



From the editor

Neuropsychiatry is back in style and for good reason

When I trained in the 1970s, some older physicians still called themselves “neuropsychiatrists.” To a psychiatry resident like me, they seemed out-of-date and “uncool.” Many did electroconvulsive therapy, and some still read EEGs. An enormous chasm seemed to exist between psychiatry’s therapeutically optimistic approach to life and what I perceived as neurologists’ dreary identification of precise but untreatable lesions.

Of course psychiatry is an outgrowth of neurology, and the specialties are connected by their study of the same organ system. That explains all those American Board of Psychiatry and Neurology certificates on our walls. Over time, however, psychiatry and neurology have developed different approaches to patient care. Psychiatrists see patients for longer sessions, we generally do not treat conditions with clear physical or lab findings, and we are always thinking in terms of multidimensional diagnoses.

Comments of archneurologist Hughlings Jackson at the turn of the 20th century illustrate the estrangement of psychiatry and neurology: “Their (psychiatrists’) hospitals are not our hospitals. Their ways are not our ways.”

Sigmund Freud trained as a neurologist. He predicted that psychiatry and neurology would reunite if neuroscience caught up with psychiatric observation. This issue of *Current Psychiatry* shows evidence of that reconnection, as we examine the psychiatric aspects of several neurologic disorders—epilepsy and seizures, schizophrenia, Parkinson’s disease, and irritable bowel syndrome.

Neurologist Michael D. Privitera, MD, goes a long way toward making EEGs “cool” again in his article on what psychiatrists should know about EEGs and epilepsy (page 14). As director of the University of Cincinnati’s Comprehensive Epilepsy Treatment Program, he tells us what EEGs really mean and offers helpful suggestions on sorting out psychiatric from neurologic symptoms.

The negative symptoms of schizophrenia—described by Rajiv Tandon, MD, and Michael Jibson, MD, PhD

(page 36)—are probably a neurologic syndrome first described by Emil Kraepelin, another neuropsychiatric ancestor.

Depression, anxiety, and psychosis often complicate advanced Parkinson’s disease (PD), a chronic neurodegenerative disorder. Stephen L. Byrd, MD—a psychiatrist—and Mary D. Hughes, MD—a neurologist—describe a team approach to managing PD’s psychiatric symptoms (page 23).

Irritable bowel syndrome is a visceral hypersensitivity disorder, but psychotherapy is showing promise in the relief of its associated GI and mood disturbances. The article by Kevin W. Olden, MD (page 47), illustrates that neurologic psychiatry can offer effective treatment for some biological diseases.

Being a psychiatrist is difficult enough, but now we need to be neurologists, too. I’ve heard it said that doctors practice medicine today the way airline ticket agents would practice if they had to keep all the flight schedules in their heads. With all the information I have to manage, I frequently wish that I could get a “brain upgrade.”

A ray of hope is *Current Psychiatry*’s new Web site—www.currentpsychiatry.com. It provides free full-text access to our issues, links to mental health resources, listings of professional opportunities, and news and information not offered in the print edition. This month we introduce “Psyber Psychiatry,” a column by John Luo, MD, on the use of computers in psychiatry (page 60). Dr. Luo, psychiatric informatics specialist at the University of California, Davis, addresses the use of virtual reality in psychiatric therapy. Please follow Dr. Luo’s future columns on the Web site.

Hope you enjoy this issue. Contact us anytime at current.psychiatry@dowdenhealth.com to tell us what you think of *Current Psychiatry*—in print or online.

Randy Hillard, MD

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