

Preface

Although one of the editors is trained in both psychiatry and neurology (DJ), the other, not originally interested in behavioral problems at all, has come, through long clinical practice, to be increasingly convinced of the broad overlap between the two disciplines. This means that the lack of an appreciation and understanding of the behavioral problems that are so common in neurological patients puts both the neurologist and the patient at a disadvantage in both diagnosis and treatment. And although there are texts on “neuropsychiatry” and “neurology for psychiatrists,” we envisioned a resource that will acquaint clinical neurologists with “bread-and-butter” psychiatric issues that these physicians face with their neurological patients. Some patients will have behavioral problems as a result of their primary neurological problems, such as Huntington’s disease or Tourette’s syndrome, whereas others have primary psychiatric disorders and later develop neurological problems, such as persons with schizophrenia who develop seizures, strokes, Parkinson’s disease, and the like. However, it becomes increasingly apparent with experience that it is the exceptional neurological patient who does not have some behavioral component as part of the illness.

In *Psychiatry for Neurologists*, we have focused on practical issues and mostly shied away from the theoretical. For example, we have favored the approach of describing depression and its treatment in Parkinson’s disease rather than addressing the role of the basal ganglia in mood. We think the available neuropsychiatry texts address these theoretical issues quite well, but that these texts have mainly targeted psychiatric audiences who are looking for a grounding in neurophysiology and anatomy, seeking “hard” explanations for disorders that until recently have been considered “functional.”

Neurology residency training only recently has mandated a rotation on the psychiatry service. This has resulted in a generation of neurologists who often have little direct experience with primary psychiatric disorders and have no intellectual foundation on which to interpret their findings. In the hospital, the liaison psychiatrists, themselves sometimes adrift in the world of neurological disorders, often prove unable to provide significant assistance in the interpretation or management of behavioral problems, leaving the neurologist without a true safety net. *Psychiatry for Neurologists* is intended to help the clinical neurologist interpret the behavioral problems in their patients themselves, not necessarily to manage the problems independently, but rather to understand the patient in a larger context. This will hopefully allow the neurologist to better interpret the psychiatric problems leading to improved interactions with psychiatric consultants, when they are needed.

When one editor (JHF) started working in Parkinson’s disease 20 plus years ago, it was clear to him that it was a movement disorder, that the discussions over depression being intrinsic or reactive were akin to wondering about the number of angels that could dance on the head of a pin. With greater experience and increased sensitivity, he has come to realize that Parkinson’s disease is really a “neurobehavioral disorder” defined clinically by its movement disorder. The most devastating aspects of Parkinson’s disease are, in fact, the behavioral aspects, not the movement dysfunction. There is sometimes a tendency to regard psychiatry as a “different” type of medical practice because the patients don’t get “sick” in the same way. The stigma against mental illness needs to be combated with education. There is an interesting “The Far Side” cartoon by Gary Larson. A patient is lying on a couch and a somewhat deranged appearing Sigmund Freud imitation is scribbling in his pad, “Just plain nuts.” It is time to move beyond this image. As we learn more and more about emotional problems, we find “organic” explanations in genetic and physiological derangements. One gene

problem creates tics, a “neurological” disorder, while a closely related mutation causes obsessive-compulsive disorder, a “psychiatric” disorder. Why these fall into separate categories owes more to accidents in history (*see* chapters by Goetz and Boller) than anything else. Alzheimer’s disease and dementia with Lewy bodies are good examples of illnesses that fall clearly into both camps, with many successful collaborations. We believe that neurology and psychiatry are increasingly coming together after a long period of moving apart. We hope to help reduce this gap at least a little with this text.

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