Perspective

Ulysses Syndrome and the COVID-19 Pandemic

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The ongoing coronavirus disease 2019 (COVID-19) pandemic has caused >73 million infections and >1.6 million deaths worldwide. The virus and public health measures to contain it are affecting the mental health of not only at-risk individuals but also the general population (Table).[1] It is causing significant disruption in the public health and world economies. Public health measures such as social distancing,[2] forced isolation, and quarantine are critical to containing a pandemic but result in adverse effects such as loneliness and separation from families and communities. Furthermore, many uncertainties exist about the COVID-19 pandemic. These uncertainties include the duration of the pandemic, the timeline for effective therapies or vaccines to become available, and the adequacy of the supply of healthcare resources such as personal protective equipment (PPE). The volume of information and misinformation on mainstream and social media further exacerbate stress, making it difficult for individuals to find ways to cope and support their mental health. In addition, the difficulties individuals face when trying to achieve goals and sustain basic needs are worsening stress levels across populations. Examples include lack of opportunities, reduced earnings, decreased access to housing and health services, and shortages of necessary items (eg, PPE). Cumulatively, all of these factors are causing tremendous stress and overwhelming the "normal" psychosocial coping mechanisms of individuals.

Odysseus (Ulysses in Latin), an ancient Greek hero, struggled with stressful and unique situations in isolation during the Trojan War. Ulysses traveled for a decade through the Mediterranean, experiencing many dangerous adventures and suffering involuntary migration before returning home. Similar cumulative effects of intense stress overwhelming the normal psychological coping mechanisms were later described in migrant workers as Ulysses syndrome.[3] Ulysses syndrome represents a spectrum between normal and disordered responses to stress that is a consequence of heightened stress response by healthy individuals to an extreme situation or stress. It manifests with symptoms of anxiety, insomnia, depression, headache, or pain. Frontline workers are experiencing extremely heightened, chronic stress associated with the COVID-19 pandemic.[4] With the high prevalence, infectivity, and fatality rates associated with severe acute respiratory syndrome-coronavirus-2, the worries among frontline workers include being at high risk of infection and the potential for transmission of the virus to loved ones. Conditions at work have become much more stressful for many people; examples include a shortage of PPE, longer working hours, risk of furlough or reduced earnings, emotionally charged interactions with clients/patients and colleagues, and ethically difficult workplace decisions. The majority of the population following large-scale disasters (traumatic or natural), is resilient and does not succumb to psychopathology[5]; however, an increase in the pervasiveness of depression, posttraumatic stress disorder (PTSD), substance abuse, domestic violence, child abuse, and other mental and behavioral disorders have been reported[6] following such disasters.

This surge of mental health needs is overwhelming the mental health support system, and the exact magnitude is unknown. Psychologists and psychiatrists advise "bracing for the looming mental health crisis." Many people will experience Ulysses syndrome, with symptoms mimicking those of depression, adjustment disorder, or PTSD. It is crucial to delineate these disorders from typical stress responses to use finite resources effectively. In Ulysses syndrome, depressed mood is present, but the other cardinal features of depression such as apathy or suicidal ideation are not, and motivation is needed to achieve social and professional goals. Distress is out of proportion to the severity of stressors in adjustment disorder compared with Ulysses syndrome. It may manifest as anxiety, insomnia, or sadness, but there is no deterioration in social and occupational functioning in Ulysses syndrome. Both PTSD and Ulysses syndrome stem from a response to fear. Disturbing thoughts about traumatic events are uncommon in Ulysses syndrome. Individuals experiencing Ulysses syndrome may not require intense mental health resources as they return to a normal state once the stressors resolve. Limited mental health resources can be used more effectively in managing marginalized and at-risk populations. At-risk individuals include older adults; individuals with compromised immune systems; people living or receiving care in congregate settings; and people with preexisting medical, psychiatric, or substance use problems.

It is crucial to consider a proactive mental health response to meet the mental health needs of a population, especially at-risk populations.[7] Primary care providers or social workers may screen at-risk populations for mental health issues to distinguish individuals with Ulysses syndrome from those with significant mental health disorders. Primary care providers and social workers may provide psychoeducation and psychosocial support early on to individuals with Ulysses syndrome and refer others who have progressed beyond this state.

Adjusting mental health efforts in the COVID-19 pandemic may benefit from developing and studying innovative psychotherapy protocols that address comorbid and acute presentations of mental health disorders. Optimizing the use of digital technology may achieve enhanced social interactions while maintaining physical distancing. An increased role for telemedicine may further

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Table. COVID-19 and mental health: summary of contributing factors and consequences

Contributing factors	Population(s), affected	Consequences
Related to COVID-19	General	Stress (Ulysses syndrome), anxiety, loss of income, low self-esteem, isolation, loneliness, negative thoughts, substance abuse, domestic violence
Risk of infection	At risk: women, young, elderly, sleep disturbances (insomnia), immunocompromised	Anxiety, negative thoughts, low self-esteem, domestic violence, isolation, loneliness, substance abuse, suicidal risk
Risk of spreading infection	Individuals with preexisting mental health issues	Isolation, inability to access timely mental health services, substance abuse, suicidal ideation, incarceration risk
Unknown	Frontline workers	Anxiety, concern about transmitting the virus to family, friends, and coworkers, lack of protective equipment, rationing of protective equipment, long working hours, burnout, PTSD
Disease course		
Therapy		
Prognosis		
Lack of vaccine		
Related to measures to control the spread of COVID-19 (NPIs)		
Physical (social) distancing		
Quarantine		
Lockdown(s)		
Business closures		
Travel restrictions		
School closures		
Miscellaneous		
Lack of protective equipment		
Misinformation (by media, digital platforms)		
Economic loss for both individuals and state		
Uncertainty about future		

COVID-19, coronavirus disease 2019; NPI, nonpharmacologic intervention; PTSD, posttraumatic stress disorder.

facilitate psychoeducation and psychosocial support. Expanded human resources are necessary to meet the increasing mental health needs of a population during prolonged widespread events such as the COVID-19 pandemic. One way to expand such resources may include task shifting[8] or expansion of the role of mental health nurse practitioners, social workers, and crisis workers. Using a stepped care approach may be beneficial[9]—for example, starting with the most effective/least-resource-intensive therapy and then stepping up care to use more resources as required.

The timely identification of Ulysses syndrome from mental health disorders is paramount. Targeting at-risk populations and expanding the workforce will help with preventive efforts. This approach also will increase the capacity of the healthcare system to mitigate the emotional impact of the pandemic, particularly for marginalized or at-risk populations.

References

1. Serafini G, Parmigiani B, Amerio A, et al. The psychological impact of COVID-19 on the mental health in the general population. *QJM* 2020;113:531–537.
2. Galea S, Merchant RM, Lurie N. The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. *JAMA Intern Med* 2020;180:817–818.
3. Achotegui J. [Emigration in hard conditions: the immigrant syndrome with chronic and multiple stress (Ulysses' syndrome)]. Vertex 2005;16: 105–113.
4. Wu PE, Styra R, Gold WL. Mitigating the psychological effects of COVID-19 on health care workers. *CMAJ* 2020;192:E459–E460.
5. Pfefferbaum B, North CS. Mental health and the Covid-19 pandemic. *N Engl J Med* 2020;383:510–512.
6. Neria Y, Nandi A, Galea S. Post-traumatic stress disorder following disasters: a systematic review. *Psychol Med* 2008;38:467–480.
7. Marques L, Bartuska AD, Cohen JN, et al. Three steps to flatten the mental health need curve amid the COVID-19 pandemic. *Depress Anxiety* 2020;37:405–406.
8. Javadi D, Feldhaus I, Mancuso A, et al. Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. *Glob Ment Health (Camb)* 2017;4:e14.
9. Cohen GH, Tamrakar S, Lowe S, et al. Comparison of simulated treatment and cost-effectiveness of a stepped care case-finding intervention vs usual care for posttraumatic stress disorder after a natural disaster. *JAMA Psychiatry* 2017;74:1251–1258.