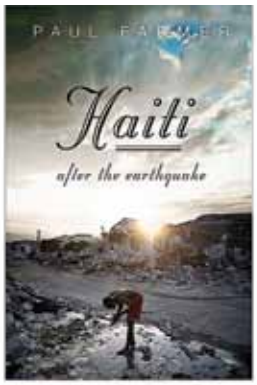

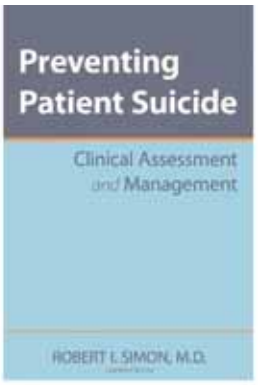

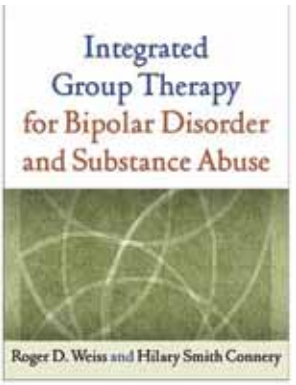

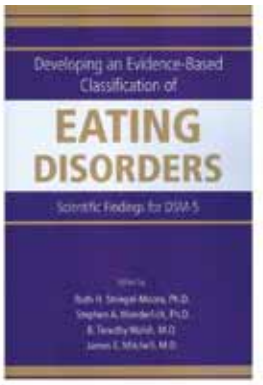

Haiti: After the Earthquake, *by Paul Farmer. New York, PublicAffairs, 2011, 456 pp., $27.99.*

The earthquake in Haiti on January 12, 2010, killed more than 300,000 people, injured and psychologically traumatized many more, and left tens of thousands homeless. Since earthquakes resulting in this scale of destruction occur primarily outside of the United States, such devastation is less familiar to those in the United States, who know more about disasters that are more common within their own country, rather than in low- and middle-income countries (1). Paul Farmer, M.D., a university professor at Harvard and a founder of Partners In Health, serves as the United Nations Deputy Special Envoy for Haiti, supporting President Bill Clinton, United Nations Special Envoy for Haiti, in disaster relief. Throughout his career, Farmer has been dedicated to providing and improving the medical care in disadvantaged countries, particularly Haiti and Rwanda, through Partners In Health. He is a role model, both here in the United States and elsewhere, for compassionate medical students and physicians who wish to use their medical skills to achieve altruistic goals in developing countries. Because of this, *Haiti: After the Earthquake*, which details the effects and sequelae of the earthquake in Haiti and is written by Farmer and his colleagues, deserves the attention of medical students, residents, psychiatrists, and other mental health professionals as well as all physicians.

After the first 247 pages, the book's collaborators add their voices with additional sections. They include Farmer's wife, Catherine Bertrand Farmer, as well as Edwidge Danticat, Michèle Montas-Dominique, Nancy Dorsinville, and Didi Bertrand Farmer in a section on women; Louise Ivers, Evan Lyon, Dubique Kobel, and Naomi Rosenberg, who authored a section titled "Doctors"; and Timothy T. Schwartz, Jennie Weiss Block, and Jèhane Sedky, who authored the concluding section titled "Humanitarians." Their voices resonate with that of Kent Ravenscroft (2), a psychiatrist who went to Haiti with a United Nations group to provide acute psychiatric care and to help train doctors in sustainable psychiatric assessment and care after the earthquake.

Does this book directly address disaster psychiatric care in Haiti? No, it does not, except as medical care for those acutely suffering in the earthquake's aftermath. In this regard, the text points out goals pertaining to care that we psychiatrists share. However, it is helpful to also know about basic sources, such as the *Textbook of Disaster Psychiatry*, by Ursano et al. (3), and the practical disaster psychiatry handbook for primary care clinicians edited by Stoddard et al. (4). The mental health implications of the book are readily apparent to individuals who work closely with surgeons in the care of severely injured patients, to those who care for children and adolescents, and to those who see many patients from Latin America and the Caribbean, including Haiti. The book does not use common psychiatric language to describe human suffering. Instead, Farmer and his collaborating authors are descriptive and often literary in the language in which they relate events that happened and to whom. For instance, Farmer includes the following quote from an article in the *Boston Globe*: "With thousands of bodies and minds shattered—and the emergence of a lethal cholera epidemic—the Partners In Health workforce in this country constituted almost exclusively of Haitians soared….Partners In Health hired mental health specialists, recruited amputees to visit the limbless, and sheltered forsaken children" (p. 238). Bereavement on a very large scale, depression, posttraumatic stress disorder, and other psychiatric syndromes are readily evident from the prose used to describe the suffering of survivors.

Hospitalized people with common syndromes for which we consult are described in detail: children whose crush injuries require amputations, patients in extreme pain and in great need of analgesia, and parents separated from their children as a result of their own injuries and need to obtain lifesaving medical care. The anguish and deaths of so many people with so few medical supplies and few doctors to care for them are nearly impossible to bear, for the authors and perhaps the readers. Nevertheless, it is a tremendous service that Farmer has provided in writing this book and, as he makes clear, a very difficult one. When one works in an acute disaster setting, doing the work is all that one can bear, much less having to revisit the disaster and write about it. Farmer recognizes the importance of this type of work, and his team aided him in completing this effort. In part, the book also represents "caring for the caretakers," an essential part of self-care in the disaster context (5). It provides a firsthand medical look at working within an acute disaster context, in a country well known to Farmer for many years, as well as social/medical system diagnoses, prognoses, and treatment recommendations on a policy level.

Farmer's social/medical diagnoses are grim, yet they leave room for hope. He and his colleagues make the point many times that Haiti, which became an independent country in 1803 after a slave revolt, has been punished ever since by Western nations (especially France and the United States),

even having to pay reparations to France until 1950 for having deprived it of a colony. Farmer traces Haiti's lack of a stable government and lack of solid medical and social services to this heritage. Because of political instability, largely secondary to this history, the prognosis is not rosy. Treatment progress will only be achieved with efforts sustained over many years by those individuals and entities, especially governments and private donors, who will work to strengthen the political, governmental, and social fabric of the whole country. There is a good start with the rebuilding and restoration of hospitals and a medical school, perhaps even a "building back better," as Farmer and President Clinton would have it. Even as the author focuses on primary care and specialty surgical care, it requires no imagination to know that the care for those who suffer from mental illness, which is likely as bad or worse, needs to be addressed as well, and such care will similarly benefit if infrastructural governmental strengthening can occur and continue.

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Preventing Patient Suicide: Clinical Assessment and Management, *by Robert I. Simon, M.D. Washington, DC, American Psychiatric Publishing, 2011, 235 pp., $57.00.*

Robert Simon is one of a handful of psychiatrists with expertise in both law and psychiatry who has made important contributions to our understanding of the risk factors for suicide, aimed at enabling clinicians to protect their patients from suicide and themselves from being blamed for a death by suicide. Particularly noteworthy in this regard is Simon's strong advice not to rely on suicide assessment forms as a substitute for clinical assessment and judgment.

Simon views suicide as the result of many factors: diagnostic, epidemiological, genetic, familial, occupational, environmental, social, cultural, existential, and chance. Although he makes reference to all of these factors, primarily the first two, his focus is on behavior and symptoms in assessing suicide risk. He is concerned with "managing" risk, avoiding the use of the word "treatment." Obviously, if you do not deal with risk, you will not have a patient to treat, but knowing and listening to patients as you do in psychotherapy has been an important source of our knowledge of suicide risk and the stimulus for research on this topic. Patients in treatment are an important part of the area of suicide research; not discussing them is a serious limitation of this otherwise fine book.

The unfortunate tendency in our profession to rely on treating symptoms leads many municipal hospitals to use a symptom checklist as a substitute for a case narrative. The patient's charts give no picture of what the patient is like and how patients differ from one another. Management of these cases in the hospitals and in those discussed in this book is largely restricted to medication, ECT, or hospitalization.

To avoid dealing with patients in treatment contributes to a lack of sensitivity to key factors in the psychology of suicide. Most important is suicidal patients' use of the possibility of their suicide to give them an illusory sense of being in control of their lives; the use of the threat of suicide serves to give them what, unfortunately, is often a not so illusory control over those who manage or treat them.

Simon recognizes the absence of a good therapeutic alliance as an important risk factor in the assessment of a suicidal patient, indicated by missing treatment sessions with patients or seeming not to care about them. His remedy is increased risk watchfulness. However, a high percentage of suicidal patients are resistant to evaluation, management, or treatment, but they have "defenses" that can be addressed.

Many years ago, I saw a young man who had shot himself in the chest. The bullet grazed his heart and came to rest a centimeter or two from his spinal cord, which was too close to be removed. No one in the hospital where he was taken had ever seen anyone survive such an entry wound. That he had come to see me under pressure from the doctors and his parents was evident before he said a word. When he did speak, his first remark to me was, "I will give you 6 months to make me feel better, and if you don't, the next time I won't miss." We spent the next month discussing his view that he could leave his fate in my hands and be a passive participant in this therapy. His attitude toward treatment changed, and he was not suicidal again in the year I saw him. He is alive and well, and when he consulted me 30 years later, he reported no further suicide attempts, and the consultation had nothing to do with suicide.

What patients say often indirectly reveals their risk for suicide, and failure to understand such communications can contribute to a suicide. For example, a bipolar patient known to his psychiatrist to be at risk for suicide called her to say that he had mistakenly taken his medication twice in one day and asked whether this was an inadvertent suicide attempt. The therapist assured him that it was not. Underlying the patient's question appeared to be an increasing preoccupation with suicide that was left unaddressed. He killed himself a few days later (1).

In this book, Simon's exclusive focus on behavioral risk factors also contributes to a seeming lack of awareness of the role of intense affective states as key risk factors for suicide. An ongoing 25-year study with therapists of patients who were in treatment with them when they died by suicide, compared with comparably depressed patients who had never been suicidal and were treated by the same therapists, reported evidence that a group of affective states that were not simply present but intense (anxiety, rage, desperation, loneliness,