Former American Psychological Association president Dr. Jeffrey Lieberman has been repeatedly quoted from his book, *Shrinks: The Untold Story of Psychiatry*, that psychiatry is “the most distrusted, feared and denigrated of all medical specialties.” Most psychiatrists reading *Psychiatric Annals* are probably acutely aware of this stigma about our profession, as well as the biases that our patients have to confront. But, what psychiatrists may be less aware of is the difficulty our patients have in obtaining evidence-based, holistic medical treatments. This issue on psychosomatic medicine is meant to provide tools and information to address our collective responsibility in assisting patients to achieve true recovery—recovery that includes the whole body.

The stigma about mental illness can make it challenging for our patients to obtain equitable medical care; we know that patients with psychiatric illness have higher morbidity and mortality than their peers, with earlier death and greater difficulty obtaining standard treatments for medical problems. This issue is an exploration of a few facets of the subspecialty of psychosomatic medicine, with a variety of articles focused on integrated psychiatric care.

The subspecialty of psychosomatic medicine is anchored in the care of patients with comorbid psychiatric and medical illness, which we are increasingly practicing in a variety of integrated care settings. There have been many barriers to overcome, including the systematic separation of medical and psychiatric care for decades at local, state, and federal levels in the United States. Wayne Katon, pioneer of collaborative care in psychiatry, wrote repeatedly and eloquently about collaborative care as an option for addressing this separation. Collaborative and integrated care in psychiatry is slowly taking hold across the country, and increasingly, part of the work of all psychiatrists involves providing and advocating for psychiatric and medical treatments in a variety of settings.

In this issue, Dr. Sheila Lahi-jani and I present some of the basic tenants of collaborative care, and review the evidence base for collaborative treatment of patients with depression and diabetes. The epidemic of opiate overuse and chronic pain is addressed in a review by Drs. Tracy Binius and Marie Tobin. They give a history of the rise in opiate use in the United States, and practical tips on both assessment and treatment options for patients. Drs. Leena Mittal, Christina L. Wichman, and Nancy Byatt present a spectrum of treatments for patients with bipolar disorder during pregnancy. In their article on capacity assessment, Drs. Maxwell Rovner, Willie Mae Jackson, and Stephen H. Dinwiddie review the method of assessing patients’ ability to give informed consent for care. Although this has long been a topic for inpatient psychosomatic psychiatrists, it is increasingly important for all psychiatrists to be able to assess capacity and then advocate for patients to give and obtain informed consent for all types of treatment. Finally, Drs. Alexandra Aaronson and R. Brett Lloyd have reviewed a difficult topic: agitation in patients after brain injury. Psychomotor agitation is a difficult problem for patients with a variety of neurocognitive disorders, and they provide some insights about etiology and treatment strategies.
Hopefully, the tide is turning and innovations of funding and collaboration will allow new opportunities for psychiatrists to contribute to the care of our patients as they progress through the life cycle and through medical and surgical conditions. Despite the stigma against our profession and treatments, for the most part, US Food and Drug Administration-approved treatments for many psychiatric diseases are lowering morbidity and mortality for patients, especially those with severe mental illness.\(^7\) There is an opportunity for all of us to work in evolving settings, and continue to contribute to the care of the whole patient.

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REFERENCES

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