Gradus et al.\textsuperscript{1} need to be complimented for studying the effects of acute stress reaction on completed suicide. This has not been studied previously and highlights the enduring medium to long-term psychological effects of acute traumatic events on individuals. Suicide may be the most extreme form of behaviour seen as a result of the acute trauma but there are a range of other psychological symptoms and reactions, ranging from fearfulness, insomnia, poor concentration, disturbed interpersonal relationships and domestic violence, to psychiatric syndromes such as post-traumatic stress disorders, anxiety and mood disorders, substance abuse and psychotic disorders, that a vulnerable individual can end up with. These can have devastating effect not only for the individual but also for his/her family as well.

Among the various causes of acute stress, natural catastrophes are one of the most common. It is estimated that following a natural catastrophe some form of psychological distress is almost universal, with 30–50% of the affected population experiencing moderate to severe distress and the remainder suffering mild distress.\textsuperscript{2} There is also an increase in suicide rates after natural catastrophes, highlighting the need for psychological support in the period following the acute stress.\textsuperscript{3} The Asian tsunami in 2004, Hurricane Katrina in 2005, the earthquakes in Pakistan in 2005 and Haiti in 2010, the large-scale flooding in Pakistan in 2010, along with the large-scale terrorist activities in many parts of the world, highlights the need to address the mental-health needs of the victims of acute stress.

In all of these situations, mental health is largely ignored or given cursory attention as the emphasis is mostly on physical needs. Once the television cameras disappear many of the victims are all too often forgotten and left to deal with the psychological trauma of such events on their own.

There are three brief comments (rather than criticisms!) on this interesting study and these could be areas of future study.

First, we need to study the nature of the acute stress. There is a qualitative difference between events that involve large groups of people, such as natural catastrophes and those that involve an individual only, such as assault or an accident. The distinction between the two is important. By studying the commonalities and differences in the two

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groups, programmes to manage psychiatric morbidity in the two populations could be devised.

Secondly, it is important to study resiliency factors in individuals exposed to acute stress. Only a small (although significant) minority of individuals who are exposed to acute stress go on to commit suicide. Clearly, individual resiliency factors play an important role in mitigating the effects of acute stress and understanding these is important.

Thirdly, there is little evidence to suggest that individuals who are suicidal immediately following the acute stress are at higher risk for later suicide. After Hurricane Katrina, there was a doubling in the prevalence of mild-to-moderate mental disorders but lower suicidal ideation. Hence measuring ‘suicidality’ at the time of the acute stress (which is likely to be high) is unlikely to serve any useful purpose.

What is clearly important is that individuals who undergo acute stress reactions must be kept under surveillance for compromised mental health and those who develop psychiatric disorders be provided with the necessary care and support.

This study shows that suicide is also an important health outcome of acute stress reactions. It suggests that mental-health support is needed after acute stress reactions, that it should be available for varying periods, and that it should take into account the needs of various age groups, both genders and of people of different marital and socio-economic status. Prevention could include providing social, medical and psychological support.

Conflict of interest: None declared.

References