Psychiatrists' Experiences and Opinions of Generative AI: An Exploratory Online Mixed Methods Survey in Germany

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Abstract

Background: The integration of generative artificial intelligence (genAI) in psychiatric practice has gained attention due to their potential to enhance clinical workflows. However, the extent of their use and the perceptions of psychiatrists regarding their effectiveness remain underexplored, particularly in the context of the German healthcare system.

Objective: This study aims to assess the experiences and attitudes of psychiatrists in Berlin and Brandenburg towards the use of genAI-based chatbots in clinical practice, focusing on their applications, benefits, and concerns.

Methods: An online mixed-methods survey was conducted from September 19, 2024 to March 14, 2025, targeting psychiatrists in public psychiatric hospitals, psychiatric departments, and outpatient practices in Berlin and Brandenburg as well as members of the German Association for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN). A total of 11,754 psychiatrists were invited, with 126 completing the survey (response rate: 0.011%). The survey included sociodemographic questions and assessed prior experience with genAI, their perceived impact on clinical work, and specific applications in documentation, diagnostics, and communication. Descriptive statistics were used for quantitative analysis, while qualitative responses were analyzed through summarizing content analysis.

Results: Approximately half of the respondents (52.0%) reported using AI chatbots, with ChatGPT being the most utilized tool (50.0%). Participants primarily employed AI for writing doctor's letters (22%) and obtaining medication information (25%). Key themes emerged regarding the potential of genAI to reduce bureaucratic burdens and improve documentation efficiency, although skepticism about their practical benefits was noted. Concerns were raised about the limitations of AI in diagnostic and therapeutic decision-making, with calls for targeted training for clinicians. Language support was highlighted as a significant advantage for non-native German speakers.While our findings provide timely insights, the sample size limits the generalizability of results and warrants further large-scale studies across diverse clinical contexts.

Conclusions: Psychiatrists expressed cautious optimism about the use of genAI, particularly for reducing administrative burdens, while voicing clear concerns about their limitations in diagnostics and the need for targeted training. These findings highlight the importance of a balanced, evidence-based approach to AI integration in psychiatry, especially in light of the EU AI Act. Further research is essential to understand the long-term clinical and ethical implications of genAI use in mental health care. Clinical Trial: This study was reviewed by the Ethics Committee of the Brandenburg Medical School, which issued a waiver of ethical approval (protocol no. 228072024-ANF).

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1. Introduction

Documentation and administrative demands are consistently identified as major contributors to clinician burnout, including among psychiatrists [1],[2]. These burdens have spurred interest in digital tools that might streamline workflows without compromising quality of care. Generative artificial intelligence (genAI) – powered chatbots – such as OpenAI's GPT-4, Google's Bard (now Gemini), and Microsoft Bing AI – are emerging as potential aids for these tasks. Their ability to generate fluent, contextually relevant text in a requested style, literacy level, or tone positions them well for applications such as drafting clinical notes or correspondence[3,4].

Early research suggests potential clinical utility. Studies show that genAI can generate more comprehensive clinical histories, and AI-driven systems like ChatGPT and ambient AI may ease documentation burdens, though accuracy and reliability concerns remain [5]. There is evidence that genAI can support empathic phrasing in clinical notes [6][7] and assist in hypothesis generation for differential diagnosis, even in complex presentations [8],[9]. However, these capabilities come with important caveats. genAI outputs can be factually incorrect, subtly misleading, or biased, reflecting and potentially amplifying inequities in healthcare [10]. Documented examples include gender, racial and disability bias [10], echoing concerns already familiar in human-mediated care [11]. Accuracy and bias are not the only challenges. Privacy risks arise when sensitive patient information is entered into non-secure AI platforms [12],[13].

Regulatory oversight remains in flux. In Europe, the Artificial Intelligence Act entered into force in 2024, with a staged roll-out extending until 2027 [14,15]. The Act introduces a risk-based framework that classifies AI systems used in healthcare as "high-risk," imposing stringent requirements for transparency, data governance, and human oversight. However, it remains unclear how these regulations will be operationalized in psychiatric practice or how they will shape day-to-day clinical workflows.

Despite these policy developments, empirical evidence on psychiatrists' engagement with genAI remains scarce. Existing studies are set in English-speaking countries; for example, a recent APA-affiliated survey of U.S. psychiatrists found that while awareness was high, clinical use was limited and accompanied by concerns about accuracy, ethics and patient impact [3]. Little is known about perspectives in other healthcare systems, where regulatory environments, technological adoption rates, and cultural attitudes toward digital innovation may differ.

Germany presents a relevant case for investigation. While efforts to digitalize healthcare are ongoing, adoption of AI in psychiatry has been cautious, and the profession operates within strict data protection laws (e.g., GDPR) and a mixed public–private healthcare model. Understanding German psychiatrists' experiences and attitudes about genAI can inform both national policy and broader international discussions about responsible AI integration in mental healthcare. Therefore this exploratory mixed-methods study aimed to assess psychiatrists' experiences with and attitudes toward genAI-based chatbots in psychiatric practice in Germany.

2. Methods

2.1. Subjects

Participants in this online survey were recruited using a stepwise sampling approach. In the first step, we contacted public psychiatric hospitals, psychiatric departments within general hospitals (n = 38), and outpatient psychiatric practices (n = 57) located in the federal states of Berlin and Brandenburg

between September 19 and 25, 2024. These regions were selected to represent both urban (Berlin) and rural (Brandenburg) areas of Germany. Institutions were contacted via email and asked to disseminate the survey among their employed psychiatrists. Through this outreach, we aimed to reach approximately 840 psychiatrists.

In the second step, we collaborated with the German Association for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN), the largest professional organization for psychiatry in Germany, with 11,754 members as of May 27, 2024. The DGPPN included a link to the survey in its monthly newsletter, distributed on December 18, 2024 and again on March 14, 2025. Since more than 95% of psychiatrists in Germany are DGPPN members, we did not add the psychiatrists from the previously contacted clinics to the number of potentially reached individuals.

All invited participants were informed that their responses would remain anonymous and that no identifying information would be shared with the research team. Informed consent was obtained from all participants prior to their participation. The Ethics Committee of the Brandenburg Medical School reviewed the study and issued a waiver of ethical approval (protocol no. 228072024-ANF), as no personally identifiable or sensitive data were collected. Based on a pretest, survey completion took approximately four to five minutes. No compensation was provided for participation.

2.2. Procedures

The online survey was based on an adapted version of a questionnaire originally developed by one of the authors [3]. It was translated into German and adapted to the specific conditions of the German psychiatric care system. To ensure content validity, three board-certified psychiatrists completed and reviewed the survey, and their feedback was incorporated into a revised version. The core questions from the original version remained unchanged.

The questionnaire consisted of two parts (see Appendix 1). In the first section, participants provided sociodemographic information. The second section included seven substantive questions. First, participants were asked whether they had prior clinical experience with genAI, such as ChatGPT, Google Gemini, Microsoft Bing AI, or other systems, using a multiple-choice format. Participants were also asked which specific tasks these AI tools had been used for. Then, participants rated the extent to which AI-powered chatbots might influence six core areas of psychiatric clinical work using a Likert scale. These areas included gathering patient information, diagnostic and prognostic accuracy, treatment planning, conveying empathy, and clinical documentation. Another question used a Likert scale to assess the degree of agreement about the potential impact of genAI use on caring for individuals with mental illness. Five subdomains were addressed: risk of patient harm, potential inequalities in care, genAI as substitute for medical treatment, training needs for clinicians, and potential efficiency gains in the healthcare system. All Likert scales offered four response options: "Strongly disagree," "Somewhat disagree," "Somewhat agree," and "Strongly agree." Each item also included the options "I don't know" and "No response.". An additional closed-ended question asked participants to estimate whether the clinical use of genAI might influence the likelihood of legal action against clinicians. Finally, two open-ended questions invited participants to share additional comments regarding the use of genAI in psychiatric practice and chatbots in general.

2.3. Analysis

We used descriptive statistics to analyze the closed-ended questions regarding physicians' experiences with and attitudes toward genAI in psychiatry. These analyses were conducted using the survey software R and Microsoft Excel.

The qualitative free-text responses were analyzed using summarizing content analysis [16]. Due to

the limited nature of the dataset – often consisting of brief phrases or sentence fragments – a full thematic analysis was deemed inappropriate [17]. Instead, we followed an iterative process: JS and OG initially read through all comments to become familiar with the data. Both then independently conducted a thematic coding, assigning short descriptive labels (“codes”) to each comment. In cases where a single comment conveyed multiple meanings, multiple codes were applied. JS and OG then met to discuss and refine the coding decisions. Based on shared meanings, the first-order codes (“categories”) were grouped into second-order themes. Finally, JS and OG reviewed and refined the thematic structure through joint discussion.

3. Results

3.1. Participant characteristics

Of the 11,754 psychiatrists invited to participate, 126 completed the survey in full (response rate: 0.011%). 51 partially completed responses were excluded from the analysis. Among the 126 respondents, 68 (54.0%) identified as male, 55 (43.7%) as female, 1 (0.8%) as non-binary, and 2 (1.6%) chose not to disclose their gender. See Table 1 for the complete sociodemographic details of both the subset of the sample that provided qualitative responses and the entire sample.

Tab. 1. Sociodemographic characteristics of the qualitative subsample (n = 47) and the total study sample (N = 126)

Parameter	*All Participants, n (%)*	*Participants with Qualitative Responses, n (%)*
Specialist title		
Psychiatry and psychotherapy	n = 111 (88.1%)	n = 39 (83.0%)
Neurology	n = 12 (9.5%)	n = 4 (8.5%)
Child and adolescent psychiatry and psychotherapy	n = 7 (5.6%)	n = 3 (6.4%)
Psychosomatics and psychotherapy	n = 4 (3.2%)	n = 1 (2.1%)
Psychotherapeutic specialty		
Cognitive behavioral therapy	n = 65 (51.6%)	n = 23 (48.9%)
Depth psychology-based psychotherapy	n = 43 (34.1%)	n = 18 (38.3%)
Systemic psychotherapy	n = 8 (6.4%)	n = 3 (6,.4%)
Psychoanalysis	n = 4 (3.2%)	n = 0 (0%)
Training status/role		
Resident	n = 37 (29.4%)	n = 14 (29.8%)
Specialist	n = 27 (21.4%)	n = 8 (17.0%)
Consultant	n = 37 (29.4%)	n = 16 (34.0%)
Chief physician	n = 16 (12.7%)	n = 5 (10.6%)
Age		
<= 35	n = 34 (26.9%)	n = 12 (25.5%)
36 - 45	n = 39 (30.9%)	n = 10 (21.3%)
46 - 55	n = 26 (20.6%)	n = 11 (23.4%)

=> 56	n = 24 (19.1%)	n = 13 (27.7%)
Year of medical license		
1970s	n = 3 (2.4%)	n = 0 (0%)
1980s	n = 7 (5.6%)	n = 5 (10.6%)
1990s	n = 26 (20.6%)	n = 13 (27.7%)
2000s	n = 22 17.5%)	n = 5 (10.6%)
2010s	n = 45 (35.7%)	n = 16 (34.0%)
2020s	n = 20 (15.9%)	n = 7 (14.9%)
Institution		
Hospital	n = 98 (77.8%)	n = 36 (76.6%)
Office based practice	n = 15 (11.9%)	n = 6 (12.8%)
Population area		
Metropolitan region	n = 66 (52.4%)	n = 24 (51.2 %)
Large city	n = 15 (11.9%)	n = 9 (19.2%)
Medium-sized city	n = 19 (15.1%)	n = 5 (10.6%)
Small town	n = 11 (8.7%)	n = 3 (6.4%)
Village/town	n = 4 (3.2%)	n = 0 (0%)
Number of Patients Treated Annually per Institution		
Don’t know	n = 30 (23.8%)	n = 6 (12.7%)
< 1000 patients	n = 22 (16.6%)	n = 4 (8.6%)
1.001 - 5.000 patients	n = 33 (25.0%)	n = 17 (36.2%)
5.001 - 10.000 patients	n = 13 (10.3%)	n = 6 (12.7%)
> 10.000 patients	n = 47 (18.3%)	n = 12 (25.6%)
Treatment setting*		
Inpatient	n = 57 (45.2%)	n = 21 (44.7%)
Day-care	n = 17 (13.5%)	n = 6 (12.8%)
Outpatient	n = 49 (38.9%)	n = 20 (42.6%)
Home Treatment	n = 16 (12.7%)	n = 3 (6.4%)

* Multiple selections possible

3.2. Quantitative responses

3.2.1. Use of generative AI

Approximately half of the respondents (52%, n = 65) reported having used AI chatbots at least once to answer clinical questions, with ChatGPT being by far the most commonly used tool (50%, n = 63). Other AI chatbots mentioned by participants included Perplexity (n = 4), ClaudeAI (n = 2), You (n = 1), Mistral (n = 1), and Aya (n = 1). In total, 48% (n = 60) of respondents stated that they had not used AI chatbots in psychiatric practice: See Fig. 2.

Participants use AI tools for various purposes, primarily for writing doctor's letters (22%, n = 28) and obtaining information about medications (25%, n = 33). Other uses mentioned by participants included suggesting treatment options, differential diagnoses, and other: See Fig. 3.

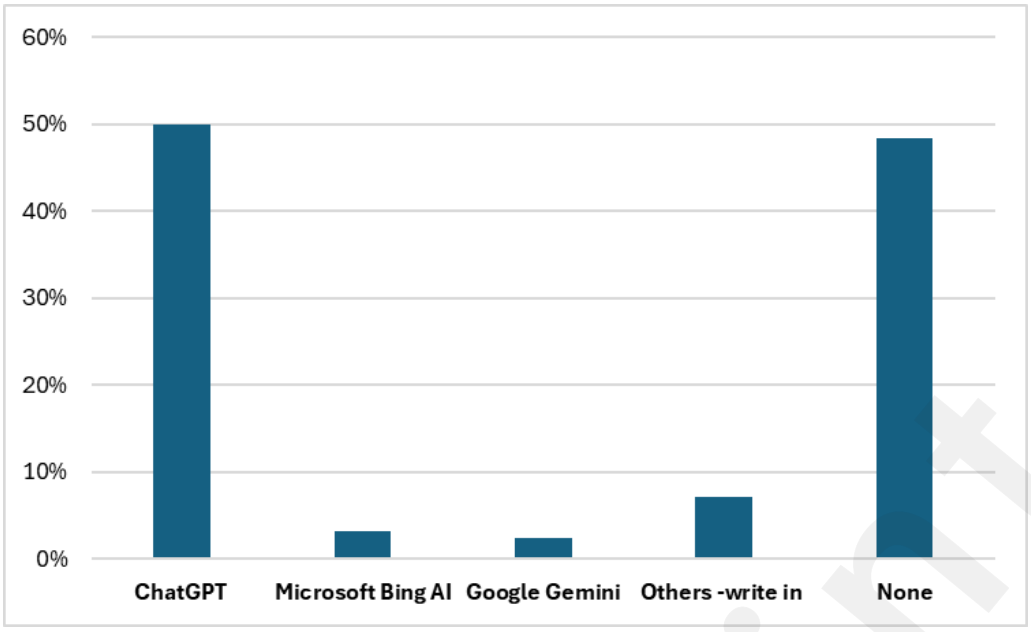

Fig. 2. Use of generative AI to answer clinical questions

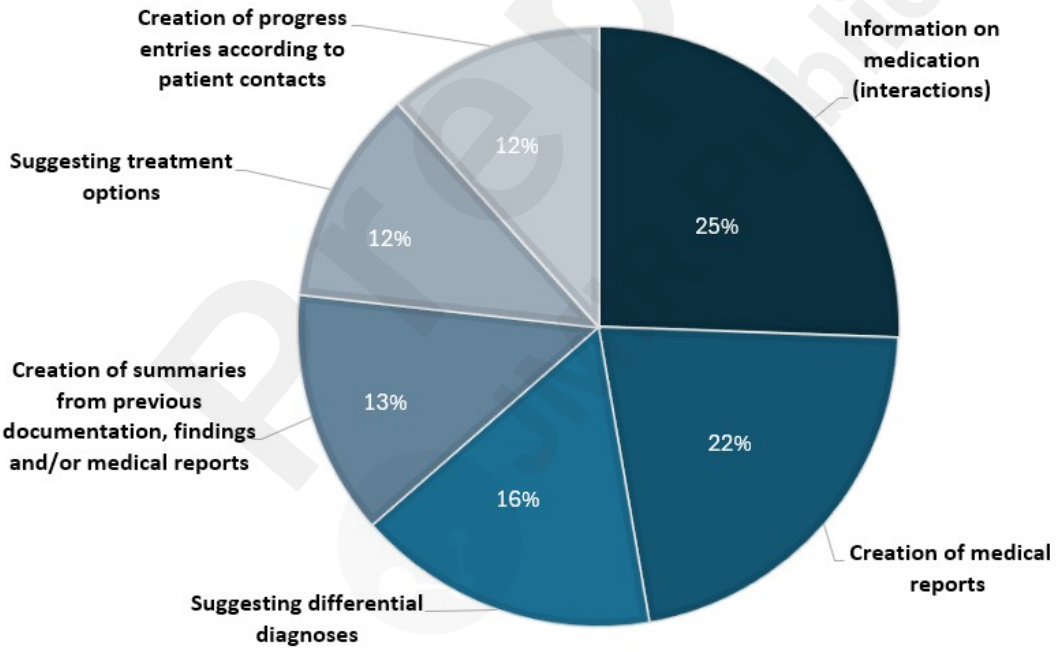

Fig. 3. Clinical tasks supported of generative AI by participants

3.2.2. Opinions about effect on practice of generative AI

See Fig.4.

	Disagree	Somewhat disagree	Somewhat agree	Agree	Don't know
Will improve findings and medical reports	7 (5.8%)	9 (7.4%)	38 (31.4%)	55 (45.5%)	12 (9.9%)
Will improve progress documentation	7 (5.8%)	11 (9%)	42 (34.4%)	51 (41.8%)	11 (9%)
Will improve the implementation of empathy	68 (55.3%)	23 (18.7%)	19 (15.4%)	2 (1.6%)	11 (8.9%)
Will improve the prognostic accuracy	24 (19.7%)	29 (23.8%)	39 (32%)	12 (9.8%)	18 (14.8%)
Will improve the creation of personalized treatment plans	28 (22.6%)	15 (12.1%)	50 (40.3%)	17 (13.1%)	14 (11.3%)
Will improve the diagnostic accuracy	20 (16.1%)	22 (17.7%)	51 (41.1%)	15 (12.1%)	16 (12.9%)
Will improve the collection of patient information	12 (9.7%)	13 (10.5%)	47 (37.9%)	31 (25%)	21 (16.9%)

Fig. 4. Opinions about effect on practice of generative AI

3.2.3. Opinions about patient's use of generative AI

See Fig.5.

	Disagree	Somewhat disagree	Somewhat agree	Agree	Don't know
Will lead to the increase of efficiency in the healthcare system	8 (6.5%)	13 (10.6%)	37 (30.1%)	49 (39.8%)	16 (13%)
Will result in clinicians needing more training to understand AI tools	3 (2.4%)	16 (12.8%)	26 (20.8%)	78 (62.4%)	2 (1.6%)
Will lead to more patients relying on AI tools instead of seeing a doctor	11 (8.9%)	23 (18.5%)	52 (41.9%)	29 (23.4%)	9 (7.3%)
Will increase the risk of inequality in care	26 (21.1%)	31 (25.2%)	30 (24.4%)	16 (13%)	20 (16.3%)
Will increase the risk of patient harm	13 (10.6%)	24 (19.5%)	50 (40.7%)	23 (18.7%)	13 (10.6%)

Fig. 5. Opinions about patient's use of generative AI

3.2.4. Connection Between AI Use and Legal Action

See Fig.6.

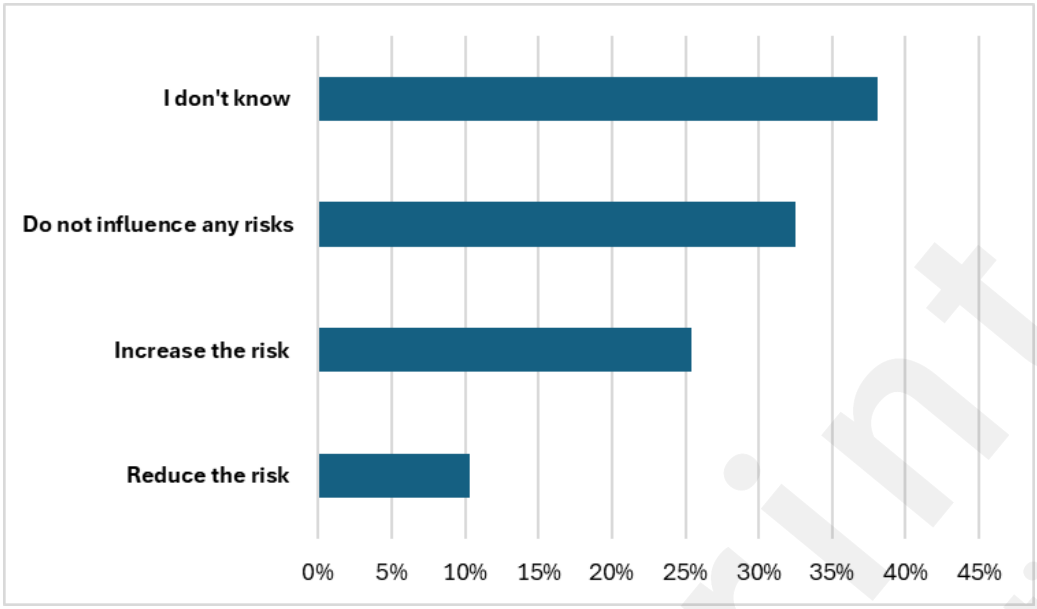

Fig. 6. Connection Between AI Use and Legal Action

3.3. Qualitative responses

Out of the 126 participants, 47 (37.3%) provided additional remarks - for example: “Can simplify regulated processes, such as writing doctor’s letters”. These comments were generally concise, often consisting of a short phrase or one to two sentences (total word count of qualitative responses = 2,152). Through an iterative process of thematic analysis, three primary themes were identified regarding the perceived impact of generative AI on mental healthcare: See Fig.7. Figures in parentheses refer to participant identification numbers, gender (M, F, or Prefer Not to Say) and whether the respondent reported using genAI to assist in with clinical tasks (Yes or No).

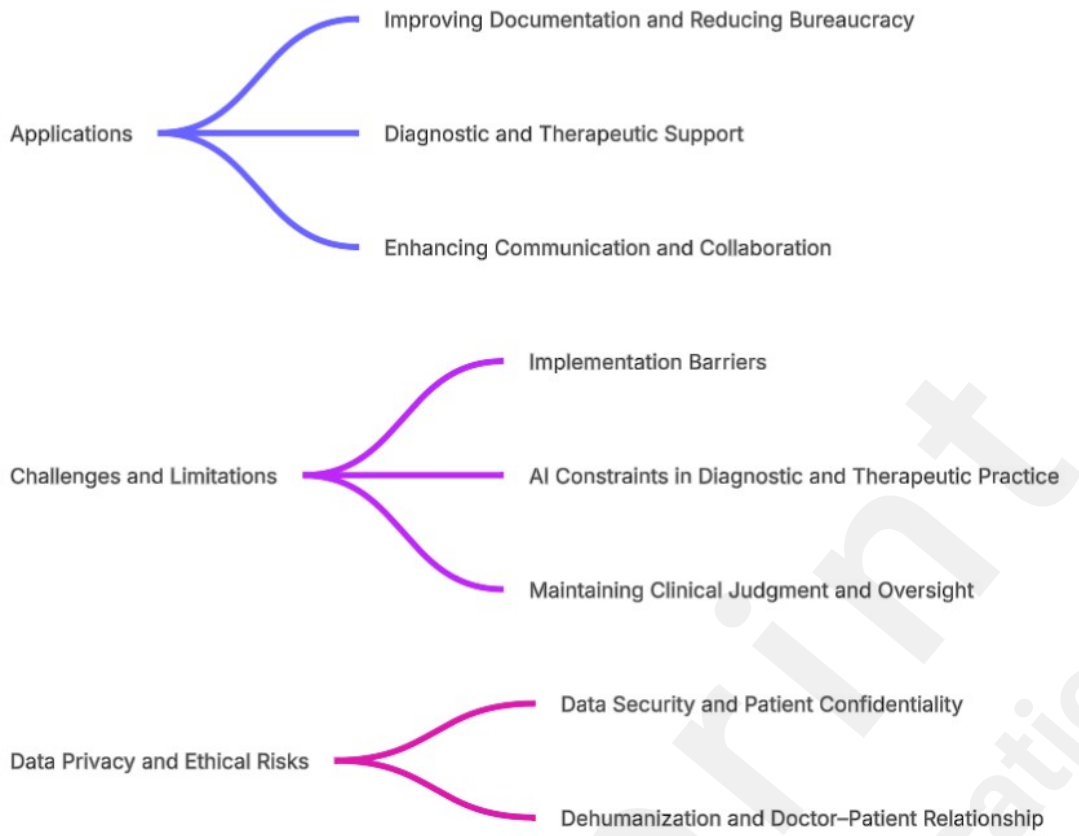

Fig. 7. Qualitative themes and sub themes concerning psychiatrists expectations towards AI

3.3.1. Applications

3.3.1.1. Improving Documentation and Reducing Bureaucracy

The potential for AI to alleviate the documentation burden in psychiatric practice was a recurrent theme among respondents. Several participants expressed optimism regarding the integration of genAI into administrative processes: “I consider the use of AI tools in our field to be absolutely sensible and desirable. The administrative tasks alone, for which there is usually little time, would be made much easier. I very much hope that it will be used more widely soon” (#68, F, No).

Time-saving was another benefit commonly mentioned: “I see a particular opportunity for AI in creating and revising documentation, findings, objection forms, etc., which currently account for too much of the bureaucratic work involved in psychiatric practice” (#52, F, No).

Some respondents acknowledged genAI’s potential to streamline workflows but emphasized the importance of understanding its limitations: “It can definitely simplify and speed up bureaucratic work and also optimize clinical work in terms of AI oversight, provided you know the limits of AI.” (#148, M, Yes). This perspective was echoed in a related comment: “They can be very helpful for creating practical texts/everyday correspondence if the problem with server locations could be solved” (#105, M, No).

However, not all respondents shared this enthusiasm. Some expressed skepticism regarding the practical benefits of AI in documentation: “Never used because I would have to enter as much data as I write in the doctor’s letter, because psychiatric epicrisis reports are so individual.” (#127, N/A,

No). Another participant voiced concern about inefficiencies: “I have only used Chat GPT once for a medical report as part of my work, but I had to make too many corrections and didn’t feel comfortable doing so. Otherwise, I don’t have any ideas for using it in my everyday life at the moment” (#67, F, Yes).

3.3.1.2. Diagnostic and Therapeutic Support

Only a minority of respondents viewed genAI positively in the context of diagnostic and therapeutic decision-making. One participant highlighted the need for targeted training for psychiatric professionals: “I have already used ChatGPT privately on various occasions and have been repeatedly pleasantly surprised – I am therefore fundamentally positive about the use of AI in a clinical context and would be very pleased to see specific applications combined with appropriate training” (#174, M, No).

Some respondents welcomed the use of AI for clinical support, particularly in differential diagnosis: “Fast and differentiated information about diseases; complex questions possible” (#164, M, Yes). Still, limitations were acknowledged: “I already use the Plus version of ChatGPT every day, for example to create handouts for lectures. However, there are significant shortcomings in literature research, e.g., invented source entries. I find it helpful for differential diagnostic considerations” (#147, M, Yes). Another respondent perceived AI’s diagnostic utility to be confined to early-career clinicians: “AI applications may increase diagnostic certainty among beginners, but are not useful in therapy” (#23, M, No).

3.3.1.3. Enhancing Communication and Collaboration

Language barriers remain a significant challenge in clinical communication, particularly for physicians who are not German native speakers. Several participants highlighted the role of genAI in addressing these challenges by offering linguistic support and improving the efficiency of written communication.

A non-German respondent reflected on how genAI facilitated his professional duties: “I and many of my non-German colleagues benefit enormously from the time saved by linguistic support in the preparation and correction of reports and discharge letters that concern diagnostic limitations. I personally anonymize the names of patients and other personal information” (#128, M, Yes).

The value of AI in collaborative clinical contexts was further emphasized: “Complete anonymization is necessary when working with patient-related data. I see considerable time savings, especially when working with foreign colleagues in connection with dictations. AI is also a good way to question your own findings and expert opinions” (#142, M, Yes).

Another participant was unequivocal in their support: “Given the quality of the assistant doctors, especially their lack of German language skills, I can only see positives in AI” (#169, M, Yes).

3.3.2. Challenges and Limitations

3.3.2.1. Implementation Barriers

Participants shared a wide range of reflections on the potential and limitations of genAI in psychiatry, often drawing on analogies and broader societal concerns. For example: “From the attempt to compose Beethoven’s Tenth with AI – that probably sums it up: everything serial, mechanical, and involving a lot of hard work becomes easier and more precise; individual and creative work is not yet possible, it’s just the nature of the system; but then again, it also depends on the users, because some are satisfied with a lot of superficial and untested information.” (#36, M,

Yes). With this analogy, one participant emphasized the perceived lack of creativity in AI-generated output.

For others, technical and organizational restrictions posed greater challenges. One respondent criticized the limited access to genAI tools in clinical environments: “Hospital operators and software manufacturers should urgently open up to the possibilities. Currently, our hospital IT even blocks ChatGPT” (#54, M., Yes). This practical concern was echoed in broader reflections about systemic readiness. As another participant expressed: “AI will have a massive impact on our lives, especially the world of work. It is doubtful whether Germany is prepared for this” (#169, M, Yes).
One participant questioned the long-term implications of investing in genAI while neglecting staffing needs: “A lot of money is being invested in AI instead of personnel. Standardized processes can be simplified, but many patients cannot be standardized. What good is it if AI creates doctor’s letters but the secretarial office remains unstaffed? Who is legally responsible for mistakes? Is it desirable to have robots driving through hospital rooms instead of hiring people?” (#59, M, No).

3.3.2.2. AI Constraints in Diagnostic and Therapeutic Practice

A further significant issue related to the perceived limitations of genAI in supporting psychiatric diagnosis and treatment planning. Some participants warned that AI cannot be fully trusted in clinical contexts due to the risk of misinformation and fabricated data. One respondent raised this concern emphatically: “ChatGPT does not provide medical evidence, only the most likely answer! ChatGPT ‘invents’ alleged sources that do not exist, without this being apparent at first glance. ‘Medical’ recommendations are therefore in no way reliable and should never be accepted without verification. Even ‘scientific research’ via ChatGPT carries considerable risks of false or at least unfounded statements!” (#64, M, Yes). This viewpoint was shared by others who had also encountered limitations, particularly when using AI for in-depth or highly specialized queries. As one participant put it: “I use ChatGPT for research questions, including writing reports and similar documents. Unfortunately, if you have in-depth knowledge of the research area or methods, you quickly reach ‘hallucinatory’ limits. Limits – critical if this is not noticed! Unfortunately, it is a disappointment (at least for now) when it comes to really in-depth questions” (#85, F, Yes).

Another respondent elaborated on the same issue, pointing out the superficiality of answers and the absence of verifiable sources: “At least in the free version, ChatGPT only provides superficial answers to medical questions; answers cannot be properly evaluated due to a lack of references” (#131, M, Yes).

3.3.2.3. Maintaining Clinical Judgment and Oversight

Concerns over diminishing human expertise and critical engagement were a recurring theme. One respondent highlighted the risk of professionals becoming overly reliant on genAI: “I expect that the ability to make a diagnosis and/or write a doctor’s letter independently will decline. The task of checking the recommendations/reports generated by AI for errors is tedious and not very creative, so I think the probability of errors is likely to increase, especially if colleagues don’t put much effort into critical review” (#74, F, No). In a similar vein, another participant reflected on the broader ethical and professional consequences of deferring to machines: “Personally, I would prefer to see the use of AI limited to this context or, more generally, to specific functions such as writing or editing. If humans stop memorizing information and thinking for themselves, they become machines and are no longer therapists.” (#150, M, Yes).

Others adopted a more moderate position. While supportive of AI-assisted clinical tools, one

respondent emphasized that these should not replace human judgment: “The use of AI for diagnosis and therapy recommendations should be supported, but not replaced” (#87, F, No).

3.3.3. Data Privacy and Ethical Risks

3.3.3.1. Data Security and Patient Confidentiality

Data privacy emerged as one of the most sensitive and frequently cited concerns in this study. Several participants expressed strong reservations about the use of genAI in clinical practice. As one respondent emphasized: “A topic of utmost relevance would be data protection when transferring patient cases, files, and reflections, especially when transferring them to AI outside the EU. For these and ethical reasons, the use of AI in psychiatry must be very well supported and thought through in order to take advantage of the great opportunities without creating new risks” (#163, M, No).
Some participants adopted a more categorical stance, rejecting the involvement of systems with insufficient transparency or international safeguards: “Procedures with non-transparent algorithms have no place in direct patient care, nor do those that involve the processing of personal health data in countries without reliable data protection regulations” (#105, M, No).
“Not resolved. Use of real patient data is not yet possible. No funding available. This would therefore be a purely unfunded hobby project with virtual dummy data that is not protected by data protection laws” (#88, M, Yes). - Others pointed not only to legal and ethical issues but also to structural barriers such as lack of funding.
Still, a note of cautious optimism was expressed by one of the respondents who acknowledged the potential benefits of genAI, particularly in documentation and support for non-native speakers, but noted infrastructure as a key limiting factor: “I believe that ChatGPT&Co can be an enormous help, especially when it comes to documentation and creating documents. This also applies to dictations and for non-native speakers. Processing in the cloud is (still) problematic. If the servers could be located securely in Europe or even in the clinic, this would dramatically expand the possibilities” (#42, M, Yes). Another participant added that with appropriate safeguards, such as strict anonymization, the use of genAI in clinical contexts could be feasible: “Complete anonymization is necessary when working with patient-related data” (#142, M, Yes).

3.3.3.2. Dehumanization and Doctor–Patient Relationship

Ethical concerns were also raised regarding the potential impact of AI on the therapeutic relationship and on clinical training. One participant articulated this apprehension directly: “I fear a deterioration in the doctor-patient relationship and communication. I fear poorer training in the ’clinical eye’” (#81, F, No). The relational and cognitive dimensions of care were further questioned in another statement, which addressed the broader role of human engagement in medical practice: “I would not feel entirely comfortable being treated by a doctor who draws their knowledge from AI. But letting it help you promotes efficiency and saves energy”. (#150, M, Yes) This comment also touched on environmental considerations, a concern echoed by another respondent who explicitly addressed AI’s resource consumption: “In addition, the use of AI consumes considerable amounts of energy and water. Therefore, at this point in time, I am against the use of existing AI systems in the medical field” (#122, F, No).

4. Discussion

4.1. Main findings

This is, to our knowledge, the first mixed methods survey in an EU country to examine psychiatrists’ experiences and attitudes toward genAI–based chatbots. Administered approximately one year after

the public release of ChatGPT, this exploratory study in Germany found that just over half of respondents had used an genAI in clinical work, most often ChatGPT. Usage was concentrated in administrative and informational domains, such as drafting letters and retrieving medication information, rather than in direct diagnostic reasoning or therapeutic interactions.

Participants were most positive about potential documentation efficiency gains, with nearly seven in ten agreeing that genAI could make documentation more efficient. This aligns with international findings that administrative relief is perceived as a primary opportunity for AI in psychiatry [3,4]. However, only around one in five respondents believed genAI could help convey empathy, and concerns were common about patient-facing use, particularly the risk of misinformation. Nearly nine in ten agreed that psychiatrists require more training to use these tools responsibly.

Views on medico-legal implications were mixed: a quarter of respondents anticipated increased legal risk, a third expected no change, and over a third were unsure. These findings are notable given that the EU AI Act, implemented in early 2025 [15] , formally categorizes healthcare AI as “high-risk” and requires transparency, human oversight, and robust data governance (European Parliament, 2024). Our results suggest that German psychiatrists have yet to see concrete guidance on how these requirements will apply in day-to-day psychiatric care.

Our findings echo those of the recent APA-affiliated U.S. survey [3], which also reported limited direct clinical use, a focus on administrative applications, and high demand for training. However, engagement with diagnostic or treatment-planning uses appeared even lower in our German sample, possibly reflecting a more cautious adoption climate, institutional restrictions, or lower integration of approved AI tools in psychiatric settings.

Our findings are also broadly consistent with an Australian survey of 107 community members and 86 mental health professionals, which reported that 43% of professionals had used AI – most often for research and report writing – while simultaneously expressing mixed attitudes about its future role in mental health care, balancing perceived efficiency and accessibility benefits against concerns about privacy, ethics, and reduced human connection [18]. Similarly, a 2025 UK survey of 1,005 general practitioners found that 25% reported purposeful use of GenAI tools in clinical practice [19]. In this survey, 69% anticipated improved documentation and 79% agreed that training is needed, figures that are broadly similar to those in our German psychiatrist sample (70% and 89%, respectively) [20]. However, UK respondents were more likely than their German counterparts to expect that patients might rely on GenAI instead of seeking medical care (59% vs. 42%), and both groups were similarly sceptical about GenAI’s capacity to enhance empathic communication suggesting that adoption remains incremental across high-income countries, with variability in uptake likely reflecting differences in regulatory environments, institutional readiness, and cultural attitudes toward AI in healthcare. We stress that, against these prevailing opinions, emerging findings suggest that GenAI tools are showing significant capacity to detect emotional states and to communicate information in ways perceived as compassionate—indeed, in some studies even outperforming clinicians [6,21].

4.2. Strengths and limitations

A key strength of this study is that it expands research on psychiatrists’ perspectives to a non-English-speaking, European context with a distinctive healthcare structure and strict data protection laws. The questionnaire was adapted from prior international work [3] and reviewed by German psychiatrists to ensure contextual appropriateness. Recruitment across both urban (Berlin) and rural (Brandenburg) regions, supplemented by national DGPPN newsletter distribution, broadened reach

across different practice environments.

Several limitations must be acknowledged. The response rate was low, limiting generalizability, and self-selection bias may have led to overrepresentation of psychiatrists with stronger interest in AI. Recruitment occurred in two widely separated phases (September 2024 and December 2024–March 2025), during which awareness, capabilities, and media coverage of genAI evolved rapidly; temporal variation in exposure and attitudes cannot be excluded. As in similar surveys, some items did not distinguish between current experiences and anticipated future effects, introducing interpretative ambiguity. The limited, non-stratified sample precluded subgroup analyses by demographic or professional characteristics.

Future studies should employ stratified or probability-based sampling, incorporate richer qualitative components, and explore variations across psychiatric subspecialties. Furthermore, little is known about patients' use of these tools in Germany – an area that warrants much more targeted survey research. Patients' perspective will be particularly critical regarding trust, stigma, and the perceived benefits or harms of genAI integration into mental healthcare including by psychiatrists [22] .

4.3. Conclusions

While our findings suggest that some German psychiatrists are beginning to integrate genAI-based chatbots into their work – mainly for administrative and informational tasks – we cannot infer that this reflects broader national practice. Efficiency gains were widely anticipated, yet significant uncertainty remains regarding clinical applications, medico-legal implications, and how the EU AI Act will be operationalized in psychiatric settings. The strong call for training underscores the urgent need for structured, evidence-based guidance. This transitional moment offers an opportunity for policymakers, professional bodies, and developers to work with clinicians to ensure that any future AI adoption in psychiatry is both ethically sound and aligned with patient care priorities.

Authors' Contributions

Charlotte Blease: Conceptualization, Supervision, Writing – original draft, Writing – review & editing. Vera Goer: Writing – review & editing. Olga Guzhova: Qualitative data analysis, Writing – original draft, Writing – review & editing. Lena Holtz: Data collection, Quantitative data analysis, Software, Visualization, Writing – original draft. Felix Mühlensiepen: Writing – review & editing. Julian Schwarz: Conceptualization, Supervision, Data collection, qualitative data analysis, Resources, Writing - original draft, Writing – review & editing.

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Conflicts of Interest

None declared.

Data Availability

The datasets generated or analyzed during this study are not publicly available due to privacy and confidentiality considerations, but are available from the corresponding author on reasonable request.

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Supplementary Files

Multimedia Appendixes

Survey instrument.
URL: http://asset.jmir.pub/assets/31d66a37e7a71530cc6ecaa75d42b7a5.docx

TOC/Feature image for homepages

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