

Kripalani we agreed a three-way classification of repeated self-harm among young people: repeated self-harm (19 out of 89), with self-harm both in the past and currently or using several (three or more) methods (since it is unlikely that multiple methods of self-injury refer to a single incident); a single incident (17 out of 89), with an explicit statement of a transient incident; unsure (53 out of 89), which constituted the remainder. The crude repetition rate of 20% is typical for self-harm (Bennewith *et al*, 2002). We proceeded to re-analyse the data from our original paper for repeat self-harm (results available on request).

In summary, we can confirm that repeated self-harm was unrelated to gender, or social class of origin, but was related to current labour market position, with youth outside the labour market more likely to self-harm repeatedly. Young people who repeatedly self-harmed were more likely to use all methods except taking pills and more violent methods, which were common to all groups. Those who repeatedly self-harmed were far more likely to do so to relieve negative emotions (anger, anxiety or to punish themselves), but self-harm with intention of killing oneself was common to all groups. Taken together this confirms that those who repeatedly self-harm are more likely to use self-injury as a coping mechanism. With regard to service use, those young people were nearly twice as likely to have used emergency services and over three times as likely to have used psychological services from the age of 11.

This suggests that young people and adults who repeatedly self-harm are heavy users of both health services in general and psychiatric health services in particular, and this is compatible with the assertion of Kripalani *et al* that a small proportion of clients may account for a large proportion of resources. Distinguishing between repeated and other forms of self-harm could provide useful clinical information, provided that both researchers and clinicians can agree on a clear definition.

Bennewith, O., Stocks, N., Gunnell, D., et al (2002) General practice based intervention to prevent repeat episodes of deliberate self harm: cluster randomised controlled trial. *BMJ*, **324**, 1254–1257.

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Attachment disorders: an evolutionary perspective

In a large twin study Minnis *et al* (2007) have demonstrated that attachment disorder behaviours can be differentiated from other common childhood emotional and behavioural disorders and appear to be strongly genetically influenced, particularly in boys. The authors also point out that, even in a population of children that was probably healthier than the general population, behaviours suggestive of attachment disorder were identified. Conventional aetiological factors are addressed but the paper would have benefited from the inclusion of an evolutionary perspective. Evolutionary or Darwinian psychiatry examines, among other things, the potential for adaptive benefits to pre-programmed psychobiological mechanisms (e.g. depressive symptoms or attachment disorders) that are sometimes incorrectly viewed as being simply abnormal or pathological (Abed, 2000).

It was surprising that Minnis *et al* made no reference to Bowlby's seminal work (Bowlby, 1958) in the area of attachment. Bowlby's perspective on attachment was an evolutionary one, in that he viewed the associated behaviours as representing evolved and adaptive psychobiological mechanisms, protecting the child from predators and the many other dangers prevalent in our ancestral environment. This 'adaptationist' perspective could have been explored by Minnis *et al* when considering why attachment disorder behaviours occurred at all in this healthy non-clinical sample.

Chisholm (1996) and Belsky (1997) proposed in more recent years an integration of life history theory (Levins, 1968) and attachment theory. Chisholm (1996) argued that, in life history theory, life cycles constitute evolved adaptive strategies. Furthermore, individuals must prioritise the allocation of their time and resources to different components of reproductive fitness (e.g. growth, mating or parenting). Therefore, the sexual strategy employed by parents (e.g. low investment in large numbers of offspring or vice versa) is an integral component of the child's early environment. Belsky (1997) argued that secure attachment in children functioned to promote a strategy of high-investment parenting, and avoidant attachment (child showing indifference to parent) as representing an adaptation to parental unwillingness to invest (e.g. when the parent

invests instead in a short-term mating strategy with relatively little investment in individual offspring).

The anxious/ambivalent style of attachment evolved in response to parental inability (e.g. through illness) to invest, and fostered a 'helpers at the nest style' in the children, whereby children would cooperate in rearing siblings. For example, Turke (1988) demonstrated (independent of attachment disorders) that women from the Micronesian atoll of Ifaluk were likely to have significantly larger families when their first-born was female: an anxious/ambivalent attachment style may further accentuate such behaviour in female children, perhaps explaining in part the gender differences in attachment disorders raised by Minnis *et al*.

These are merely a few examples of the insights that evolutionary psychiatry can provide. In the total absence of such an evolutionary perspective, one is reminded of Abed's (2000) cautionary comments: 'In recent years psychiatry has attempted to circumvent such problems by engaging in an atheoretical research enterprise involving gathering masses of data and calculating sophisticated statistical associations. However, such an endeavour of itself cannot generate a scientific discipline, for science is a method of discovering the world and not simply a body of facts'.

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