increase in peer reviewers who have, like corresponding editors, an understanding of the issues in these countries. Otherwise, reviewers, who I am sure are fair-minded professionals, will continue to judge papers from poorer countries on the same basis as those submitted from rich countries, thereby perpetuating the problem of disproportionate publication. Surely there must be reviewers who will undertake this task – if not, appropriate professionals need to be encouraged to get involved so that they can make a significant contribution to ending editorial racism. Additionally, their participation will also encourage greater opportunities for publications from researchers from poorer countries which in itself, I believe, is a worthy cause.

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Reading habits of British psychiatrists

Jones *et al*'s (2004) reassuring article that British psychiatrists read British journals may indicate the preoccupation of the British with British services. It would not be surprising to find that British people use the Royal Mail, watch the BBC or ITV, read British newspapers, fly British Airways (I wonder)! Tables 1 and 2, however, reveal another interesting observation, which the authors did not address in their otherwise interesting article. *Advances in Psychiatric Treatment* was more often read by those without academic commitments, in all the age groups. The difference in the adult psychiatric group is quite marked – 17% of psychiatrists without academic commitments read *Advances*, compared with only 2% of those with academic commitments, a difference which may even be statistically significant. These trends are maintained in Table 2, where another difference between academic and non-academic psychiatrists emerges: academic psychiatrists ranked the *American Journal of Psychiatry*, *Archives of General Psychiatry*, *Biological Psychiatry* and the *Journal of Psychopharmacology* higher than did psychiatrists without academic commitments. One could infer that psychiatrists without academic commitments preferred journals like *Advances in Psychiatric Treatment*, which have practical, management-related reviews and updates, and psychiatrists with academic commitments preferred research-based journals. Or these differences could confirm the Editor's hunch that *Advances in Psychiatric Treatment* will gradually become more popular (Tyrer, 2004).

Jones, T., Hanney, S., Buxton, B., *et al* (2004) What British psychiatrists read. Questionnaire survey of journal usage among clinicians. *British Journal of Psychiatry*, **185**, 251–257.

Tyrer, P. (2004) From the Editor's desk. *British Journal of Psychiatry*, **185**, 276.

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One hundred years ago

'Kinds of insanity'

THE preparation of a new set of statistical tables by the Medico-Psychological Association of Great Britain and Ireland for the annual recording of the vast clinical and pathological data and returns of all public asylums in the future has brought forward the inevitable question of the nomenclature and classification of the insanities. Dr. C. A. Mercier, in an article in the *Journal of Mental Science* for January, deals with the "kinds of insanity" which he thinks fulfil the necessary conditions of true diseases. The arrangement suggested is first to separate congenital from non-congenital cases of insanity. The congenital cases would include all idiots and most imbeciles. The classification of these is a matter of subordinate importance, whereas the division of the insanities proper into natural groups is the main desideratum in mental science and the most important aid to clearness of thought of diagnosis, and of prognosis. Cases of insanity are proposed to be considered in one of two classes – viz., general paralysis (paralytic dementia) and non-paralytic insanity. Dr. Mercier suggests that the latter class contains "diseases sufficiently distinct that merit the same separation that is given to general paralysis.... As to general paralysis the symptoms are so distinct that it is recognisable at every stage in its progress. It has a definite history, runs a definite course, and forms a complete clinical picture separable from that of any other form of insanity." Examining other varieties of insanity and their titles or claims to be called diseases, Dr. Mercier would admit "acute delirious mania" owing to its characteristic symptoms and its course as a definite variety of insanity. "The clinical picture of acute delirious mania is distinct and prevents it from being confused with any other type of insanity. On the contrary," he says, "puerperal insanity presents us with no distinct clinical picture. The very fact that it has been divided into puerperal mania and puerperal melancholia is proof of what I say. Puerperal insanity is acute insanity occurring within an uncertain time of childbirth, and if the antecedent of childbirth is disregarded there is nothing whatever in the clinical picture of the disease that is different from other causes of acute insanity that have no connexion with the puerperium or even in acute insanity occurring in men." The insanity of pregnancy is regarded as having a much better right to be considered a disease, "for the fact of pregnancy is a continuing feature in the clinical picture, a feature which at once marks off the case from all other cases of insanity." What is true of the insanity of pregnancy, he adds, is emphatically true of the insanity of lactation. It is an insanity of exhaustion – of innutrition – and differs in no respect from other cases of insanity of similar origin. Few cases of insanity occurring at the menopause in women deserve recognition as a separate variety

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of insanity. Similar cases may occur at other times of life and present the same clinical picture. The definite form of insanity of the menopause "with its special facies" is, says Dr. Mercier, rare. Senile insanity has no right to a special place in nosology. "The term means, it appears, insanity not assigned to any distinct category except by its occurrence in advanced age. It would, in my opinion, be unreasonable to base the differentia of the disease on so slender a foundation." The insanity of epilepsy is admitted to have "a good title to the denomination of a disease." Cases of insanity associated with bodily diseases, whether the latter be regarded as a cause or not, in no case present a clinical picture of sufficient distinctness to entitle them to separate rank as diseases. Dr. Mercier would admit the claims of a stupor, paranoia, recurrent and alternating insanity, and the two forms of insanity occurring in adolescents or young adults known as hebephrenia and katatonia. Causes of fixed delusion would also find a place in classification, being further subdivided as the delusions are persecutory, exalted, and personal. Alcoholic insanity would be recognised in its subdivisions of *mania a potu*, delirium tremens (acute forms), or alcoholic insanity proper of the chronic form. This threefold subdivision of alcoholic insanity would exclude all cases in which alcohol was not the main actuating cause of the malady. The above-named varieties of insanity, concluded Dr. Mercier, "have claim to the title of distinct diseases from the distinct clinical pictures they present; all other cases must be lumped together under the heading of insanity *simpliciter*."

REFERENCE

Lancet, 18 February 1905, 445.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Retrospective analysis of risk factors in patients with treatment-emergent diabetes during clinical trials of antipsychotic medications. *BJP*, **184** (suppl. 47), s94–s101.

After publication of this paper, the authors became aware of errors in the original analysis. These are explained in a data supplement to the online article, located at http://bjp.rcpsych.org/cgi/content/full/184/47/s94/DC1.

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