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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