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Generative artificial intelligence in psychotherapy: a multicountry qualitative analysis of mental health professionals' open-text survey responses

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ABSTRACT

Background Generative artificial intelligence (GenAI) tools are being adopted rapidly across clinical disciplines, yet the perspectives of mental health professionals remain largely unexplored at an international level.

Objective To explore the views, concerns and experiences of a multicountry convenience sample of mental health professionals regarding the role of GenAI in psychotherapy.

Methods A cross-sectional, multicountry convenience sample of mental health professionals included an optional open-ended, free-text question. Responses were analysed using inductive thematic coding by two independent coders.

Findings Of 766 survey respondents, 354 (46.2%) provided substantive free-text comments totalling 16 021 words and were included in the thematic analysis. Commenters were not more likely to have used GenAI than non-commenters (p>0.05). Four major themes emerged: (1) the primacy of the therapeutic relationship—clinicians across therapeutic modalities asserted that AI cannot replicate the relational, embodied and cocreated dimensions of psychotherapy; (2) conditional utility for clinical and administrative tasks—documentation, psychoeducation and report writing were endorsed as appropriate applications, while respondents expressed marked reservations about direct therapeutic work; (3) concerns about potential harm—including confidentiality, risks to vulnerable patients, dependency and practitioner deskilling; and (4) the training and governance deficit—widespread unfamiliarity with GenAI and concern that institutional guidance, professional training and regulatory frameworks lag behind adoption.

Conclusions Mental health professionals across multiple countries hold a cautious stance towards GenAI in psychotherapy, rooted in commitment to relational practice. Concerns about patient safety, data protection and deskilling underscore the need for competency-based AI education, field-specific ethical guidelines and coproduced regulatory frameworks.

Clinical implications Clinicians appear to accept GenAI for documentation, psychoeducation and case reflection but reject it for direct therapeutic work—a boundary that is partly evidence based, partly professional assumption and one that patients do not observe. Training and regulatory guidance remain inadequate. Harm concerns for vulnerable patients are credible but need dedicated study rather than assumption. Closing the preparation gap between clinicians, patients and regulators is now the priority.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Generative artificial intelligence (AI) adoption in healthcare is accelerating, including among mental health professionals.
⇒ Surveys of physicians have identified limited training, mixed attitudes and documentation as the dominant use case.
⇒ No multicountry qualitative study has explored how mental health professionals view AI in the specific clinical context of psychotherapy practice.

WHAT THIS STUDY ADDS

⇒ Provides the first global qualitative analysis of mental health professionals' views on generative AI in psychotherapy, drawing on 16 021 words of free-text responses from 354 clinicians across 25 countries.
⇒ Identifies four major themes, including the irreplaceability of the therapeutic relationship and pervasive safety concerns unique to the mental health context (psychosis, suicidality, dependency).

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Reveals an acute training and governance deficit, with practitioners calling for competency frameworks and ethical guidelines tailored to the relational nature of psychotherapy.

INTRODUCTION

Since the release of ChatGPT-3.5 to the general public in November 2022, generative artificial intelligence (GenAI)—defined as systems capable of producing text and other content in response to natural language prompts—has attracted intense interest across healthcare. Clinicians in primary care, psychiatry and other specialties are increasingly using GenAI, predominantly commercial tools such as ChatGPT, for documentation, clinical

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decision support and patient communication, with adoption often outpacing institutional governance frameworks.[1–3]

Psychotherapy presents a particularly compelling and complex case. Unlike most areas of medicine, psychotherapy is constitutively relational: the therapeutic alliance—the quality of the collaborative relationship between therapist and client—is the single best replicated predictor of treatment outcome across all modalities.[4] Emerging research suggests some patients may experience conversational GenAI as supportive or relational,[5 6] raising questions about how such interactions compare with, complement or potentially substitute for human therapeutic relationships.

At the same time, clinicians face substantial administrative demands, including writing documentation after visits that new technologies may help address.[7] How GenAI intersects with both dimensions of clinical work—the relational and the administrative—remains an open empirical question, and one that practitioners themselves are well placed to inform.

To date, empirical investigation of how mental health professionals themselves understand GenAI in clinical practice is scarce. Existing surveys have largely sampled physicians in high-income countries and focused on quantitative outcomes—adoption rates, attitudes and tool preferences.[1 2 8] Qualitative explorations of clinician experience have received little systematic attention; one study in the USA reported that therapists found benefits of GenAI tools for documentation and administrative purposes.[9] However, no known multicountry qualitative analysis has previously examined both mental health professionals' practical experiences of using GenAI in psychotherapy-related work and their broader professional views about its appropriate role, benefits and risks.

Objective

This paper aims to address that gap. We report a thematic analysis of free-text comments provided by a global convenience sample of mental health professionals as part of a larger cross-sectional survey on AI in psychotherapy. Our aim was to characterise both clinicians' experiences of using GenAI in psychotherapy-related practice and their broader professional views about its potential role, benefits, limitations and risks.

METHODS

Main survey

A full methodological description of the survey is reported separately.[10] Briefly, we conducted a cross-sectional online survey of mental health professionals worldwide between 13 January 2026 and 30 March 2026 (approximately 10 weeks), administered via LimeSurvey (LimeSurvey, Hamburg, Germany). Eligible participants were trained psychotherapists, psychologists (clinical and counselling), counsellors, psychiatrists incorporating psychotherapy, social workers and mental health nurses providing psychotherapy, and other registered mental health practitioners. Participants were recruited through professional networks and association mailing lists using a multicountry convenience sampling strategy. The survey was distributed through professional associations, professional networks and academic and clinical mailing lists rather than through public social media platforms. The survey was available in English and German owing to resource limitations. To preserve anonymity, IP addresses, cookies, registration identifiers and other identifying metadata were not collected. Accordingly, duplicate-IP checks and timestamp-based duplicate-response screening were not undertaken. CAPTCHA, attention-check items, timing-based checks and formal response-pattern screening were not used. Eligibility was based on self-identification as a qualified mental health professional meeting the study inclusion criteria.

Qualitative component

Section C of the survey contained a single optional open-ended, free-text question: "Please add any comments about this topic or the survey. Please add 1–2 brief comments." This intentionally brief framing was designed to maximise response rate while allowing respondents to elaborate on issues raised by the preceding structured survey items.[11] The complete survey instrument is provided in online supplemental material 1, enabling readers to assess the potential influence of question framing and order on the free-text responses; in addition, the quantitative component is published separately.[10]

Responses were exported, cleaned prior to analysis to remove comments consisting solely of non-substantive entries (eg, 'none', 'N/A', 'no comment') which were excluded. Translation of German comments (including Swiss German) was undertaken by LH and JS. Remaining responses were imported into an Excel file for systematic coding. Two coders (CB and JT) independently read the full dataset multiple times to achieve familiarity with the material prior to coding.

An inductive thematic coding approach was applied[12]: descriptive codes were assigned to each response or discrete idea within a response, without the imposition of a prior framework. Comments containing multiple distinct ideas were assigned multiple codes. Codes were then reviewed comparatively to identify patterns, similarities and divergences. Through iterative discussion between CB and JT, first-order codes were organised into higher order themes and subthemes reflecting shared meaning. Minor discrepancies were resolved by consensus meetings.

Participant quotes are reported verbatim (for English language responses) or as provided by the team translation by LH and JS (for German language responses). Participants are identified by an anonymised numerical code and, where available, professional role and country of practice. Professional role is not reported alongside quotations because respondents could report multiple professional roles; assigning a single role would risk mischaracterising participants' professional identities.

This study is reported in accordance with the Standards for Reporting Qualitative Research (SRQR)[13]; the SRQR checklist is provided in online supplemental material 2.

Commenter versus non-commenter analysis

To contextualise the qualitative findings, we compared participants who provided substantive free-text comments with those who did not. Demographic and professional variables (gender, age, professional role, primary delivery modality, practice setting, country income group and AI use history) were compared using χ^2 tests for categorical variables and Mann-Whitney U tests for continuous variables. This analysis follows the approach used in our parallel work with UK general practitioners.[2 8]

FINDINGS

Overview and commenter characteristics

Of 766 respondents who completed the survey, 354 (46.2%) provided substantive free-text comments, totalling approximately 16 021 words. Comments ranged in length from single sentences to extended reflective paragraphs; many respondents clearly exceeded the '1–2 brief comments' prompt, offering detailed, passionate and theoretically grounded perspectives.

Table 1 Demographic and professional characteristics of commenters versus non-commenters (n=766)

Characteristic	Commenters n (%)	Non-commenters n (%)	P value
Gender: female, n (%)	238 (46.7)	272 (53.3)	0.668
Age (years), median (IQR)	51 (38.25–60)	44 (35–55)	<0.001
Professional role: private psychotherapist, n (%)	96 (51.3)	91 (48.7)	0.106
Primary modality: mostly teletherapy, n (%)	42 (58.3)	30 (41.7)	0.030
Practice setting: urban, n (%)	232 (43.4)	303 (56.6)	0.016
High-income country, n (%)	345 (45.9)	406 (54.1)	0.242
AI use in clinical practice: yes, n (%)	187 (44.7)	231 (55.3)	0.369

Age was compared using the Mann-Whitney U test; categorical variables were compared using χ^2 tests. P values <0.05 denote statistical significance.
AI, artificial intelligence.

The mean comment length was approximately 45 words (SD 44.1). Participants who left comments did not differ significantly from non-commenters in prior use of GenAI tools in psychotherapy practice (p=0.369).

Table 1 presents a comparison of commenters and non-commenters by demographic and professional characteristics. Compared with non-commenters, those who left comments were older (median 51 years vs 44 years, p<0.001). They were also more likely to report a higher level of teletherapy use (p=0.030) and to work in non-urban settings (p=0.017). No significant differences were observed by gender (p=0.907) or country income (p=0.242).

Thematic analysis

Thematic analysis identified four major themes and 11 subthemes. These are summarised and described below and in table 2 (see illustrative quotations in online supplemental material 3).

Table 2 The four themes and subthemes

Main theme	Subtheme
Theme 1: the primacy of the therapeutic relationship	The irreplaceability of human relational presence
	The embodied and unconscious dimensions of therapy
	AI as pseudorelationship
Theme 2: conditional utility	Documentation, report writing and administrative burden relief
	Psychoeducation, resources and between-session support
	Reflection, supervision and case formulation support
Theme 3: concerns about patient and practitioner harm	Confidentiality, data protection and institutional distrust
	Risk to vulnerable patients: psychosis, suicidality and dependency
	Practitioner deskilling and erosion of clinical judgement
Theme 4: training and governance deficits	Unfamiliarity and the need for field-specific education
	The regulatory and ethical vacuum

AI, artificial intelligence.

Theme 1: the primacy of the therapeutic relationship

The single most prominent theme across the dataset was an unequivocal assertion that the therapeutic relationship constitutes the irreducible core of psychotherapy that cannot be simulated, replicated or replaced by AI. This theme was expressed, oftentimes, with emotional force.

The irreplaceability of human relational presence

Respondents articulated the conviction that what makes psychotherapy effective is precisely what AI cannot provide, which they identified as human presence, empathy and the therapeutic alliance. With regard to the latter, many drew explicitly on the therapeutic relationship literature. The phrase 'AI will never replace human connection' or close variants appeared repeatedly.

The embodied and unconscious dimensions of therapy

A substantial subset of respondents articulated a more specific claim: that the mechanisms of therapeutic change are not merely relational in a cognitive sense but are fundamentally embodied, non-verbal and in part unconscious. These dimensions, they argued, are categorically inaccessible to AI.

Practitioners working with psychodynamic and psychoanalytical approaches were particularly emphatic, citing transference, countertransference and the corrective relational experience as processes that, they contended, presuppose the need for human therapists.

AI as pseudorelationship

Another subtheme was the characterisation of AI-generated relational behaviour as fundamentally hollow—a simulation that mimics the surface features of relationship without the underlying conditions that make relationship meaningful or therapeutically effective. Several respondents were concerned about AI's unconditional positive affirmation—its tendency to validate user input—as a flaw in the therapeutic context.

Theme 2: conditional utility

Despite the dominant critical tenor of comments regarding GenAI's role in direct therapeutic work, a substantial proportion of respondents acknowledged uses for these tools in adjacent professional activities. This conditionality consistently articulated: AI is welcome at the margins of therapy (documentation, resources, research) but unwelcome at its centre (the therapeutic encounter). We emphasise that AI applications were grouped analytically by the clinical functions respondents described, rather than on the assumption that the underlying technologies were technically or ethically equivalent.

Documentation, report writing and administrative burden relief

Across countries and professional roles, documentation emerged as the most broadly accepted legitimate use of GenAI tools, with multiple respondents citing specific positive experiences with ambient AI scribing tools—in particular Heidi Health, referenced explicitly by name by several respondents—as well as ChatGPT and Claude.

Several respondents specifically valued AI-assisted documentation because it enabled them to remain more fully present with clients during sessions, rather than dividing attention between the client and note taking. The perception that AI reduces cognitive load in ways that paradoxically enhance the therapeutic encounter was noted by a number of experienced practitioners. This perceived benefit, however, was consistently paired with data protection concerns (addressed under theme 3), and several

respondents had either limited their use of ambient AI scribing tools or abandoned them on those grounds.

Psychoeducation, resources and between-session support

A second widely endorsed application was the generation of psychoeducational materials for clients—worksheets, homework exercises, structured self-monitoring tools and tailored resources—where GenAI's ability to rapidly produce bespoke content was seen as genuinely useful.

Between-session use was considered the most defensible application of GenAI for clients themselves, with several practitioners acknowledging that these tools may offer accessible, immediate support at times when professional contact is unavailable, while cautioning that this supplement must not displace the therapeutic relationship.

Reflection, supervision and case formulation support

A smaller but notable group of respondents had found AI useful as a reflective tool—a sounding board for case conceptualisation—used with carefully anonymised case material. Importantly, this use was framed by experienced practitioners as a supplement to, not replacement of, clinical supervision.

Theme 3: concerns about patient and practitioner harm

Expressions of genuine alarm were also common. Respondents described specific, concrete harms they had observed or feared, and several articulated criticisms of GenAI that went beyond individual clinical risk to encompass systemic and societal dangers.

Confidentiality, data protection and institutional distrust

Data protection and confidentiality were the most frequently cited practical concerns, with respondents from both European jurisdictions governed by General Data Protection Regulation and US practice governed by the Health Insurance Portability and Accountability Act, expressing acute anxiety about the security of client information when processed by commercial AI systems. Distrust of technology companies was explicit.

Several respondents distinguished between the ethical acceptability of different forms of AI use: anonymised use for non-identifying tasks (generating resources, drafting communications) was deemed acceptable; session recording or ambient scribing was widely felt to be a categorically different and far more serious step requiring explicit client consent and robust institutional governance.

Risk to vulnerable patients: psychosis, suicidality and dependency

A theme that frequently emerged was the articulation of patient safety risks arising from clients' use of GenAI for mental health support. Respondents described concerns grounded in their clinical experience, including cases in which they perceived GenAI use as having contributed to harm.

Several respondents attributed delayed help seeking to clients' reliance on GenAI tools and, in one reported case, attributed an inpatient admission in part to such reliance. Beyond acute safety risks, respondents also identified the longer term risk of client dependency on AI—a risk seen as particularly problematic for clients with attachment difficulties, personality disorders or social isolation.

Practitioner deskilling and erosion of clinical judgement

A third harm articulated by respondents was the risk that routine AI use would erode the clinical reasoning, creative engagement and reflective practice that constitute current psychotherapeutic expertise.

Theme 4: training and governance deficits

Across the dataset, a fourth and structurally important theme emerged: a pervasive sense that the profession, and the respondents themselves, institutional guidance and regulatory clarity to navigate GenAI safely and ethically in clinical practice. Respondents framed their need for training not as generic digital literacy but as field-specific education about the appropriate, safe and ethical use of GenAI in psychotherapy.

Unfamiliarity and the need for field-specific education

A significant proportion of respondents acknowledged limited familiarity with GenAI tools, with many expressing that the survey itself had prompted their first sustained reflection on the topic. This was distinct from the emphatic rejection of AI seen in theme 1 and reflected genuine uncertainty grounded in lack of exposure and training. Respondents framed their need for training not as generic digital literacy but as field-specific competency.

The regulatory and ethical vacuum

Beyond individual training gaps, respondents articulated a broader structural concern: the absence of professional association guidance, regulatory clarity and ethical frameworks specific to AI use in psychotherapy. This concern was expressed across jurisdictions and professional bodies and was often accompanied by explicit calls for action. Several called for professional associations to interpret and apply regulatory frameworks specifically to the psychotherapy context rather than leaving practitioners to navigate them on their own.

DISCUSSION

Principal findings

This online convenience sample survey is the largest international qualitative study of mental health clinicians who use psychotherapy and their opinions about GenAI tools. Of 766 respondents in total drawn from 30 countries, free-text responses were provided by 354 clinicians across 25 countries (response rate for free-text comments: 46.2%). As a convenience sample, these findings should be interpreted cautiously. Four themes emerged from the text produced (16 021 words). First, surveyed clinicians across roles and countries asserted that the therapeutic relationship is irreplaceable by AI. Second, GenAI was conditionally accepted among our respondents for documentation, psychoeducation and case reflection but appeared to be rejected for direct therapeutic work. Third, a number of specific harms were identified—including risks to patients experiencing suicidality, psychosis and dependency, as well as practitioner deskilling—alongside concerns about data protection. A fourth theme captured respondents' concerns about deficits in professional training and regulatory guidance.

Comparison with the literature

Where it arose, the assertion that human relational presence is irreplaceable by AI should, however, be treated as a professional assumption rather than a settled empirical fact. A UK study found one in three adults had used GenAI for emotional support, with two in three reporting benefit[5]; an estimated 17% of US adults use these tools for mental health purposes, with higher rates among uninsured, younger and minority populations who cite cost, accessibility and freedom from stigma as primary

drivers.[14] These patterns echo decades of research showing that the anonymity of computer-mediated interaction can itself be therapeutically facilitative.[15] The identified concern that GenAI offers only a pseudorelationship may miss the point entirely: people readily anthropomorphise conversational agents, and within a usability framework it is the natural language interface that drives uptake, not the ontological status of the interaction.[16] Clinicians who dismiss this may be applying a standard their own patients are not. Furthermore, the assertive language used by the participants suggests a narrow perception of the future capabilities of GenAI tools. Extensive research is being carried out in applications of multimodal GenAI tools in healthcare.[17] Such tools can process not just text but also images and audio—enabling richer interaction in mental healthcare that captures more of the 'bodily dimensions' of interpersonal exchange.

Clinician endorsement of GenAI for documentation is unsurprising—administrative burden is a leading driver of burnout, and ambient AI scribing is growing rapidly across healthcare systems, although robust evidence that it materially reduces documentation time remains limited.[18] Emerging evidence from psychiatry further supports documentation as one of the most promising implementation areas for GenAI. However, studies also demonstrate that AI-generated patient-facing documentation may introduce clinically relevant errors, highlighting the continued need for human oversight even in seemingly low-risk applications.[19] Similar developments are now being reported in psychotherapy, where AI-assisted documentation is increasingly viewed as a practical strategy to reduce administrative burden while preserving therapists' attention during patient encounters.[20] The notion of conditional utility sits in some tension with the quantitative findings from the same sample, in which around 4 in 10 clinicians reported using GenAI for treatment planning and around 3 in 10 for supervision support[10]—applications rarely volunteered in qualitative comments, possibly because they feel professionally borderline and less acceptable to disclose openly.

Harm concerns were emotionally charged but merit scrutiny. Clinicians in this study largely ignored the 'compared to what' question: for patients without access to psychotherapy, the comparison is no support at all—and emerging evidence suggests GenAI may help reduce symptoms of depression and anxiety.[21 22] Clinicians in this convenience sample also largely overlooked evidence that conventional therapy carries its own risks,[23] and some literature on AI-induced psychosis appears overstated.[24] Whether this reflects patient advocacy or professional self-interest, the data cannot resolve. Client dependency remains a credible risk, and harms to vulnerable groups—including those with eating disorders and psychosis—need dedicated research beyond clinician report.

Contextualising the findings: psychotherapy as a special case

Clinicians in this study appeared to accept GenAI for administrative tasks and reject it for direct therapeutic work—a pattern consistent with perceived usefulness varying by task type. Whether this reflects clinical wisdom or professional assumption, it seems that patients are not observing the same boundary.[5 6] Clinicians, patients and regulators are operating in the same space with very different levels of preparation, and the governance frameworks needed to manage this safely remain underdeveloped. These findings closely align with the recently proposed Society of Digital Psychiatry roadmap, which identifies clinician education, digital navigation, AI evaluation and implementation science as key priorities for the safe integration of GenAI into mental healthcare.[25] That gap is the most actionable finding in this paper.

Strengths and limitations

This study has several strengths: it is the largest multicountry qualitative dataset on mental health professionals' views on GenAI to date, spanning multiple countries, roles and therapeutic traditions. Comment depth and sophistication attest to respondents' engagement with the topic, while the parallel commenter/non-commenter analysis contextualises the qualitative findings.

However, several limitations must be acknowledged. First, this is a convenience sample, and self-selection likely introduced a bias towards more engaged and opinionated respondents. Relatedly, the broad open-ended prompt may also have made responses susceptible to recency and availability effects, with some comments reflecting wider media or professional narratives rather than direct clinical experience.

Second, the sample was predominantly German and English speaking and drawn overwhelmingly from high-income countries, likely reflecting, at least in part, the survey language restrictions, professional networks and recruitment channels of the international authorship team; accordingly, the findings should not be interpreted as globally representative. Indeed, clinicians in low- and middle-income countries, where AI adoption stakes are highest, are under-represented.

Third, the sampling and survey design were explorative and not intended to support robust comparative qualitative analyses across countries, professional groups, age groups or levels of prior GenAI use; subgroup sizes were uneven and, in some cases, small. Accordingly, the study cannot determine whether the themes identified vary systematically across these characteristics, and future purposively sampled qualitative research should examine such differences directly.

Fourth, the single open-ended question, though designed to maximise response rate, limits response depth; interviews or focus groups would yield richer accounts. Fifth, as a single-timepoint self-report survey, findings represent a snapshot of a fast-evolving landscape.

Finally, future work should continue to explore which versions of the GenAI tools mental healthcare professionals are using. The least expensive and most accessible tools are older versions of models, more likely to hallucinate.[26] Institutional action is needed to ensure that the safest and most capable models are being adopted in clinical settings.

CONCLUSIONS

Mental health professionals in this multicountry convenience sample drew a boundary between GenAI at the margins of clinical work and at its centre. This boundary may be partly evidence based and partly self-interested. Patients, however, may be drawing no such clear line and appear to use these tools in large and growing numbers. Governance is not keeping pace, and the problem is not primarily clinician training or patient consent. Commercial technology is operating at scale in mental health spaces without adequate regulation or accountability. That is where policy now needs to focus.

Clinical implications

Clinicians in this study advocated the use of GenAI at the margins of practice, in documentation, psychoeducation and case reflection, if outputs are checked given known error rates. However, their reported concerns about the use of GenAI for direct therapeutic work sit uneasily alongside clinician-reported use for

treatment planning and supervision.[10] Training and regulatory guidance remain inadequate and should be prioritised, alongside efforts to steer clinicians towards more capable, less error-prone models. Harm concerns for vulnerable patients are credible but require dedicated study rather than assumption.

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Contributors CB conceived and led the study. CB and JT conducted the thematic analysis and led the coding. JH led the quantitative analyses. CB, JH and JG led the data collection and management. CB, JG and JCW contributed to survey design and ethical approvals. CB drafted the manuscript; all authors reviewed, revised and approved the final version. CB is the guarantor for the overall content of the work. AI (Claude (Anthropic) and ChatGPT (OpenAI)) was used only for copyediting—refining sentence phrasing and correcting typos. It was not used for any aspect of study design, analysis, interpretation or content generation. The authors take full responsibility for all content in the manuscript.

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