Book review

***Mental Health and Disasters*, Edited by Y. Neria, S. Galea & F.H. Norris. Cambridge, Cambridge University Press. (2009)**

This book, with 35 chapters by almost 100 experts, provides a comprehensive overview of current thinking and practice in disaster mental health. The book (624pp) is logically arranged under seven headings: concepts, psychopathology, vulnerability and resilience, special groups, interventions and health services, case studies and future directions. This makes it easy for the reader to find relevant information. Almost everything that one might want to know about mental health after disasters is covered, although the main (and perhaps only) flaw of the book is that it is strongly focused on resource-rich countries such as the United States, Australia and The Netherlands.

The two chapters on low or middle income countries and the complex humanitarian emergencies that cause most victims worldwide, lack sufficient depth to cover the breadth of the mental health responses to them Barbara Lopes Cardozo describes the mental health impact of the Asian tsunami in 2004. In line with her research for the international department of the Centers of Disease Control, the chapter focuses on the epidemiology of post-traumatic stress disorder (PTSD) and depression, and pays limited attention to psychosocial and mental health programming. I must agree with her conclusion that we know far too little of the effectiveness of such interventions and that these need to be studied more rigorously.

The other chapter on a low or middle income country is by Turkish-British psychiatrist Metin Başoĝlu. He describes in depth what we know about the mental health effects of earthquakes, drawing heavily on research findings of his group after major earthquakes in Turkey, and using a theoretical framework based on the principles of (cognitive) behavioural therapy. His most significant proposition is that, after exposure to a very frightening, uncontrollable and unpredictable stressor such as an earthquake, psychological symptoms such as avoidance should be seen as unproductive attempts to regain the sense of control that was lost during the traumatic event. Effective treatment should therefore be geared towards restoring the sense of control. Başoĝlu developed a multi-level Control-Focused Behavioural Treatment (CFBT) model. Most earthquake survivors (an estimated 60%) will not need any intervention. The remaining 40% should be offered guidance through a '*single session self-exposure*' via a self-help manual, (i.e. without a therapist). Most of those who correctly follow the instructions of the manual (80%) will recover, while the remaining 20% will need additional treatment in the form of a single session of therapist-assisted exposure. This is done in an '*earthquake simulator*', a wooden room on a machine that can shake and tremble, as if it were an earthquake. Most of the earthquake-survivors leave the box with an extinguished fear-reaction. Only those who do not respond well (less than 1% of the total population of earthquake-survivors) may need more intensive therapy which requires more than one session. Başoĝlu promotes this model as a simple intervention that can be used in low resource settings, and, interestingly, contrasts this hard-core '*behaviourist*' approach with techniques such

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as '*eye movement desensitisation and reprocessing*' (EMDR) which he sees as lacking context-specific evidence. He warns against dependence on interventions '*imported*' from Western countries and promotes his approach as a sound alternative. I remain somewhat sceptical about the feasibility of the mass use of self-help manuals.

Of course, Başoĝlu has a strong argument when he advocates less dependency on specialist treatment. In the United States, more than half of those who report high levels of symptoms indicative of severe psychopathology had not received any treatment six months after Hurricane Katrina. Ronald Kessler, the lead author of the chapter on Hurricane Katrina, writes that:

> *'It would be unrealistic to think that mental health professionals could successfully meet the dramatically increased needs of the many people with mental distress after a disaster as severe as Hurricane Katrina' (page 437).*

If that is indeed true for a high-resource setting such as the United States, then we should not have any illusions about meeting such needs in low or middle income countries. Kessler proposes mobile mental health units in post-disaster areas and ensuring that medical staff in primary care are trained to deliver mental health services.

While many chapters in the book talk about PTSD, some of the chapters present a refreshing look at its predominance as a diagnosis. Robert Ursano, head of the Centre for Traumatic Stress in Bethesda, Maryland, emphasizes that the constellation of psychiatric symptoms that we call PTSD is 'neither the only trauma-related disorder, nor, perhaps the most common' (page 133). He attempts to de-emphasise the significance of PTSD, comparing it to something like the common cold; experienced at some time in one's life by nearly everyone. Only in certain cases, when symptoms persist and progress, does it represent a '*substantial illness*'. A different way to approach the abundance of multiple, transient symptoms which appear after disasters is to avoid labelling distress as a disorder in the first place. This is what Neil Greenberg and Simon Wessely propose. They found that 11–13 days after the 2005 terrorist attacks on the London transport system 31% of the Londoners were experiencing substantial distress. Eight months later 11% did. The authors warn that '*distress*' is not the same as '*illness*' and that '*residual levels of distress are unlikely to present a clinical problem requiring treatment*' (page 554).

Highly relevant for those working in chronic emergencies is the plea by George Bonanno & Somati Gupta to give more attention to the concept of '*resilience*' and the factors that could bolster it. '*Resilience*' is the ability of people who are confronted with potentially highly-disruptive events to maintain a healthy level of psychological and physical function and retain their capacity to generate positive emotions (page 149). Social support and other social resources are important predictors of resilience. Bonanno & Gupta approvingly cite the Israeli expert Arieh Shalev who wrote:

> *'Interventions in communities suffering mass traumatic events should consist of general support and bolstering of the recovery environment rather than psychological treatment' (page 155).*

This brings us to the conclusion that the most urgent and the most effective collective interventions after disasters are profoundly social in nature.

Reviewed by Peter Ventevogel

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