'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.

**American Psychiatric Association (2001)** *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, revised) (DSM–IV–TR). Washington, DC: APA.

**Avina, C. & O'Donohue, W. (2002)** Sexual harassment and PTSD: is sexual harassment diagnosable trauma? *Journal of Traumatic Stress*, **15**, 69–75.

**McNally, R. J. (2003)** Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology*, **54**, 229–252.

**Olff, M., Koeter, M. W. J., Van Haaften, E. H., *et al* (2005)** Impact of a foot and mouth disease crisis on post-traumatic stress symptoms in farmers. *British Journal of Psychiatry*, **186**, 165–166.

**J. D. Elhai** Disaster Mental Health Institute, The University of South Dakota, 414 East Clark Street – SDU 114, Vermillion, South Dakota, USA. E-mail: jelhai@usd.edu

**T. B. Kashdan** Department of Psychology, George Mason University, Fairfax, Virginia, USA

**B. C. Frueh** Charleston Veterans Affairs Medical Center and Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, USA

**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-typical traumatic 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 subthreshold 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.

**Breslau, N. & Kessler, R. C. (2001)** The stressor criterion in DSM–IV posttraumatic stress disorder, an empirical investigation. *Biological Psychiatry*, **50**, 699–704.

**Frances, A., First, M. B. & Pincus, H. A. (1995)** *DSM–IV Guidebook*. Washington, DC: American Psychiatric Press.

**McNally, R. J. (2003)** Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology*, **54**, 229–252.

**Olff, M., Langeland, W. & Gersons, B. P. R. (2005)** Effects of appraisal and coping on the neuroendocrine response to extreme stress. *Neuroscience and Biobehavioral Reviews*, **29**, 457–467.

**Rosenbaum, L. (2004)** Post-traumatic stress disorder: the chameleon of psychiatry. *Nordic Journal of Psychiatry*, **58**, 343–348.

**M. Olff, B. Gersons** Centre for Psychotrauma, Academic Medical Centre/De Meren, Department of Psychiatry, University of Amsterdam, Tafelbergweg 25, 1105 BC Amsterdam, The Netherlands. E-mail: m.olff@amc.uva.nl

## 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



https://doi.org/10.1192/bjp.187.2.190 Published online by Cambridge University Press