Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

Going to war always hurts

I was disappointed and saddened by the carelessness of the title 'Going to war does not have to hurt' in the June issue of the *Journal* (Hacker Hughes *et al*, 2005). One does not even have to mention the considerable number of British casualties in Iraq to realise that this headline is completely ill thought out and a particularly misplaced euphemism that fails to appreciate that war in modern times always kills civilians rather than military personnel. As the historian Norman Davies points out, almost 100% of casualties in modern warfare are civilians and this is no different in Iraq today. To minimise the considerable and well-documented consequences of going to war for Army personnel and to ignore the plight of civilians is, in my opinion, shameful. Health professionals should be very careful not to collude with politicians in minimising the impact of war and armed conflict, because they can easily become a vehicle of such policies.

Hacker Hughes, J., Cameron, F., Eldridge, R., *et al* (2005) Going to war does not have to hurt: preliminary findings from the British deployment in Iraq. *British Journal of Psychiatry*, **186**, 536–537.

P. Lepping Llwyn Y Groes Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD, UK. E-mail: PETERLEPPING@new-tr.wales.nhs.uk

Authors' reply: Dr Lepping has expressed strong views on the plight of the Iraqi civilians who have suffered tragic and devastating casualties in the conflict that has followed the war in Iraq. Our paper was not attempting to belittle their suffering or to make excuses for the political ideologies behind the conflict; rather we examined the mental health of UK military personnel who had been deployed to Iraq in the line of duty.

With the exception of Professor Simon Wessely (who is an unpaid Honorary Civilian Consultant Advisor in Psychiatry to the Director General of the Army Medical Services), all of the authors are either civilian or uniformed members of the Defence Medical Services. As such, it is our duty and privilege (along with our many colleagues) to look after the mental health needs of the servicewomen and men of the UK's Armed Forces to the best of our ability. It is these professional sailors, soldiers and aviators (both full-time and reservist) who are mobilised by our government to go to war on behalf of the country for whatever purpose. Their going to war is distinct from those civilian inhabitants of war zones who of course do not choose to 'go to' war but who inevitably suffer the consequences of warfare and armed conflict.

The effects of war on civilian populations have been extensively investigated and published elsewhere (Horton, 2004; Roberts *et al*, 2004) and, although continued investigation of the health needs of civilians caught up in war is indeed pressing, our paper concerned itself solely with the mental health of those professional soldiers who are called upon to fight.

The conclusion of the study was that, for a highly prepared elite group of soldiers involved in war fighting in Iraq, there was a positive effect on soldiers' mental health, at least in the short term. In that context, the title of the short report was, in our opinion, highly appropriate.

Declaration of interest

J.H.H., F.C., R.E. and M.D. are employed by the UK Defence Medical Services. S.W. is an unpaid Honorary Civilian Consultant Advisor in Psychiatry to the Director General of the Army Medical Services.

Horton, R. (2004) The war in Iraq: civilian casualties, political responsibilities. *Lancet*, **364**, 1831.

Roberts, L., Lafta, R., Garfield, R., *et al* (2004) Mortality before and after the 2003 invasion of Iraq: cluster sample survey. *Lancet*, **364**, 1857–1864.

J. Hacker Hughes, S. Wessely King's Centre for Military Health Research, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, UK. E-mail: J.Hacker-Hughes@iop.kcl.ac.uk

F. Cameron, R. Eldridge, M. Devon Defence Medical Services, Department of Community Mental Health, Colchester, UK

Traumatic events *v.* life events: does it really matter?

We read with great interest the paper by Mol *et al* (2005). However, we would like to point out some weaknesses. First, 'serious illness (self)' was considered a life event rather than a traumatic event. There is a vast literature concerning post-traumatic stress disorder (PTSD) in people with AIDS and cancer. Serious illness definitely meets the DSM–IV criterion A1 for life-threatening situations (Barak *et al*, 1998).

Second, there is a big problem with Mol *et al*'s definition of 'sudden death' of loved ones, which ranges from watching a loved one die violently to hearing about the death of a loved one or a close relative. The same is also true for accidents and serious illness. The magnitude of a traumatic event is linked directly to PTSD symptomatology (Sunger & Kaya, 2001). If we were to exclude sudden death and accidents from the traumatic events group we would see a significant difference between the life events group and the traumatic events group, with more symptoms in the latter. This is a crucial point since most people in the traumatic events group reported sudden death or accident as their worst event; they also had a low level of PTSD symptomatology. If Mol *et al* had subdivided the sudden death and accident groups according to the magnitude of the event, this would have helped to determine whether the event could be considered a life event or a traumatic event. This is important when dealing with the issue of traumatic grief (Stroebe *et al*, 2001), which is a combination of PTSD and bereavement. If the participants had undergone normal grieving the sudden death should be considered a life event rather than a traumatic event.

Third, the magnitude of the traumatic event was clearly associated with PTSD

https://doi.org/10.1192/bjp.188.1.83-a Published online by Cambridge University Press

symptomatology, with extremely traumatic situations such as physical and sexual abuse being related to very high PTSD symptomatology scores. However, the number of participants with exposure to such traumatic events was very small (n=9 for physical abuse, n=4 for sexual abuse and n=13 for physical and sexual abuse as a child).

Notwithstanding, the basic message of the paper is important: the line between life events and traumatic events is at best thin, and sometimes nonexistent. The best support for this can be found in the case of the Dutch farmers (Olff *et al*, 2005) whose cattle were exposed to foot and mouth disease leading to the killing of the herds. This was not a life-threatening event for the farmers, but was a major life event that can easily be considered traumatic.

Barak, Y., Achiron, A., Rotstein, Z., *et al* (1998) Stress associated with asbestosis: the trauma of waiting for death. *Psycho-Oncology*, **7**, 120–128.

Mol, S. S. L., Arntz, A., Metsemakers, J. F. M., *et al* (2005) Symptoms of post-traumatic stress disorder after non-traumatic events: evidence from an open population study. *British Journal of Psychiatry*, **186**, 494–499.

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.

Stroebe, M., Schut, H. & Finkenauer, C. (2001) The traumatization of grief? A conceptual framework for understanding the trauma–bereavement interface. *Israel Journal of Psychiatry and Related Sciences*, **38**, 185–201.

Sunger, M. & Kaya, B. (2001) The onset and longitudinal course of a man-made post-traumatic morbidity: survivors of the Sivas disaster. *International Journal of Psychiatry in Clinical Practice*, **5**, 195–202.

M. Ben-Ezra Department of Psychology, Tel Aviv University, PO Box 39040, Tel Aviv 69978, Israel. E-mail: menbe@post.tau.ac.il

D. Aluf Department of Psychology, Open University, Rannana, Israel

Post-partum depression

We would like to raise some concerns about the paper by Evans *et al* (2005), which oversimplifies the aetiology of post-partum depression. Depression in pregnancy and post-partum has been globally linked to psychosocial issues (marital problems, social support, childhood adversity) and pregnancy-related factors, all of which interact with personality (Patel *et al*, 2002; Dennis & Boyce, 2004). For the findings of the paper to be clinically relevant, it would have been useful to study the relative roles of at least some of these mediating variables, rather than focusing on personality alone.

We also feel that using six items from an interpersonal sensitivity scale for assessing the main explanatory variable is not fully justified. The items chosen measure only some aspects of the self; more-robust measures such as the Dysfunctional Attitude Scale (Weissman, 1979), or the Crandell Cognitions Inventory (Crandell & Chambless, 1986) could have been used to assess self-schemas.

We would also like Evans *et al* to speculate on why some women developed depression earlier and some later (after 3 years) despite having high negative self-schemas at baseline. Is it possible that self-schema also change with experiences such as motherhood, or that support might have mediated the later onset of depression? Also, did women in the higher tertiles for negative self-schema score develop depression earlier?

In the absence of information about important psychosocial variables and factors related to the development of schemas, it is difficult to presume that negative self-schemas are alone sufficient to predict the onset of depression. The inclusion of women who had negative self-schemas but did not develop depression, and repeat assessment of those with negative self-schemas would have also better delineated state versus trait concerns. Finally, it would have been useful to have a control group of non-pregnant women to determine whether personality as a vulnerability factor is unique to pregnancy and the post-partum period.

Crandell, C. J. & Chambless, D. L. (1986) The validation of an inventory for measuring depressive thoughts: the Crandell Cognitions Inventory. *Behaviour Research and Therapy*, **24**, 403–411.

Dennis, C. L. & Boyce, P. (2004) Further psychometric testing of a brief personality scale to measure vulnerability to post partum depression. *Journal of Psychosomatic Obstetrics and Gynecology*, **25**, 305–311.

Evans, J., Heron, J., Lewis, G., *et al* (2005) Negative self-schemas and the onset of depression in women: longitudinal study. *British Journal of Psychiatry*, **186**, 302–307.

Patel, V., Rodrigues, M. & DeSouza, N. (2002) Gender, poverty, and postnatal depression: a study of mothers in Goa, India. *American Journal of Psychiatry*, **159**, 43–47.

Weissman, A. (1979) The Dysfunctional Attitude Scale: a validation study. *Dissertation Abstracts International*, **40**, 1389–1390.

P. S. Chandra Departments of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore 560029, India. E-mail: chandra@nimhans.kar.nic.in

P. Sudhir Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bangalore, India

Authors' reply: Drs Chandra and Sudhir appear to have misunderstood the aim of our paper. The paper is not primarily about post-partum depression. We did not aim to study the overall aetiology of post-partum depression nor did we aim to accurately predict post-partum depression from the negative self-schema measure. We did aim to test an important aspect of the cognitive theory of depression, namely whether a measure of negative self-schema is associated with the onset of depression. We found there was an association and that it was equally strong whether the onset was during pregnancy, in the post-partum period or 3 years later. In the main analysis we adjusted for the psychological and socio-economic variables outlined in Table 3.

We agree, as stated in our discussion, that a more detailed questionnaire such as the Dysfunctional Attitude Scale would have provided a more comprehensive measure of self-schema. Furthermore, repeated measures would have allowed comparison with other studies and a test of the stability of these 'schemas'. It is possible that schemas change with an experience such as motherhood, although theoretically they should be relatively stable. As these were secondary data analyses of an existing data-set, we were limited to the data available to us and these did not include any more-detailed or repeated measures of schemas.

There are clearly multiple factors that influence the onset of depression. The correspondents ask why some women have earlier onset than others. This may well be related to changing support or adverse events, but it was not the aim of our paper to address this question. Rather than speculate, the ALSPAC data-set provides an opportunity to answer this question and many others by undertaking further detailed analyses of those data.

The analyses we presented in Table 4 indicate that the strength of the association between negative self-schema and onset of depression does not diminish with time, so it is unlikely that those in the highest tertiles for depression have onset which is sooner.

https://doi.org/10.1192/bjp.188.1.83-a Published online by Cambridge University Press