CNS Spectrums (2016), **21**, 221–222. © Cambridge University Press 2016
doi:10.1017/S1092852916000249

GUEST EDITORIAL

Neuropsychiatry

*Michael Trimble**

Institute of Neurology, London, England

What is neuropsychiatry? This question needs to be addressed, if not simply because of the number of practitioners who refer to themselves by the moniker "neuropsychiatrist."

There is a long and a short history. The hint of a brain basis for behavioral disorders stretches back to the times of Hippocrates, but really did not bud until the Renaissance and the later Enlightenment epochs. These times gave us early pioneers of the exploration of brain anatomy and more careful descriptions of what we may refer to as neuropsychiatric disorders. These include epilepsy, syphilis, movement disorders, dementia, psychoses and melancholia, and hysteria. Much early theorizing on brain function assumed that the brain was a passive receptacle of sensory information, and motor responses were driven by reflexes; somewhere in between were "spirits."

In the late 17th and 18th centuries, perspectives shifted. The era of "neural Romanticism" began. This study explored the creative brain, as active and instrumental in constructing the individual's world, with "spirit" becoming a metaphor for the importance of feelings and action rather than logic and the *cogito* as the basis of being. These ideas burgeoned in the later 19th century with lurid descriptions of abnormal mental states, interest in memory and dreams, and especially with Sigmund Feud, the unconscious palimpsest of behavior and its disorders. This had the unfortunate consequence of pulling a psychologically based, neuroscience-free psychiatry away from the "new" discipline of neurology as we know it today. Neuropsychiatry eclipsed.

The history of these events is followed in some detail in my book *The Intentional Brain: Motion, Emotion and the Development of Modern Neuropsychiatry*.[1] The modern era of clinical neuropsychiatry began perhaps around the 1980s. My own *Neuropsychiatry* was published in 1981, and Jeff Cummings' *Clinical Neuropsychiatry* in 1985. The British Neuropsychiatric Association was established in 1987, the American Neuropsychiatric Association in 1988, and the Japanese Neuropsychiatric Association in 1996. The International Neuropsychiatric Association (INA) was formed in 1998, and neuropsychiatry is now a well-recognized discipline in many countries.

In *Neuropsychiatry*, I had ventured the following definition: Neuropsychiatry is a discipline that references certain disorders "which, on account of their presentation and pathogenesis, do not fall neatly into one category, and require multidisciplinary ideas for their full understanding" (p. xiv).[2] The clinical aspects of the subject matter were central, and cover a spectrum of disorders referenced above. Yet, neuropsychiatry is not only interested in clinical abnormalities that are explained by our understanding of brain–behavior relationships; it is much concerned with the "meaning" of abnormal behavior. This requires consideration of content as well as form, and the various life contingencies that impinge on patients which may influence their signs and symptoms. This recognizes the distinction between disease (pathology) and illness (what patients present with), and a propensity to tolerate diagnostic uncertainty. Alwyn Lishman in his article "What Is Neuropsychiatry?" explained that neuropsychiatry was not an "all-exclusive domain" embracing only the neurosciences, but "Social, developmental, psychodynamic and interpersonal forces must also be considered." He warns us that "One must take issue with those who claim that the neuropsychiatric approach can account for all mental disorder. Such vaulting ambition is reminiscent of the once proud claims of psychodynamic theory."[3]

Neuropsychiatry, I argue, is not simply an offshoot of psychiatry. It is a discipline that has arisen out of a clinical need for patients who have fallen badly between the cracks engendered by the developments of the clinical neurosciences in the 20th century, the neurology–psychiatry fracture, and the cleaving of clinical understanding.

There seem to be many psychiatrists who would label themselves as neuropsychiatrists, in order to single themselves out as having a special expertise. While the necessity for establishing training programs for neuropsychiatry seems widely accepted, they have yet to be structured in many countries. Without an intimate

* Address for correspondence: Michael Trimble, MD, Institute of Neurology, Queen Square, London WC1N 3 BG, England.
(Email: m.trimble@ucl.ac.uk)

https://doi.org/10.1017/S1092852916000249 Published online by Cambridge University Press

acquaintance in particular with neuroanatomy, neurophysiology, and neuropsychology in particular, and a clinical grounding dealing with the spectrum of disorders noted above, simply struggling with the names of various neuro-receptors and transmitters and knowing enough psychopharmacology to adequately prescribe psychotropic agents does not add up to being a neuropsychiatrist. Neuropsychiatrists must understand the signs and symptoms of a range of central nervous system disorders, as well as the psychology behind human motivation and desire. What is it that makes us tick, and when does the tic become pathological?

Disclosures

Prof. Michael Trimble does not have anything to disclose.

REFERENCES:

1. Trimble MR. *The Intentional Brain: Motion, Emotion and the Development of Modern Neuropsychiatry*. Baltimore, MD: Johns Hopkins University Press; 2016.
2. Trimble MR. *Neuropsychiatry*. Chichester, UK: John Wiley & Sons; 1981.
3. Lishman A. What is neuropsychiatry? *J Neurol Neurosurg Psychiatry*. 1992; **55**(11): 983-985.

https://doi.org/10.1017/S1092852916000249 Published online by Cambridge University Press