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RESEARCH ARTICLE

VIEWS ON AI AS AN INSTRUMENT OF MENTAL HEALTH CARE: QUALITATIVE PERSPECTIVES OF PSYCHOLOGISTS FROM INDIA AND NEPAL

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ABSTRACT

BACKGROUND:

AI innovation in research, therapy, education and health care has made informed and strategic implementation an inevitable step forward for practitioners, clients, policy makers and AI developers. To create and empower a holistic system that helps in filling the gap in mental health care, Psychologists must have a realistic understanding of the power and limitations of using AI-based tools and chatbots in mental health care.

OBJECTIVE:

To explore the attitudes and perceptions of psychologists from India and Nepal toward the integration of AI-based tools in mental healthcare and how they view the potential benefits, challenges, and risks associated with using these in mental health practice.

DESIGN:

In this qualitative study thematic analysis was used as an analytical method. The study explored the perceptions and experiential accounts of psychologists regarding the integration of AI-based tools in mental health contexts.

RESULTS:

Seventeen practising psychologists were recruited, fourteen from India and three from Nepal. Three overarching themes were identified: (i) Current Utilisation of AI– AI's current use as a vector for procedural streamlining and optimization of preliminary processes; (ii) Complaints, Cautions and Risks– current concerns as well as the dissatisfaction and general atmosphere of uncertainty surrounding it; and (iii) Hope and hesitation– functional scope in behavioural analytics and preliminary diagnosis along with concerns surrounding ethics, dependency risks, and exclusion of certain socially marginalized or technically inept demographics.

CONCLUSION:

The emergent discourse reflects a persistent ambivalence- AI is valued for its capacity to enhance logistical fluency and broaden access yet remains restricted by its inability to engage with the embodied, cultural, and relational substrates of psychological care. Robust planning and monitoring are required for the ethical implementation of AI-based tools in mental health care to avoid misuse and prevent harm.

KEYWORDS

Artificial Intelligence, AI-based tools, Chatbots, Human-AI Interface, India, Mental Health care, Nepal, Psychologists

INTRODUCTION

Artificial Intelligence (AI) is defined as "a system's ability to interpret external data correctly, to learn from such data, and to use those learnings to achieve specific goals and tasks through flexible adaptation" [1]. In mental healthcare, AI offers detection methods, therapeutic tools and virtual platforms. AI has a great potential to enhance existing mental healthcare by increasing and improving its delivery, supporting clinical decision-making, providing round-the-clock support as well as personalized treatment [2]. Despite the potential, the adoption of AI has been slower in mental health than in physical health [3], particularly since mental health professionals use guidebooks, assessment tools and rely on experience and therapeutic skills to diagnose, classify and implement intervention techniques [8].

The research on AI in mental health has evolved significantly over the past decade, with the applications ranging from natural language processing for symptom detection to the use of chatbots that reduce depression and anxiety depending on the severity, digital literacy and degree of comfort with non-human agents. Studies conducted on young college students and adult psychiatric groups with measurable depression and anxiety symptoms, show a reduction of 29 - 34% in symptoms following therapy with AI chatbots [4] [5] [6]. Despite AI's efficiency in triage and workflow management [7] [2], concerns persist about weakened therapeutic alliance and patient preference for human judgment in ambiguous and nuanced cases [8] [9]. Researchers are concerned about privacy, algorithmic bias, and reliance on Western-centric models that might misinterpret non-Western expressions of distress [10] [11] [12]. Another issue that exacerbates the concern is the digital divide, which reinforces inequities in terms of access, literacy and infrastructural robustness [13] [14]. Along with creating discrepancies in clinical trials, data protection and user retention, the unregulated mental health apps risk misinformation, self-diagnosis and commodification [15] [16]. Though the practitioners welcome AI as an adjunct, they express unease about its encroachment in core therapeutic functions, deskilling of professional judgement, the erosion of empathic engagement, and the medico-legal liabilities entailed in AI-driven decisions [3] [17] [18].

In India, mental disorders were the leading cause of non-fatal disease burden in 2017, with one in seven suffering from a mental disorder (197 million people), with depressive and anxiety disorders contributing the most [19]. Similar concerns exist in the neighboring country, Nepal, with a 12.9% prevalence (13.2% among adults and 11.2% among children) of mental disorders [20]. Scarcity of mental health professionals per 100,000 population in India (0.07 psychologists and 0.3 psychiatrists) is also reflected in Nepal (0.68 psychiatrists and 0.17 and psychiatric nurses) and both are lower than the global average which according to the World Mental Atlas is 9 per 100,000 population [21]. Both governments allocate approximately 1% of total health expenditure on mental health services (India 1.30% and Nepal 1%) [21] [22]. India and Nepal, both lower-middle-income countries, face substantial gaps in access to mental health care [23]. So, AI can be positioned as a supplement to reduce diagnostic delays, outreach issues and systemic deficits [24]. Global attitudes towards AI mental health chatbots seem to vary significantly by region and culture.

In a comprehensive literature and narrative review, Balcombe (2023) points to higher trust and awareness about AI-based tools among adolescent, young adults, university students, managers and other specific underserved groups like veterans [25]. In a multinational study across 21 Arab countries, majority (72.5%) of the population were aware of chatbots, yet usage was low (26.4%). AI was viewed as a supplementary tool to human healthcare professionals [26]. Western adolescents prefer direct, solution-focused communication, whereas Eastern and Indian adolescents prioritize privacy and responses that emphasize social harmony and family relationships [27]. Nepal focuses mainly on AI for general healthcare but shows early promise for mental health uses. AI use in mental healthcare in Nepal is held back by weak infrastructure and local adaptation issues [28]. A study on Australian mental health professionals revealed that despite carrying a positive attitude towards AI, these professionals used it more for research and report writing [29].

AI use is expanding in most sectors particularly in Information Technology, Finance, Banking and Healthcare. In mental health care, a crucial factor is the attitude and perceptions of mental health practitioners in using and promoting AI-based mental health apps in their work with clients. This study was designed to explore their unique perspectives as a decisive influencing factor in the escalating use of AI in mental health care.

Despite the increasing evidence of AI-based tools in mental health care, there are significant research gaps to be addressed. Current studies related to AI chatbots in mental health care are mostly focused on chatbot efficacy and adolescent preferences. The researchers have not found studies which explore mental health practitioners' attitudes towards use of AI chatbots or tools, particularly in the Indian subcontinent. Though India and Nepal share similar mental health burdens and shortage of skilled manpower few comparison studies have been identified. There are no guidelines for mental health professionals on the integration or adoption of AI [10], except for qualitative research which proposes such a framework [3]. In addition, the application of Western-centric AI-based tools and the possibility of misinterpretation of psychological distress when applied to South Asian clinical contexts are yet to be explored.

Keeping these gaps in mind this study aims to explore the attitudes and perceptions of psychologists from India and Nepal towards the use of AI-based apps in mental health care. Analysing the views of psychologists will help the mental health fraternity, as well as app developers, gain a better understanding of optimum utilization and risks of AI-based apps in mental health care. It can also outline future direction in relation to wider use. The following research questions guided the research:

1. What are the attitudes and perceptions of psychologists from India and Nepal toward the integration of AI-based applications in mental healthcare and how they view the potential benefits, challenges, and risks associated with using AI-powered apps in mental health practice?

METHODS

STUDY DESIGN

This qualitative study employed thematic analysis to explore the perceptions and experiential accounts of psychologists regarding the integration of AI-based tools in mental health contexts. Ethical clearance was obtained from the Departmental Ethics Committee (DEC/Psy/2023/A003, 14/09/2023) prior to the commencement of data collection, and all procedures were conducted in accordance with established academic research standards. COREQ [30] reporting guidelines were followed.

PARTICIPANTS AND RECRUITMENT

Participants were practising psychologists based in India and Nepal. Psychiatrists and social workers were excluded to maintain professional homogeneity. Purposive sampling was utilized to capture variation across geographical location, gender, qualifications, years of experience, and employment context. Out of thirty-two psychologists approached, twenty-five consented to participate. Following attrition due to scheduling conflicts and technical limitations, seventeen participants ultimately contributed to the study. Each psychologist was assigned a participant code (P1 to P17) to preserve confidentiality.

DATA COLLECTION

Initially the participants were identified through professional contacts of the researchers in India and Nepal. These participants also referred their colleagues through professional networks. The researchers made an attempt to identify participants from various geographical locations in India through their contacts. The participants who gave consent were given the option of responding to the study questions either through a semi-structured interview or in written form. This approach accommodated different participant preferences while maintaining consistency in the questions asked. Five interviews were through telephone/ Google meet and twelve were written responses.

Semi-structured interviews conducted through telephone or via Google Meet were carried out by both Author 1 and Author 2 between October 2023 and April 2024. On an average, the interviews lasted for 30 minutes each. With participant consent, verbal interviews were recorded and then transcribed verbatim.

For written interviews, participants received an email with an interview schedule, details about the purpose of the interview and the contact details of the authors if case of any queries or clarifications. Participants took their time to respond to the email. Reminder emails were sent to the participants after a week if no response was received.

DATA ANALYSIS

The interview transcripts and written responses were treated as equivalent qualitative textual data and was analysed using thematic analysis. Authors 1 and 2, both (PhDs), females, with a combined experience of 25 plus years in academics and consultancy were at the time of the study, engaged in full time teaching and administrative posts in higher education. They independently analyzed the data thematically through iterative reading and manual coding. Codes were consolidated into subthemes and overarching themes through collaborative deliberation. Codes and themes were further reviewed to align with the research questions.

RESULTS

The demographic information of all the 17 participants is mentioned in table 1.

TABLE 1. DEMOGRAPHIC DETAILS OF THE PARTICIPANTS

Participant	Age (in years)	Gender	Experience (in years	Qualification	Practice	Country	Region
P-1	26	Female	3	M.Phil	Public	India	East
P-2	41	Male	10	M.Phil, PhD	Public	India	North
P-3	32	Male	5	M.Phil	Public	India	East
P-4	29	Female	4	M.Phil	Public	India	East
P-5	38	Male	8	M.Phil, PhD	Public	India	Central
P-6	39	Female	15	M.Phil, PhD	Public	India	West
P-7	75	Male	40	M.Phil, PhD	Private	India	South
P-8	28	Female	2	M.Sc Counselling Psychology	Private	India	South
P-9	33	Female	8	M.A, EdM Counselling Psychology	Private	India	Central
P-10	42	Female	3	M.A Clinical Psychology, Diploma in DBT	Private	India	Central
P-11	47	Female	8	M.A, PhD	Private	India	Central
P-12	35	Female	7	M.Sc, PhD	Private	India	West
P-13	40	Female	8	M.A Clinical Psychology	Private	India	West
P-14	55	Male	21	PhD Clinical Psychology	Public	Nepal	Nepal
P-15	45	Male	15	PhD Clinical Psychology	Private	Nepal	Nepal
P-16	46	Male	16	PhD Clinical Psychology	Public	Nepal	Nepal
P-17	45	Female	15	M.Sc, PhD	Private	India	West

Out of the 17 participants, nine were female and eight were male. Fourteen Psychologists were from India and three from Nepal. The average age of the Psychologists was 41 years with an average professional experience of 11. 5 years. The qualitative analysis revealed three themes. The first theme- current utilization of AI, incorporates the experiences and perceptions of participants on the use of AI based tools to optimize the process of registration, case history taking, assessment, monitoring and feedback. It also includes how they view AI as a good assistant. The theme also talks about the familiarity of participants with AI based tools. Since some of the participants have not used these tools, it also explores their awareness regarding them.

The second theme- complaints, cautions and risks, reveals how participants perceive AI-based tools in terms of cultural nuances and the therapeutic characteristics of AI. It also focuses on the perceived lack of reliability and accuracy, risk of over-dependence and cautions for their use.

The third theme of hope and hesitation mentions how the participants see a ray of hope through AI-based tools to reduce the existing gap by being available all the time and for quick access. Despite this, the participants seemed hesitant of its use due to biases it might generate, the automatic responses it gives and the confidentiality concerns.
The themes, codes and the selected excerpts are presented in table no. 2.

TABLE 2. THEMES, SUB-THEMES AND EXCERPTS

Themes	Sub-themes	Excerpts
Current Utilisation of AI	**Optimization of processes**	*Effective in providing pre-existing check-list based diagnosis [P-3]*
		We use these tools for scoring only [P-5]
		I have used AI to book appointments and do registrations…the data collected by these applications are very useful for follow-ups [P-7]
		Use AI tools to ease out the workload and for follow-ups. They act as quick reference guides…save a lot of time [P-10]
		They are used while preparing the report of assessment and diagnosis [P-14]
	Diagnosis and finding links	*These tools accurately diagnosed neuropsychological impairments and cognitive functioning among patients with organicity [P-4]*
		They offer continuous monitoring and feedback…identify patterns and triggers…provide valuable insights…can help in the screening and early detection [P-5]
		Case history modules are good...based on ICD -11 they give quick diagnosis [P-7]
	AI as an assistant	*AI tools should be used as complementary aids that can help in the screening and early detection…are not a substitute for qualified professionals [P-5]*
		It's a foot in the door. It is currently on par with self-help books [P-8]
		Most of the AI apps I have suggested to numerous clients are meditation apps like…as they are solely geared towards meditation [P-9]
		Analysis must be done by psychologists and not AI…because there are no generalizations made for attributes…diagnosis has to be done by the human professional [P-10]
		It can be fairly accurate provided there are inputs from a team of practising professionals [P-17]
	Limited awareness and adoption	*I'm not using or familiar with diagnosis tools [P-9]*
		I am still exploring…I have heard of some tools…but I am still a little traditional because I was not born in that era of education [P-11]
		I am not aware of AI based tools but there are some softwares being used. They are used for assessment only [P-12]

		Not widely used, currently a chatbot in child and adolescent mental health is in discussion [P-15]
		To my knowledge...we use AI-based tools to write report. However, I do not think these tools are used to explore mental health issues [P-16]
Complaint, cautions and risks	**Lack of knowledge of cultural nuances and empathy**	*Lack the human empathy and emotional support that individuals may need…AI cannot provide the level of personalized and specialized care [P-4]*
		May lack the human element that is crucial for effective therapy [P-5]
		Cultural factors and nuances may not be adequately captured or understood by AI algorithms, limiting their effectiveness for users from diverse backgrounds [P-6]
		The therapists' attitude towards the client…space that they provide, just mere presence in general…gets eliminated in the form of an AI… [P-9]
		The background, the causes, and the triggers are so diverse, coming from genetics to social issues, to current situations [P-11]
	Lack of reliability and accuracy	*AI-powered apps may provide inaccurate or misleading information, leading to incorrect self-diagnosis or inappropriate treatment recommendations [P-5]*
		AI algorithms can inherit biases present in the data they are trained on, which may lead to disparities or inaccuracies [P-6]
		Making of a diagnosis requires a lot of clinical knowledge…if AI is not able to pick up on certain things that the client is presenting…giving wrong feedback can have negative consequences..not confident about the accuracy of AI [P-9]
		They are not up to the mark…they are still amateur…so, I fully can't rely on AI [P-11]
		AI tools are not up to the mark...I wouldn't recommend fully relying on them yet [P12]
		The accuracy of these tools cannot be commented yet because it needs more use and study in the relevancy of this technology [P-14]
		I think AI-based tools are accurate to some extent, especially with proper instructions, but need practicing professionals' input [P17]
	Absence of therapeutic environment and human touch	*The absence of human interaction and understanding may hinder the therapeutic process…lack of individuation can limit the effectiveness of the support provided [P-4]*
		The therapist's body language, tone, eye contact, and just their presence in general account for a large part of whether or not therapy will be successful[P-9]
		Personally, I would not prefer AI it because certain things are observational only [P-10]
		Lack of specific and customized approaches can lead to inadequate success of the therapy [P-17]

	Risk of over-reliance and dependency	*Overreliance on AI apps may create dependency…can lead to individuals' neglecting other important aspects of their well-being [P-4]*
		We can end up having further psychological issues in humans if we are using AI a lot…one of my known person is now continuously talking with the AI on the Apple Siri.. So I see that again as a problem. [P-11]
		AI apps are designed beautifully which can attract the clients aesthetically so one can feel connected to the app…but they may not be very client friendly. It just becomes another business model [P-13]
		It is likely that use of AI tools may produce internet addiction [P-14]
	Addressing cautions and possible guidelines	*The accuracy of these tools depends on how you develop them…if you have a disclaimer then there is no danger or risk [P-7]*
		But should not be given to the patient themselves…[P-10]
		It cannot be a fixation [solution], like a fixation for not having more mental health professionals…that cannot be, can never be an alternative [P-11]
		Only if it is done ethically and keeping client in mind [P-13]
		Needs regular research and development to enhance the accuracy [P-15]
		Proper training to users can to large extent help can reduce the gap…provided AI is used properly and is monitored properly [P-16]
Hope and Hesitation	**Bridge the gap**	*AI definitely will reduce the gap and give immediate access…just to make the person feel a few positive words here and there..but that can be a temporary relief for the person [P-11]*
		Referred to who don't feel comfortable for face-to-face counselling [P-13]
		They are evolving and likely to be incredibly helpful, further down the line [P-17]
	Increased accessibility and availability	*When you have that insecurity of revealing yourself or taking a leap of faith and going for the mental health help to a human professional...it will reduce the gap…if via apps I can speak with someone… availability will reduce that gap of seeking a psychologist [P-10]*
		It can be used as a, like a catalyst where the person is reaching out for immediate help and then figures out a way to reach out to a real[human] professional [P-11]
		People can get service on time [P-14]
		Recommended to those who cannot afford fees [P-17]
	Professional concerns: Biases, Marginalization and Automation	*Rural populace will still be marginalized…can increase hopelessness in people who do not benefit [P-2]*
		If individuals solely rely on AI applications for mental health support, they may delay seeking face-to-face therapy or professional help when it is needed [P-4]
		Another thing is, people should not get the impression that this is the only one [P-7]

	of therapeutic processes	*It will only reach people willing to engage with it and is not applicable for people all demographics and backgrounds[P-8]*
		This generation is very, very different…if you give them a machine or the robot and if that is helping them even for a bit, they'll be happy to go with them… probably the human mental health professionals may have to be prepared for [P-11]
		With little knowledge and training, AI based tools can be error prone [P-16]
	Client level concerns: Privacy, Data-Security and Confidence	*Potential algorithmic bias, privacy concerns might hinder personalized care [P-3]*
		AI algorithms can inherit biases present in the data they are trained on, which may lead to disparities or inaccuracies in the assessment and recommendations [P-6]
		Issues related to data breaches, privacy, and confidentiality are always there. Since most of the data is on the cloud, safety is an issue here [P-7]
		Breach of ethical standards and safety of client's data can be a risk… access of AI apps to client who actually needs immediate medical attention could be a problem...consistency of the sessions may get reduced [P-13]
		Accuracy of understanding of instructions and activity is in doubt that may produce negative result of treatment than positive [P-14]

DISCUSSION

This study offers an insightful look into how psychologists in India and Nepal perceive and engage with Artificial Intelligence (AI) in mental health practice. With AI-based tools becoming more embedded in clinical and institutional workflows, the findings reveal a careful balancing act: psychologists acknowledge the operational advantages of AI, especially in reducing administrative burdens, but remain cautious when it comes to more interpretive or relational uses. These views echo prior research, such as Zhang et al. [3], where AI was welcomed as an assistive tool but viewed with hesitation when proposed as a clinical decisionmaker. Participants in this study largely saw AI as helpful in saving time, improving efficiency, and supporting routine processes like appointment management and client follow-ups, confirming similar conclusions in Rollwage et al. [7] and David et al. [31]. Still, the value of AI was perceived in how it supports human effort, not in its potential to replace it.

The first major theme, Current Utilization, shows AI being used primarily for basic, structured, and often clerical purposes. Participants described how AI assists with administrative tasks and serves as a reference point during scoring or preliminary assessment, particularly when used in conjunction with formal diagnostic systems. This mirrors prior findings from Jiang et al. [32] and Sadeh-Sharvit et al. [6], who noted AI's growing role in early detection and behavioral monitoring. However, psychologists were also quick to point out the limits of such systems, especially in handling complex, comorbid, or culturally nuanced cases. Most of them emphasized that AI-generated insights, though sometimes accurate, cannot substitute professional judgment. This aligns with Maslej et al. [9], who found a strong preference for human-led decisions in ambiguous diagnostic scenarios. In short, AI was perceived as useful, but only when closely guided by clinical expertise.

In contrast, the second theme, Complaints, Cautions, and Risks, highlighted strong concerns about AI's ability to engage in therapeutic relationships or respond meaningfully to emotional nuances. Many participants described the absence of non-verbal sensitivity in AI systems, such as failure to recognize tone, posture, or eye contact, as a key reason why AI cannot be trusted in deeper clinical roles. Gabbard and Crisp-Han [8] have similarly argued that empathy, attunement, and embodied presence are foundational to effective therapy. Beyond emotional limits, psychologists were also worried about potential over-reliance. They noted how clients might develop dependency on AI tools, even interacting

compulsively with chatbots, creating a false sense of therapeutic progress. This risk of relational displacement is consistent with Sadeh-Sharvit et al. [6], who warn of AI systems acting as inadequate relational substitutes. Ethical concerns, including data privacy and algorithmic opacity, were also central. Many participants expressed discomfort about how client information is stored or shared, particularly given the lack of regulation in some regions. These fears echo those in Malik et al. [16] and Fiske et al. [10], where the ethical infrastructure around AI remains patchy or insufficiently transparent. The theme highlights how much importance the Psychologists give to the core therapeutic qualities of a professional required for successful therapy and how they feel that AI-based tools lack these. The participants were also concerned about the misleading information that AI tools might provide and the harm they may cause.

In the third theme, hope and hesitation, participants perceived AI as having the ability to bridge gaps in access, especially for individuals who are reluctant to seek traditional therapy. The anonymity, constant availability, and digital accessibility of AI-based tools were seen as valuable starting points, particularly for people in distress who might not yet be ready to engage in human therapy. This is consistent with findings from Bucci et al. [14] and Wasil et al. [15], who noted that AI can act as a catalyst for initial help-seeking. However, these benefits were viewed as temporary or supplementary. Participants in the present study also raised concerns about the digital divide, literacy barriers, and unequal infrastructure, particularly in less urbanised areas. These limitations, noted by Robotham et al. [13], suggest that AI might inadvertently exclude the very populations it aims to support. Several also warned that AI might oversimplify complex clinical processes or deskill human practitioners if implemented without nuance, echoing concerns from Terra et al. [33] and Joseph and Babu [18].

Within this limited sample, participants from Nepal frequently raised infrastructure and connectivity issues. Indian participants frequently discussed cultural sensitivity, ethical safeguards and issues of overreliance and dependency. An interesting finding related to the demographic information of the participants was the adoption of AI-based tools by them. It was observed in this limited dataset that psychologists working in public sector, i.e., the hospital settings were more open to the use of AI-based tools in mental health care as compared to those working in private set ups. Another important finding was the limited knowledge of the participants regarding the AI-based tools in mental health care. This finding indicates a potential gap in awareness and suggests a need for professional training and workshops in this area. Structured training and workshops might help psychologists develop knowledge and skills to appropriately integrate AI-based tools into their own professional practice and into client care as and when needed.

The study reveals a profession that is cautiously optimistic yet ethically alert. Psychologists appear ready to engage with AI where it enhances procedural efficiency and access, but remain guarded about its application in emotionally complex or culturally sensitive scenarios. AI, at this stage, is seen as a support system, not a substitute, for human clinical work. Psychologists in this study have acknowledged that AI-based tools have potential but also emphasize the need for rigorous standards, enhanced training, and human oversight to ensure that the tools are ethically sound and clinically useful. Future directions must include participatory design with both practitioners and clients, greater regulatory clarity, and long-term studies examining not just outcomes but relational quality, cultural fit, and practitioner identity.

LIMITATIONS

Despite taking care to eliminate room for subjectivity, this study being a qualitative one, is subjected to constraints and limitations of methodology and analysis. Only Psychologists were recruited in the present study. Including Psychiatrists and other mental health professionals could have helped in gaining broader perspective as well as in comparing the perspectives of different professionals on the same area. Though caution was taken to cover all the regions of India and include psychologists with a variety of experience, level of education and interests the purposive sampling used in the present study could have limited the participant pool. The sample size of Psychologists from Nepal was very small which in turn affects the generalizability of results. Another limitation is the unequal representation of Psychologists from India and Nepal. Regarding method limitations, the interview modes were heterogenous and the participants differed in their actual exposure to AI-based tools. Despite the limitations, this study may be considered as a stepping stone in identifying the views and perceptions of Psychologists from India and Nepal towards the probable use and current utilization of AI-based tools in mental health care.

CONCLUSION

This study elucidates the layered and often ambivalent orientations of psychologists toward the use of AI in mental health care. While AI-based tools are acknowledged by psychologists for their operational and diagnostic utility, the views on limitations in empathy, contextual interpretation, and cultural nuance restrain their therapeutic applicability. Psychologists in the study think that the AI-based tools should be integrated in mental health care system under supervision rather than as an autonomic replacement of a professional. Their views echo the stress on privacy, cultural adaptation, professional accountability and human oversight. These views also warn against unmonitored implementation that might create public health concern. Training and capacity building programmes might help psychologists in increasing awareness about AI-based tools, use them appropriately and integrate them in professional practice and client care when required.

ETHICAL CONSIDERATION

The current study was approved by the Department Ethics Committee, Department of Psychology, Hislop College, Nagpur (Ref: Hislop/DEC/Psy/2023/A003, 14/09/2023). Informed consent was obtained from all the participants.

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CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest.

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