This month, Karl Goodkin, MD, PhD, guest edits a series of very important topics related to the psychiatric treatment of patients with the human immunodeficiency virus (HIV).

Although I found all the articles had something to teach, the one by Stephen J. Ferrando, MD (see page 223), “The Psychopharmacological Treatment of Patients with HIV/AIDS,” particularly inspired me to think about psychiatry as a specialty. I remember years ago when I would give lectures to general physicians about the recognition and treatment of depression and being told by some, “I don’t treat anything from the neck up.” Now, it is customary for primary care physicians, obstetricians/gynecologists, and pediatricians to prescribe selective serotonin reuptake inhibitors (SSRIs) and other psychotropic medications. Nurse practitioners and, in some states, even psychologists with no medical training beyond a “certification course,” can prescribe these medications.

What makes us psychiatrists any different in the realm of psychopharmacology? In my career, I can remember diagnosing 3 glioblastomas in 2 patients presenting with depression, and 1 with panic attacks. One of them had been prescribed antidepressants.

**DRUG-DRUG INTERACTIONS**

What stood out to me was Ferrando’s mention of the possible negative interactions between psychiatric medications and those for suppressing HIV. The potentially serious interactions of certain SSRIs with cytochrome P450 isoenzymes and carbamazepine, even to the extent of allowing the HIV virus to progress in the brain, is a striking reminder of the intricacies between all bodily systems. We, as specialists, must know about these interactions. We have to be able to think of the possibilities when we see the patient — being able to look it up is not enough — if we don’t think of it. That is what being a specialist is about.

We have to know how to use less common medications, such as monoamine oxidase inhibitors and pramipexole, so we can treat refractory mood disorders. You may say these are the needles in haystacks, but as time goes on, the justification for the field of psychiatry will be based on recognizing and treating these “uncommon” conditions that unfortunately, are not that uncommon. Managing high-risk suicidal patients, patients who don’t seem able to tolerate medications, difficult patients with comorbid personality disorders, all require specialty care by highly skilled psychiatrists.

So we need to study issues like managing HIV/AIDS patients, as well as managing patients who are pregnant, have heart disease, diabetes, etc. We need to know about cytochrome P450 interactions. And that’s just in the psychopharmacology realm. We also need to know about various psychotherapeutic approaches and how to recognize our patient’s strengths. And when treating patients, we must not let insurance companies influence how we make our decisions.

Psychiatry is a wondrous specialty that requires knowledge about all human experience, from basic proteins to society. That’s what makes it so exciting, so wonderful. We must cherish and fulfill the demands of this specialty for it to remain a specialty.

**DSM-5**

Although there has been much discussion about certain criteria chosen for inclusion in the DSM-5, out this month, great effort was made to ensure criteria were as evidence-based as possible. Looking forward, the intention is that the DSM-5 is, as I have called it before, “a living document.” As new data surface, the hope is that the DSM-5 will respond to include the practical value of those studies, instead of waiting decades. This will help treatment to advance incrementally and with more efficacy. We can only do what we know how to do at the time while not causing any harm. See you at the APA!