The gap and the bridge between neurology and psychiatry has been the subject of a recent review entitled “Closing the great divide”. The early luminaries of neurology such as Charcot, Babinski, Alzheimer, and Oppenheim also held academic posts in psychiatry and yet the 20th century marked a period of separation between specialties. The “gulf and the bridge” was the subject of a seminal lecture by Sir Dennis Hill, late professor at the Institute of Psychiatry. This provides essential historical reading for those who wish to know more about physicians, philosophers, the separation of psychiatry from medicine, and the shared ground between the psychiatrist and the neurologist.

This modern day divorce has hitherto been reflected in our training programmes, with psychiatry all but disappearing as a core component. Such a state has no doubt disadvantaged countless patients and clinicians alike for long enough. The much needed increase in the numbers of neurologists, better accessibility, and heightened patient knowledge with concern and expectation has changed the spectrum of illness seen in the clinic. The anxious, depressed, and worried are the “daily bread” of current neurological practice. A working understanding of psychiatry and the psychiatric manifestations of neurological disease are now a prerequisite for safe practice. The recent development and expansion of liaison psychiatry now allows improved training opportunities and shared clinics, all to our patients’ benefit.

Clinical neuropsychology has been defined as “an applied science concerned with the behavioural expression of brain dysfunction” and can be readily seen as a branch both of neurology and psychiatry. As it provides a substantial plank for the bridge between the two specialties we include some contributions that can be seen as “behavioural neurology” or “organic psychiatry”, but either way can be viewed from a neuropsychological perspective, and measured using neuropsychological tools.

In this issue of Neurology in Practice we have chosen to focus on areas where there is the greatest overlap between neurology and psychiatry, of brain and mind. We start in the neurology department with those patients who present with unexplained neurological symptoms. In a pair of articles, Jon Stone, Alan Carson, and Michael Shape consider the terminology (they argue for the term functional) and discuss the diagnosis and management of patients with functional symptoms and signs. Staying in the neurology clinic Chris Kipps and John Hodges outline a practical approach to cognitive assessment. We then move very clearly into the hinterland between the subjects. First Chris Butler and Adam Zeman consider whether a “psychiatric” disorder could be “neurological”, and then John Moriarty, a psychiatrist, considers how neurologists should go about recognising and evaluating disordered mental states. We then bring psychiatry into the neurological clinic and consider how to best manage psychiatric illness in patients with chronic neurological disease—Margaret Jackson and Douglas Turkington for patients with epilepsy, and Hugh Rickards for patients with other neurological disease. Finally, as a departure Tony David and Martin Prince present a closely argued analysis of the potential role played by head injury in the origin of schizophrenia, a debate possibly generalisable to other forms of acute brain injury.

We hope this issue will narrow the knowledge divide and emphasise the contribution of psychiatry to neurological practice. The title of our parent journal is a clue as to how close these relationships need to be!

REFERENCES
