was undoubtedly a badly administered asylum" is justified. My own reading of the history of the Burntwood asylum (Budden, 1989) has revealed nothing like that; on the contrary, there were summary dismissals of staff at the slightest suggestion of ill-treatment of patients, whatever the provocation.

No doubt Lomax was well justified in describing the conditions he found and in seeking improvements. However, it would be grossly unfair to use the description of conditions during 1917–1919 to castigate the asylum service and to denounce the provision which had been made by the Victorians for their mentally afflicted citizens.

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## Brain transplants: myth or monster?

Sir: Henderson (*Journal,* May 1990, **156,** 645–653) cites brain transplants (in brackets) as one of the possible future treatments for dementia. The question which has been left unanswered is: who will be the donor? Will Mr A receive Mr B's (or Mrs B's) brain tissue with which to think and control his own body, or will B (male or female) wake up (again!) in A's body?

I put this question informally to a number of psychiatrists and got almost as many different replies. What I did learn was that the debate between Descartes and Franz Alexander was alive and kicking (Brown, 1985). Some psychiatrists see the mind as being synonymous with the physical brain, others view it as some ethereal envelope about our person, whereas still others conceptualise it in terms of a supernatural and eternal soul which utilises an otherwise selfless brain during life.

Will brain transplantation join the growing list of procedures requiring lengthy ethical (and theological) debates along with predictive genetic testing and organ donation from anencephalics? Or, are the technical aspects of full brain transplantation so complicated as to render the whole argument academic or fictional? Perhaps partial brain transplants would not arouse the same emotions, but which parts and how much?

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## Patterns of attendance at child psychiatry clinics

Sir: I read with interest the paper by Stern *et al* (*Journal,* March 1990, **156,** 384–387) and would like to offer local experiences in Hong Kong to widen the discussion.

In a seven-year survey of referrals to the child unit of a department of psychiatry in a teaching hospital in Hong Kong (Luk & Lieh-Mak 1985), somatic complaints were the most common reason for referral (19.6%). When we opened a self-referred primary mental-health care clinic for children at a well-established voluntary agency, conduct problems became the most common complaint (46.4%; Chung & Luk, 1990). The clinical diagnoses made also differ between the two settings. While these might be explained by referral bias, Hong Kong parents did seem to seek help for different problems from different sources: somatic problems from doctors, and 'bad' behaviour from non-hospital settings. The fact that Drs Stern *et al* found Asian children referred had a narrower range of problems might be explained in this way. Furthermore, when the primary mental-health care clinic for children was set up in Hong Kong with minimal advertisement, a half-year waiting-list promptly accumulated: Hong Kong parents, acutely aware of their 'problematic child', actively sought help, but unfortunately not usually from hospital. This might shed light on why Asians were under-represented in Dr Stern *et al*'s paper. Although Dr Stern *et al* did point out that the department accepted self-referrals, it was the hospital setting itself that carried the stigma. Those parents who think that their child has problems might not know or like the idea of attending child psychiatric clinics in hospital settings. The under-representation of Asian children can therefore be explained not only in terms of cultural differences concerning what is acceptable behaviour in children, but also in terms of the parents' perceptions of who and what problems

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should be taken to a child psychiatric clinic in a hospital.

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## First-rank symptoms

SIR: O'Grady's review of first-rank symptoms is most welcome (*Journal*, April 1990, **156**, 496–500). It is a pity, however, that his summary chose to highlight the newsworthy rather than the useful aspect of his study.

Using the normal definitions, all 13 first-rank positive patients in his sample had Research Diagnostic Criteria (RDC) schizophrenia or schizoaffective disorder. Indeed, almost three-quarters of his RDC schizophrenics showed first-rank symptoms. This makes Schneider's symptoms very useful as a diagnostic aid.

'Widening' (i.e. blurring the definitions) reduced their selectivity without increasing their sensitivity.

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SIR: Trimble (*British Journal of Psychiatry*, February 1990, **156**, 195–200) manages to side-step the problematic concept of schizophrenia by proposing a psychopathological cause of the first-rank symptoms. Thus he brings psychiatry closer to neurology, and increases our hopes that, just as a particular abnormality of the expression of speech may be localised to a particular area of the brain, so, one day, we might find that a particular symptom of schizophrenia is associated with a discrete cluster of abnormal neurones. Such an approach also allows us to accommodate, without any difficulty, the similarities (Johnstone *et al*, 1988) and differences (Cutting, 1987) in phenomenology between different psychoses. The clock is turned back from Schneider to Bleuler since these psychotic symptoms can, once again, be given a central psychopathological role.

However, although Dr Trimble convincingly argues that the first-rank symptoms occurring in temporal lobe epilepsy arise in the temporal lobe, he then suggests that *all* such symptoms arise in the temporal lobe ("If we are to regard first-rank symptoms as specific to the temporal lobe, then we must say that they all arise there"). The evidence for this is, firstly, that schizophrenia is associated with temporal lobe abnormalities and, secondly, that the temporal lobe is ideally placed to produce all the first-rank symptoms. Indeed it is, but then it is also ideally placed to produce all other disorders of thought and perception. We are left with the conclusion that first-rank symptoms arise in the temporal lobe, but might also arise elsewhere, and that temporal lobe pathology causes first-rank symptoms, but is likely to cause other disorders of thought and perception. Thus, these symptoms seem rather *non*-specific.

Furthermore, the first-rank symptoms, as with all psychotic beliefs and hallucinations, are unlikely to each be unitary phenomenon (i.e. even these symptoms are themselves 'clusters' of symptoms). It is not just the experience but the interpretation of that experience that justifies the label of 'psychotic'. In other words, each first-rank symptom can itself be subdivided into the 'experience' and the cognitive appraisal of that experience (which may or may not be accurate), although these events may be experienced as simultaneous and therefore as a unitary phenomenon. Dr Trimble's theory is unable to elucidate which of these different components arise in the temporal lobe.

First-rank symptoms are complex phenomena that arise only if there is a failure of information processing in a number of different areas of the brain. We lack both a coherent understanding of the mechanisms underlying the production of psychotic phenomenology, and knowledge of the many pathways whereby these phenomena may be produced. Like the butterfly of psyche, they continue to evade our attempts to pin them down to a specific locality of the brain.

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