MIGRATION PSYCHIATRY: ODYSSEUS' MODERN DAY SAVIOUR GODDESS ATHENA

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INTRODUCTION

Through out the history of mankind, migration has been a distinguishing feature that left mark in our DNA. Consumer genetic testing increasingly building a picture of diverse geolocations of our ancestors across the globe. The reasons for migration are varied from existential crisis, natural and manmade calamities to novelty and thrill seeking in search of greener pastures. It is human nature to stay put in their place of abode despite apparent hardships. Inhabitants living in inhospitable places such as barren deserts, extreme polar regions or deep forest do not move out to places where moderate environment offer better comfort. In clinical practice we commonly encounter migrant patients always pining to return to home.

The mental health-related aftermath of forced migrants' tumultuous voyage to a foreign land has been named the Ulysses (or Odysseus) syndrome by Joseba Achotegui, a cultural psychiatrist working with migrants in Spain. Ulysses is the Roman (Latine version) name for Odysseus, a hero in ancient Greek poet Homer's epic poem the Odyssey. Ulysses (Odysseus), the King of Ithaca, began his journey after being unwillingly recruited to a decade long fight in the Trojan War and undertook 10 year long journey back to his home Ithaca. His journey was fettered with uncertainty, extreme hardship, and constant battle with monsters which modern day fleeing refugees are experiencing in their pursuit to escape from persecution. Immigrants affected by this syndrome present with atypical depressive symptomatology, where depressive symptoms are mixed with anxious, somatoform and dissociative symptoms.

The construct of Ulysses syndrome essentially describes a normal human reaction to an abnormal and inhuman context of the migratory journey. Such normal emotional reaction would likely culminate in mental disorder unless addressed early. An analogy of prediabetic state leading to diabetes in case of rising obesity could be made advocating public health approach in refugee mental wellbeing.

Fig1: A Mental Health care centre in Rohingya camp in Bangladesh. Note the effort of having a welcoming garden in the clinic reception within constraints of space.

KEY TERMS FOR PEOPLE ON THE MOVE

Nearly one-seventh of the world's population is now living in a location different from the one in which they were born and nearly one billion people are estimated to be migrating within and/or between countries in all regions of the world . Migration is politically loaded topic and terminology around migration also confusing and allow disavowal in media.

A migrant is someone who has moved across an international border or within her or his own country away from their habitual place of residence. Whilst the term economic migrant and expatriate have positive connotation, international migrants who are forcibly displaced do not enjoy welcoming reception as either refugees or asylum seekers.

A refugee is defined by the 1951 UN Convention Relating to the Status of Refugees as someone who has fled beyond the borders of their country and is unable or unwilling to return owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.

Asylum seeker is a person who has fled their country and made an application in another country to be recognised as a refugee under the 1951 Convention, but who has not yet been granted this status. Upon a successful processing of his or her asylum request, an asylum seeker will be considered a refugee.

Article 1 of the 1954 Convention

Statelessness renders people invisible and can act as a catalyst for human rights violations, including protection from the state to access basic socio-economic rights such as to education and health. Statelessness also blocks access to justice and can render people vulnerable to exploitation and abuse by organised criminal networks. Rohingyas are an example of stateless ethnic group expelled from Myanmar and taking refugee across the globe. About a million Rohingyas has settled in Bangladesh and Government of Bangladesh refer them as Forcibly Displaced Myanmar Nationals (FDMNs) whereas Myanmar refers them as "illegal immigrants" from Bangladesh.

There is another category of people who does not have a piece of paper to describe their "legal identity and sometimes described as "illegal".

A person can never be illegal, and it is the construction of the law that degrade humanity to a prejudiced terms that led to unbearable suffering and increase vulnerability for mental disorder. Widespread reporting of the term "illegal migrant" in media creates an impression of "criminal person" to destitute people fleeing persecution.

All health care professional working with migrant should be aware of the key terms used without prejudice and rights associated with refugee and asylum seekers under the international law.

A key statistic that is overlooked is 85% of refugees are being hosted in Low- and Middle-Income Countries (LMICs) whereas prominent discourse focuses almost exclusively on migration from LMICs to high-income countries (HICs). Most international work around migrant health is led by HICs with little leadership from LMICs. One would expect more resources should be allocated where the problem is sheer.

MIGRANT MENTAL HEALTH

Migrant morbidity understandably varies across the board as the diverse and dynamic interacting factors such as an individual's pre-departure health, socio-economic and environmental conditions, local disease patterns and risk behaviours, cultural norms and practices, and access to preventive or curative therapies throughout the migration process.

The common mental health problem seen in refugees/asylum seekers are PTSD and Depression. The prevalence of anxiety disorders and psychosis among refugees are more comparable to findings from general populations . However, a recent Swedish population study identified refugees were at increased risk of psychosis (adjusted hazard ratio 2.9, 95% CI 2.3– 3.6) and non- refugee migrants (1.7, 95% CI 1.3– 2.1) after adjustment for confounders . This finding is in keeping with earlier research on migration as an established risk factor in the development of schizophrenia and other nonaffective psychoses .

The cross-cultural barrier and transdiagnostic validity in diagnosis of mental disorder add challenges in

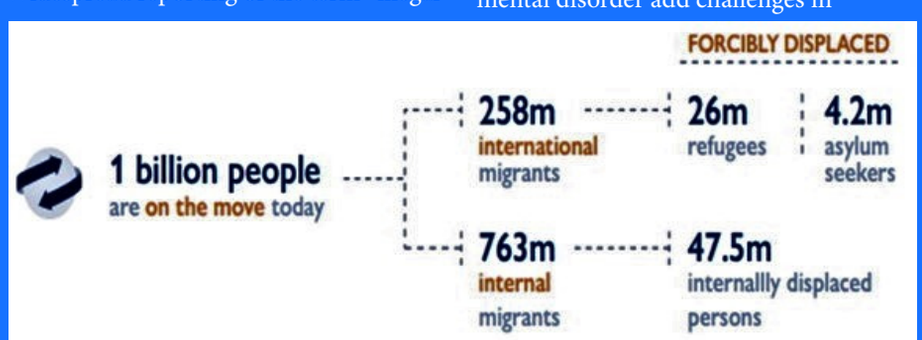

Fig 2: One Billion people on the move and their pathway based on immigration status.

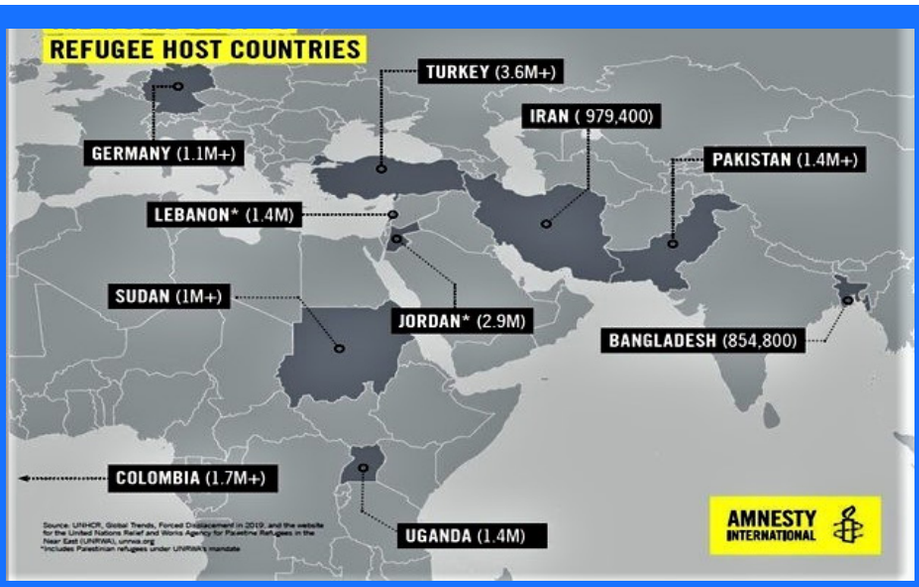

Fig 3 : The world's top 10 refugee host countries are low and middle income countries.

studying prevalence of mental disorder in refugee population. For example, Somatization presentation is common in refugee population and undiagnosed medical condition can be dismissed as mental disorder. In addition, somatization presentation can be the prominent way to express emotional distress in population where mental health literacy is poor.

The ecology around refugee camp is not conducive for health and wellbeing of the population. Living conditions in camps are devoid of basic amenities. Lack of hope and meaningful activities breed boredom, whereas constant preoccupation with anxiety and inability to escape from suffering perpetuates conditions for ill mental health. It is noteworthy Dr. Victor Frankel's personal experience in gruesome Auschwitz concentration camps formed the basis of Logotherapy described in his seminal book Man's Search for Meaning

COMPETENCY IN REFUGEE AND MIGRANT MENTAL HEALTH

WHO published a competency framework for health professionals working with migrant and refugees . The importance of person-centred, culturally responsive care is emphasized in the nine competency standards, which recognize the need for health workers to be trained, supported, and empowered within strong health systems. Cultural and language barriers are the most obvious obstacle health care professional face.

The use of interpreter in mental health setting needs nuanced approach to preserve the confidentiality in close knit society and a balance needs to strike to use family members as interpreter in resource poor setting. Patients may feel reluctant to share intimate personal history in the presence of family members or well-known interpreter in the community. Use of telephone interpreter from distant location and withholding patient personal identification can be considered as alternative option.

Cultural norms such as knowing one's birthday do not have same salience in many cultures. Healthcare /Law enforcing agencies may become sceptical if patients are unable to recount their own date of birth. I learnt in some countries in rural areas date of birth is recorded by the school admin and children of the same class would be given the same date of birth for the ease of administration. The most common date of birth in such instances is the first of January of the year children admitted to school. Lack of understanding of societal and cultural practices can cause rift of trust and hamper therapeutic alliance.

Competence in psychopharmacology is relevant in prescribing for refugees. There are significant variations in the polygenic genes underlying CYP206 and other enzymes involved in the metabolism of medication so that some people are slow and others fast metabolizers, with as much as a 100- fold variation in blood levels between two apparently similar individuals. This variation is reflected in ethnic groups as well, so, for example, black Africans and East Asians are known to be slow metabolizers, while up to a

Fig 4 : Only sports facility for vast number of young Rohingyas at camp in Bangladesh.

third of Ethiopians have gene duplications and are ultra- rapid metabolizers . These enzyme systems may also be influenced by environmental factors such as dietary practices and the use of herbal remedies so that a slow metabolizer in one country might 'speed up' on migration and adoption of a different diet .

Some cultures may have preference for physical intervention over psychological therapies. An embodiment of intervention in the form of tablet to swallow or a talisman/amulet to wear from spiritual healer might have better acceptance than psychological intervention that requires a degree of "psychological mindedness". Health professionals need to be aware of some harmful practices by the traditional healer that may violate human rights of the vulnerable patients.

CONCLUSION

Migration is a fact of life that is likely to increase in our lifetime. Majority of the burden of refugee crisis fall on LMIC and it is time to allocate resource in those countries and initiatives need to come from the ground rather than top down from western world. Ulysses (or Odysseus) syndrome described above is an eponymous of western mythology, however many other cultures have similar stories on migration and hardship along the way and the tales of human suffering has stark similarity across all culture .

The one billion people who are on the move would not have the chronicler to capture their journey as many of the "illegal migrant" simply do not exist in official records. In times of difficulties Odysseus had divine interventions from goddess Athena. Health care professional could be the only solace for the modern-day unfortunate individuals to turn to in their odyssey and only a compassionate and competent mental health professional can help them in navigating the sea of storms.

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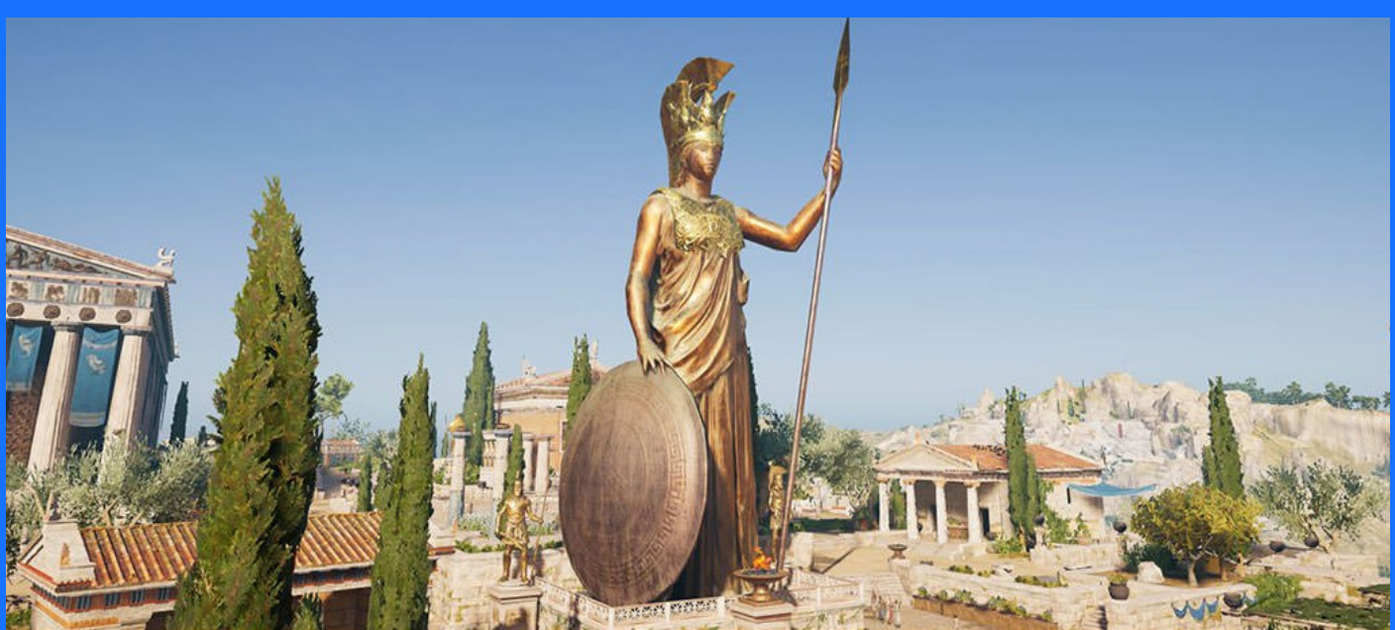

Picture Source: A SUMMARY OF THE POWERS OF THE GREEK GODDESS ATHENA November 25, 2019 by Learnodo Newtonic