%) required crisis intervention five times and eight (7%) six times during the same period. Two patients came for crisis intervention seven and eight times respectively. No patient underwent crisis intervention more than eight times within six months of the first one.

We were further interested in investigating which of the patients would need crisis intervention more than once and which would not. Fifty-seven patients came for one crisis intervention only once (group 1), 60 had more than one crisis within six months of first presenting at the psychiatrist practice (group 2). Table 5 shows some characteristics of the patients in the two groups.

Differences between the two groups were not statistically significant. Other sociodemographic variables investigated also proved to be of no predictive value for the occurrence of further crises. We also compared the diagnoses and psychopathological symptoms of the two groups (Table 5). While patients with major depression and dysthymia tended to have more than one crisis, the opposite tendency was found in patients with anxiety disorders, including PTSD. Patients with more than one crisis intervention had both higher HAMD scores and higher HAMA scores after the first contact with the psychiatrist. Although these differences are statistically significant, they are fairly small. Thus, psychiatric diagnoses and degree of symptoms were associated with the need for further crisis interventions.

Follow-up examination after six months

Seventy two (59%) patients (44 women, 28 men) of the original sample came to the first follow-up examination. Fifty (41%) patients did not turn up at the follow-up interview.

Table 5
Characteristics, psychopathological symptoms and diagnoses of patients having undergone only one crisis intervention and of those having undergone more than one following the first contact with the psychiatrist

	1 Crisis (group 1) N = 57	> 1 Crisis (group 2) N = 60	P
<i>Sex</i>			
Female	34	41	NS ¹
Male	23	19	NS ¹
Age (years)	31.0	31.4	NS ²
<i>Symptoms</i>			
Before decision to leave	25	36	
After decision to leave	32	24	NS ¹
<i>Previous treatment</i>			
None	37	32	
Psychiatric	11	17	
General practice	9	11	NS ¹
HAMD	12.8	16.0	.001 ²
HAMA	14.8	18.8	.001 ²
	N ³	N ³	
Major depression	8	21	
Dysthymia	6	11	
Anxiety disorders	12	7	
PTSD	4	3	
Adjustment disorders	22	19	
Somatoform disorders	5	2	NS ¹

¹ Chi-square test; ² two-tailed t-test; ³ number of principal diagnoses

The group that attended, and the one that did not, did not significantly differ in any of the variables that had been recorded in the first interview. In the patients we examined the symptoms took a very positive course. Both the frequency of spontaneously reported symptoms and the scores on the clinical rating scales (HAMD, HAMA, GAF) decreased significantly during the first six months (Table 2). The mean GAF had increased from 59.6 ± 7.1 to 69.4 ± 10.1 (range: 45-88). During the first follow-up period 35 patients had been given antidepressants for a short period, 18 benzodiazepines, and nine neuroleptics. Eight patients had received short-term psychotherapy. Five patients had taken part in relaxation training. None of the 72 patients reported having sought psychiatric help from other sources.

The occurrence of more than one crisis was associated with a greater severity of psychopathological symptoms after the first follow-up period. The frequency of further crises following the first was significantly correlated to the clinical and self-ratings at follow-up. The coefficients of the correlations between the number of interventions and the scales ranged from .42 (HAMA) to .52 (HAMD), indicating that the more crises occurred, the greater the severity of symptoms was after six months.

After the first follow-up period 45% of the patients had found a flat and 44% had a more or less satisfactory job. While the housing situation did not differ between patients with only one and those with more than one crisis, patients who had only one crisis had significantly more often found a job ($p < .05$)

Follow-up examination after two and a half years

Thirty-seven patients (30% of the initial sample and 51% of the patients who were re-interviewed after six months; 23 women, 14 men) were examined a third time after two and a half years. These 37 patients had had lower scores in the clinical rating scales at the first follow-up examination after six months than the 35 patients who failed to return after two and a half years. However, these differences in the rating scales did not reach statistical significance. Moreover, we failed to find any differences between the two groups on sociodemographic variables. Both the frequency of spontaneously reported symptoms and the scores on the clinical rating scales were lower than at the first follow-up after six months (Table 2). Only two patients reported to have been in any sort of psychiatric treatment or crisis intervention between first and second follow-up. Ninety-two percent of the patients stated further improvement of symptoms. Only one patient reported a deterioration since the last interview. This last patient was admitted to a psychiatric hospital for treatment of depressive illness. Sixty percent of the patients reported that their symptoms subsided. Adjustment to life in the West was satisfactory in most cases. The mean score on the Global Assessment of Functioning Scale was 76.2 ± 7.8 (range: 53-88). Eighty-eight percent reported a general improvement in their life situation. Eighty-one percent of the patients stated that they had a satisfactory job, and 89% that they had satisfactory accommodation. In answer to an open question as to what had been most helpful for their adjustment, the patients most often mentioned talks with their partners (27%), talks with other family members (14%) or friends (10%), walking in the park, going to a theatre or other hobbies (16%) and a satisfactory job (10%). Two patients said that relaxation through self-hypnosis had helped, one patient mentioned talks with a physician.

DISCUSSION

While representative samples of refugees from East Germany have been investigated in other studies (Gunkel & Priebe, 1992) this sample was highly selective. It was heterogeneous as regards formal psychiatric diagnoses and sociodemographic variables, but completely homogenous in regard to life circumstances: all patients had moved from East to West Germany during the same period of time and had to start a new life in the West under similar conditions; all patients experienced a crisis situation and crisis intervention within the first six weeks of arrival in West Berlin; and all of them had to adjust to the Western system under the same historical conditions in Germany between 1989 and 1992. The patients in this study had been exposed to prolonged stress situations in the GDR and to additional distress during and after flight and migration to West Berlin. These prolonged stress situations may have triggered psychological and vegetative

symptoms particularly in those persons who tended to react to stressful situations in general by developing those symptoms.

The findings are contradictory to the assumption that most crises were caused by special adjustment problems in the West. While being in East Germany, most patients could easily attribute the symptoms to their unsatisfactory and uncertain life situation. Thus, many of them did not see any reason to consult a psychiatrist. On the other hand, they may have been reluctant to seek help from psychiatrists in a country with a communist system. When they arrived in West Berlin and the symptoms did not immediately cease, they may have found the same symptoms more bothersome because they no longer had an obvious explanation for them. The patients became more disconcerted, and consequently the symptoms were enhanced rather than overcome. An increasing disconcertedness and additional distress may have led to crises in many of the patients we examined.

At the time of the first crisis most patients were suffering from a syndrome of anxiety and depression accompanied by vegetative complaints and symptoms of increased arousal. Although this syndrome seemed fairly characteristic to us, according to the guidelines of the DSM-III-R it was necessary to make various diagnoses. In some characteristic aspects the syndrome resembles the mental sequelae of other political stress situations such as political persecution and the concentration camps in NS-Germany and Kampuchea, although the nature and duration of the stressors and symptoms of patients in this study were clearly less severe (Eitinger, 1980; Allodi, 1991; Mollica *et al.* 1987; Bauer *et al.* 1993; Carlson & Rosser-Hogan, 1993). In contrast to many concentration camp survivors (Eitinger, 1980; Westermeyer *et al.* 1983; Hauff & Vaglum, 1993) all refugees who were examined in this study resettled in a country with the same language and a similar cultural background, and were economically supported by the West German government.

Diagnostic classification was often difficult and unsatisfactory. This may be reflected by the fact that 7% of the patients received an NOS (not otherwise specified) diagnosis of some kind. Therefore more specific diagnoses for stress-induced psychiatric disorders might be needed.

Patients who were assessed as more severely ill and more distressed during the first crisis were more likely to experience one or more crises within the next six months. This finding is in line with a study by Mann *et al.* (1981) showing that the twelve-month outcome of patients with neurotic illness in general practice is best predicted by initial severity. Yet, data from patients' histories and the sociodemographic variables and clinical ratings assessed at the first interview did not allow a satisfactory prediction as to whether a given individual patient suffered more than one crisis. However, the occurrence of further crises is a clearly negative prognostic sign. Patients with two or more crises improved less during the next months and were less likely to find a job within that time.

The main finding of this study is the fact that the symptoms followed a very positive course over time. In the patients who were re-interviewed in follow-ups the symptoms improved markedly within six months when the stressful situation ceased following migration. After two and a half years the patients' social integration was satisfactory, and their psychopathologic symptoms were not significantly more frequent than in the general population (Schepank, 1987). It should be noted that this positive long-term adjustment

was seen in individuals who initially experienced severe crises following migration and showed psychiatric disorders with at least moderate symptoms. Thus initial crisis after migration does not necessarily predict poor adjustment under the new social circumstances. The patients were able to cope within the Western system, although the skills they needed to obtain suitable accommodation and satisfactory jobs and to negotiate with public authorities in the West were different from those commonly learnt in the Communist system. The finding of positive long-term adjustment might be partly due to a selection process in this longitudinal study. After six months only 59% and after two and a half years only 30% of the original sample were re-investigated. We have no information about the course of the symptoms or the quality of adjustment in the remaining 70%. Nor do we know how many of them have experienced further crises and/or how many have sought psychiatric help from other institutions. However, we found no significant differences on the variables assessed at the first interview between the patients who were re-examined and those who were not. Thus, there is no empirical support for the hypothesis that the patients who dropped out were different in any relevant respect from those we did follow up. While the sample in this study showed favourable long-term adjustment we would like to emphasise that some patients who were imprisoned for political reasons in the GDR now suffer from psychiatric disorders that have to date followed a chronic course without improvement (Bauer *et al.* 1993).

When the patients left East Germany and subsequently required crisis intervention, the political and historical situation was unique. It therefore remains unclear whether - and if so, to what extent - the results presented here are applicable to other refugees who experience an initial crisis after migration.

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