Correspondence

EDITED BY KHALIDA ISMAIL

Understanding violence

There are potentially significant absences in Professor Fonagy's otherwise illuminating editorial on the developmental aspects of violence, and he neglects to consider other related theories (Fonagy, 2003).

The word 'father' does not appear in his review and this would seem a major absence in the context of research showing consistent absences of stable paternal figures in those exhibiting antisocial behaviour, which is itself associated with violence (Pfiffner *et al*, 2001). It is particularly puzzling, as Professor Fonagy has himself explored the possible role of the absent father in the development of violent propensities (Fonagy & Target, 1995).

It is also perhaps premature to dismiss (or pathologise) the use of the term 'psychopathy'. The literature, which includes distinguished psychoanalytic contributions (Reid Meloy, 2001), as well as explorations of possible biological factors (Dolan, 1994), suggests that the term has considerable utility in research, treatment and risk management, as well as potential dangers (Edens, 2001).

Other social aspects of violence are also not explored, including group dynamic aspects, which are possibly best illustrated by the breakdown of normal social mores in conflict and war. A relatively recent example is the Rwandan genocide, where individuals capable of perpetrating atrocities were then able to return to everyday existences.

Fonagy's review was also clearly concerned with violence at a population level and in relation to normal development. He does not consider, however, the important question of how violence in people with mental disorders might potentially differ from that in the general population, and how this issue needs continuing exploration by mental health professionals.

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Author's reply: Dr Beales makes several important points and I disagree with none of them, but discussion of each would have taken the length of my editorial beyond its permitted limits. The absence of a male figure in the developmental history of the child may contribute to the emergence of violence because the dominant role models are more likely to be violent peers rather than mature adults, or, as I have suggested (Fonagy, 2003), because of the deficit in social perspective-taking that being deprived of the opportunity to identify with a person observing one's relationship with another can generate.

I agree that psychopathy is a helpful clinical concept and that even among children we find those whose aggressive behaviour is not associated with the behaviour of attachment figures (Wootton *et al*, 1997). However, an overemphasis on constitutional predisposition is risky, insofar as it can lead to an underestimation of both the importance of psychosocial factors in the causation of violence and the opportunities for change.

I particularly regretted that I did not have space to explore the effect of group factors on violence. The anonymisation of the individual by the large group is a risk factor, specifically because it removes the inhibition that the developmental process of enculturation imposes on a natural human propensity for violence. Examples such as Rwanda or the current proliferation of terrorist attacks palpably demonstrate how a group process can obliterate personal awareness of the other as an intentional being, reducing others to the status of stereotypes invested with powerful negative valences. The ability of the suicide bomber to bring a violent end to his or her own life at the same time as destroying those of others suggests just how easily undermined the developmental process that brings our capacity for violence under control might be. To isolate the violent individual as somehow inherently and radically different from the rest of us, which a clinical perspective can sometimes do (Hering, 1997), may also serve to reassure us that we are at no risk of perpetrating mindless violence. Tragically, history tells us that this is simply not so. Violence is impossible for us to contemplate precisely because it is ultimately an act of humanity (Abrahamsen, 1973).

Abrahamsen, D. (1973) *The Murdering Mind*. London: Hogarth Press.

Fonagy, P. (2003) The developmental roots of violence in the failure of mentalization. In *A Matter of Security: The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy* (eds F. Pfafflin & G. Adshead), pp. 13–56. London: Jessica Kingsley.

Hering, C. (1997) Beyond understanding? Some thoughts on the meaning and function of the notion of 'evil'. *British Journal of Psychotherapy*, **14**, 209–219.

Wootton, J. M., Frick, P. J., Shelton, K. K., *et al* (1997) Ineffective parenting and childhood conduct problems: the moderating role of callous–unemotional traits. *Journal of Consulting and Clinical Psychology*, **65**, 301–308.

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Suicide and sexual orientation

King *et al* (2003) have published a valuable contribution to the literature regarding the mental health of lesbians and gay men. However, they erred in asserting that, 'No study has examined whether gay and lesbian people have elevated rates of completed suicide. . . .' (p. 557). This is important because studies of sexual orientation and attempted *v.* completed suicide have yielded different results. Nearly all studies of sexual orientation and attempted suicide have found that gay men and lesbians have

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higher rates of self-harm than heterosexuals. Conversely, all studies of sexual orientation and completed suicide have concluded that gay men and lesbians do not die by suicide at a higher rate than heterosexuals.

Spencer (1959) followed 100 Oxford undergraduates referred by their general practitioners. Relative to 35% of controls (n=100), a significantly greater proportion of patients (51%) had homosexual behaviour, fantasies or desires. 'No patient was lost by suicide' but 9 of 10 who attempted suicide were 'persistently homosexual' (pp. 402–403). Cohen (1961) found only one same-sex couple (1.7%) among 58 completed suicide pacts. O'Hara (1963) found only 4% lesbians and gay men in a 1-year incidence study of double suicides in Japan. Rich *et al* (1986) reported that 13 (11%) of 119 males aged 21–42 who died by suicide in Los Angeles had disclosed a homosexual identity prior to death. In New York City, Shaffer *et al* (1995) found that in 3 (2.5%) of 120 completed youth (aged ⩽20 years) suicide cases the individual was gay. However, they found no gay or lesbian young people among 147 living controls matched for age, gender and ethnicity.

Thus, contrary to King *et al*'s assertion, at least five peer-reviewed studies of sexual orientation and completed suicide have been published.

Cohen, J. (1961) A study of suicide pacts. *Medico-Legal Journal*, **29**, 144–151.

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Shaffer, D., Fisher, P., Hicks, R. H., *et al* (1995) Sexual orientation in adolescents who commit suicide. *Suicide and Life-Threatening Behavior*, **25** (suppl.), 64–71.

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Occupational psychiatry

In their editorial on work and employment for people with psychiatric illness, Boardman *et al* (2003) overlook an important group of patients with mental ill health who are not 'mental health service users', yet who experience difficulty coping in the modern workplace. Occupational physicians are seeing an increasing number of patients with mental ill health, and a national surveillance scheme recently reported that, along with musculoskeletal symptoms, mental ill health is among the commonest reasons for consultation (see http://www.coeh.man.ac.uk/thor/opra.htm). Furthermore, mental ill health is responsible for a large proportion of early retirements due to ill health (Poole, 1997) and a large proportion of incapacity benefits are currently being paid for medically unexplained illnesses (Waddell, 2002).

Much of the burden of occupational ill health is managed in primary care, but overburdened general practitioners may miss the psychological or workplace components in these patients. To make matters worse, current psychiatric practice is dominated by 'serious' mental illness such as schizophrenia and 'dual diagnosis' patients, to the exclusion of patients with 'minor' mental illnesses such as anxiety, depression and the functional disorders. Yet it is these latter conditions that are commonly being seen in the workplace, in primary care and in those on state benefits by doctors who have little training in mental illness. Unfortunately, some psychiatrists do not receive adequate training in the management of these disorders (Bass *et al*, 2001), in part because they are presenting in locations outside of psychiatric services (Henderson *et al*, 2001). Good evidence exists that these illnesses can be treated effectively using, for example, cognitive–behavioural therapy and interpersonal therapy (Creed *et al*, 2003). A key feature of these studies is that the best results are usually achieved at the site where the patient presents, which is likely to be outside the province of the community mental health team.

We believe that there is a lack of expertise in the management of occupational mental ill health at its site of presentation. Psychiatrists need to engage with occupational physicians to improve the diagnosis and management of patients with psychiatric illnesses that are preventing them from working. There is also a need for more collaborative training in occupational psychiatry for psychiatrists, occupational physicians and general practitioners. Such training should be integrated into the syllabuses of all three professional groups. A diploma in occupational psychiatry might be very popular.

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Globalisation and biculturalism

In their recent review article, Bhugra & Mastrogianni (2004) describe the cultural and mental health aspects of what is now called globalisation, and its present and future impact upon mental disorders, with a special reference to depression. Among the many unknowns in that matter, the authors point towards the issue of whether cultures will homogenise, which seems improbable, or whether the tendency for communities to reassert their distinctive ethnic identities will prevail. Eventually, it seems reasonable to believe that different forms of equilibrium will develop between these apparently opposed forces, including what anthropologists call 'creolisation of cultures'. In that perspective, the issue of biculturalism deserves further elaboration.

Until recently, biculturalism was considered mainly in the perspective of partnership for ethnic minorities in a mainstream cultural environment. Different models of second-culture acquisition have been recognised and studied. In their classical work, LaFromboise *et al* (1993) reviewed typical patterns of biculturalism: the assimilation, acculturation, alternation, multicultural and fusion models. In that acceptance of biculturalism, the ideal goal for an individual

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