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Editorial

Throughout this century neurology and psychiatry have developed independently in many parts of the world with very little cross-fertilisation. To some degree each discipline has become entrenched in its own jargon and dogma which has lead to a degree of stagnation at the interface between the two specialities. In the United Kingdom for instance, a period of post-graduate training in internal medicine is regarded as essential for a neurologist in training, whereas one is expected to pick up the skills of the psychiatrist by extra curricula reading or "by applying one's common sense". In contrast, British psychiatrists are at least encouraged to spend a short period of time on a neurology service and are examined rigorously on neurological disease in their post-graduate examinations. However, few would feel comfortable with the ritualistic examination of the nervous system and the interpretation of the physical signs which is central to a neurologist's everyday practice. This mind/brain split has always been less pronounced on the continent of Europe where it remains respectable to be both an accomplished neurologist and psychiatrist.

Although Hippocrates believed that emotion and feeling were mediated through the brain and that insanity resulted as a consequence of brain disease, it was Griesinger in 1845 who could be said to have begun the movement to bring together mental disorders and neurological disease as one speciality. The epidemics of general paralysis of the insane and later encephalitis lethargica, in which classical neurological and psychiatric disorders occurred commonly together in the same patient, strengthened the notion of neuropsychiatry as a respectable discipline. Around the turn of the century a small group of French and German neurologists was also meticulously dissecting and defining the spectrum of language disorders based on detailed case histories and neurological examination. However, the momentum of psychoanalysis and social psychiatry proved to be too strong for this fledgling science and most neurologists elected to refer their patients with personality or mood disturbances to their psycho dynamically orientated psychiatric colleagues. The increasing influence of clinical neuropsychological methods and biological psychiatry in everyday psychiatric practice has lead to a renewed interest in psychiatry by some neurologists. This new approach has been termed Behavioural Neurology but its roots undoubtedly lie in the almost defunct neuropsychiatry. Broadly, Behavioural Neurology includes the study of disorders of mood, personality, intelligence, perception and arousal and is concerned with the structural basis of normal and abnormal behaviour. In addition to the conventional foundation stones of the neurosciences: neuroanatomy, neurophysiology and neurochemistry, it is dependent on the practical skills of neuropsychology and social anthropology. It insists on the detailed history traditional to the psychiatric examination combined with the stringent methodical neurological examination beloved of the neurologist. The major advances in

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neuro-imaging now permit precise localization of structural lesions within the cerebral cortex without the need for post-mortem which has greatly facilitated the growth of interest in this area. In addition to acquiring these skills the behavioural neurologist must be, first and foremost, a compassionate physician who will be involved in the care and rehabilitation of patients with severe brain damage.

It is hoped that this Journal will provide a forum for neurologists interested in the cerebral cortex and basal ganglia and psychiatrists interested in biological and organic psychiatry so that each group may learn from the other's experience and that this in turn may lead to real advances in the understanding and management of neurobehavioural disorders.