The Ulysses Syndrome: Migrants with Chronic and Multiple Stress Symptoms And the Role of Indigenous Linguistically and Culturally Competent Community Health Workers.

Authors:

Alba L. Diaz-Cuellar, Ed.D in Internacional & Multicultural Education, University of San Francisco, CA, U.S.
Assistant Professor, Department of Community/Border Health, School of Health and Human Services, National University, San Diego, CA, U.S. UNICEF Consultant. adiaz@nu.edu

Henny A. Ringe, MA in Cultural Anthropology, Free University, Amsterdam, Netherlands.
Researcher; Teacher, Escuela Popular del Pueblo, San Jose, CA, USA. hennyantonius@gmail.com

David A. Schoeller-Diaz, MA in Law & Diplomacy, The Fletcher School, Tufts University, Medford, MA, U.S.
Professor, School of Legal and Political Sciences, and International Relations,
Universidad de Bogotá - Jorge Tadeo Lozano, Bogotá, Colombia. dschoellerdiaz@gmail.com

Abstract

The Ulysses Syndrome is a series of symptoms experienced by migrants facing chronic and multiple stressors. The identification and reduction of complication of symptoms associated with the Ulysses Syndrome pertains entirely to the areas of prevention and psychosocial wellbeing, not to the curative one. In other words, the Ulysses Syndrome is immersed in the mental health scope not in the one of the mental disorders.

Community Health Workers (CHWs) benefit from being linguistically and culturally competent professionals, and trusted members of the communities they serve. As such, they are often ideally positioned to deliver a grassroots-level complement to the existing resilience mechanisms of the community.

Moreover, CHWs play a vital role in delivering culturally sensitive health support to migrants experiencing chronic and multiple stress symptoms associated with the Ulysses Syndrome. This is especially significant for migrants' psychosocial wellbeing, which may be affected by events and conditions in the place of origin, the migratory journey, and the adaptation processes.

This paper examines the unique contribution that CHWs make in facilitating the adaptation process of migrants and addressing the context-specific challenges they face.

Key Words

Ulysses Syndrome –Community Health Workers (CHWs) - Community Health Volunteers.

I. INTRODUCTION

"In a world defined by profound disparities, migration is a fact of life and governments face the challenge of integrating the health needs of migrants into national plans, policies and strategies, taking into account the human rights of these individuals, including their right to health".
(WHO/HAC/BRO/2010.3)

The lives and livelihoods of migrants are often threatened by various health problems that arise from events and conditions in the place of origin, as well as the migratory and adaptation processes. When confronted with extreme levels of stress in the receiving country, the migrants present chronic and multiple symptoms, which have been documented as the "Ulysses Syndrome".

Dr. Joseba Achotegui, Professor of Psychotherapy at the University of Barcelona, described the concept of the Ulysses Syndrome in 2002, after over two decades of working with migrants. He has focused on the often-misunderstood psychosocial challenges, including varied forms of recurring and protracted stress experienced by immigrants in their departure from the home country, and the adaptation to a different environment.

The key contribution of this concept to the discipline of cultural psychology is the elucidation of the direct correlation between the extreme levels of stress and the onset of psychosomatic symptoms, which belong to the area of mental health, but not necessarily to that of psychopathology.

The term Ulysses refers to the ancient Greek hero who spent ten years living in a distant land and another ten seeking to return to his city-state of Ithaca. The significance of Ulysses' story is such that the term Odyssey is defined as a complex and treacherous journey in multiple languages and multiples cultures around the world.

Now much more than then, migration is a complex undertaking with often-profound human impacts. Since the second half of the 20th century it has grown exponentially and become largely characterized by the movement of lower-income individuals seeking prosperity and/or safety in wealthier countries in the northern cone. There are currently an estimated 1 billion migrants, of whom 214 million are international and 740 million are internal.[1] Many observers, including UNDP and the World Bank, perceive migration as an agent for the advancement of living conditions through a large-scale economic lens. Receiving countries, especially those with declining population numbers and aging demographics, often benefit from the acquisition of a young labor force.

This paper examines the valuable contribution that Indigenous Linguistically and Culturally Competent Community Health Workers offer in facilitating the adaptation process of migrants and addressing context-specific challenges they face. CHWs can effectively educate, advocate for, and empower migrants to manage the effect of severe conditions encountered through the migratory process. Thus, they should be key part of a comprehensive strategy to prevent and alleviate the chronic and multiple stress symptoms associated with the Ulysses Syndrome.

II. THE ULYSSES SYNDROME

> *"Ulysses spent his days sitting on the rocks by the sea, being consumed by tears, sighs and sadness…"*
> *Odyssey, Song V.*

> *"We live in bad times where mere mortals have to behave like heroes in order to survive. … the people who are arriving at our borders are creatures of flesh and blood."*
> *Dr. Joseba Achotegui (2010)*

[1] UNDP Human Development Report, 2009.

The Ulysses Syndrome refers to the psychosocial symptoms experienced by migrants who live in extreme situations. These symptoms are the response to the efforts of the migrant to adapt to contextual stressors.

TABLE 1.

LEVES OF STRESSORS		
SIMPLE	**COMPLICATED**	**EXTREME (Ulysses Syndrome).**

The Ulysses Syndrome takes place at the extreme level of stressors. The complex migration context may include factors causing high levels of stress such as: forced separation, dangers of the migratory journey, social isolation, absence of opportunities, sense of failure of the migratory goals, drop in social status, extreme struggle for survival, and discriminatory attitudes in the receiving country.

These factors aggravate the presence of symptoms such as: migraines, insomnia, recurrent worrying, nervousness, irritability, disorientation, fear, and gastric and osteo-physical pains. It is important to note that the multiplicity and chronicity of these factors is increased by the lack of a healthy network of social support and the inappropriate intervention of the medical system in the host country.

The stages of acculturization can be very painful for many migrants, and in the process of trying to adapt, many healthy but with chronic and multiple stress symptoms, pay the price of being misdiagnosed and unnecessarily treated as having mental disorders.

Biomedical approaches see these symptoms not as a reactive response to the predicaments met in the receiving country, but as signs of depression and other mental disorders, leading to a series of treatments that instead of mitigating, may exacerbate the already existing stressors for the migrant.

Furthermore, nowadays many migrants just for the fact of bringing distinct cultural traits from their home countries are being pathologized due to the failure of the dominant Western medical system to recognize structural or culturally specific challenges.

III. WHAT IS MENTAL HEALTH

The diagnosis of depression fits into a particular medical (read "Western") model, which is considered objective, value free, and universally applicable.

It is said that "we" have "medicine", while "they" (the others) have ethno medicine. The biomedical approach has an aura of factuality and objectivity that leaves no role for social action or social change. Concerningly, it is often utilized to cloud threats to the existing status quo or justify the perpetuation of social inequalities and injustices.

The diagnosis of "drapetomania" offers a striking example of how a seemingly medical diagnosis can play a discriminatory sociopolitical role. Prior to the American Civil War, some slaves were diagnosed with suffering from this affliction, an alleged mental illness leading to the slaves possessing an irrational desire for freedom and a tendency to try to escape. By classifying such a dissident attitude as a mental disorder, medical doctors promoted cultural biases about mental normality and abnormality and legitimized ongoing oppression.

This perspective eclipses larger socio-economic issues that lie at the root of the individual's mental and physical well-being. This situation is clearly illustrated by the case of Dutch miners after the closing of the mines (*Individualisering en Uitstoting, Individualization & Exclusion*). After the massive firing of many Dutch mine workers in the late 1960's, many of them, already suffering from silicosis, started experiencing other somatic medical disorders, as well as multiple and chronic episodes of sadness, frustration, irritability and insomnia. They were generally diagnosed with depression, resulting in their isolation and treatment as isolated cases. This mechanism obscured the injustices and structural violence being suffered by the workers at large.

Individualizing the problem, made the afflictions to be seen not as a reaction to a particular socio-economic context, but instead the afflicted ones were silenced to a point of inaction towards the betterment of their socio-economic conditions. In the words of Michael Foucault, this is the mechanism of "disciplination".

Foucault asserts that the Western Psychiatric diagnosis system is not neutral, but a social construction conditioned by a particular ideology linked to the structure of power, control and domination. The dominant model is exercised to exclude outsiders by marginalizing their responses to social injustice with a perception that these are detached from existing conditions. Thereby, the perception that the Western point of view is the only scientifically valid and objective approach becomes a very powerful mechanism of "disciplination" and oppression. Foucault argued that characterizations of "mental illness" reflect the hierarchical structures of the societies from which they emerge, rather than any precisely defined qualities that distinguish a "healthy" mind from a "sick" one.

His varied examination into the judgment of "abnormality" is highly relevant in the analysis of migrant conditions, and the often oppressive functions of the Western medical model, especially in the psychiatric realm.

IV. CORRELATION BETWEEN PSYCHIATRIC LABELING AND CULTURAL OPPRESSION

The uses of standard diagnostic criteria applied to members of different cultural groups pose various levels of discriminatory practices. While in ethno-medicine the existence of the spiritual world is widely considered, standard diagnoses fail to capture the knowledge, attitudes, practices, values, and beliefs of those from other cultural groups.

In Bali, Indonesia, for example, there is a daily practice of offerings to the ancestors and protective spirits, as a way of maintaining a balanced relationship with the whole environment, including the unseen forces. In Latin America, there are many legends and myths that support the mental balance of members in rural communities. To mention just one: In indigenous communities "La Llorona" is recognized as a roaming spirit of a deceased woman in grief who is considered real, to the point that many claim they often hear her crying. In the Western psychiatric approach, acknowledgement of supernatural dimensions would be considered as irrelevant; and the condition of "hearing voices", would be seen as "pathological" and as "lack of contact with reality". The indigenous perception looks at the whole human being in all his relations with this world and also with the unseen one, and incorporates such spiritual forces in the healing practice.

The case of Eka, a Moluccan woman in the Netherlands, is emblematic of this. Her father died on her wedding day. Shortly thereafter, she started having experiences that, within the Western bio-medical approach, are perceived as olfactory

hallucinations. She also became increasingly sad and withdrawn from social contacts. Her brother brought her to a psychiatrist who diagnosed her with depression and borderline psychosis. He proposed that she undergo a combined treatment of "talk therapy" and anti-psychotic drugs. This only served to worsen her condition. Besides the severe side effects of the drugs, her therapist tried to convince her that she had unresolved conflicts, which further exacerbated her sadness. A couple of friends intervened and obtained funds to enable her to travel to her home country of her ancestors, where she had an extensive social network with clear understanding of the need for closure. Shortly thereafter, she recovered. Not only did her physical and mental symptoms disappear, but her overall wellbeing also improved. This outcome was possible thanks to the supportive conditions that were available to her.

The authors of this paper do not negate the fact that International Psychiatric research has demonstrated varying degrees of efficacy for improving and managing most advanced mental disorders through either psychotherapy (including talk treatment) and the use of medication (antidepressant, tranquilizers, stimulants, and a wide range of anti-psychotics). However the increasing prescription of them in basic general medical practice in the United States, where many of the largest psycho-pharmaceutical producers are based, deserves a careful critical analysis.

The case of Teresa, a migrant girl from Central America, is one of many of newly arrived migrants experiencing the Ulysses Syndrome, including sadness, migraines, fatigue and bone pains. Teresa was seen by her general and primary physician who without providing her with any form of health education in Spanish, her native language (e.g., brochure, flyer, booklet or basic information), proceeded to prescribe her Proxac, a medication used by adults for the treatment of major depressive disorder, panic disorder, obsessive-compulsive disorder, and treatment-resistant depression. The medication did not alleviate Teresa's symptoms of sadness (i.e., homesickness). Rather, it worsened the initial condition and induced undesirable side effects, including lack of coordination, increased anxiety, impulsive and dangerous behavior, and thoughts about suicide. Her case illustrates how physicians often over prescribe medication, and minimize the evidence of dependency and adverse secondary drug reactions, especially to migrants of different cultural backgrounds experiencing extreme levels of stress.

The extensive therapeutic use of stimulants and a large number of psychoactive drugs in the cases of the many migrants with chronicle and multiple stress syndrome, represents not only the ethnocentric medical approach in the west as the only valid and scientifically objective approach, but also a means of unjust social control of this population.

As stated above, the diagnosis of depression is an easy way out and fits into a particular Western medical and cultural model, which reduces the psycho-social problem to that of an individual who in the diagnosis, is abstracted from a socio-economic content and then held solely responsible for his/her mental well being.

The authors and co-authors of this paper, (Osorio, L. and Labarca, C.) all aware of the studies of Dr. Joseba Achotegui on the Ulysses Syndrome, and who are working with migrant and refugee populations in different parts of the world, propose that a socio cultural approach using Indigenous Linguistically and Culturally Competent Community Health Educators, (ILCCCHEs) working in a well designed and a well monitored community-based program can be the essential missing link for the identification and help to migrants experiencing the Ulysses Syndrome.

VI. INDIGENOUS LINGUISTICALLY AND CULTURALLY COMPETENT COMMUNITY HEALTH WORKERS.

"*Health literacy is crucial for people to know how and to teach others how to navigate the system. Health for all, but health that is founded inhuman dignity, loving care, and fairer distribution of resources and power."* *(Werner, 1987)*

The Community Health Workers (CHWs) model was re-emphasized at the Alma Ata Conference in 1978, and since then there have been many variation of the term meeting the varying demands and differing levels of the health issues within countries, regions, and villages.

In South East Asia, Africa and Latin America the term CHWs has come to include: Health Auxiliaries, Health Volunteers - Barefoot Doctors – Health Agents –Family Welfare educators – Community Health Volunteers – ILCCCHES - to simply "*Promotores"*, the Spanish name for natural leaders (women and men).

CHWs act as "bridges" between communities and institutions. They are trained to deal with the health problems of community members, and to work in close collaboration with the health services. According to WHO: CHWs serve as connectors between health care consumers and providers to promote health among groups that traditionally lack access to adequate care. By identifying community problems, developing innovative solutions and translating them into practice, CHWs can respond creatively to local needs. In fact there is compelling evidence that local level CHWs can effectively provide health services to the entire local population. Numerous examples from around the world demonstrate that dramatic improvements can be achieved with a well designed, and well monitored community based CHWs.

VII. COMMUNITY HEALTH WORKERS (CHWs) AND THE ULYSSES SYNDROME.

Evidence-Based studies have demonstrated that Community Health Volunteers, are able to reach the "hard to reach" community members and to have an impact by educating, linking them to resources and advocating on their behalf. As effective community health educators and system navigators CHWs receiving appropriate training on the identification of the Ulysses Syndrome, can intervene to reduce the stress levels that migrants experience as a product of the migratory journey and the efforts and the adaption to the new country.

CHWs' role is completely based entirely on the area of prevention. The identification and reduction of complication of symptoms associated with the Ulysses Syndrome pertains to the prevention and psychosocial area, not in the curative one. The Ulysses Syndrome is immersed in the mental health scope, not in the one of the mental disorders.

TABLE 2.

MENTAL HEALTH	**ULYSSES SYNDROME**	**MENTAL DISORDER**

"The assertion that these immigrants suffer from a mental illness is not being made up. These immigrants exhibit anxiety and depression based on results to the Hamilton Questionnaire. The term indicates that they suffer a series of symptoms, which pertain to the mental health sector, which is a wider area than that of psychopathology.

The Ulysses Syndrome forms a gateway between mental health and mental disorder. This syndrome is a subject's response when faced with a situation of inhuman stress, stress of such a character that it is superior to the adaptation capacities of the individual (living permanently alone, with no way out, with fear etc.). However, if this situation is not resolved there is a great risk that it finally crosses the limits of illness". Achotegui (2010).

VIII. METHODOLOGY

The methodology used in the training of CHWs on the Ulysses Syndrome applies Paulo Freire's Popular education and the Participatory approach focusing on the issues that affect migrants. The combination of Freire's participatory methods with the Community Health Worker model increases the CHWs potency as effective agents of social education and disease prevention in migrant communities. CHWs are often ideally positioned to deliver a grassroots-level complement to the existing resilience mechanisms of the community. The principles of Freire's methodology provides the basis not only for the utilization of strategies that enhance the CHW's capacity to participate in health promotion and educational activities, but empowers CHWs as Agent of Change to advocate for migrants' rights and community empowerment.

IX. CONCLUSION

The concept of the Ulysses Syndrome poses a powerful challenge to dominant Bio medical approaches. It is a non clinical and more comprehensive assessment of the plight of migrants who suffer from chronic and multiple stress syndrome. This calls for Prevention, not just at the individual level, but also at the community level at large. With this approach the migrant is not isolated, but integrated and made aware of the importance of keeping and maintaining strong ties with his/her language and culture as the most empowering factors in the overall wellbeing. The CHWs many of whom have had the same or similar experiences play a vital role in supporting these going through the migratory process to achieve their goals without compromising their health condition. They can also alleviate the worsening of grief associated with the separation from loved ones and the trauma of the journey; they can be healers by bringing natural and culturally relevant techniques from their own culture. Furthermore, CHWs can initiate community organization, community building, and community empowering processes.

Evidence- based studies demonstrate that CHWs programs can be very effective as long as there is periodic program monitoring and evaluation in order to make the necessary adjustments and to take corrective measurements. The expected outcome of the current CHWs interventions in the prevention of the Ulysses Syndrome is that the results of the ongoing programs will help health practitioners, program managers and policy makers of various countries to adapt, replicate and or scale up their interventions with migrants with chronic and multiple stress symptoms. Interventions are needed around the world, to educate communities as well as Health Care providers in the most appropriate ways to assist migrants in their adaptation to the new country and to avoid misdiagnosing.

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