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.

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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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is seen as becoming a socially competent person in a second culture without losing the same competence in his or her culture of origin. However, new concepts of biculturalism and bicultural identity are emerging that are relevant to globalisation. Traditional definitions imply migration processes, either voluntary or forced, as in the case of refugees. Migrant individuals then form ethnic minorities, while different pathways towards biculturalism take place among specific communities. However, if globalisation can be conceptualised as 'a compression of time and space', biculturalism should be considered in the absence of peoples' geographical displacement.

Some authors argue that most people around the world will develop a different form of bicultural identity, combining their local identity with an identity linked to the global culture. This phenomenon is particularly relevant in adolescents, as contemporary urban teenagers worldwide tend to follow similar consumption patterns and do not have memories of times when their ancestral culture was preserved from globalisation (Arnett, 2002). This new form of biculturalism could be both an opportunity for personal fulfilment and a source of identity confusion. Factors influencing these possible outcomes one way or the other should be integrated in cultural psychiatry research agendas.

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Humanity and biology in psychiatry

Further to our previous letter (Owen *et al*, 2003) we are writing to respond to Dr Turner's assertion (Turner, 2003) that biological psychiatrists secretly want to take the humanity out of the humanities. This highlights a conceptual division within psychiatry and one partisan misunderstanding that stymies the debate.

It can be argued that academic psychiatrists are divided into two camps. The first is those who were drawn to the higher functioning of the brain as a conceptual frontier, and see logico-deductive empirical methodology as leading to the accumulation of universally applicable valid evidence. The second is those who were attracted to psychiatry (often away from other branches of medicine) because of its shared space with the humanities. The latter group focus on the difficulties of applying scientific method to the interpretation of meanings and intentions, emphasising cultural relativity, and issues of power and politics.

Highlighting the above division is not new. What we suggest is that the proponents of both camps, by their unwillingness to engage with or understand the field of the other, risk conceptual disaster at both extremes.

The argument from the humanities is of relevance to any scientist. The late-20th century critique of the hubris, historicism and relativity of science strikes at the core of the assumptions of biological psychiatry. Unfortunately, it is an argument that many do not even feel to be relevant. This seems to be an opinion based largely on a lay view that anything within the humanities is of little utility.

This is the very hubris that leads to the name-calling that Dr Turner exemplifies in his response to our perceived 'biological' letter. However, this assumption, among many in the humanities, that the biological psychiatrists are all washed up – applying a suspect statistical method in suspect circumstances – has led to them dangerously disengaging from any medical aspect of their profession. If our assertion is right, and this is a motivation for coming to psychiatry in the first place, this is hardly surprising.

The worrying thing is, of course, that despite the shortcomings of current approaches to categorisation, aetiology and treatment, mental illness *does* exist, and hence psychiatry has a role to play in its understanding and treatment. Our job, if we remain interested in being doctors, is to see (based on what evidence we have) where the medical model can add to the care of someone mentally unwell.

If this is hopeless, as some (e.g. Szasz, 1960) have argued, then what are we doing in psychiatry? Given this position, the responsibility for looking after the mentally unwell is surely better handed to others. The irony is that many of the most nihilistic psychiatrists prescribe psychotropics; either this amounts to extreme hypocrisy, or the methodology and results of biological research do matter after all.

With biological research becoming increasingly specialised and complex, a new technology will only be understood by relatively few. In the humanities, the language remains esoteric and hard for the uninitiated to engage with. If the proponents from both ends of the debate do not see the worth in the others' business, when will the results or arguments of one ever be valid for the other?

In essence, in response to Turner's assertion (2003) that biological psychiatrists wish to take the humanity out of the humanities, we fear that he hints at a desire within the humanities to take the medical science out of psychiatry. If this is the position, then we fear a psychiatrist is left adding nothing to the multidisciplinary team other than personal opinion. Although much empirical research is burdened with vested interests, criticised for not being conscious enough of its assumptions, and maladapted to studying the profound experimental suffering we see in mental illness, it remains the only way to replace opinion with anything more certain.

The humanities help us to see what mental illness is, but there will always be an accompanying biology and we have always known that modulating the biology can modulate the illness. If we value the treatment of mental illness, we must value both humanistic and biological investigations.

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Heroic, not disordered: creativity and mental illness revisited

Dr Wills (2004) assumes that I have overlooked Jamison's 1993 work. In fact, the hyperbolic *Touched with Fire* only compounds the research problems of her original (1989) study. No matter how many famous artists she collects to 'prove' her case, there is no triumph in finding so much disturbance when your self-selected

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