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Are neurological and psychiatric disorders different?†

Anthony S. David and Timothy Nicholson

Summary
There have been recent calls to abandon the distinction between neurological and psychiatric disorders on philosophical and moral grounds. Crossley and colleagues, in this issue, meta-analyse published structural brain imaging data and prove that they are different after all – or do they?

Background
The study by Crossley and colleagues, in this issue of the BJPsych, is a rare and therefore welcome empirical contribution to the debate, recently revived, on whether the distinction between psychiatric and neurological disorders is real and/or should be abandoned. Psychiatric disorders are not just ‘mental’ but physical too.

The ‘reality’ of the psychiatry–neurology distinction, refers to the soundness of its theoretical basis. This might be best summarised by the following rule: if a disorder in question is reliably associated with a recognisable pathological process affecting the central nervous system (CNS), then it is neurological. But that of course just begs questions about what is meant by ‘reliably’? Does this mean ‘necessary and sufficient’ to cause the condition? What is ‘recognisable pathology’? Does this refer to the microscopic or macroscopic level? What then do we make of ‘quantitative change’ in the CNS in relation to some normative standard of a given magnitude? Is that ‘pathology’?

If we take schizophrenia, there is ample evidence of quantitative regional change in the CNS thanks to the widespread use of structural magnetic resonance imaging, but only insofar as this is detectable at the group level against a control group and according to some more or less arbitrary statistical threshold. The same can be said of affective disorder but at a rather lower statistical threshold. So are these neurological disorders? Perhaps, yet we do not see much interest among our neurology colleagues to start seeing these patients or engaging in research on them. What then of Alzheimer’s disease? Clearly a neurological disorder. In terms of functional abnormality, it would be hard to argue that this is not a disease of the CNS.

Turning to psychiatric disorders, we do not need to rely on intrinsic neurobiology to argue that these should not be considered neurological. It is true that some abnormalities in the areas of the brain associated with ‘higher’ processes might be linked to psychiatric disorders. But that is a very different question from the one regarding the soundness of the distinction as such. None of the putative ‘higher’ brain regions associated with self-consciousness and emotion are claimed to be the same organ, the brain. Going along with the idea one might then hypothesise that neurological patients show the bulk abnormalities tended to centre on (although not being confined to) the heart, the kidney and the skeleton, respectively? But it is not quite the same since both psychiatry and neurology are laying claim to the same organ, the brain. Going along with the idea one might then hypothesise that neurological patients show the bulk abnormalities in the areas of the brain associated with more basic functions: movement, sensation and, with respect to Alzheimer’s disease, memory, whereas psychiatry patients show differences in ‘higher’ brain regions associated with self-consciousness and identity (the frontal lobes) or emotion (the ‘limbic system’).

The results were more nuanced. First and foremost, there was a clear and statistically robust difference between the two classes of disorder. Second, the pattern was to some extent in line with predictions but with surprises. Summarising the data both quantitatively and qualitatively, the basal ganglia and insula clearly fell on the neurological side of the divide as did primary sensory and motor networks. However, so did the dorsal Prefrontal 'executive' region, which might not have been envisaged. On the other hand the area that came out as clearly ‘psychiatric’ was the medial prefrontal region, an area with a growing reputation for functions concerning self-reflection and social cognition. This region is part of the so-called ‘default mode network’, thought to be involved in awareness and stimulus-independent thought.
which was generally less implicated in studies of neurology patients and includes attentional systems reaching back to the posterior cingulate cortex. An unexpected and frankly odd finding was that regions of the visual association cortex were significantly more allied with psychiatric disorders. These included the lingual gyrus, which may after all be genuinely important given its role in face perception. The temporal cortex was, perhaps predictably, the truly contested area – containing both the hippocampus (reflecting the arbitrariness of regarding dementia as neurological or psychiatric) and components of the limbic system, as well as being a key area of epilepsy pathology, such as mesial temporal sclerosis.

Conclusions

The results may be taken as a slap in the face to the distinction-abolitionists, yet such individuals might take heart in them in that there is no implicit hierarchy in what emerges as the brain-based hallmark of neurological versus psychiatric conditions; they both involve the functionally interesting parts of the brain, it is just that they are, quite subtly, different.

Perhaps one lesson that we can all take from this novel and ingenious work is that we need to continue to use every ounce of our brains to answer the question of what makes a psychiatric disorder. As McHugh & Slavney\textsuperscript{11} wrote in their thoughtful The Perspectives of Psychiatry:

"In the everyday world of the clinic, psychiatrists are distinguished from other medical specialists not because they are concerned with "minds" rather than "bodies," but because they focus on complaints appearing in people's thoughts, perceptions, moods, and behaviour rather than their skins, bones, muscles and viscera . . . The diagnostic process may be difficult, but causal explanations are always complex and depend on the physician's capacity to evaluate issues ranging from intermediary metabolism (a "body" issue) to interpersonal misunderstanding (a "mind" issue). Psychiatric concerns thus extend from the ultrastructure of the body to the relationship of groups of minds within a social context."

References

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