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Subscriptions
Advances Volume 17, 2011 (six issues)
(full airmail £19/US$34 extra)

	Members of the Royal College of Psychiatrists	Non-members	Institutions
Print (+free online)			
Europe (& UK)	£63	£133	£144
USA	US$112	US$209	US$248
Elsewhere	£70	£143	£155
Online (only)			
Worldwide	£40/US$64	£105/US$158	£131/US$203

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Printed by Henry Ling Ltd, 23 High East Street, Dorchester, Dorset DT1 1HD.

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ISSN 1355-5146

Biopsychosocial psychiatry

FROM THE EDITOR

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 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 put the patient's values centre stage (Webster, pp. 309–316). Might measuring health-related quality of life give 'a subjective "biopsychosocial patient perspective"'? But measuring quality of life is controversial – 'whose values are these measurements based on, and what is being measured, by whom and for whom?' (Wallcraft, pp. 266–274).

Treating bipolar disorder early

Elanjithara *et al* (pp. 283–291) write that 'Accumulating evidence has challenged the notion that, compared with schizophrenia, bipolar disorder is a more benign illness with a relatively good prognosis'. Their article, my Editor's pick, explores the challenges of making an early diagnosis, the use of medications and their possible mechanisms of action. In a contentious area, it is right up to date and eminently applicable to clinical practice.

Engel GE (1977) The need for a new medical model: a challenge for biomedicine. *Science* **196**: 129–36.

Sharfstein S (2005) Big pharma and American psychiatry: the good, the bad, and the ugly. *Psychiatric News* **40 (16)**: 3–4.

https://doi.org/10.1192/apt.17.4.239 Published online by Cambridge University Press