

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)

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Nakash-Eisikovits, O., Dutra, L. & Westen, D. (2002)

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

Westen, D., Dutra, L. & Shelder, J. (2005) Assessing adolescent personality pathology. *British Journal of Psychiatry*, **186**, 227–238.

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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.