

I was struck by the extent to which certain factors derived from the Q-factor analysis appear to map onto current conceptualisation of attachment categories, a point borne out partially by the same research group (Nakash-Eisikovits *et al*, 2002) using Bartholomew's attachment classification (Bartholomew & Horowitz, 1991). Specifically, the 'psychological health' factor shows strong correspondence to features of a secure internal working model, while the 'histrionic sexualisation' and 'emotional dysregulation' factors contain items integral to the conceptualisation of ambivalent/preoccupied attachment. It is interesting that in their 2002 study, the group found that attachment avoidance was correlated with their 'avoidant' Q-factor but not with DSM-IV avoidant personality disorder; on this basis, they questioned the prevailing conceptualisation of avoidant personality disorder. It is unclear how attachment disorganisation is related to the SWAP-200-A factors, as it is still uncertain the extent to which Bartholomew's 'fearful' category corresponds to disorganised/unresolved attachment.

Therefore, it is perhaps logical to hypothesise that some personality trait constellations (the most maladaptive of which may constitute personality disorders) are indeed disorders of attachment. This hypothesis, which is supported theoretically (Nakash-Eisikovits *et al*, 2002) and which makes intuitive sense to many adolescent mental health professionals, needs to be tested with longitudinal research. In addition to other empirical work, the above research shows the continuing clinical importance of attachment theory. However, there is still no easily administered validated measure of adolescent attachment in widespread clinical use currently in the UK. Surely, this is a deficit that needs to be addressed.

Bartholomew, K. & Horowitz, L. M. (1991)

Attachment styles among young adults: a test of a four-category model. *Journal of Personality and Social Psychology*, **61**, 226–244.

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Relationship between attachment patterns and personality pathology in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, **41**, 1111–1123.

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Dementia prevalence

Shaji *et al* (2005) have estimated the prevalence of dementia in an urban population in Kerala, India and have provided a glimpse into the various factors associated with dementia in their study. A few methodological issues of the study need further clarification.

Although a cut-off score of 23 on the Mini-Mental State Examination (MMSE) was used for all the participants, a different cut-off score would have been appropriate among those who were illiterate (11.2%) as educational status has been shown to affect MMSE scores.

With no objective evidence to suggest hypertension in the participants other than the verbal account of the caregivers, the very high odds ratio for hypertension is misleading. Furthermore, with such a small number of individuals, the selection of the controls should have been more stringent. It would be advisable to take a larger number of controls for such a small sample of individuals with vascular dementia ($n=22$).

Although age has been shown to be a risk factor for dementia in many studies, how this conclusion was reached in this study is not clear.

There is a discrepancy in the number of patients reported as receiving treatment for Alzheimer's dementia (21 out of 31) compared with the total number of individuals with Alzheimer's dementia detected in the study ($n=30$).

Despite a few limitations, this study adds to the growing literature of the epidemiology of dementia in developing countries and would be helpful for healthcare planners for adequate resource allocation for preventive and curative services.

Shaji, S., Bose, S. & Verghese, A. (2005) Prevalence of dementia in an urban population in Kerala, India. *British Journal of Psychiatry*, **186**, 136–140.

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Involuntary placement in Italy

Salize & Dressing (2004) show figures for various indicators for involuntary placements in psychiatric facilities in the European Union countries. According to the authors, Italy was unable to provide nationwide data from the 1990s. Therefore, in Table 1 they showed data from the Lombardy region, concerning only the percentage of in-patient episodes that were involuntary placements for an 'unknown year'. Data from Lombardy on number and rate of involuntary placements per 100 000 population are indicated as 'not available'.

Actually, nationwide data have been published up to 1997, and data from the Lombardy region are available for the period 1995–2001 (see Table). The Italian data can be found on the website of the National Institute of Statistics (<http://www.istat.it/Societ-/Sanita-e-p/Storico>) and those of Lombardy on the website of the Regional Directorate of Health (<http://www.sanita.regione.lombardia.it/documenti>).

Also, Salize & Dressing report a rate of 11 involuntary placements per 100 000 for France. This is not correct, as can be seen looking at absolute numbers of 61 063 involuntary admissions in France. Given the French population of about 59.3

Table Involuntary placement in Italy

Year	Involuntary placements					
	Lombardy ¹			Italy ²		
	<i>n</i>	Percentage of all in-patient episodes	Per 100 000 population	<i>n</i>	Percentage of all in-patient episodes	Per 100 000 population
1996	2832	12.3	37	14 882	10.9	26
1997	2818	11.6	37	15 048	11	26
1998	2803	12.1	36			
1999	2792	12.6	36			
2000	2794	11.8	35			
2001	2487	10.8	31			

1. Source: Regione Lombardia Sanità, I Servizi Psichiatri della Regione Lombardia, anni 1996–2001.

2. Source: Istituto Nazionale di Statistica, Annuario Statistiche della Sanità, anni 1996 e 1997.

million, the correct rate is 103 per 100 000 population.

Salize, H. J. & Dressing, J. (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry*, **184**, 163–168.

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Dissociative symptoms after plague in the 15th century

Accounts of the post-traumatic reactions to plague, particularly in the Renaissance era, are scarce; here is an example in the form of Ibn taghri birdi writing about a funeral during the plague epidemic of 1429 in Cairo.

‘The child of an individual in our service named Shams ad-Din adh Dhahabi died, and we went out with him to the oratory; the boy was less than seven years old, and when we set him down to pray over him among the dead, a large number of others were brought, until their numbers

went beyond counting. Then prayer was said over them all, and we went to take up the dead boy but found that someone else had taken him and left to us another one of about the same age. His family took him up but did not become aware of it; I, however, perceived this and told a number of others; but we did not inform his parents of it and said: Perhaps the one who took him will give him the best interment; there is no profit in talking about it – there would be only an increase in grief. But when the boy had been buried and the proprietors of the funeral office took up the bier they cried out and said, “This is not our bier; this is an old one and its furnishings also are worn out”. I advised them to be silent, and then one of the mamluks threatened to beat them; then they took it and went away. This occurrence was a strange and distressing one’ (Dols, 1977: pp.241–242; Gottfried, 1983: p.39).

This is a remarkable early historical example of dissociative symptoms as a result of psychological trauma due to a medical condition. The above symptoms clearly accord with criterion B in DSM–IV

for acute stress disorder (American Psychiatric Association, 1994). Most accounts of dissociative symptoms as a result of psychological trauma are from the 20th century (Jones *et al*, 2003). It is interesting to see that in comparison with the modern era, dissociative symptoms as a result of traumatic events are still far less common than hyperarousal symptoms, which are much better recognised.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th edn)* (DSM–IV). Washington, DC: APA.

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Gottfried, R. (1983) *The Black Death: Natural and Human Disaster in Medieval Europe*. New York: Free Press.

Jones, E., Vermaas, R. H., McCartney, H., et al (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

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One hundred years ago

Pyromania, a psychosis of puberty

IN the *Archives de Neurologie* for December, 1904, Dr. Raoul Leroy, assistant physician at the Evreux Asylum, refers to the medico-legally important subject of pyromania in young persons of both sexes, a form of mental disorder which leads to acts of incendiarism. “Whenever reported fires occur,” he says, “in a village or in the country suspicion generally falls on persons of incomplete mental or physical development – weak-minded youths or girls – among the inhabitants and it generally proves to be well-founded.” The mental state of such incendiaries, says Dr. Leroy, is peculiar and characteristic. They are weak-minded and are often members of families in which epilepsy, insanity, or alcoholism occurs. Reference is made to the fact that among the peasant population of Normandy, where alcoholism prevails to a high degree, juvenile crimes of the nature of incendiarism are common. These

feeble-minded delinquents are prone to set fire to buildings or other objects in revenge against their owners or in some cases merely to amuse themselves with the spectacle. A few cases, says Dr. Leroy, suffer from the influence of an obsession which irresistibly impels them to such acts, such cases forming a special form of insanity to which the term “pyromania” is applied. True cases of pyromania manifest themselves for the first time at the period of puberty. The following typical case is given in illustration of this affection. The patient or culprit in this case was a girl, aged 15 years, a domestic servant, who on three separate occasions had set fire to the house of her master. She was the child of respectable parents and at first no suspicion was entertained of her but on being questioned before the police at the third outbreak of fire she showed much agitation and finally confessed her guilt. “When she had stated the facts fully and was asked if she realised the wickedness of her crime,” she replied,

“Something supernatural urged me to set the place on fire.” Although she was reasoned with and her wrong-doing demonstrated in the clearest manner “she remained unshakable and invariably repeated the same words in justification.” She had no reason to hate her master, there was no motive whatever of vengeance that impelled her, only a presumably morbid impulse. The medico-legal inquiry revealed the fact that a highly neurotic hereditary taint existed in the family; the grandfather was a man of excessively violent disposition, a first cousin was liable to periodic attacks of insanity during which he wandered about, the grandmother committed suicide at the age of 63 years, and the patient’s mother was a very nervous, emotional, weak-willed woman afflicted with coxalgia. The patient herself was a child of but little intelligence and never could read and write correctly. Her character was excitable, violent, and impulsive, with a total lack of good judgment. At the age