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Persisting Depression Among Katrina Survivors

Welcome to ReachMD's Medical Focus Series. This month ReachMD explores our nation's progress in disaster medicine and public health preparedness.

You are listening to ReachMD XM 157, the channel for medical professionals. Welcome to the clinician's roundtable. I am Dr. Maurice Pickard, your host, and with me today is Dr. Sandro Galea, Associate Professor of Epidemiology at the University of Michigan. Today, we are going to be discussing mental health and increased prevalence of anxiety mood disorders in residents of New Orleans.

DR. MAURICE PICKARD:

Thank you very much doctor for joining us.

DR. SANDRO GALEA:

Thank you for having me.

DR. MAURICE PICKARD:

Dr. Galea, it has been over two years since Katrina. Can we look at the mental health in New Orleans and make any judgments about it?

DR. SANDRO GALEA:

The mental health of residents of New Orleans specifically and of the Gulf Coast in general has been poor, but in any respect this is surprising. We expected there to be substantial psychopathology after Hurricane Katrina. We expected there to be not only an increase over baseline in terms of psychopathology, but also that the levels of psychopathology recorded would probably to be worse than what we found after other natural disasters. So, in many respects, this paper and this part of a larger set of research showed us what we expected. What was a bit more surprising in terms of what we found was (01:30) the observation that one of the biggest drivers of psychopathology after Hurricane Katrina, were financial and social and situational stressors and that people who are having difficult time getting housing, people having a hard time finding contractors, those who had lost a job or having a hard time making ends meet, these

were the people who are at the greatest risk for psychopathology and this was a greater risk for psychopathology over and above their exposure to the hurricane itself. So, what this study shows I think fairly clearly and hopefully convincingly, is that the aftermath circumstances after these events are important drivers of public mental health, the respective, of course, that has important implications.

DR. MAURICE PICKARD:

You mentioned that you expected or anticipated that this type of problem might be worse in New Orleans. Why did you make that judgment?

DR. SANDRO GALEA:

It has pretty well shown that after disasters and terrorism and mass trauma in general, probably the single biggest driver of the scope of psychopathology is the extent of exposure to traumatic events. By traumatic events here, we are referring to specifically DSM category A traumatic events per definition of posttraumatic stress disorder, and we knew very well that residents of New Orleans were exposed to more traumatic events per capita than were residents say of (03:00) Louisiana overall or Mississippi or Alabama. So, it was entirely predictable and turned out to be the case that psychopathology would be worse off in residents of New Orleans than the rest of the Gulf Coast area.

DR. MAURICE PICKARD:

Yeah. You did mention that. So, residents of Louisiana, Mississippi, and Alabama did not have as much in the way of posttraumatic stress as people who actually lived in New Orleans, but how about the residents from New Orleans who do not return to New Orleans. What is the data show on those individuals?

DR. SANDRO GALEA:

Well, our study was not just among the residents of New Orleans who returned to New Orleans. We looked for residents, people who were in the Gulf Coast area regardless of where they were when we studied them, so the estimates that we came up with apply to be who were living there before, not just those who have come back. Now, the larger question you raised what does dislocation and relocation do to psychopathology over time and that is a difficult question. Our intention is to continue doing this study longitudinally to try to get a little bit at this question. The role of displacement after these events is not terribly clear. In many respects, displacement is thought to be likely an adverse event with respect to psychopathology and the reasoning behind that is displacement is associated with breaking of social bonds, people having more limited access to help and social resources with which they are familiar, but on the plus side, displacement is also (04:30) associated with people being less exposed to the traumatic events that are going on on a day-to-day basis in an area that is being affected by a disaster, and displacement might have well be associated in certain cases with the receipt of better services from health and social services point of view, so the role of displacement is an interesting one, it's a complicated one, and one which we will look at more carefully both in this study and the another study.

DR. MAURICE PICKARD:

You mentioned that the driving stressors were such things as loss of a job, loss of residence, not being able to obtain healthcare. Is that to say that those kind of stressors had a greater impact than say actual physical illness or injury from the disaster or actually even a loss of a loved one?

DR. SANDRO GALEA:

What I said was that the stressors, from calling stressors, you have to distinguish them from traumatic events, were important over and above the role of traumatic events and loss of a loved one or personal, physical injury is itself a traumatic event. So, these stressors were present and important independently than was exposure to traumatic events like loss of a loved one or personal injury. Now, which one is more important that is always a tricky question. It is a tricky question because I can tell you relative risks of one versus another, but that does not quite capture which one is more important. The relative risks are quantifying something that probably is ultimately quality, if any different, and I think statistically the best conclusion (06:00) one can draw is that both are important and both are important independently of one another and there is no surprise that the traumatic event like loss of a loved one or being injured yourself in a disaster is an important determinant of psychopathology after these events. What is a little bit more surprising is that financial and situational stressors are important determinants of psychopathology, separate and apart from the traumatic events.

DR. MAURICE PICKARD:

Did you notice or has your study shown any sociodemographic differences in your cohort.

DR. SANDRO GALEA:

It is a very good question. We expected sociodemographic differences. In particular, we expected gender differences, which have been shown before. Women are typically at a greater risk of posttraumatic stress disorder than are men, for example, but we actually found no such demographic differences in the sample in this analysis in terms of risk for psychopathology, which was a bit of surprise and we speculated in the paper that the reason for that is that the traumatic events and the stressors were so ubiquitous as to blot out any variability in between the sociodemographic categories. It was not an unexpected finding, it was a relatively new finding, and I don't think that it means that there are no sociodemographic differences in risks of psychopathology under normal circumstances, but these were pretty far from normal circumstances. I think it tells us something about (07:30) the fact that in situations of ubiquitous exposure to traumatic events and stressors, we may expect that the rules of the game are different than the factors that drive psychopathology are quite different than the factors that drive psychopathology under other circumstances.

DR. MAURICE PICKARD:

I guess if somebody who is used to being able to purchase healthcare easily, is well insured, is financially stable when faced with a disaster might really be affected possibly even more than somebody who has been marginalized in our healthcare system for years. What would you say to that?

DR. SANDRO GALEA:

Yeah, I think there is very little evidence that that's the case. I think the evidence all points in the direction of the fact that people who are worse off after these events, and by worse off, I mean financially and socially, do worse from a point of view of psychopathology than people who are better after these events. Now, you could argue presumably that somebody who was doing well tends to lose more, that's fair enough, but the reality is that people who are doing well, even if they lose a lot still have enough resources and enough of reserve that they are still doing better than those who are not doing so well. So, it seems like what matters is status post event, and status post event is fairly clearly linked to (09:00) status pre-event; that the better off you were before, relatively speaking, you are still doing better off after an event.

DR. MAURICE PICKARD:

I see. I assume that in your study, you had some non-responders. How do you evaluate non-responders? My question really means is that non-responder so mentally ill that he does not respond to your attempt at getting data and therefore your results become skewed.

DR. SANDRO GALEA:

That's a great question and it's always a big question with this kind of studies in terms of the non-responders. There are always non-responders and the question is who are they? I mean, one could argue with both ways. You could suggest that non-responders are so ill that they don't want to talk to you, in which case you are underestimating illness, or you could argue non-responders are well and they do not want to talk to you because they feel there is no interest in talking to you in which case you are overestimating. Of course, most of the time you can't know and in this study we had <_____> non-responders were, but it has been looked at another studies in these kind of circumstances and it has been looked at, in particular, from the point of view of attrition in longitudinal studies. The fact is that most of the time we suspect that nonresponse either to a single study or attrition in a longitudinal study is non-differential to psychopathology that it is certainly differential by sociodemographics, for example, we know that women and older people tend to talk to researchers more than do men and younger people, for example, but from the point of view of psychopathology, there is very little evidence that (10:30) nonresponse is differential to such an extent as to invalidate results from further large samples.

DR. MAURICE PICKARD:

One of the things I was struck by when I read your paper was the low suicide attempt and also even the low suicidal thought processes that were in your patients that you talked to. How do you answer that?

DR. SANDRO GALEA:

The low suicidal thinking is in some ways puzzling us in the samples since the beginning <_____> published the previous paper with specific focus on that and the broader mind is that we don't really know why this low suicidality. There have been a lot of theories about it including hopes and growth after these kind of events and all that is relatively controversial and the role of different psychological domains after such events is untested and unclear. So I think it would have to come down on the side of 'I don't know' and it will require much more careful thinking about it and research that explicitly aims to address that question. There currently exists no good studies that have convincingly shown whether suicides increase or decrease after these kind of events, for example, there have been some studies the ones that have been published all have substantial limitations. I think the question about actual suicides pre and post these events remains (12:00) open and I think similarly the question about suicidality and suicidal intention pre and post these events remains open as well.

DR. MAURICE PICKARD:

I want to thank Dr. Sandro Galea who has been our guest today and we have been discussing the mental health problems of survivors of Katrina.

I am Dr. Maurice Pickard, and you have been listening to the clinician's roundtable on ReachMD XM 157, the channel for medical professionals. For questions and comments, please send your e-mails to xm@reachmd.com or visit us at www.reachmd.com. Thank

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