'post-traumatic' reactions? According to DSM–IV–TR criteria for post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2001), a traumatic event requires that 'the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others' (further requiring that 'others' must be persons, not animals) and that 'the person’s response involved intense fear, helplessness, or horror' (p. 467). We seriously question livestock loss as a traumatic event.

Loosening criteria for a traumatic event represents a progressive 'conceptual bracket creep' in defining trauma (McNally, 2003). Will the next study examine PTSD in children 'traumatised' by their pet hamster’s death, or from watching Bambi die in the famous Disney movie? What about being exposed to offensive remarks by others (Avina & O’Donohue, 2002)? With the current trajectory all negative experiences will be synonymous with traumatic events, trivialising the experiences of real trauma victims. We ask where will researchers finally draw the line in what is considered traumatic? Continued disregard for the criteria will lead to anyone being considered trauma-exposed and eligible for a PTSD diagnosis. With healthcare resource limitations, truly trauma-exposed and symptomatic patients could consequently be denied care (at a minimum subjected to extensive waiting lists), and our courts would be crippled with unnecessary PTSD litigation.

Olff et al (2005) claim that ‘Although the foot and mouth crisis is not a traumatic event in the usual sense, the consequences do resemble features of PTSD’ (p. 166). This statement minimises (without justifying) the authors’ disregard for trauma criteria, and poses a circular argument in contending that the presence of PTSD symptoms confirms trauma exposure. However, trauma exposure must be distinguished from PTSD, since minor stressors (e.g. taking a nightshift job) can result in symptoms (e.g. difficulties in sleeping, problems concentrating) that are aetiologically distinct from PTSD.


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Authors’ reply: Post-traumatic stress disorder is unusual among DSM disorders in that the diagnostic criteria specify an aetiological event: exposure to a traumatic stressor. In their letter Elhai et al cite examples that do not meet the stressor criterion, the symptom criteria for PTSD, or the criteria of distress or impairment. The DSM–IV symptoms (re-experiencing, avoidance/numbing and hyperarousal) are defined in terms of their connection with a traumatic event. The ‘conceptual bracket creep’ (McNally, 2003) refers to the broadening of the stressor criterion in DSM–IV, especially to the inclusion of ‘second-hand exposure’, such as learning about the unexpected death of a close friend/relative or watching atrocities on television (see Rosenbaum, 2004). This seems to increase the eligible events by about 20% (Breslau & Kessler, 2001). However, more important is the question addressed in the DSM–IV guidebook ‘whether or not to include reactions to the numerous stressors that are upsetting, but not life threatening (Frances et al, 1995: p. 259) or even to eliminate the stressor criterion altogether. The fear that more inclusive definitions will vastly increase the frequency of the diagnosis seems to be unrealistic. More minor stressors simply will not result in the other diagnostic criteria for PTSD.

McNally (2003) makes an important point in stating that with the inclusion of such diverse events it will be difficult to identify common psychobiological mechanisms underlying symptomatic expression. In our opinion, to develop PTSD the stressor – often associated with severe sadness – should be intense enough to evoke a psychobiological dysregulation of the fear system, which results in the event being re-experienced, avoided and leading to a state of hyperarousal where the person feels that danger could strike again at any moment. This psychobiological stress response is dependent on subjective appraisal of the event and not on objective criteria of stressor severity (Olff et al, 2005). This would suggest that ‘second-hand exposure’, non-traditional stressors or even life events might in some instances evoke an intense psychobiological dysregulation leading to ‘PTSD’ symptoms. Apparently, this was the case for the farmers who witnessed (saw, heard, smelled) all their animals being destroyed, an event that was beyond their control and is certainly ‘outside the range of their normal experience’.

Mental healthcare should be available to those with significant mental health problems, even if these are considered sub-threshold for PTSD. By conducting a large epidemiological survey in The Netherlands we hope to determine what kind of stressors (including life events) evoke what kind of ‘post-traumatic’ symptoms, as well as the implications for mental healthcare.


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Potentially preventable suicide

We read the short report by Bennewith et al (2005) with interest. The authors attempted to address one of the objectives of the National Suicide Prevention Strategy for England, restricting access to means of suicide (Department of Health, 2002).

The authors found 10 cases (6%) of ‘potentially preventable’ suicide by hanging in controlled environments such as hospitals and prisons, among 162 cases of a
randomly selected sample of suicide by hanging from a wide geographical area in England.

We would like to make the following comments. The report made no reference to the proportion of older victims in the randomly selected sample. The mean age given in the report (41 years) is almost the same as that for all people over the age of 16 years in England and Wales who hanged themselves in the same year as the study (2001) and over the past 23 years. These cases include, on average, 16% over the age of 64 years. This means that the study sample of 162 contained at least 25 victims over the age of 64, a sizeable older element that was not referred to in the report.

This is important and ought to have been clarified particularly in relation to the deaths that occurred in hospital when the victims were found seated (4.7%), kneeling (7.4%), lying (8.7%) or partially suspended (3.4%) and to individuals who were found alive (4.3%). However, this does not apply to hanging in prison where victims had an estimated mean age of 28 years (Shaw et al., 2004).

We calculate the expected annual rate of ‘potentially preventable suicides by hanging’ within institutions (controlled environment) in England and Wales to be about 110 cases of a total of 1300 expected annual suicides by hanging: 86 in prison (Shaw et al., 2004) and 24 (about a third of 71 hanging incidents by psychiatric in-patients) in hospital (Department of Health, 1999). ‘Potentially preventable suicide by hanging’ in controlled environments involving prisoners represents 5% of all suicide by hanging in England and Wales and 2% in the case of psychiatric in-patients. This is remarkably similar to the 6% in the report of Bennewith et al.

It would be of real interest, and certainly of practical value, if future studies specifically investigated suicide by hanging within controlled environments such as hospitals and prisons using an appropriately selected sample over a period of time (e.g. 220 incidents expected over 2 years in England and Wales, based on current figures). This would provide a study with acceptable power and some inferential value compared with the modest 10 cases reported by Bennewith et al.


Authors’ reply: The aim of our research was to undertake a detailed assessment of a sample of all (community and institutional) suicides by hanging in a defined geographical area over a 6-month period, focusing on potentially preventable aspects of these deaths. The context for the research was the rise in suicides by hanging in England and Wales (Gunnell et al., 2005) and the National Suicide Prevention Strategy for England (Department of Health, 2002). Of note, rates of suicide by hanging have not increased among men or women aged 65 years and over (Gunnell et al., 2005). Although generally Office for National Statistics figures for England and Wales from the 1970s onwards show that rates per 100 000 for deaths by hanging were higher in those aged 65 and over compared with rates in other age groups, this is not the case from 2000 onward when rates for death by hanging increased in the 15- to 44-year age group and decreased among those aged 65 and over (Gunnell et al., 2005).

The Editor decided that our paper should be resubmitted as a short report. The limited space did not enable us to give a full breakdown of the distribution of age, gender, race, social class, etc. of all of our sample. In response to the concern of Drs Salib and Theophanous we can confirm that 13 (8.0%) of the 162 cases in our study were aged over 65 years. Furthermore, 19 (11.7%) were aged under 25 years and 139 (85.8%) were male.

For those interested in a more detailed account of suicides in psychiatric hospitals and prisons we suggest the following sources: Dooley (1990), Shaw et al (2003), Shaw et al (2004) and Gunnell et al (2005).