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Towards a joint classification of neurological and psychiatric disorders

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Psychiatry has been called the other half of medicine,[1] reflecting the separation of mental health services from the rest of health care. Patients with a mental illness are treated in different clinics and hospitals to those with physical illnesses. Advances in neuroscience and medicine have gradually eroded the justification for this divide, but the compelling evidence for the interdependence of brain and mind is easily neglected within our siloed specialties and services. We believe this separation causes harm to patients with disorders on either side of the line and propose that a joint classification of neurological and psychiatric disorders is theoretically justified, practically feasible, and would benefit psychiatry, neurology, and medicine more broadly.

Some argue that psychiatry's separate status protects the funding of mental health services and research, but funding remains lower than is needed.[2] This separation not only maintains the stigmatisation of people with mental health conditions,[3] but also affects their physical health care—which is often suboptimal in psychiatric services[4]—contributing to premature mortality.[5] Stigmatisation and discrimination against people with mental health conditions could be partly responsible for the relatively poor resources for psychiatric care globally, and particularly in low-income and middle-income countries.[6] A hybrid survey of the lived experiences of people with a mental health condition found that "the distinction between mental and physical health can be experienced as restrictive or unhelpful by patients…and it would be beneficial to consider different aspects of health more holistically".[7] Insufficient psychological and psychiatric expertise in neurological services—and other medical services—hampers the recognition and management of comorbid psychiatric disorders, although these are common and treatable. The intrinsic psychiatric features of many neurological and systemic disorders are increasingly

	Why the distinction fails	Clinical examples
Structural disorder *vs* functional disorder	All CNS disorders involve brain network dysfunction; shared and disorder-specific structural abnormalities occur in many psychiatric disorders	Frequent grey matter reductions across psychiatric disorders; ventricular enlargement in schizophrenia
Observational signs *vs* subjective experience	All symptoms are, by definition, subjective and many neurological diagnoses rely only on subjective experiences; observational findings occur in traditionally psychiatric disorders	Migraine and many primary headache diagnoses are only based on symptom reporting; pain and fatigue in neurological conditions; objective clinical findings in functional neurological disorder and schizophrenia
Neurological *vs* psychiatric symptoms and signs	Psychiatric symptoms are common as part of traditionally neurological conditions; neurological symptoms occur in psychiatric conditions	Anxiety and depression in Parkinson's disease; post-ictal psychosis in epilepsy; obsessive compulsive disorder and attention deficit hyperactivity disorder in Tourette syndrome; loss of empathy in frontotemporal dementia; catatonia in schizophrenia
Pathology *vs* psychosocial factors	Psychosocial factors are relevant to the aetiology of neurological conditions; pathology, including genetic and immune factors, is common in many psychiatric disorders; genetic risk factors occur in both neurological and psychiatric disorders and are often shared	Adverse experience leading to alcohol misuse and consequent alcohol-related brain damage; psychosis in autoimmune encephalitis; inflammation in depressive disorders
Neurologists look after diseases *vs* psychiatrists look after disorders	In practice, psychiatrists often look after so-called diseases and neurologists often look after so-called disorders	Psychiatric care for dementia or Huntington's disease; neurological care for functional neurological disorder (among the most common of presentations to neurology)

Table: **Traditional distinctions between neurology and psychiatry and examples of how they fail modern neuroscience and clinical practice**

recognised and can affect quality of life more than their physical symptoms.[8]

This unhelpful separation of mental health from the rest of medicine is reflected in how we classify such illnesses. Psychiatric diagnoses are codified in a separate book (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*)[9] or a separate chapter in the International Classification of Diseases 11th Revision (ICD-11).[10] The separation of psychiatric and neurological conditions has been taken to imply that neurological disorders originate physically, whereas mental illnesses are considered to be psychological, which is a stigmatising belief still widely held today. This outdated division also causes a range of nosological anomalies and challenges to classification. Some conditions, such as dementia, are now classified under both neurology and psychiatry in ICD-11.[10] Others, such as functional neurological disorder, present primarily to neurologists, yet are classified as psychiatric disorders.[9,10]

The questionable distinctions between neurological and psychiatric conditions are outlined in the table and illustrate the close relationship between these types of disorders. The brain is the organ of the mind and the mind has a pervasive influence within neurology and throughout medicine. A biopsychosocial approach to illness is therefore widely helpful beyond psychiatry.[11]

A potential solution to the problems created by the nosological separation of neurological and psychiatric conditions is to merge the ICD's neurological and psychiatric chapters into one chapter about the nervous system (or of nerve, brain, and mind).[8] We suggest that the evidence in favour of such a merger is now so overwhelming that it should occur in the next (12th) version of the ICD, for which a date is not yet set. This proposal builds on the growing interest in brain health, defined by WHO as "the state of brain functioning across cognitive, sensory, socio-emotional, behavioural and motor domains, allowing a person to realize their full potential over the life course".[12] We endorse this broad conception of brain health, which lends itself to an integrated view of neurology and psychiatry of the kind we propose here.[13] It is also in keeping with current transdiagnostic approaches to understanding the many symptoms presenting to both neurologists and psychiatrists, such as apathy, fatigue, and hallucinations.[14,15]

Such a merger would, we believe, foster a closer relationship between the clinical disciplines of neurology and psychiatry to the benefit of patients. Potential clinical advantages for patients with mental health conditions include challenging discrimination, enhancing the care of physical comorbidities, and encouraging shared approaches to many conditions that span both disciplines, such as dementia. Patients with neurological conditions would benefit from more comprehensive assessment of the cognitive and affective consequences of neurological disorders, rapid detection and treatment of psychiatric comorbidities, and enhanced detection and management of conditions in the area between neurology and psychiatry, such as functional neurological disorder. The new ICD chapter might helpfully incorporate orphan conditions that currently sit in neither category in the ICD, such as chronic primary pain and some sleep–wake disorders. More generally, we believe that such a move will help doctors to regard mental health as everyone's business, not someone else's responsibility.

Arguments against this proposal include theoretical, professional, and therapeutic objections. The theoretical objections include criticisms that the proposal downplays the mind's role in health, begs the philosophical mind–brain question, or ignores the personal, social, or symbolic levels of illness. The professional objection is that, despite the differing skill sets of neurologists and psychiatrists, the proposal would lead to a merger of the clinical disciplines of neurology and psychiatry. Therapeutic objections include a slide towards excessively neurocentric approaches,[16] the sidelining of psychological therapies, and increased stigmatisation of mental illnesses when regarded as purely biological.[17]

We believe that these objections are either ill-founded or outweighed by the benefits.[18] We do not deny the importance of the mind; indeed, it is important throughout medicine.[8,11] Our proposal is neutral regarding the mind–brain philosophical problem and simply insists that the brain is, to a first approximation, the organ of the mind. We fully recognise the importance of personal, symbolic, and social aspects of illness, but reinforce that these are not confined to mental illness. We agree that neurologists and psychiatrists require different, albeit complementary skillsets, but argue that because neurologists and psychiatrists work with the same organ, they would benefit from increased

collaboration in training, service, and research. Cardiac surgeons and cardiologists, for example, share the same category of disorders in the ICD while maintaining separate but collaborative training programmes and collaborating closely in shared care. The proposal would not affect psychotherapeutic approaches, which exert their influence via their effects on the brain.[19] We believe that the merger would likely decrease the stigma attached to mental illness, given that stigma related to depression, for example, has decreased as public understanding of the biomedical basis of mental illnesses has grown.[20]

We call for detailed discussion of such a merger, not only between and within the disciplines of psychiatry and neurology, but also among key clinical disciplines, from psychology to neurosurgery and, crucially, among patients with these conditions. We encourage WHO to address this proposal and to draft a merged chapter of the nervous system as the 12th version of the ICD is developed. A joint classification of psychiatric and neurological disorders would improve the understanding of these disorders by health-care professionals and the wider public, encouraging integrated holistic care for conditions that make up a large proportion of the global burden of disease.

PW did consultancy work for the Swiss Re insurance company up until 2023; received travel expenses for an educational neuropsychiatry lecture in 2023; and was a trustee for the Voluntary Hospital of St Bartholomew's until 2025. TRN receives royalties for medical textbooks and online lectures; receives travel expenses for talks at medical and scientific meetings; does expert witness medicolegal work; and is a trustee of the patient charity FND Action. JS declares grants from National Health Service Lothian; is a National Research Strategy Career Fellow at the University of Edinburgh; receives royalties for UpToDate; has been paid for a lecture by the University of Toronto; does expert witness work in personal injury and negligence medicolegal work; has had travel expenses for various neurology and neuropsychiatry meetings; is President of the FND Society; and sits on the Medical Board of FND Action. AZ does medicolegal work as an expert witness in cases involving disorders relevant to this Comment and receives travel expenses for educational neuropsychiatry meetings that he organises or speaks at. LFB declares no competing interests. We thank Professor Ed Bullmore for his input to an earlier draft and thank two individuals with lived experience for providing feedback on a previous version.

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