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Domestic violence is most commonly reciprocal

Morgan *et al*[1] highlight the high incidence of being a victim of intimate partner violence among female psychiatric patients in the UK. This is in keeping with a historic approach that has conceptualised domestic violence as something that men do to women and has only sought evidence for violence by men against women.

Partly this may be because women are more likely to report intimate partner violence than men. One study found that in the same sample of couples 28% of the women, but only 19% of their male partners, reported that their relationships were violent, suggesting underreporting in a third of men.[2]

In recent years researchers have approached populations without preconceptions as to the direction of violence. Large epidemiological studies have demonstrated that domestic violence is most commonly reciprocal and that when only one partner is violent there is an excess of violent women. Whitaker *et al*,[2] in a study of 14 000 young US couples aged 18–28 years, found that 24% of relationships had some violence and half of those were reciprocally violent. In 70% of the non-reciprocally violent relationships women were the perpetrators of violence. Reciprocal violence appears to be particularly dangerous, leading to the highest rate of injury (31.4%). This may be because reciprocal violence is more likely to escalate.

The International Dating Violence Study[3] found that among students at 31 universities worldwide male and female students had similar rates of physically assaulting a partner (25% of men and 28% of women at the median university). There was parity for perpetrating severe assaults (used a knife or gun, punched or hit partner with something that could hurt, choked partner, slammed partner against a wall, beat up partner, burned or scalded partner on purpose, kicked partner) – 9% of male and female students at the median university. For severe injury (passed out, required medical attention or broke a bone) the perpetration rate was higher for males (median rate 3.1% by men and 1.2% by women).

A review of 62 empirical studies of female-perpetrated intimate partner violence[4] found rates of physical violence of 4–79% among adolescent girls, 12–39% among female college students and 13–68% among adult women. The researchers concluded that a significant proportion of females seeking help for victimisation are also perpetrators of intimate partner violence, and that those who treat battered women may need to consider addressing the perpetration of violence with their female clients.

Archer[5] attempted to resolve two competing hypotheses about partner violence, either that it involves a considerable degree of mutual combat or that it generally involves male perpetrators and female victims. His meta-analysis of 82 studies of gender differences in physical aggression between heterosexual partners showed that men were more likely to inflict an injury; 62% of those injured by a partner were women, but men still accounted for a substantial minority of those injured. However, women were slightly more likely than men to use one or more act of physical aggression and to use such acts more frequently. Younger aged couples showed more female-perpetrated aggression.

Only examining rates of violence perpetrated against women risks perpetuating an inaccurate stereotype of women as victims and men as aggressors. This may hinder women from receiving support to reduce their own perpetration of violence and may contribute to the underreporting of violence perpetrated by women against men.

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What is the object of the psychiatrist's expertise?

Craddock *et al*[1] are to be congratulated for asking 'What is the core expertise of the psychiatrist?'. In responding to this rhetorical question, they make reference to psychological and social factors in mental illness; yet the impression remains that they consider biomedical factors central to psychiatry and the others more peripheral. Why else, for example, do they refer to diagnosis but not case formulation in psychiatry?

Craddock *et al* attempt to identify the expertise of the psychiatrist without first defining the object of his or her expertise. If the nervous system is the object of the neurologist's expertise and the whole person/family is the object of the general practitioner's expertise, what is the object of the psychiatrist's expertise? For Ikkos *et al*[2] this is affect. Affect refers to feelings, agitations and moods, which are manifested in consciousness, behaviour and relationships in family and society. It is disturbed affect that brings individuals to the attention of psychiatrists, whether voluntarily or not, especially when it cannot be contained in the family and primary care. Disturbed affect may be caused by neurological

disease or functional impairment of the central nervous system, or by disturbed experience or relationships.

Elements of affect and its disturbance can be studied biologically because we share common evolutionary affective substrates with lower animals, including the basic emotions.[3] However, as we move from basic to higher emotions closer attention needs to be paid to social, cultural and psychological factors. Higher emotions depend on basic emotions. But higher emotions, in turn, influence basic emotions through the impact of 'meaning'.

Meaning cannot be reduced to molecules. Different levels and models of explanation are required – a green piece of paper is not a dollar bill until social convention decrees so. Those engaged in its physical production and counterfeit surveillance need to understand the physical structure of the dollar but its major significance can only be understood at the level of meaning and social convention. Craddock *et al*'s assertion that 'any psychological explanation is, in principle, capable of being understood at the level of cellular function' is embarrassingly naive for psychiatrists. Together with their statement that 'psychology can be considered as a sub-branch of biology, in the same way that chemistry is a sub-branch of physics' it is plainly wrong.

Psychiatry requires a broad understanding of human evolution. Behaviour narrowly defined by cellular biology is not sufficient.[3] Biology, ethology and paleoanthropology have shown that social living has been the most important recent evolutionary pressure for brain development. Emotions are the glue of social interactions; from the moment of birth we are instinctually driven to engage with others. The representation of affect states in self and other (mentalisation) is vital to affect regulation and effective social adaptation. Affect regulation and mentalisation are acquired through secure attachment relationships and contribute to emotional resilience, which help us to weather the challenges that life presents us with reduced risk of psychiatric illness.

The distinguished American developmental psychologist, Jerome Kagan, writes: 'The influence of biology on human psychological functions is extensive but not unlimited. Evolutionary psychologists like to write that genes keep cultures "on a leash". However culture, like a large powerful dog, can pull the person holding the leash to new, unplanned directions' (p. 81).[4] He also writes: 'For reasons that are not obvious, British psychiatrists retain an interest in the psychological and sociological correlates of mental illness and have resisted a narrow biological perspective more effectively than their American counterparts' (p. 53).[4] Craddock *et al*'s formulation threatens to take British psychiatry down the American cul-de-sac. Its reductionist outlook necessarily downgrades the importance of training and continuing professional development of psychiatrists in psychological, social and cultural matters to second place.

The history of the National Health Service has been fundamental in shaping British psychiatry today; it is an example of fundamental cultural influence. The relevance of psychosocial factors to the full range of mental disorders is well documented.[5] Psychiatry is a broad integrative specialty, with significant diversity within. Our core expertise is the management and not the elimination of the necessary tension between advances in biomedical science and a broader biopsychosocial model of practice. The broad biopsychosocial model is the only one consistent with the facts and not a compromise. A broad evolutionary perspective permits the examination of religion and spirituality as well as culture and society and their relevance to psychiatry.

In the context of the credit crunch British psychiatrists face renewed threats to add to old woes. Its enemies would like to caricature the specialty as limited and reductionist. Craddock *et al* give them further ammunition! However, Nesse[3] aptly captures the core expertise of psychiatrists when he writes (in this case specifically in relation to depression): 'The clinical challenge is the same as it has always been – trying to understand people and their relationships, goals and feelings in order to understand, and help them understand, why they do what they do and why they feel what they feel. That, in combination with new diagnostic tests, genomic findings, and effective new drugs that block depression, will offer a bright future for treating depression' (pp. 171–2).

The academic and professional leadership of psychiatrists should reflect the full range of our expertise.

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Don't forget offenders with an intellectual disability

Appleby's editorial[1] on how best to tackle offender health, particularly mental ill health and substance misuse, was a stimulating read. However, it contained no reference to the estimated 5800 prisoners with an intellectual disability. This group of offenders are effectively excluded from interventions within prisons aimed at reducing re-offending. Moreover, research from the Prison Reform Trust indicates that individuals with an intellectual disability in prison are subject to routine human rights abuses, are five times more likely to be restrained and three times more likely to be segregated compared with prisoners without intellectual disability.[2] These are harrowing statistics.

Appleby highlighted three essential service provision aims for offenders with mental ill health – early intervention, alternatives to prison and multi-agency packages when leaving prison. Any services and interventions established to meet these aims for individuals with mental illness would not necessarily meet the needs of offenders with an intellectual