

Editorial

Neurology in the German training system for psychiatrists – a personal view

Cornelia Thiels

**Summary**

In mid-19th-century Germany the conviction that 'mental disease is brain disease' was accompanied by a call for social reform in psychiatry. During neurology training, future psychiatrists often encounter patients with mental disorders rarely seen in psychiatric departments

and learn how to avoid misdiagnosing brain diseases as mental disorders.

Declaration of interest

None.

Cornelia Thiels is Professor of Social Medicine and general and child psychiatrist in private practice. She trained at the Free University Berlin, Germany, and the Maudsley Hospital London, UK.

Some historical aspects of psychiatry in Germany

Wilhelm Griesinger, the leading German psychiatrist in the mid-19th century, believed that 'all mental disease is brain disease'.¹ This did not reduce his awareness of the need for social reform in psychiatric treatment. He was a strong advocate of non-restraint.¹ His influence resulted in the development of a combined specialty of neuropsychiatry, until in the 1960s academic neurology became independent from psychiatry. At this point, psychiatry lost most of its physical components (apart from treatment with psychoactive drugs), while psychological and social theories predominated (H. Helmchen, personal communication, 2013). Departments of Psychiatry changed their name to Departments of Psychological Medicine or Social Psychiatry. Young psychiatrists worked hard to improve the social conditions of the mentally ill. Outside psychiatric hospitals, training in psychodynamic psychotherapy parallel to psychiatric training led to interpretation predominating over clinical observation and description. Three decades later, the development of molecular genetics, brain imaging and other neuroscientific advances – together with the increasing prevalence of neurodegenerative or vascular brain disorders in an ageing population – resulted in young psychiatrists returning their attention to the brain, but not to learning systematic, clinical, neurological assessment (H. Helmchen, personal communication, 2013).

The 5-year training programme in 'psychiatry and psychotherapy' (since 2003, training in psychiatry alone no longer exists) includes a mandatory year of training in neurology and at least 2 years in in-patient general psychiatry and psychotherapy, with (at most) 1 year in child and adolescent psychiatry and psychotherapy (a separate medical specialty) or in psychosomatic medicine and psychotherapy, or 6 months in internal medicine, general practice, neurosurgery or neuropathology.² There is no formal training in liaison psychiatry, although psychiatrists are asked to see patients in other hospital departments and doctors working as specialists in their own surgeries are paid for providing consultation or second opinions to other specialists on particular patients.

Until 2003, medical doctors could specialise in psychiatry, neurology or a combination of both. The latter is the most

common specialisation for those working as out-patient specialists in their own practice.

The President of the *Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde* (DGPPN, German Society for Psychiatry, Psychotherapy, Psychosomatics and *Nervenheilkunde* (reflecting those specialised in a combination of psychiatry and neurology, see above)) wrote:

'Mental disorders are brain disorders driven by the psychosocial environment. Therefore, the understanding of brain functions is crucial in our field. On this basis there have been intensive discussions between the German Society for Psychiatry at the German Society for Neurology about the mandatory year of training in neurology for psychiatrists and in psychiatry for neurologists. It is agreed that mutual training is important and meaningful for both sides' (W. Maier, personal communication, 2013).

Psychiatric disorders rarely seen in psychiatric departments

In spite of rotating every 6 months to a different ward or department at the Maudsley Hospital, London, it was only in the Department of Neurology of Free University Berlin that I saw: dissociative convulsions and dissociative hemiplegia (at first mistaken for a stroke); water intoxication in a woman with intellectual disability referred for her seizures; benzodiazepine dependence that had been mistaken for epilepsy for decades and seemed to respond only to diazepam; chronic headaches caused by the misuse of analgesics; and a patient with alcohol dependency who crawled on admission and left the ward after B12 replacement therapy walking upright, albeit with his feet rather wide apart. In addition, I learned what hypnotics can do to the elderly. An elderly woman who fell when getting up at night was investigated for the presence of a neurological disorder. Working in a neurology department can be excellent preparation for liaison psychiatry, for learning when to transfer patients from neurological to psychiatric care, for making neurological diagnoses where appropriate and for knowing when to refer to a neurologist for a specialist opinion.

Further lessons to be learned during training in neurology

Examples of further lessons to be learned during training in neurology include the following.

- (a) It can be helpful to know about the libido-enhancing influence of anti-Parkinsonian medication when trying to understand the behaviour of previously faithful husbands who cheat on their wives when prescribed these drugs. In contrast, the

resistance of young men to taking antipsychotic medication can best be understood by recognising the negative effects that such medication has on male libido.

- (b) People with epilepsy have a higher prevalence of mental disorder than the general population. It is advantageous if the psychiatrist treating the mental health problems of patients with epilepsy has an understanding of this disease.
- (c) Hallucinations may be symptoms of petit mal status rather than schizophrenia.³
- (d) The olfactory hallucination of nuts may be the first sign of a glioblastoma rather than a psychotic disorder.
- (e) Impairment of olfactory sensation may be an early sign of dementia.
- (f) Electroencephalography can show, for example, benzodiazepine use and epileptic or other organic origins of psychopathology.^{4,5}
- (g) Psychiatrists wishing to demonstrate the enduring impact of sexual child abuse or the effect of cognitive-behavioural therapy on brain structure will use imaging techniques with more confidence if they are experienced in interpreting brain scans. Psychiatrists can acquire useful knowledge of structural and functional neuroanatomy if they are exposed to neurology training.

Psychiatry in the media

Increasingly, the media is highlighting cases of neurological disorders being misdiagnosed as psychiatric conditions. Consequently, service users, their carers and the general public may start demanding that psychiatrists are more knowledgeable about neurological disorders. For example, a woman with anti-*N*-methyl-D-aspartate receptor encephalitis published a book⁶ and gave an interview (BBC World Service, 7 February 2013) in which she described how her encephalitis was first misdiagnosed by a psychiatrist as the effects of overwork and alcohol, and later as schizoaffective disorder. Also, on 21 December 2012 the BBC World Service broadcast an interview with a man who described how his daughter died of Creutzfeldt–Jakob disease but who had been treated with electroconvulsive therapy for severe depression before the correct diagnosis was made. Such exposure will suggest to the general public that psychiatrists should receive some training in neurology.

The weekly magazine *Der Spiegel* recently published a lengthy article on the topic of what Blech⁷ considers to be the overdiagnosis of mental disorder and overprescription of psychoactive drugs from childhood onwards. The article was widely circulated on Facebook. In the article, Blech quoted an account of brain damage supposedly caused by antipsychotics. Such magazine articles and books (e.g. *Anatomy of an Epidemic*⁸) may make readers wish psychiatrists

were more aware of the effects that prescribed drugs have on the brain.

Although the media should not be allowed to determine the content of psychiatric training, especially when the human rights of people with mental illness are endangered by pressure from the public for greater security, there should perhaps be greater responsiveness to public concerns about the quality of psychiatric diagnoses and treatment, with greater attention being given to training in neurology.

Conclusions

The contribution of non-biological approaches to psychiatry should not be underestimated. However, as Kendell⁹ claimed, if psychiatrists wish to make specific contributions in practice and research beyond those made by psychologists, nurse therapists and social workers, they need a sound knowledge of the brain and good working relationships with neurologists. To acquire these, training in neurology for a year – preferably at the beginning of a rotation (H. Helmchen, personal communication, 2013) – is essential.

Cornelia Thiels, MPhil, MRCPsych, DrMed, Ärztin für Psychiatrie und für Kinder- und Jugendpsychiatrie, Department of Social Science, University of Applied Sciences Bielefeld, Kurt-Schumacher-Str. 6, D-33615 Bielefeld, Germany. Email: cornelia.thiels@fh-bielefeld.de

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