Author's reply: Professor David highlights important points in relation to the trial of cognitive therapy for the prevention of psychosis. He asks for clarification regarding the exclusion of two participants for having been psychotic at inception, but only reporting this on second contact with an assessor. This was certainly what happened, and following this the research assistants were instructed to ask all participants about this. This was not in the original protocol for the study, as such an event was unexpected (although, with hindsight, maybe it should not have been). It did seem reasonable to exclude these participants, especially given that the study is the first of its kind (clearly future studies should address this issue in the protocol).

He also raises the issue of randomisation. The procedure for randomisation is very clearly outlined within the original paper and the difference in gender rates was due to chance. It is true that this method resulted in more of the treatment group being female, which is an indicator of better outcome for such a population; however, the method also resulted in the treatment group having a higher proportion of people who were unemployed and a significantly higher level of baseline positive symptoms, both of which would predict poorer outcomes for the treatment group. It is also worth noting that gender was utilised as a covariate in all analyses regarding transition that were reported.

Professor David has identified two important issues that can only be clarified by replication of the results of this study with a more rigorous protocol and an alternative method of randomisation; we would agree that such research is required to determine whether the preventive effects of cognitive therapy with people at ultra-high risk of developing psychosis are generalisable and robust.

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Guided self-change for bulimia

Bower & Gilbody (2005) raised questions about stepped care in psychological therapies to which I would like to provide some answers. Our treatment evaluation study of guided self-change for bulimia nervosa incorporated a self-care manual and investigated acceptability, drop-out rate, 'extra treatment' and longer-term outcome (Thiels *et al*, 1998*a*, 2003). We did not dare to offer the manual only as a first step to Germans spoilt by a healthcare system with excellent provision of long-term psychotherapy. Instead we compared 8 fortnightly sessions plus a self-care manual (guided self-change) with 16 weekly individual sessions of cognitive–behavioural therapy (CBT). There were no significant differences between therapies regarding drop-out rate, general satisfaction with treatment and views regarding the usefulness of the therapies.

A journalist who wanted to write about our study in the weekly newspaper *Die Zeit* met with strong resistance. Although we published the 6-month follow-up results in the *American Journal of Psychiatry* (Thiels *et al*, 1998*b*, quoted by Bower & Gilbody, 2005) the head of the science section of *Die Zeit* did not believe that such low therapist input could work. Some psychiatrists in the hospital where the journalist's husband worked feared for their jobs.

Bower & Gilbody (2005) state that 'research on the patient acceptability assumption would need to access the views of a number of different populations...'. We invited family physicians, psychiatrists, gynaecologists and various counselling services to refer those who complained of symptoms suggestive of bulimia nervosa (the clinical picture of which was briefly described) (Thiels *et al*, 1998*b*). An article about the service in a local newspaper led to several self-referrals. Unfortunately, we did not compare acceptability according to the source of referral and thus can only report the overall acceptability.

Follow-up by personal interview using expert and self-rated instruments was carried out a mean of 54.2 months (s.d.=5.8) after the end of therapy. Significant improvements were achieved or maintained in both groups on the main outcome measures. These included eating disorder symptoms from expert ratings (Eating Disorder Examination sub-scores: overeating, vomiting, dietary restraint, shape and weight concern), self-report (Bulimic Investigatory Test, Edinburgh) and a global five-point severity scale. Improvement was also seen on the subsidiary outcome variables Beck Depression Inventory, Self-Concept Questionnaire and knowledge of nutrition, weight and shape. During the week before follow-up 66.7% of the guided self-change group and 61.5% of the CBT group had not binged, vomited or misused laxatives.

A considerable proportion in both groups had extensive further psychological treatment, mainly for their eating disorder. The majority of these had not done well during initial treatment. An analysis of covariance showed a significant interaction between treatment group and additional treatment between the 6-month and the 4-year follow-up. Cross-tabulation showed that this difference was due to the fact that three of the five in the CBT group with additional treatment between the two follow-up assessments improved more than the eight in the CBT group without additional therapy (χ^2=6.24; d.f.=1; P<0.035). However, the six in the guided self-change group who received additional treatment made as little progress as the seven who did not (χ^2=0.26; d.f.=1; P<1.00). Four out of 12 individuals received additional treatment from their study therapist, the other eight received additional treatment elsewhere. The question is whether those who were allocated to guided self-change would not have recovered in the course of 4 years with any therapy or whether they might have done better with more therapist contact from the beginning of treatment.

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What is a traumatic event?

Olff *et al* (2005) sampled farmers during a foot and mouth epidemic, concluding that half whose livestock were culled had 'post-traumatic stress at levels requiring professional help', and 'the high prevalence of post-traumatic stress symptoms is an underestimation of the real levels of psychopathology' (p. 166). What was the 'traumatic event' implicated in these

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'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-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.

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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

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