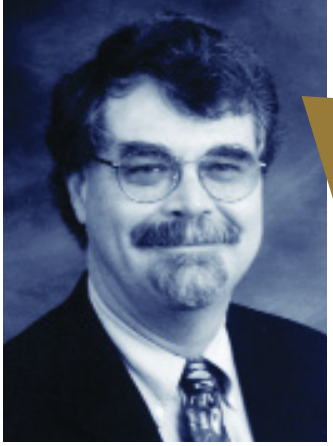


From the editor

'That's really cool, Dad, but—how is that psychiatry?'

The title above is a direct quote from my teenage son after I had finished a somewhat overlong description of the obesity research going on in my department. I can't remember what I said at the time—something about obesity relating to the intersection of biology and behavior, and that is what psychiatry is about. On the other hand, since I was caught off guard, I probably said something really stupid like, "It's psychiatry because we are doing it in our offices."

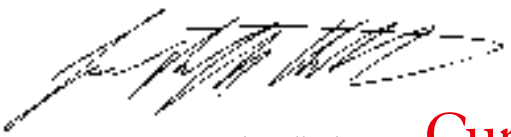
Which disorders are "psychiatric" and which are not? It really is a non-trivial question. In this issue, we have an article on rapid-cycling bipolar disorder, which everybody would agree is a psychiatric condition. On the other hand, I think that others may wonder why we chose the other topics included in this issue:

- Obesity? Bariatric medicine, whatever that is.
- Hypothermia? Internal medicine.
- Dementia? Neurology.
- Shyness? Not a disorder at all.
- Stalking? A matter for the police.

Of course, I do not agree with those who might assign these disorders to other disciplines or I would not have chosen to have articles on them in the journal. But why are these psychiatric topics? All of them do represent an intersection of biology and behavior, and all cause a lot of pain for those who suffer from them.

As our knowledge of neurobiology and behavior have expanded, so have the boundaries of psychiatry to include topics such as shyness, once thought to be purely "psychological," and dementia, once perceived as "biological." Hypothermia can complicate our treatment of various mental disorders. Shyness causes an enormous range of symptoms. On its more severe end, shyness probably combines a biological predisposition with a vicious cycle of symptoms leading to stress, which in turn leads to worse symptoms. Effective treatment of obesity must be something more than instructions to "just eat less and exercise more." Stalking is a dilemma that, like it or not, can just walk into our offices.

Which brings me back to what I am afraid I actually said to my son: "It's psychiatry because we are doing it in our offices." I guess you could call it an operational definition. Anyway, what psychiatrists are actually doing in their offices is precisely what *Current Psychiatry* is about.



Randy Hillard, MD

Current Psychiatry

Have a case from which other psychiatrists can learn?

Check your patient files—past and present—to identify a case that offers "lessons learned" and send it to Senior Editor Pete Kelly, pete.kelly@dowdenhealth.com. Keep it to 1,500 words, outlining history and treatment options, with interspersed commentary to point up the key decision points.

If you have questions before writing, check with Pete Kelly. He'll submit it to our Editorial Board and Case History Editor for review—and you'll hear from us soon.