

There are many social factors that predispose an individual to depression including social deprivation, living alone, and divorce (**Singleton et al., 2001**). The common thread through these is stress. There is a well-established link between depression and chronic stress (**Hammen, 2004**). Chronic stress is becoming a public health crisis perpetuated by worries about finances (APA, 2011). The work environment can be extremely stressful, due to a negligent supervisor, unsupportive coworkers, heavy workloads, demanding deadlines, and unforgiving customers, amongst other things causing mental health difficulties (**Standfeld & Candy, 2006**). Chronic stress is linked to negative intrusive thoughts (**Horowitz, 1975**) and overworks the cortisol system in the brain leading to excitotoxicity and cellular death (**Lee et al., 2002**). Furthermore, genetics and stress are also linked together. A study by **Caspi et al., 2013** found that depression was most likely to follow a stressful event in individuals who had one or two short alleles of the serotonin transporter gene. In sum, it is undeniable that biological, psychological, and social systems are interconnected.

A clinical vignette can best illustrate the biopsychosocial model in action: Lucy is a 25 year old female (females more likely to get depression (Van de Velde et al., 2010) whose mother placed her in the foster care system (socioeconomic factors of depression (Singleton, 2001)) due to her inability to care for Lucy as a result of depression (Genetics). As a result, Lucy never had a stable family home, leaving her with the feeling that she was rejected (Beck's early life experiences). Lucy's job underwent job cuts and leaving her responsible for the work of two people. This leaves her with a heavy workload and increased chronic stress (chronic stress model). After being in this role for months, Lucy begins to feel low mood, a lack of energy, and difficulty concentrating (cortisol leading to cellular death; problems of 5HT and NA signalling). She thinks badly of herself (thinking she's not good enough or she would be able to manage (Beck's maintenance model)). This in turn makes her feel worse and more depressed.

While the model is useful for holistic conceptualization of disorder, not all health professionals agree that this model represents an advance in medicine (**Benning, 2015**). One of the most generally cited problem with the BPS model is that its inclusiveness results in an unscientific, "fluffy", pluralistic approach where, all perspectives have won and deserve prizes. The goal of science is analytic understanding and that understanding requires intelligible frames that break the world into its component parts. In contrast to this, the BPS model potentially justifies a morass of "anything goes" in medicine and health (**Ghaemi, 2009**).

Furthermore, **Ghaemi (2009)** argues that the physician who adopts the BPS model is in real danger of losing clear boundaries regarding their knowledge and expertise. In short, must a physician now understand everything? If knowledge expectations and training become too diffuse, then expertise will inevitably suffer. However, while multiple considerations may be difficult for professionals to balance, scientific evidence confirms the interplay of the 3 systems (Horowitz, 1975; Lee et al., 2002; Caplan et al., 1975). To dismiss the model due to inconvenience would be professionally negligent.

While the BPS model has limitations, it is undeniable that biological, psychological and social factors all influence each other and feed into each other in an interdependent way. This interdependent nature makes it urgent that all factors be taken into account when attempting to form a complete explanation of depression.