

Artificial Intelligence in Psychotherapy: experiences of Aftercare Programme Clients

Kristýna Hellerová, David Urban, Jana Hamhalterová

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Abstract

AI tools are increasingly present in mental health and addiction aftercare, yet little is known about clients' perspectives in these settings. This qualitative study examines how adults in Czech aftercare programmes experience AI-supported tools across emotional, cognitive, and ethical dimensions. Using reflexive thematic analysis (Braun and Clarke) of transcribed semi-structured interviews with five clients in post-treatment recovery, the analysis identified themes of emotional support, cognitive structuring, and ambivalence regarding trust, relational authenticity, and data privacy. The findings suggest that AI can complement psychosocial care by supporting self-reflection and between-session preparation, while remaining clearly distinct from the therapeutic alliance. Implications include guidance for hybrid models in social work and addiction services, emphasising digital literacy, informed use, and clinician oversight within ethically governed frameworks.

Keywords: artificial intelligence, psychotherapy, mental health, aftercare, qualitative research, addiction recovery, client experience, ethical aspects

Introduction

AI-Assisted CBT and Ethical Perspectives in a Czech Context: CBT and AI Therapeutic Mechanisms

Digital mental health apps have shown small but significant effects on symptoms of depression and anxiety. According to a recent meta-analysis of 176 randomised controlled trials, their effectiveness increases when the apps incorporate cognitive-behavioural therapy (CBT) features, mood-monitoring functions, or chatbot technology. These characteristics were associated with larger effect sizes compared to apps without such components.¹

A randomised controlled trial demonstrated that a fully automated conversational agent based on cognitive-behavioural principles was able to reduce depressive symptoms among university

¹ Jake Linardon et al., 'Current Evidence on the Efficacy of Mental Health Smartphone Apps for Symptoms of Depression and Anxiety: A Meta-Analysis of 176 Randomized Controlled Trials', *World Psychiatry* 23, no. 1 (2024): 139–149, <https://doi.org/10.1002/wps.21183>.

students over a two-week intervention.² Evidence from a randomised controlled trial shows that a culturally adapted AI chatbot grounded in cognitive-behavioural principles can significantly decrease depressive symptoms and loneliness among Chinese university students over a brief, seven-day intervention.³ Qualitative findings indicate that users often experienced generative AI chatbot conversations as an ‘emotional sanctuary’, offering insights into issues such as trauma and relationships, while also expressing a desire for improvements including stronger safety guardrails and more consistent memory.⁴ Findings from mediation analyses in digital cognitive-behavioural interventions indicate that improvements in pain self-efficacy and reductions in pain-related disability may function as key mechanisms through which these programmes alleviate depressive symptoms.⁵

Ethical and Critical Frameworks

Catholic social teaching and recent Vatican initiatives emphasise that artificial intelligence must respect human dignity and uphold relational values. The Rome Call for AI Ethics affirms that all people possess equal dignity and that AI should serve and protect human beings rather than expose them to harm. It further stresses that AI should be developed in ways that promote human well-being, prevent discrimination and unjust harm, and support the inclusion and protection of those who are most vulnerable.⁶ The Vatican City State’s AI Guidelines likewise emphasised that technology must place people at the centre. They state that artificial intelligence can never replace humans and must respect human autonomy, and that its use should remain transparent, non-discriminatory and consistently subject to human decision-making.⁷

Crucially, Christian anthropology underscores relationality: human beings are, by their very nature, ordered to interpersonal communion, and human intelligence is exercised in relationships, finding its fullest expression in dialogue, collaboration, and in love and service to others.⁸ The recent Curial document *Antiqua et nova* stresses that human intelligence attains its fullest expression in relationships marked by dialogue, collaboration and solidarity, rather than in isolation. In light of this relational anthropology, AI tools used in therapeutic contexts should strengthen authentic human connection, fostering social support and compassion rather than detachment. Taken together, current Catholic ethical frameworks call for AI-assisted therapeutic tools to respect human dignity and rights, avoid bias or exploitation, and support the human vocation to community and love.⁹

2 Kathleen K. Fitzpatrick, Alison Darcy, and Molly Vierhile, ‘Delivering Cognitive Behavior Therapy to Young Adults With Symptoms of Depression and Anxiety Using a Fully Automated Conversational Agent (Woebot): A Randomized Controlled Trial’, *JMIR Mental Health* 4, no. 2 (2017): e19, <https://doi.org/10.2196/mental.7785>.

3 Yining Wang et al., ‘Effect of a Cognitive Behavioral Therapy-Based Artificial Intelligence Chatbot on Depression and Loneliness Among Chinese University Students: Randomized Controlled Trial With Financial Stress Moderation’, *JMIR mHealth and uHealth* 13 (2025): e63806, <https://doi.org/10.2196/63806>.

4 Steve Siddals, John Torous, and Astrid Coxon, ‘It Happened to Be the Perfect Thing’: Experiences of Generative AI Chatbots for Mental Health’, *NPJ Mental Health Research* 3, no. 1 (2024): Article 48, <https://doi.org/10.1038/s44184-024-00097-4>.

5 Arne G. Lutsch et al., ‘Mechanisms of Change in Digital Cognitive Behavioral Therapy for Depression in Patients With Chronic Back Pain: A Mediation Analysis of a Multicenter Randomized Clinical Trial’, *Behaviour Research and Therapy* 168 (2023): 104369, <https://doi.org/10.1016/j.brat.2023.104369>.

6 Pontifical Academy for Life, *Rome Call for AI Ethics*, Rome, 28 February 2020.

7 Pontifical Commission for Vatican City State, *The Principles behind the Guidelines on Artificial Intelligence*, (Vatican City State, 16 January 2025).

8 Dicastery for the Doctrine of the Faith, *Antiqua et nova: Note on the Relationship Between Artificial Intelligence and Human Intelligence*, (Vatican City, 28 January 2025).

9 Pontifical Academy for Life, *Rome Call for AI Ethics* (Vatican City: Pontifical Academy for Life, 2020); Pontifical Commission of Vatican City State, *The Principles behind the Guidelines on Artificial Intelligence* (Vatican City State, 2025); Congregation for the Doctrine of

Czech Research

In the Czech Republic, mental-health care is increasingly addressing the development of community-based and multidisciplinary models, yet substantial systemic gaps persist. The National Mental Health Action Plan 2020–2030 emphasises the expansion of integrated community mental-health services alongside efforts to reduce the dominance of inpatient and subsequent-care institutions.¹⁰ However, experts indicate that continuity of care remains weak in practice. A qualitative study on post-accident psychological support found that follow-up services are unevenly distributed and fragmented: affected individuals often encounter long waiting times or financial barriers to accessing therapy, and many are not captured by the aftercare system at all. The authors conclude that there is ‘no simple and well-connected system’ securing continuity between immediate crisis response and longer-term psychological support.¹¹ Moreover, Czech stakeholders point to the lack of systematic data collection, and the national reform documents themselves call for stronger monitoring mechanisms and evidence-based evaluation.¹² On the whole, current practice continues to show significant deficits in the integration of aftercare, with many individuals remaining outside the follow-up system. At the same time, empirical research on digital CBT or AI-supported mental-health interventions is still largely absent in the Czech context.¹³

Research Questions

In light of the limited empirical research on AI use in Czech addiction aftercare contexts, the present study was guided by the following research questions:

1. How do clients in addiction aftercare describe their use of AI tools in everyday and therapeutic contexts?
2. How do clients make sense of the emotional and cognitive functions of AI in their recovery process?
3. How do clients describe the role of AI in relation to the therapeutic relationship and professional support?
4. What concerns or ethical reflections (e.g., trust, authenticity, data privacy) emerge in their accounts?

Methodology

This study employed a qualitative design grounded in reflexive thematic analysis, as articulated by Braun and Clarke.¹⁴ Reflexive thematic analysis is an interpretative approach suited to exploring how participants make sense of their experiences and to generating meaning-based patterns across qualitative data. The aim of the study was not to assess prevalence or effectiveness, but to examine how clients in addiction aftercare programmes understand, experience, and articulate

the Faith, *Antiqua et nova: Note on the Relationship Between Artificial Intelligence and Human Intelligence* (Vatican City, 2025).

10 Ministerstvo zdravotnictví České republiky, *Národní akční plán pro duševní zdraví 2020–2030: Příloha č. 2 – Analytická část* (Praha: Ministerstvo zdravotnictví, 2020).

11 David Červinka et al., ‘Comprehensive System of Post-Accident Care in the Czech Republic – A Qualitative Study’, in *Proceedings of the 14th International Conference on Applied Human Factors and Ergonomics (AHFE 2023)* (AHFE International, 2023), 194, <https://doi.org/10.54941/ahfe1003805>.

12 Ministerstvo zdravotnictví ČR, see note 10.

13 Červinka et al., *Comprehensive System...*, see note 11.

14 Virginia Braun and Victoria Clarke, ‘Toward good practice in thematic analysis: Avoiding common problems and becoming a knowing researcher’, *International Journal of Transgender Health* 24, č. 1 (2023): 1, <https://doi.org/10.1080/26895269.2022.2129597>.

their use of artificial intelligence (AI) tools, with particular attention to emotional, cognitive, and ethical dimensions.

Data were generated through semi-structured interviews conducted as part of routine aftercare activities. Clients were approached by an aftercare practitioner and invited to participate voluntarily in the study. Interviews invited participants to reflect on their experiences with AI tools, including perceived benefits, concerns, and the relationship between AI use and their therapeutic process. Interviews were transcribed into a text format for analysis, producing concise, experience-focused accounts situated within the practical realities of aftercare settings. The AI tools discussed by participants primarily included large language model-based conversational systems, most notably ChatGPT, as well as various mobile chatbot applications used for emotional support, reflection, or thought organisation. Participants referred to these tools in general terms, reflecting everyday, self-initiated use rather than systematic or clinically guided digital interventions.

The sample consisted of five adult clients (three women and two men) aged 28–53 years, all of whom had completed primary addiction treatment and were engaged in aftercare following alcohol or methamphetamine dependence. The limited sample size reflects the exploratory and context-specific nature of the study, as well as the voluntary character of participation; additional clients declined to take part.

In line with reflexive thematic analysis, the study does not aim at statistical generalisation. Instead, the sample was considered analytically sufficient for developing an interpretative understanding of recurring patterns of meaning within this specific context. During analysis, attention was paid to the demographic and experiential context of participants, including age range and type of substance dependence, as factors that may shape familiarity with digital technologies, trust in AI systems, and patterns of use. These variables functioned as analytically sensitising contexts rather than as bases for formal comparison.

All participants provided written informed consent prior to participation. Participants were informed about the aims of the study, the voluntary nature of their involvement, and their right to withdraw at any time without consequences for their care. All data were anonymised prior to analysis, securely stored, and used solely for research purposes.

Data analysis followed the six phases of reflexive thematic analysis described by Braun and Clarke:

- (1) familiarisation with the data;
- (2) generation of initial codes;
- (3) construction of candidate themes;
- (4) review and refinement of themes;
- (5) definition and naming of themes;
- (6) production of the analytic narrative.

Coding was conducted inductively and at a semantic level, focusing on participants' explicit accounts while remaining attentive to emotional and relational meanings embedded in the data. Themes were not treated as entities that 'emerged' from the data, but were actively generated through iterative and reflexive engagement with the written material. Reflexive memos were maintained throughout the analytic process to support transparency and theoretical sensitivity. Interpretative credibility was supported through ongoing analytic discussions with a co-author who works directly with the client group in the aftercare setting. These discussions served to contextualise interpretations and challenge premature conclusions, rather than to verify a single correct or objective reading.

Characteristics of AI Use Among Participants

Participants reported heterogeneous patterns of AI use. Two participants explicitly referred to ChatGPT as the primary tool they used, with one describing near-daily use. Another participant reported using AI tools more generally (e.g., chatbots, translation tools, or search-based systems) without identifying specific platforms. The remaining participants referred to AI in broader terms (e.g., ‘AI tools’ or ‘technology’), and one participant reported no prior use of AI tools at all.

Frequency of use varied considerably across participants. One participant described near-daily use of AI tools. Others reported occasional or situational use, including one-time use to solve a specific practical issue or exploratory use motivated by curiosity. In one case, AI was used during a period of acute emotional distress following the death of a close person. Some participants described recurrent but unspecified use when seeking clearer answers or structured responses.

With regard to purpose, participants described using AI for:

- emotional articulation and crisis coping,
- cognitive structuring of thoughts,
- preparation for therapy sessions,
- practical information-seeking (e.g., recipes, legal information, everyday administrative matters).

The study did not systematically collect longitudinal usage metrics (e.g., duration of use in months or years). Participants referred primarily to current or recent patterns of use and to specific past situations in which AI was employed. As such, the analysis focuses on participants’ meaning-making rather than behavioural quantification of AI engagement.

Results

Of the five participants included in the study, four reported personal experience with AI tools (P2–P5), while one participant (P1) stated that she had never used AI. The thematic analysis therefore draws primarily on the accounts of these four AI users, while also considering the absence of experience as analytically relevant in understanding the boundaries of AI engagement in aftercare contexts.

The sample comprised three women and two men aged 28–53 years, all enrolled in Czech addiction aftercare programmes following treatment for alcohol or methamphetamine dependence. Their duration in aftercare ranged from two to seven months. Basic anonymised characteristics are provided below:

Participant	Gender	Age	Substance	Aftercare Duration
P1	Female	37	Alcohol	2 months
P2	Female	53	Alcohol	5 months
P3	Male	35	Methamphetamine	7 months
P4	Female	28	Alcohol	4 months
P5	Male	42	Alcohol	6 months

Participants’ experiences were captured through semi-structured interviews that were subsequently transcribed into text for analysis, producing concise, experience-focused interview accounts describing perceived benefits, perceived risks, and the ways AI tools were understood

and positioned in relation to participants' therapeutic process. In accordance with the principles of reflexive thematic analysis, the Results are presented as an interpretative account of meaning patterns across the interview material, rather than as a summary of individual responses or their frequency. The analysis does not aim to establish prevalence, causality, or effectiveness, but focuses on how participants made sense of AI use within the specific context of addiction aftercare. The thematic analysis identified five interrelated thematic areas, which reflect recurring meaning orientations across the interview transcripts:

- (1) AI as emotional support,
- (2) AI as a cognitive structuring aid,
- (3) trust and mistrust in AI,
- (4) the perceived influence on the therapeutic relationship,
- (5) awareness of data vulnerability.

These themes should not be understood as discrete or isolated categories, but as analytically connected aspects of participants' meaning-making, which frequently overlapped and informed one another within interview accounts. Rather than 'emerging' from the data, the themes were constructed through reflexive engagement with the transcribed interview material, with attention to how participants linked emotional, cognitive, and ethical considerations when describing their experiences with AI tools

AI as Emotional Support

Emotional support emerged as a salient but not universally shared theme, articulated primarily by two participants (P3 and P5). Other participants did not describe AI as emotionally meaningful to the same extent, framing it rather as a practical or informational tool. Emotional reliance on AI therefore represents a specific experiential pattern within this sample rather than a dominant cross-case tendency.

In contrast, P5 positioned AI as a crisis-management tool rather than a general source of emotional reassurance. She described using AI during a period of bereavement: *'I wasn't sure what I was feeling, but writing it to the bot helped me realise it.'* (P5) P5 further explained that AI provided step-by-step support that helped her regulate emotions and avoid relapse into alcohol use. In her account, AI facilitated emotional awareness through articulation and structured reflection rather than through reciprocal emotional understanding.

Notably, P4 explicitly rejected the idea that AI could provide genuine emotional support, emphasising that empathy and relational attunement are inherently human qualities. This contrast further underscores that emotional engagement with AI was present but not evenly distributed across participants.

AI as a Cognitive Structuring Aid

The cognitive structuring function of AI was the most consistently described theme across AI users (P2–P5), although with varying intensity and depth. Participants described using AI to clarify thoughts, formulate questions, or prepare for therapeutic encounters. For P2, this function was primarily practical: *'It helped me with clearly formulated answers to my questions.'* (P2) P4—despite her broader scepticism toward AI—reported using it once to assist with practical administrative steps, illustrating that even limited users

engaged with AI as a structuring tool in concrete situations. For P3 and P5, cognitive structuring extended into the therapeutic domain. P5 described using AI prior to therapy sessions: *'Before going to an individual session, I was able to partly work through things with the help of AI and then discuss more of them face to face'*. (P5) P3 indicated that some topics felt sufficiently processed through AI interaction and therefore required less discussion in therapy. Taken together, cognitive support represents the most widely shared and stable function of AI within this sample, spanning both practical and therapeutic contexts.

Trust and Mistrust in AI

Trust in AI tools emerged as a polarised theme within the dataset. While one participant (P4) expressed explicit mistrust and strong concerns regarding data misuse, the remaining AI users (P2, P3, and P5) adopted more pragmatic or indifferent stances toward potential risks. This division suggests that privacy awareness was not evenly distributed across participants but clustered around a single strongly sceptical case. In some interview accounts, trust was framed pragmatically, with limited reflection on potential risks and a primary focus on immediate usefulness: *'I never thought about risks. It helped, and that's what mattered'*. (P2)

P2's account reflects a pragmatic orientation in which usefulness outweighed consideration of data security.

In contrast, P4 articulated explicit scepticism and concern about data handling: *'I don't really believe it. I'm afraid the data could be misused'*. (P4) Here, mistrust was closely linked to uncertainty about data governance and a reluctance to disclose personal or sensitive information.

P5 acknowledged that data misuse was theoretically possible but did not experience significant fear or hesitation when interacting with AI, illustrating a position between explicit concern and active indifference.

Taken together, trust in AI was not described as a stable or uniform attitude but as context-dependent and shaped by individual perceptions of risk and personal comfort with technology.

Influence on the Therapeutic Relationship

The perceived influence of AI on the therapeutic relationship was differentiated rather than uniform across participants. None of the AI users described AI as a full replacement for therapy; however, the degree of complementarity varied.

For most participants (P2, P4, and P5), AI was framed as a preparatory or supplementary tool rather than a substitute for professional care. P5 described using AI to clarify themes prior to sessions *'I used it to clarify things I later discussed with my therapist'*. (P5) In his account, AI and the therapist functioned as complementary dialogical partners, whose perspectives he compared and integrated.

P3 represented the most substitution-oriented stance. He suggested that in certain cases AI interaction reduced the perceived need to process specific issues during therapy sessions: *'I didn't really need therapy'*. (P3) This statement indicates a momentary functional substitution of selected topics rather than a rejection of therapy as such.

In contrast, P4 explicitly rejected the idea that AI could replace the human dimension of therapy, emphasising that empathy and relational attunement cannot be substituted by technological tools. P2 similarly reported no meaningful change in her perception of therapy as a result of AI use.

Overall, AI was most commonly described as shaping how participants entered therapy sessions—helping them prioritise themes, articulate concerns, or organise thoughts—without fundamentally displacing the relational core of therapeutic work.

Awareness of Data Vulnerability

Participants demonstrated a clear divergence in their perception of privacy risks, ranging from active refusal to share personal data to a relative absence of reflection on the issue. The interview material indicates that for the majority of AI users (P2, P3, P5), privacy was not a primary concern during their interaction with AI. Both P2 and P3 explicitly stated that they had ‘never thought about’ what happens to their personal data. P5 represented a more nuanced position, noting a lack of fear regarding AI specifically while acknowledging broader internet-related risks: *‘I don’t really deal with it and I don’t feel fear that AI would specifically misuse it. But I know that there are other applications on the internet that can misuse data.’* (P5)

In contrast, the account of P4 represents a distinctly cautious orientation within the sample. Her explicit concern about data governance directly limited her engagement with the tool. She expressed a proactive refusal to share sensitive content:

‘I think about it a lot, and for that reason, I don’t use it [AI] much. I refuse to share my personal, inner information so that it doesn’t get ‘gathered’ somewhere.’ (P4)

Taken together, these accounts reveal a spectrum of digital literacy and risk perception. While most participants prioritised the immediate utility of the tool over abstract data concerns, P4’s experience demonstrates that for some individuals in aftercare, perceived lack of confidentiality may constitute a meaningful barrier to AI use.

Cross-case Synthesis of AI Use

Across participants, two distinct patterns of AI engagement can be identified. First, cognitive structuring emerged as the most consistent and widely shared function of AI use. All participants with prior experience of AI (P2–P5), including those who were otherwise sceptical, described using AI to organise thoughts, clarify questions, or prepare for practical or therapeutic situations. This suggests that cognitive support represents a stable cross-case pattern within the dataset.

In contrast, emotional engagement with AI was unevenly distributed. Only two participants (P3 and P5) described AI as emotionally meaningful, particularly in contexts of distress or personal difficulty. Other participants framed AI primarily as a practical or informational tool, and one participant (P4) explicitly rejected the possibility of emotional support from AI. Emotional use of AI therefore appears as a case-specific rather than a generalised pattern.

A similar differentiation was evident in relation to trust and data privacy. While most participants adopted a pragmatic stance focused on immediate usefulness, concerns about data misuse were concentrated in a single case (P4), where they directly limited engagement with AI. This indicates that attitudes towards trust were not uniformly distributed but clustered around individual perceptions of risk.

Taken together, the findings suggest that while certain functions of AI—particularly cognitive structuring—are shared across participants, other aspects, such as emotional reliance or trust, are shaped by individual experiences, beliefs, and situational contexts.

Discussion

The present study explored how clients in addiction aftercare experience AI tools in the context of their emotional wellbeing and therapeutic engagement. The findings are broadly consistent with international literature, which identifies both the perceived benefits and limitations of AI-based support in mental health contexts. Although the sample size was small ($n = 5$), this is aligned with the principles of reflexive thematic analysis, which prioritises depth, nuance, and richness of individual accounts over statistical generalisation or representativeness.

A recurring theme across studies is the utility of AI tools for emotional expression and regulation. In the present study, AI chatbots were described as supporting the articulation of difficult emotions, particularly in situations where interpersonal support felt limited. Similar patterns are reflected in recent research, which shows that AI-based mental-health tools can offer users a non-judgmental and private space for expressing emotions, often accompanied by supportive or validating responses.¹⁵ Qualitative research in alcohol and other drug counselling likewise suggests that AI-driven chatbots may improve accessibility and efficiency in hybrid human–AI models, but are still perceived as lacking the empathy and relational depth associated with human care.¹⁶ The findings also suggest that AI tools may facilitate reflection and cognitive organisation prior to therapy. These accounts mirror findings from recent research showing that conversational AI can support users in structuring their thoughts, clarifying emotional states and setting goals related to their mental health.¹⁷ A recent qualitative study of user reviews of the Wysa mental-health chatbot similarly found that users valued its structured, supportive conversations that fostered self-reflection, while at the same time expressing concerns about the system's reliability and data privacy.¹⁸ A key point of convergence lies in the ambivalence toward AI's capacity for relational depth. While strong trust and reliance on AI were present in individual accounts, most respondents viewed AI as a supportive tool rather than a replacement. These findings align with recent qualitative research on wearable-based digital detection systems in substance use treatment, which showed that AI-driven monitoring can increase self-awareness and support the management of stress and craving, while being used as an adjunct to, rather than a replacement for, human therapeutic care.¹⁹ The concern for trust and data privacy, also reflected in the present study, reflects broader discussions about users' comfort and perceived safety when engaging with AI tools. Survey data from India similarly show that worries about data privacy and security are among the main reasons why people remain cautious about using AI-driven mental-health applications.²⁰ Recent US survey data show that adolescents and young adults frequently turn to generative AI for emotional support and often perceive these tools as private or safe spaces, despite limited awareness of the associated risks and the lack of transparency behind AI-generated mental-health advice.²¹ These patterns are echoed in recent work on general-purpose LLM chatbots for mental health, where

15 Fahad Alanezi, 'Assessing the Effectiveness of ChatGPT in Delivering Mental Health Support: A Qualitative Study,' *Journal of Multidisciplinary Healthcare* 17 (2024): 461–471, <https://doi.org/10.2147/JMDH.S447368>.

16 Anthony Barnett et al., 'Enacting "More-Than-Human" Care: Clients' and Counsellors' Views on the Multiple Affordances of Chatbots in Alcohol and Other Drug Counselling,' *International Journal of Drug Policy* 94 (2021): 102910, <https://doi.org/10.1016/j.drugpo.2020.102910>.

17 Alanezi, *Assessing the Effectiveness...* see note 14.

18 Beenish M. Chaudhry and Happy R. Debi, 'User Perceptions and Experiences of an AI-Driven Conversational Agent for Mental Health Support,' *mHealth* 10 (2024): 22, <https://doi.org/10.21037/mhealth-23-55>.

19 Jazmin Hampton et al., 'Digital Detection of Craving and Stress for Individuals in Recovery from Substance Use Disorder: A Qualitative Study,' *Drug and Alcohol Dependence Reports* 15 (2025): 100336, <https://doi.org/10.1016/j.dadr.2025.100336>.

20 Mahima Anna Varghese et al., 'Public Perception on Artificial Intelligence–Driven Mental Health Interventions: Survey Research,' *JMIR Formative Research* 8, no. 10 (2024): e64380, <https://doi.org/10.2196/64380>.

21 Ryan McBain, K. Robert Bozick, Melissa Diliberti et al. 'Use of Generative AI for Mental Health Advice Among US Adolescents and Young Adults,' *JAMA Netw Open* 8, no. 11 (2025): e2542281, doi:10.1001/jamanetworkopen.2025.42281

users often rely on these systems for emotional support while simultaneously underestimating the security and privacy risks associated with data handling and confidentiality.²² Taken together, this body of research highlights recurring tensions between perceived emotional usefulness and limited awareness of data-related risks.²³ Evaluations of empathy-oriented conversational agents such as Wysa show that users often experience the interaction as helpful and encouraging, indicating that such tools can support emotional expression and engagement. At the same time, these findings are typically situated within controlled or app-specific contexts.²⁴ Findings from a maternal mental health study of the Wysa app showed that higher-engagement users experienced greater reductions in self-reported depressive symptoms, and that their conversations often focused on expressing concerns, seeking support, reframing thoughts, and sharing victories and gratitude. These outcomes should be interpreted in relation to specific user groups and intervention designs, rather than generalised across mental health contexts.²⁵ However, qualitative interview data with adults living with anxiety suggest that, although people recognise the potential of conversational agents in mental health care, they still want human clinicians involved to provide empathy and a sense of therapeutic safety.²⁶ Recent experimental work on multi-modal AI systems in psychological support shows that such tools can assist users' emotional well-being by offering structured feedback, reflective prompts, and real-time supportive responses that help individuals process difficult experiences and regulate distress.²⁷ This is relevant to the present study, in which AI tools were described as supporting reflective engagement within aftercare contexts. Similarly, recent qualitative work suggests that generative AI chatbots can support reflection and emotional processing, yet users continue to view them mainly as helpful supplements rather than replacements for human therapy.²⁸ However, several respondents emphasised that an AI tool cannot replace the human factor—particularly the empathy, attunement, and relational depth provided by a therapist—a concern that aligns with recent conceptual work arguing that current AI systems lack the emotional understanding and ethical judgement needed for genuine therapeutic engagement.²⁹ Previous research suggests that the use of general-purpose LLM chatbots for emotional needs may be concentrated among a small subset of highly engaged users. Some studies further indicate that comparatively high-intensity usage across modalities has been associated with self-reported indicators of emotional dependence and problematic use.³⁰ Automated systems may misinterpret context or fail to provide adequate support in crises, reinforcing the need for human oversight. Recent findings similarly show that while LLM chatbots can assist with reflection and emotional

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- 22 Zikun Liu, Wenxue Zou, and Cong Lin, 'Exploring the Influence of Privacy Concerns, AI Literacy, and Perceived Health Stigma on AI Chatbot Use in Healthcare: An Uncertainty Reduction Approach', *Patient Education and Counseling* 140 (2025): 109271. <https://doi.org/10.1016/j.pec.2025.109271>
 - 23 Jabari Kwesi et al., 'Exploring User Security and Privacy Attitudes and Concerns Toward the Use of General-Purpose LLM Chatbots for Mental Health', in *Proceedings of the 34th USENIX Security Symposium* (Seattle, WA: USENIX Association, 2025), 6007–6024.
 - 24 Becky Inkster, Shubhankar Sarda, and Vinod Subramanian, 'An Empathy-Driven, Conversational Artificial Intelligence Agent (Wysa) for Digital Mental Well-Being: Real-World Data Evaluation Mixed-Methods Study', *JMIR mHealth and uHealth* 6, no. 11 (2018): e12106, <https://doi.org/10.2196/12106>.
 - 25 Becky Inkster, Madhura Kadaba, and Vinod Subramanian, 'Understanding the Impact of an AI-Enabled Conversational Agent Mobile App on Users' Mental Health and Wellbeing with a Self-Reported Maternal Event: A Mixed Method Real-World Data mHealth Study', *Frontiers in Global Women's Health* 4 (2023): 1084302, <https://doi.org/10.3389/fgwh.2023.1084302>.
 - 26 Hyein S. Lee et al., 'Artificial Intelligence Conversational Agents in Mental Health: Patients See Potential, but Prefer Humans in the Loop', *Frontiers in Psychiatry* 15 (2024): 1505024, <https://doi.org/10.3389/fpsy.2024.1505024>
 - 27 Ninda Lutfiani et al., 'Emotional Well-Being and Psychological Support in Infertility: A Multi-Modal AI Approach', *International Journal of Cyber and IT Service Management* 5, no. 1 (2025): 81–92, <https://doi.org/10.34306/ijcitsm.v5i1.188>.
 - 28 Siddals, Torous, and Coxon, 'It Happened to Be the Perfect Thing', see note 4.
 - 29 Zhihui Zhang and Jing Wang, 'Can AI Replace Psychotherapists? Exploring the Future of Mental Health Care', *Frontiers in Psychiatry* 15 (2024): 1444382, <https://doi.org/10.3389/fpsy.2024.1444382>.
 - 30 Jason Phang et al., *Investigating Affective Use and Emotional Well-Being on ChatGPT* (OpenAI & MIT Media Lab Report, 2025).

expression, they remain insufficient when users seek empathic attunement or deeper relational support.³¹

These findings should be interpreted in light of several limitations. The sample size was small ($n = 5$) and context-specific, consisting of clients engaged in addiction aftercare within the Czech Republic. The aim of the study was not to generate generalisable claims but to provide an in-depth understanding of how AI tools are experienced in a particular therapeutic context. The patterns identified here should therefore be understood as exploratory and situated rather than representative of broader populations. At the same time, the findings highlight the role of individual differences in shaping engagement with AI, particularly in relation to digital literacy and perceptions of risk. While most participants prioritised the immediate usefulness of AI tools, one participant expressed explicit concern regarding data privacy, which directly limited her use of AI. This suggests that awareness of data-related risks may function not only as a cognitive factor but as a practical barrier to engagement. Differences in how participants evaluated trust, usefulness, and safety therefore appear to be closely linked to their broader digital understanding and personal attitudes towards technology.

Conclusions

This study highlights how clients in addiction aftercare settings interact with AI-based tools, particularly in moments of emotional need, cognitive disorganisation, or therapeutic reflection. The findings suggest that such tools are perceived as non-judgemental, accessible, and helpful in supporting self-expression, organising thoughts, and enhancing emotional regulation. While clients do not necessarily view AI as a replacement for therapy, they often use it to prepare for or process therapeutic encounters. This is consistent with broader evidence suggesting that AI can function as an auxiliary mental-health resource, especially for individuals with limited access to immediate human support. Given the exploratory character of this study and its small, context-specific sample, the following reflections should be understood as tentative considerations rather than prescriptive recommendations. The findings may encourage further exploration of how digital literacy discussions could be integrated into aftercare settings. They may also invite reflection on whether structured conversations about AI use during therapy sessions support or complicate therapeutic engagement. Concepts such as crisis-sensitive ‘red-flag’ approaches or clearer communication regarding data governance in hybrid human–AI contexts represent potential areas for future empirical and conceptual development, rather than immediate procedural implementation. Within a Christian ethical frame that foregrounds personal dignity and relational care, the findings tentatively support the view that AI may assist but should not displace the interpersonal essence of helping professions.

31 Inhwa Song, Sachin R. Pendse, Neha Kumar, and Munmun De Choudhury, ‘The Typing Cure: Experiences with Large Language Model Chatbots for Mental Health Support’, *Proceedings of the ACM on Human–Computer Interaction* 8 (2024): Article 14362, <https://doi.org/10.48550/arXiv.2401.14362>.

Contact***Kristýna Hellerová, MA***

University of South Bohemia in České Budějovice
Faculty of Theology
Department of Social Work and Caritas Studies
Kněžská 8, 370 01 České Budějovice 1, Czech Republic
hellek02@jcu.cz

Assoc. Prof. Dr. David Urban

University of South Bohemia in České Budějovice
Faculty of Theology
Department of Social Work and Caritas Studies
Kněžská 8, 370 01 České Budějovice 1, Czech Republic
durban@tf.jcu.cz

Jana Hamhalterová, MA

Prevent – Counselling Centre for Non-Substance Addictions
Novohradská 1452/1
370 01 České Budějovice, Czech Republic
hamhalterova@prevent99.cz