

carried out by an extremely skilled and experienced practitioner. As he points out, supportive psychotherapy is most often carried out by the multidisciplinary team rather than specialist psychotherapists, and often there is no supervision or training available. An inexperienced therapist might be able to practice the distributive psychotherapy referred to by Holmes, that is, to spend a part of the session questioning and history-taking, and the rest in a more passive, listening and understanding mode. However, judging the niceties of when to draw attention to transference issues, or at what point to challenge instead of contain the patient, are no matters for a novice therapist, especially when faced with the type of patient thought to require supportive rather than dynamic therapy—in other words, the more damaged and vulnerable patient.

I suspect that Dr Holmes' own training and skills are not shared by the majority of those medical and non-medical practitioners of supportive psychotherapy who might well come to grief if they attempt to blend supportive and dynamic features in the way he suggests.

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#### **Ethnic Density and Schizophrenia**

SIR: It is doubtful if 'ethnic density', as determined simply by population size within an area (especially one as large as a Regional Health Authority), can have any useful meaning. This measure used by Cochrane & Bal (*Journal*, September 1988, 153, 363–366) may be taken less as a determinant of 'density' than as denoting the presence or absence of a particular community within the area. The daytime density of psychiatrists in Belgrave Square is high compared with Eaton Square, but this tells us little about the individual motivations and psychology of these particular individuals, or their patterns of settlement within the Square.

Minority groups are hardly free to 'diffuse' throughout an area for reasons purely associated with individual psychopathology, as contrasted with external constraints associated with a racially biased provision of housing and employment. The actual pattern of distribution within a smaller local area may be a more significant indicator of those demographic factors possibly associated with psychopathology, such as 'social drift', group cohesion, and community support, let alone nosocomial factors which we now suspect account for much of the differential 'pathology' between ethnic groups.

To take the case of Nottingham: the 'foreign-born' community has settled predominantly in the inner-city areas where it also has the highest rate of schizophrenia, arguing against the ethnic density hypothesis of Faris & Dunham (Giggs, 1986). While higher rates of schizophrenia for each group taken separately are found among European and South Asian migrants in the outer-city council estates than in 'inner-city, low status' areas, the highest rates among West Indians occur when they live in the 'inner-city, high status' areas. For each of the three groups, however, the highest rates of settlement are in the inner city. Thus the ethnic density hypothesis seems to fit Europeans and South Asian migrants, but not West Indians.

It is in the specific pattern of settlement within a particular area, with all its political, economic, and psychological constraints, that explanations of differential pathology and access to services can be found. While I am sure this was not the intention of the authors, the bald 'ethnic density' argument by itself comes perilously close to ethological and thus biological explanations (e.g. Esser & Deutsch, 1977).

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#### **References**

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#### **Treatment of Suicidal Manic Depression**

SIR: I read with great interest the paper by Schou & Weeke (*Journal*, September 1988, 153, 324–327). In their guidelines for improving suicide prevention in manic depressive illness they state that "continuation or prophylactic treatment with antidepressants should presumably be carried out with full therapeutic dosage". They base this argument mainly on their finding that 13 patients who were treated prophylactically with sub-therapeutic doses of antidepressants committed suicide. However, 10 patients who received full therapeutic doses of antidepressants also committed suicide. In Modestin's (1985) study too, 21% of the patients had received full therapeutic dosage, compared with 26% who were