By Joe Bouch

Over three decades ago, Engel (1977) challenged the ‘dominant’ biomedical model, which ‘leaves no room within its framework for the social, psychological, and behavioural dimensions of illness’. Today, for many clinicians, a biopsychosocial model of psychiatry is a given – self-evident and uncontested. And yet in this issue of Advances there are warnings of its demise and challenges for it to embrace.

Chiding the American Psychiatric Association, Sharfstein (2005) has written: ‘as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model’. In turn, Denman (pp. 243–249) warns psychiatrists of the risk of becoming ‘at worst pill-pushing agents of social control’. She urges us not only to develop competence in ‘prescribing formal psychotherapy appropriately’, but also to cultivate and maintain our ‘emotional literacy skills’ – skills required in forming therapeutic relationships in the presence of ‘anger, distrust and defeat’, not merely the ‘soft skills’ of politeness and consumer management taught by businesses.

Psychotherapeutic competence is essential too when it comes to treating with medication. Take clozapine as an example. As many as two-thirds of patients with schizophrenia have treatment-resistant illnesses and up to 60% of these would improve with clozapine. It is both cost-effective and the most effective antipsychotic in reducing mortality in schizophrenia. Surely this is a simple case of the need to implement evidence-based practice?

But consider how evaluations of the positive and negative effects of the drug ‘differ considerably’ between patients, their families and clinicians (Mistry & Osborn, pp. 250–255). Consider the patient with a severe mental illness whose ‘anxiety about having to “come out” about their illness or having to explain their need for psychotropic medication’ leads to ‘intentional celibacy’ (Smith & Herlihy, pp. 275–282). Consider the pain and challenges of an ‘awakening’ – where insight resulting from a therapeutic response may lead to depression and even suicidality. There are many possibilities and pitfalls in ‘getting the best out of clozapine’ (Mortimer, pp. 256–265).

And of the current challenges that biopsychosocial psychiatry must address, none is more pressing than how to incorporate the patient’s perspective. Certainly, new psychological therapies such as acceptance and commitment therapy can address, none is more pressing than how to incorporate the patient’s perspective. Certainly, new psychological therapies such as acceptance and commitment therapy can address, none is more pressing than how to incorporate the patient’s perspective. Certainly, new psychological therapies such as acceptance and commitment therapy can address, none is more pressing than how to incorporate the patient’s perspective. Certainly, new psychological therapies such as acceptance and commitment therapy can address, none is more pressing than how to incorporate the patient’s perspective. Certainly, new psychological therapies such as acceptance and commitment therapy can address, none is more pressing than how to incorporate the patient’s perspective.