are born listeners of this sort, most of us are not. It is a psychological skill that we can acquire – but, I have found, one that needs psychological understanding and training. So, diagnosis is not just about working through questionnaires and searching for physical signs, but about a more subtle and interactive process of building trust and establishing a clear dialogue.

What about prescription? The fact is that even if I aspire only to be a humble manipulator of neurochemicals and pharmaceuticals, psychology and culture keep getting in the way. Apparently straightforward conversations about pharmacological treatments are actually highly loaded psychological interactions which demand psychological skills to negotiate successfully. Which may be why adherence to medication is poor across all areas of medicine.[3] And when you bear in mind the limited effectiveness of most biological treatments (again, not unlike the rest of medicine), the prescriber is burdened with the purely psychological task of supporting the patient through the difficult task of trying one drug (or combination) after another to achieve a worthwhile result.

So, the retreat to a biopharmacological bunker might be attractive to those who like the spurious certainty of diagnostic and treatment algorithms. It might suit others who prefer to focus on one domain rather than straddle several. However, it just won't work therapeutically. If you separate off psychological skills and social understanding from the training of psychiatrists, we will be training a generation of idiot savants, good only for delivering simplistic (and ever-changing) diagnostic labels, or for prescribing medications that their patients don't take.

1 Fitzgerald M. All future psychiatrists should be neuropsychiatrists. *Psychiatrist* 2013; **37**: 309.

2 Ley P. *Communicating with Patients: Improving Communication, Satisfaction and Compliance*. Nelson Thornes, 1997.

3 Osterberg L, Blasche K. Adherence to medication. *N Engl J Med* 2009; **353**: 487–97.

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Some psychiatrists should continue to directly provide psychological therapies

Fitzgerald[1] suggests that psychiatrists should not directly provide psychological therapies. There are a number of reasons why some of them should.

First, specialist experience in delivering psychological therapies may strengthen the skill of a psychiatrist in choosing when and how to use psychopharmacology. A psychiatrist's experience in administering both psychotherapy and psychopharmacology may improve their ability to judge when to commence, combine or cease either treatment.[2] Indeed, the *New Ways of Working for Psychiatrists* report[3] predicted an increase in the need for support from consultant psychiatrists in psychotherapy for individuals with complex problems.

Second, some individuals may need difficult risk assessments while receiving psychotherapy. The different career path of a psychiatrist to that of a psychotherapist may make them better suited to make these assessments.

As for the financial cost of psychiatrists providing psychotherapy being 'prohibitive', Layard *et al*[4] have argued that the implementation of NICE guidelines requiring psychological therapies may be self-financing when the effect of depression and anxiety disorders on the wider economy is taken into account.

1 Fitzgerald M. All future psychiatrists should be neuropsychiatrists. *Psychiatrist* 2013; **37**: 309.

2 Royal College of Psychiatrists, Royal College of General Practitioners. *Psychological Therapies in Psychiatry and Primary Care* (College Report CR151). Royal College of Psychiatrists, 2008.

3 Department of Health. *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services through New Ways of Working in Multidisciplinary and Multi-Agency Contexts*. Department of Health, 2005.

4 Bell S, Clark D, Knapp M, Layard R, Meacher MC, Priebe S, et al. *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London School of Economics and Political Science, 2006.

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Author response: There is no need for professional concern about psychiatrists being largely neuropsychiatrists. The family factors, psychodynamic and sociological factors will still be acknowledged by the neuropsychiatrist but treatment of persons where these factors are relevant will be by non-medical professionals, psychotherapists, psychologists and social workers at a much lower financial cost. The neuropsychiatrist will still be team leader and have overall clinical responsibility.

Dr Black makes an interesting point. I may not have been clear enough in my original letter. I believe all consultant adult and child psychiatrists should be trained to about masters level in psychotherapy for the purpose of supervising junior staff in training. The actual face-to-face individual psychotherapy would be done by junior staff and non-medical staff.

Dr Timms mentions the psychiatrist's role in the 'interactive process of building trust and establishing a clear dialogue' with patients. I would have thought this was part of the role of all doctors, including all mental health professionals. Dr Khan writes about the Department of Health's view of the 'need for support from consultant psychiatrists in psychotherapy'. There is no doubt that psychotherapists with difficult patients need the support and second opinion of their consultant psychiatrist colleagues, especially with those patients who are not making progress because of missed diagnoses or not being on appropriate medication.

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